STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westminster	7751 Zenobia CT Westminster, CO 80030

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and interviews, the facility failed to ensure one (#1) of three residents out of three sample residents was kept free from neglect. Resident #1, who had a known history of falls and was dependent on staff for transfers, had a documented plan of care which required the assistance of two staff members for transfers with a mechanical lift. The resident was unable to perform a stand and pivot transfer related to her diagnosis of cerebral palsy (affects the body movement, muscle control, reflexes, posture and balance). On 1/26/24 a facility certified nurse aide (CNA) requested assistance from an agency CNA to help transfer Resident #1 from a shower chair to the resident's wheelchair with a mechanical lift. Despite Resident #1 and the facility CNA informing the agency staff that the resident was a mechanical lift transfer, the agency CNA proceeded to transfer Resident #1 by herself by standing the resident up and pivoting her to the wheelchair. Per Resident #1, when the agency CNA transferred her without the use of the mechanical lift, her left leg bent under the wheelchair and she heard some pops. Resident #1 reported to the facility staff that she hit her left knee and it hurt. The facility obtained an x-ray of the left knee on 1/27/24 which did not reveal any fractures and a physical therapy evaluation was ordered for a knee splint. On 1/29/24 a physician's order was obtained for an emergency computed tomography (CT) scan of Resident #1's left knee. The resident was transferred to the hospital for the CT scan, which revealed Resident #1 had sustained an acute fracture of her left femur (thigh bone). Due to the facility's failure to ensure the agency CNA transferred Resident #1 using the appropriate transfer method, Resident #1 sustained a fracture to her left femur. Findings include: I. Facility policy and procedure (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Abuse and Neglect policy, revised 5/15/2020, was provided by the director of nursing (DON) on 6/17/24 at 12:12 p.m. It revealed in pertinent part, Neglect means the failure of the facility, its employees or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. Residents must not be subjected to abuse by anyone. This includes, but is not limited to, staff, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the resident's representative, friends or any other individuals. It is the policy and practice of this facility that all residents will be protected from all types of abuse, neglect, misappropriation of resident property and exploitation. It is the policy of this facility to prevent and prohibit all types of abuse, neglect and misappropriation of resident property and exploitation. The Mechanical Lift policy, revised 5/17/22, was provided by the DON on 6/17/24 at 12:12 p.m. It revealed in pertinent part, The procedure of the facility upon admission will be to assess the resident to determine transfer status. The transfer information will be captured in the medical record and communicated through the care plan. The facility will provide education upon hire and annually to staff members on the proper use of lifts in accordance with the manufacturer guidelines. The education will include the need to have two staff members present during the transfer. II. Facility investigation of the incident on 1/26/24 The 1/26/24 facility investigation revealed the facility reported an allegation of neglect to the State agency occurrence site. It revealed an agency CNA transferred Resident #1 from the shower chair to her wheelchair via a stand and pivot transfer. The CNA did not utilize the mechanical lift required for all transfers of Resident #1. The facility substantiated the allegation and indicated the agency CNA was not to return to the facility. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included cerebral palsy, difficulty in walking, muscle weakness, history of falling, abnormal posture and fracture of the left femur. The 5/3/24 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 had impairment to both sides of her lower and upper extremities. She used a wheelchair and was dependent on staff for transfers. She received scheduled and as needed pain medications as well as non-medication interventions for pain. She received opioid medication. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	B. Resident interview Resident #1 was interviewed on 6/17/24 at 12:43 p.m. Resident #1 said she was supposed to be a mechanical lift transfer. She said a facility CNA asked an agency CNA to help her transfer her from the shower chair to the wheelchair since the mechanical lift required two staff members when in use. Resident #1 said the agency CNA mumbled something to the facility CNA, who told her the resident was always a mechanical lift. Resident #1 said she and the facility CNA explained to the agency CNA that she was a hoyer lift three times. She said the agency CNA said it would be faster to just pick her up and place her in the wheelchair. She said the agency staff took it upon herself to lift her up manually and place her in the wheelchair. Resident #1 said her right leg went out straight in front of her and her left leg folded under her wheelchair and she heard some pops. She said she told the agency CNA that she broke her leg. She said she did not receive an opioid medication prior to the incident, but currently took it to control the pain in her left leg following her femur fracture. C. Record Review Resident #1's fall care plan, initiated 11/1/21, documented the resident was at risk for falls related to a history of falls. The goal was for the resident to not sustain a serious injury requiring hospitalization . The interventions included a mechanical lift for transfers with two staff members for assistance. The pain care plan, revised 6/14/24, documented the resident expressed pain due to a recent femur fracture. The goal was to express pain relief through the review date. The interventions included observing the resident and reporting to the nurse the residents complaints of pain or requests for pain treatment. The 1/26/24 event note documented the nurse was informed by the CNA on duty that Resident #1 was injured during a transfer. An agency CNA was assisting with the transfer and did not utilize the mechanical lift as care planned. Resident #1 said she hit her left knee during the transfer. There was no visible bruising, redness or edema present. Per Resident #1, the CNA helping to transfer her from the shower chair to her wheelchair picked her up and placed her in the wheelchair without using the mechanical lift. She said she hit her knee on something hard and it really hurt. Her pain was 7 out of 10 on a 1-10 numerical pain scale. The DON, the executive director, the unit manager and the resident's family were notified. The physician was called and an order for a two view x-ray of the left knee was obtained. A health status note, dated 1/27/24, documented the x-ray results, with no identified fracture, were called to the physician. New orders were received to get a physical therapy evaluation and treatment for a knee splint, ice to the left knee every four hours as tolerated and to call if pain could not be managed. Tylenol and Advil would be staggered to control pain. A health status note, dated 1/29/24, documented a new order for an emergency (stat) computed tomography (CT) scan of the left knee. Resident #1 was transferred to the hospital for the scan. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An order note, dated 2/7/24, documented the resident reported to the nurse pain from her left femur fracture and that the medication only helped for a little bit. The as needed pain medication could only be given every eight hours. A new order was received for a pain patch and the physician would evaluate her pain in the morning. The radiology results from the hospital CT scan, dated 1/29/24, revealed the resident had a CT of her lower left extremity and an acute fracture of the left femur was found with slight fracture fragments up to 3-4 (three to four) mm (millimeters). IV. Staff interviews CNA #1 was interviewed on 6/7/24 at 12:49 p.m. CNA #1 said Resident #1 was transferred via a mechanical lift at all times. She said all lifts, including sit to stand lifts, required two staff members when in use. She said if she was unable to find another CNA for a transfer with a mechanical lift, she would ask a nurse or management to assist. CNA #2, who was also responsible for scheduling staff in the facility, was interviewed on 6/7/24 at 12:51 p.m. CNA #2 said the facility CNA involved with the incident no longer worked for the facility. She said the CNA who actually transferred the resident was an agency CNA and did not work for the facility, but a third party. CNA #2 said Resident #1 was a two-person assist with a mechanical lift. She said Resident #1 was not able to stand and pivot related to her diagnosis. She said all agency staff had a background check, a license check and abuse and dementia training before working the floor. She said the agency CNA involved in the transfer was reported to the agency and the state board of nursing and was not allowed back into the facility. Licensed practical nurse (LPN) #1 was interviewed on 6/7/24 at 12:54 p.m. LPN #1 said Resident #1 was a two-person assist with a mechanical lift due to her lack of mobility. She said an agency CNA transferred Resident #1 from a shower chair to a wheelchair without using the mechanical lift. She said the failure of the agency CNA to transfer Resident #1 as care planned resulted in a fractured femur for the resident. The DON was interviewed on 6/7/24 at 1:08 p.m. The DON said the facility CNA was assigned to care for Resident #1 and asked the agency CNA to help transfer the resident from the shower chair to her wheelchair because the mechanical lift required two staff members when in use. She said the agency CNA was in a hurry and it was faster just to stand and pivot transfer Resident #1 back to her wheelchair. Resident #1 screamed out in pain and heard a loud pop. She said the facility no longer utilized agency staff.