

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Longmont		STREET ADDRESS, CITY, STATE, ZIP CODE 2451 Pratt St Longmont, CO 80501	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on observations, record review and interviews, the facility failed to promote and maintain resident dignity for one (#1) of three residents reviewed out of three sample residents by providing care in a dignified, respectful and individualized manner.</p> <p>Specifically, the facility failed to ensure dignity was maintained for Resident #1 by emptying urine from her external catheter canister in a timely manner.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Dignity policy and procedure, dated 9/25/23, was provided by the nursing home administrator (NHA) on 9/9/24 at 4:44 p.m. It read in pertinent part,</p> <p>Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as honor and value their input.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age 78, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included cellulites (infection of the skin) of the right lower leg, post-polio syndrome (affecting persons who had polio, causing weakness, pain and fatigue), chronic pain and muscle weakness.</p> <p>The 6/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required total assistance with transfers and substantial assistance with bed mobility.</p> <p>B. Resident interview and observations</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 was interviewed on 9/9/24 at 2:00 p.m. Resident #1 said she used an external catheter at night because she had frequent urination. She said the staff did not always empty the urine from the canister in the morning when she got up. Resident #1 said she emptied it herself sometimes because it was embarrassing to have the urine sitting in her room all day and other people seeing it.</p> <p>At 2:05 p.m. the external catheter canister was in the lower drawer of Resident #1's night stand. The canister was about one-third full and the urine was visible from across the room.</p> <p>C. Resident #1's representative interview</p> <p>Resident #1's representative #1 was interviewed on 9/9/24 at 3:45 p.m. The resident's representative #1 said she visited Resident #1 several afternoons a week and the canister usually had urine in it. She said she had found Resident #1 trying to empty it herself on occasion.</p> <p>D. Record review</p> <p>The physician's order, dated 4/29/24 indicated Resident #1 was using an external catheter. The order indicated catheter care was scheduled for the night shift. The canister was scheduled to be inspected every night shift and emptied when the canister was three quarters full of urine.</p> <p>A grievance was filed by email on 8/29/24 by Resident #1's representative regarding care of the external catheter. In the email, Resident #1's representative requested that the staff empty and rinse the urine canister every morning.</p> <p>III. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed 9/9/24 at 3:45 p.m. RN #1 said the nurses emptied and rinsed the canister every morning after Resident #1 got up. She said they emptied it during the night if it was almost full.</p> <p>The director of nursing (DON) was interviewed on 9/9/24 at 4:43 p.m. The DON said she was not sure how often the external catheter canister should be emptied. The DON said she would check the policy. The DON said the user manual indicated the canister should be emptied before it reached 1,800 milliliters to prevent overflow. The DON said the staff should empty it for Resident #1 if she wanted it emptied in the morning and not leave urine sitting out in her room all day.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on record review and interviews, the facility failed to act promptly upon the grievances concerning the issues of resident care and life in the facility that were important to the resident, for one (#1) of three residents out of three sample residents.</p> <p>Specifically, the facility failed to respond timely to Resident #1's grievances regarding long call light wait times and maintain a systematic approach to ongoing resident grievances.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Grievance policy and procedure, dated 9/25/23, was provided by the nursing home administrator (NHA) on 9/9/24 at 4:44 p.m. It read in pertinent part,</p> <p>The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal.</p> <p>Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>The resident has the right to, and the facility must make prompt efforts to resolve grievances the resident may have.</p> <p>Facilitate meetings and/or conversations with residents and families who have repeated concerns to better meet their needs.</p> <p>Follow up with the resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction.</p> <p>II. Resident status</p> <p>Resident #1, age 78, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included cellulites (infection of the skin) of the right lower leg, post-polio syndrome (affecting persons who had polio, causing weakness, pain and fatigue), chronic pain and muscle weakness.</p> <p>The 6/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required total assistance from staff with transfers and substantial assistance with bed mobility.</p> <p>III. Resident and representative interviews</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 was interviewed on 9/9/24 at 2:00 p.m. Resident #1 said she usually waits 30 to 50 minutes for her call light to be answered by staff. She said she did not use her call light at shift change because it took even longer for the staff to answer the call light at that time. Resident #1 said she complained to multiple staff members about the long waits but all she was told was they were working on it.</p> <p>Resident #1's representative #1 was interviewed on 9/9/24 at 3:45 p.m. She said she had expressed concerns about long call light times to staff but it had not improved. She said she visited the facility on 9/8/24 and Resident #1 waited 48 minutes for her call light to be answered for assistance in the bathroom.</p> <p>IV. Record review</p> <p>A grievance was filed on 8/29/24 by Resident #1's representative that stated Resident #1 had not been provided with a resident handbook and the grievance process was not explained to the resident. The resident's representative requested that a resident handbook be provided so she could understand the process for filing a formal grievance if necessary.</p> <p>Resident council minutes, dated 6/26/24, revealed a couple of residents in attendance who lived on different floors expressed concerns regarding long call light wait times of 45 minutes to get care assistance. The facility responded that they would continue to conduct call light audits for response times.</p> <p>V. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 9/9/24 at 2:15 p.m. The DON said she had reviewed several complaints from the residents at the June 2024 resident council meeting. She said to address the complaints she talked to the nursing staff and none of the staff had any concerns about not being able to answer call lights timely. She said all of the staff believed that they were answering call lights timely.</p> <p>The DON said after talking with the staff, she and one of the receptionists conducted a few observations on 6/27/24 of the nursing staff answering call lights and found they were answering call lights within six minutes of a resident activating the call lights. The DON said she was unable to find any concerns.</p> <p>-The facility had not assessed any other factors of what was causing longer call light wait times, and no resident interviews were completed to assess how many residents had concerns over long call light wait time; how long call light wait time affected the resident population; or why the problem of long call light wait time existed.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (#1) of three residents reviewed out of three sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Arrange medical appointments with a dermatologist and urologist as requested by Resident #1 and ordered by the physician; and, -Arrange for a medical appointment with an infectious disease specialist for Resident #1 in a timely manner. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Transportation Coordination and Services policy and procedure, dated 6/12/24, was provided by the nursing home administrator (NHA) on 9/9/24 at 4:44 p.m. It read in pertinent part,</p> <p>The facility will assist residents in making necessary appointments for services not provided in the facility and arranging for transportation to and from such appointments.</p> <p>The facility will assist the resident and or resident representative in the making of necessary appointments, such as but not limited to, medical specialists (e.g., orthopedics, cardiology, neurology, surgical).</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age 78, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included cellulitis (infection of the skin) of the right lower leg, post-polio syndrome (affecting persons who had polio, causing weakness, pain and fatigue), chronic pain and muscle weakness.</p> <p>The 6/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required total assistance from staff with transfers and substantial assistance with bed mobility.</p> <p>B. Resident and representative interviews</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 was interviewed on 9/9/24 at 2:00 p.m. Resident #1 said she had been waiting for an appointment with a dermatologist because of a rash on her back. She said she was also waiting for an appointment with a urologist. She said urine just poured out of her and that was why she used the external catheter at night.</p> <p>Resident #1's representative #2 was interviewed 9/9/24 at 3:15 p.m. The representative said that he had to call Resident #1's primary physician to request a referral to an infectious disease specialist for her chronic cellulitis, because the facility was not getting the appointment made. The representative said Resident #1 did have an appointment scheduled on 9/17/24. The representative said Resident #1 was still waiting for an appointment with urology and dermatology specialists.</p> <p>Resident #1's representative #1 was interviewed on 9/9/24 at 3:45 p.m. She said the family requested an appointment with the infectious disease doctor on 2/1/24. She said the representative had to call the primary care provider himself for a referral because the facility had not taken action.</p> <p>B. Record review</p> <p>The May 2024 CPO revealed the following physician's orders:</p> <ul style="list-style-type: none"> -Referrals to urology, dermatology and infectious disease, ordered on 5/2/24; and, -Referral to infectious disease, ordered on 8/16/24. <p>-However, a review of the resident's EMR did not reveal documentation indicating the appointments had been made.</p> <p>-Review of the May 2024 medication administration record (MAR) indicated a nurse had signed off that the referral had been completed.</p> <p>III. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 9/9/24 at 4:43 p.m. The DON said the unit managers received the referrals for specialists appointments and put the order into the EMR. She said the unit managers sent the referrals to the transportation manager and the transportation manager scheduled the appointments. The DON said if an order was written in May 2024, she would expect the appointments to have been made by now. The DON said the unit manager was not aware of the referrals for Resident #1. The DON said she did not attend the care conference meetings and had not met with the family of Resident #1, therefore she was not aware of the requests. The DON said she was working on scheduling the appointments today (9/9/24).</p>