STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065356	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Colorado Springs	2490 International Cir Colorado Springs, CO 80910

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)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47818 Based on observations, interviews, and record review, the facility failed to ensure one (#15) of two residents reviewed for communication out of 28 sample residents was provided appropriate treatment and services to maintain or improve their abilities. Specifically, the facility failed to provide Resident #15, who had difficulties with speech due to a stroke, with an appropriate communication tool to ensure the resident was able to effectively communicate her needs to staff. Findings include: I. Resident #15 A. Resident status Resident #15, under age 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), the diagnoses included cerebral infarction (stroke). The 3/8/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a (BIMS) score of 14 out of 15. She needed substantial assistance from one staff member for transferring and needed supervision or hands on assistance of one staff member for eating and personal hygiene. The MDS assessment indicated Resident #15 was usually understood with difficulty communicating some words or finishing thoughts but was able if prompted or given time and was able to understand others with clear comprehension. B. Observations and interview (continued on next page)

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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 9:31 a.m. Resident #15 was sitting in her room pointing at her chest and using her index finger to draw a line from her throat to her chest area. Certified nurses aide (CNA) #2 asked Resident #15 if she needed something to drink or eat, Resident #15 shook her head to indicate no. CNA #2 asked Resident #15 if she needed something for her throat and the resident shook her head to indicate no and continued using her index finger to draw a line from her throat to her chest. CNA #2 asked the resident if her chest was bothering her. Resident #15 attempted to verbally communicate but was unable to pronounce words clearly. CNA #2 said she was unable to understand what Resident #15 was trying to say and left to find assistance from another staff member. CNA #2 did not return, unit care coordinator (UCC) #1 returned instead, approached Resident #15 and asked if the resident was trying to something about her throat to CNA #2. Resident #15 shook her head indicating no and looked at the ground. UCC #1 asked the resident if she wanted juice and Resident #15 shrugged her shoulders and shook her head to indicate yes. C. Record review The communication care plan, revised on 10/23/24, revealed Resident #15 had a communication problem related to cerebral infarction and unclear speech. It indicated the resident would be able to make basic needs known on a daily basis through the review date. Pertinent interventions included using alternative communication tools as needed. -The care plan did not indicate what communication tool to utilize when communicating with Resident #15. D. Staff interviews CNA #2 was interviewed on 4/15/24 at 9:35 a.m. CNA #2 said staff needed to take their time with Resident #15 when trying to understand what she was trying to communicate or find another staff member who was better at communicating with the resident. CNA #2 said Resident #15 expressed frustration in the past when she could not be understood. CNA #2 said she was not aware of any communication devices being used by staff to assist in communicating with Resident #15. CNA #1 was interviewed on 4/15/24 at 9:31 a.m. He said he was aware of Resident #15 having a communication board but had never used it with her. He said another staff member informed him of Resident #15 having a communication board and he would not have known of it otherwise. CNA#1 was unable to locate a communication board in Resident #15's room. Registered nurse (RN) #1 was interviewed on 4/15/24 at 9:40 a.m. She said Resident #15 had a communication board available to staff in her room but the resident may have thrown it away. RN #1 said she did not know why Resident #15 threw her communication board away. RN #1 said there was a communication board at the nurses station that was kept in the narcotic count book. RN #1 said she did not know how direct care staff would know to look in the narcotic count book for a communication board for Resident #15. UCC #1 was interviewed on 4/15/24 at 10:00 a.m. UCC #1 said using alternative communication tools for Resident #15 was indicated to CNAs in the Kardex (tool utilized by staff to provide person centered care). UCC #1 said the Kardex did not specify what the alternative communication tools were. UCC #1 said the care plan would be updated to specify the communication board as an alternative tool. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, despite UCC #1 indicating the communication care plan would be updated, it was not updated prior to the end of survey on 4/16/24. The speech therapist (ST) was interviewed on 4/16/24 at 11:00 a.m. The ST said prior to 4/16/24 Resident #15 had never been on her caseload. She said she was going to assess the resident for swallowing issues. The ST said Resident #15 had not been assessed by therapy for the use of a communication board and she was unsure when the resident started using it or who recommended it to be used. Social services assistant (SSA) #1 was interviewed on 4/16/24 at 12:43 p.m. She said she was unaware Resident #15 had a communication board prior to 4/15/24. II. Facility follow up The education material that was provided to the CNAs and nurses was provided on 4/14/24 at 2:30 p.m. by the director of nursing (DON). It read in pertinent: Be aware of having difficulty communicating with Resident #15 there is a communication board taped to the inside of her closet. In addition, one is always available on the nurses cart.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on observations, record review and interviews the facility failed to ensure one (#55) of one resident received treatment and care in accordance with professional standards of practice out of 28 sample residents. Specifically, the facility failed to ensure Resident #55 was assisted with applying her compression stockings to treat her bilateral lower leg edema. Findings include: I. Facility policy and procedure The Anti Embolism (compression) Stocking Application policy, revised 9/8/23, was received by the director of nursing (DON) on 4/16/24 at 10:43 a.m. It read in pertinent part, The facility will provide anti embolism stocking application in accordance with professional standards of practice. The services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet the professional standards of quality. The facility will utilize [NAME] (nursing) procedures for anti embolism stocking application. The Anti Embolism stocking application checklist, undated, was provided by the DON on 4/16/24 at 10:43 a. m. It read in pertinent part, To apply knee-length anti embolism stockings according to standard of care; -Insert your hand into the stocking from the top, grasp the heel pocket from the inside, and turn the stocking inside out; -Position the stocking over the patient's foot and heel; -Grasp a few inches of the stocking and begin pulling it up around the patient's ankle and calf; -Continue pulling the stocking up the patient's leg using short pulls, alternating from the front to the back, until the bottom of the stocking's band falls one to two inches below the knee; -Smooth out wrinkles in the stocking; -Make sure the patient's toes are visible through the toe inspection area; and, -Document the procedure. II. Resident #55 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #55, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included pain in fingers, low back pain, pain in the shoulder and congestive heart disease. The 3/10/24 minimum data set (MDS) assessment revealed Resident #55 was cognitively intact with a brief interview for mental status (BIMS) score of 15 of 15. Resident #55 was independent with putting on her shoes and socks and dressing her upper and lower body. -However, the resident needed assistance in applying her compression stockings. B. Resident interview and observations On 4/11/24 at 10:30 a.m., Resident #55 said staff did not help her put on her compression stockings. She said the stockings helped control the swelling in her feet. She said she was unable to pull them up on her own. Resident #55's feet were observed to be swollen. She was wearing slippers that went over the top of her foot and had open heels to accommodate the swelling in the resident's feet. On 4/15/24 at 9:15 a.m., Resident #55 had slippers on her feet and her feet were swollen. Resident #55 was in the hallway outside her room and asked certified nurse aide (CNA) #1 to assist her. She said staff would not help her put on the compression stockings. CNA #1 said he did not know the resident. He said he did not feel comfortable applying the compression stockings because her feet were so swollen. CNA #1 spoke with licensed practical nurse (LPN) #1. LPN #1 said staff was supposed to put her compression stockings on every morning. CNA #1 said he needed larger stockings because the stockings for Resident #55 were too small to fit over her legs due to the increased swelling. The unit care coordinator (UCC) #1 walked up to where CNA #1 and LPN #1 were talking in the hall. UCC #1 said Resident #55 was supposed to put the stockings on herself. Resident #55 said she was unable to pull the stockings up on her own because it was too difficult for her to do. Resident #55 said she previously told staff but no one helped her apply the compression stockings. On 4/16/24 at 9:15 a.m., Resident #55 was in her room and was observed without her compression stockings on. Resident #55 said staff had not offered to assist her in putting her compression stockings on. She said staff did not help her with the stockings on 4/13/24 or 4/14/24. III. Record review Review of Resident #55's medical records revealed a physician's order, dated 4/9/24, which read in pertinent part, Please give resident compression stockings to wear during the day while awake. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The edema care plan, initiated on 3/9/21 revealed the resident had edema related to her diagnosis of congestive heart failure. -A review of the comprehensive care plan did not reveal an updated intervention to include the 4/9/24 physician's order for compression stockings. IV. Nursing interview The DON was interviewed on 4/16/24 at 9:45 a.m. The DON said Resident #55 had a history of refusing to wear compression stockings. The DON was unable to find documentation in April 2024 that Resident #55 refused to wear the compression stockings. The DON said the physician's order for compression stockings was entered incorrectly and did not prompt the staff to assist the resident with the compression stockings. The DON said because the physician's order was not correctly entered, it did not prompt the staff to document when they assisted the resident in putting on the compression stockings. She said when UCC #1 confirmed the physician's order on 4/9/24 she should have clarified the order to ensure it was entered correctly. The DON was interviewed again on 4/16/24 at 10:40 a.m. The DON said staff had just helped Resident #55 apply the compression stockings. The DON said she clarified the physician's order for the resident to have compression stockings applied and removed daily. The DON said she updated Resident #55's care plan to include the application of the compression stockings and to apply the compression stockings and monitor Resident #55's edema.