

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/16/2024
NAME OF PROVIDER OR SUPPLIER  Hillcrest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  360 Canyon Ridge Dr Wray, CO 80758	
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>41172</p> <p>Based on observations, record review and interviews, the facility failed to address and/or act promptly upon the grievances and recommendations during resident council on issues of resident care and quality of life in the facility that were important to the residents.</p> <p>Specifically, the facility failed to ensure resident council grievances were addressed to resolve resident concerns related to residents being left in the dining room for up to an hour after meals, lack of staff in the dining room, inappropriate staff conversations, rude staff members and call light response times.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Resident and Family Grievance policy, dated 4/23/23, was received from the nursing home administrator (NHA) on 7/16/24 at 2:00 p.m. The policy documented in pertinent part,</p> <p>Grievances may be voiced in the following forums: Verbal complaint during resident council meetings. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgment of complaint grievances and actively working toward a resolution of that complaint grievance.</p> <p>In accordance with the residents' right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include, at a minimum, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.</p> <p>II. Resident interview</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065316
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #4 was interviewed on 7/16/24 at 9:27 a.m. Resident #4 said she attended the resident council meetings each month. Resident #4 said concerns brought up in the resident council meeting were not addressed by the facility. She said she had not received any follow up on the concerns raised. Resident #4 said concerns were brought up in resident council about residents who were left in the dining room for up to an hour after meals, no nursing staff in the dining room, inappropriate staff conversations, rude staff members and call light response times.</p> <p>Resident #4 said staff came in to answer call lights but they turned off the light and said they would be back without ever returning. She said staff were on their cell phones in the dining room, and did not speak to the residents. Resident #4 said when a resident requested something off the alternate menu because they did not want what was being served she could hear the staff complaining, and that made the resident's feel like they were an imposition.</p> <p>Resident #4 said some of the resident's who were left for periods of an hour after meals were long time friends of hers and this made her feel sad. She said the NHA said he would have a manager on duty in the dining room to help but this did not consistently happen. She said the same issues came up every month in resident council meetings without resolution or follow up communication from the facility.</p> <p>III. Resident council minutes and grievances</p> <p>On 7/15/24 at 1130 a.m. the NHA provided the resident council minutes for April 2024, June 2024 and July 2024. The NHA said there was no May 2024 resident council meeting due to inclement weather.</p> <p>The resident council minutes identified the residents had concerns regarding residents being left in the dining room for up to an hour after meals, inappropriate staff conversations, rude staff members and call light response times.</p> <p>-The concerns remained unresolved. The minutes did not identify how the facility was addressing the unresolved concerns.</p> <p>The April 2024 resident council minutes documented, under the old business section, residents reported that other residents needed help out of the dining room after meals. This was still occurring and was a confusing mess. Residents reported nursing staff were not prominent in the dining rooms and now it was worse than ever. Residents reported staff would answer call lights and say they would be back but they never came back to assist residents.</p> <p>The new business section of the April 2024 resident council minutes documented the staff were impatient and the residents could hear the staff talking about other residents in the hallways. The residents said the conversations between staff in the dining room were inappropriate. There was no further information documented in the minutes regarding the resident's concerns.</p> <p>Grievances related to the April 2024 resident council concerns were received from the NHA on 7/16/24 at 10:30 a.m.</p> <p>On 4/9/24 a grievance from the resident council documented the residents were concerned with the amount of time residents who needed assistance were in the dining room after meals. The grievance documented the residents called the situation a confusing mess.</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 - Some</p>	<p>The director of nursing (DON) responded and documented there was at least one certified nurse aide (CNA), nurse or support staff assisting residents out of the dining room consistently.</p> <p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>On 4/9/24 a grievance documented there were no prominent nursing staff in the dining room and it was worse than ever before.</p> <p>The DON documented she interviewed the staff and they said they were in the dining room. She interviewed a resident who said it was hard to spot any staff in the evening.</p> <p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>On 4/9/24 a grievance from the resident council said they could still hear the staff talking about other residents in the hallways.</p> <p>The DON's response was that the staff had been asked to speak quietly.</p> <p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>The June 2024 resident council meeting minutes documented the residents who needed assistance out of the dining rooms were still having to wait a significant amount of time and that nursing staff were not prominent in the dining rooms. The minutes documented the issue with not returning after a call light was answered and turned off continued. The resident reported conversations in the hallways seemed better but not in the dining rooms. The residents reported nursing staff conversed with themselves in the dining room and not the residents. The residents said the nursing staff made rude gestures and body language while caring for them.</p> <p>Grievances related to the June 2024 resident council concerns were received from the NHA on 7/16/24 at 10:30 a.m.</p> <p>On 6/10/24 a grievance form from resident council documented the residents were concerned with rude body language and gestures from staff during resident care.</p> <p>The DON documented this concern would be reviewed at the nursing meeting in July 2024 but she did not know what the rude body language or gestures were.</p> <p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>On 6/10/24 a grievance form from resident council documented the residents were concerned with conversations between nursing staff and dietary staff.</p> <p>The DON documented the dining room staff yelled out curse words in front of residents. She documented she would discuss the concern at the next nursing meeting.</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 - Some</p>	<p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>On 6/10/24 a grievance form from resident council documented the residents were concerned with residents who needed assistance out of the dining room being left for extended periods of time. The grievance documented the concern had been reported in every resident council for a year, since 6/13/23.</p> <p>The DON documented she would be tracking and verifying the concern.</p> <p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>On 6/10/24 a grievance form from the resident council documented the residents were concerned with getting help timely from nursing staff. There was no further information documented regarding specific details of the concern.</p> <p>The DON documented she did not know what timely meant and she would discuss the concern at the next nursing meeting.</p> <p>-There was no documentation on the grievance form of a plan to assess, audit, monitor or take any further action regarding the grievance.</p> <p>The July 2024 resident council minutes again documented the issue with residents being assisted out of the dining room after meals was still a problem. Additionally, the residents said staff still did not converse with them in the dining room and only spoke with each other and the call lights were still being turned off without staff returning to assist the residents.</p> <p>-There were no grievances documented for the July 2024 resident council meeting.</p> <p>IV. Staff interviews</p> <p>A frequent visitor (FV) was interviewed on 7/15/24 at 2:10 p.m. The FV said she attended most of the resident council meetings for the facility. The FV said the residents had brought up the same concerns since June 2023 without any resolution from the facility.</p> <p>The FV said concerns were related to residents being left in the dining room for up to an hour after meals, staff talking to each other during meals about what they did on the weekend and who they slept with. She said complaints included dining staff and nursing staff being rude to residents and lack of call light response time. The FV said she had received weekly complaints about the issues from residents and their families. She said she had spoken to the director of nursing (DON) and the NHA about the concerns but the complaints had not been resolved.</p> <p>The NHA was interviewed on 7/16/24 10:30 a.m. The NHA said he had identified the lack of and inappropriate response to the resident grievances a month ago (June 2024). The NHA said he knew the facility's grievance process was not effective. He said the grievance responses for nursing did not include any kind of assessment or plan.</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 - Some</p>	<p>The NHA said he had not developed any kind of plan to address the residents' concerns. He said he had educated the DON regarding ensuring grievances were thoroughly investigated and included a plan to resolve the situation. He said the DON was supposed to correct the grievances and come up with a plan for each resident concern but she had not had time.</p> <p>-However, the DON was interviewed and said she had not received any education regarding the grievance process (see DON interview below).</p> <p>The DON was interviewed on 7/16/24 at 1:45 p.m. The DON said she had not had any education on responding to grievances. She said she was out all last week (7/7/24 to 7/13/24) and grievances sat on her desk for the entire week. She said she did know that she needed to respond within 72-hours to the grievances.</p> <p>The social service director (SSD) 7/16/24 at 2:41 p.m. The SSD said she received and logged all grievances. The SSD said she had been concerned that there were not acceptable responses to the grievances and she forwarded them to the NHA for follow up. She said there was not always an acceptable investigation or resolution of the issues. The SSD said, additionally, the facility needed to be having a follow up conversation with the resident to ensure the grievance had been resolved if possible. She said the facility's lack of an effective grievance process was a problem.</p>		