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	11/13/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on interviews and record reviews, the facility failed to ensure residents had the right to a dignified existence for two (#1 and #3) of three residents out of three sample residents Specifically, the facility failed to ensure residents' call lights were answered in a timely manner. Findings include: I. Facility policy The Resident Rights policy and procedure, revised on 9/10/24, was received from the nursing home administrator (NHA) on 11/11/24 at 11:54 a.m. It revealed in pertinent part At the time of admission and periodically throughout their stay, the facility will inform each resident, orally and in writing, of their rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The resident has the right to reside and receive services in the facility with reasonable accommodations of resident preferences except when to do so would endanger the realty and safety of the resident or other residents. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. II. Resident interviews Resident #1 was interviewed on 11/12/24 at 1:00 p.m. Resident #1 said the NHA and the director of nursing (DON) had never responded to her call light. She said she had to wait a long time for help when she pushed her call light button for assistance. She said when staff took a long time to respond to her call light, it made her feel neglected and like no one cared. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #3 was interviewed on 11/13/24 at 8:58 a.m. Resident #3 said she had waited 30 minutes to three hours for someone to answer her call light recently. She said she had never had the NHA or the DON respond to her call light. Resident #3 said it made her feel neglected when she could not get the help she needed in a reasonable amount of time. III. Call light observations Resident call light observations were conducted on 11/12/24 The following was observed: At 10:44 a.m. the call light for room [ROOM NUMBER] was activated. At 10:54 a.m. the NHA entered room [ROOM NUMBER] and deactivated the light. At 12:56 a.m. the call light for room [ROOM NUMBER] was activated. At 1:01 p.m. an unidentified male staff member walked past the room. At 1:02 p.m. an unidentified female staff member walked past the room. At 1:03 p.m. the same unidentified female staff member walked past the room again. At 1:06 p.m. a second unidentified female staff member walked past the room. At 1:07 p.m. the call light for room [ROOM NUMBER] was deactivated when a third unidentified female staff member entered the room. -Three different unidentified staff members walked past the activated call light for room [ROOM NUMBER] on four separate occasions before a fourth unidentified staff member answered the call light, 11 minutes after it was activated. At 1:08 p.m. the call light for room [ROOM NUMBER] was activated. A family member entered the hallway looking for assistance. An unidentified housekeeper walked past the room twice. At 1:12 p.m. the call light for room [ROOM NUMBER] was deactivated when a nurse entered the room. -Despite a family member attempting to get assistance for the resident who resided in room [ROOM NUMBER], an unidentified housekeeper walked past the activated call light for room [ROOM NUMBER] without attempting to answer the call light or see what the resident needed. At 1:47 p.m. the call light for room [ROOM NUMBER] was activated. There were four staff members standing at the nurses station, including the DON. None of the staff members answered the call light. At 1:52 p.m. there were two nurses and two certified nurse aides (CNA) standing at the desk. None of the staff members answered the call light in room [ROOM NUMBER]. At 1:57 p.m. one of the nurses walked down the hallway towards room [ROOM NUMBER] but did not answer the call light. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	At 2:01 p.m. a CNA entered room [ROOM NUMBER] and deactivated the call light. -The resident's call light in room [ROOM NUMBER] was not answered until 14 minutes after it was answered, despite several staff members, including the DON, being present at the nurses station. -One nurse walked past the activated call light in room [ROOM NUMBER], 10 minutes after the call light was activated, however, the nurse did not attempt to answer the resident's call light. At 2:03 p.m. the call light for room [ROOM NUMBER] and room [ROOM NUMBER] were activated. Four staff members walked past the rooms without answering the call lights. At 2:06 p.m. the NHA entered room [ROOM NUMBER] and deactivated the call light. At 2:43 p.m. the call lights for room [ROOM NUMBER] and room [ROOM NUMBER] were activated. There were three staff members standing at the nurses station. At 2:46 p.m. the NHA entered room [ROOM NUMBER] and deactivated the call light. At 2:47 p.m. the NHA entered room [ROOM NUMBER] and deactivated the call light. IV. Staff interviews CNA #1 was interviewed on 11/12/24 at 2:49 p.m. CNA #1 said she had been working in the facility since September 2024. She said one night, toward the end of September 2024, she was the only CNA on the entire unit. She said staffing had gotten better but she did not think the facility had enough staff scheduled to meet residents' needs in a timely manner. The NHA was interviewed on 11/13/24 at 10:20 a.m. The NHA said he expected staff to respond to call lights within 15 minutes. He said all staff were expected to respond to and answer call lights, however, he said not all staff may be able to assist the resident depending on their needs. The NHA said if he saw staff walking past a call light without stopping in to check on residents, the staff members would get a verbal warning for not answering call lights.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to honor resident choices for three (Resident #1, #2 and #3) of three residents out of four sample residents. Specifically, the facility failed to honor residents' preferences to include beverages, specifically soda, of choice at any time. Findings include: I. Facility policy and procedure The Resident Rights policy and procedure, revised on 9/10/24, was received from the nursing home administrator (NHA) on 11/11/24 at 11:54 a.m. It revealed in pertinent part At the time of admission and periodically throughout their stay, the facility will inform each resident, orally and in writing, of their rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The resident has the right to reside and receive services in the facility with reasonable accommodations of resident preferences except when to do so would endanger the realty and safety of the resident or other residents. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis, epilepsy and osteoporosis. The 8/29/24 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 maximum staff assistance with transfers, toileting and showering. B. Resident interview (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #1 was interviewed on 11/12/24 at 1:00 p.m. Resident #1 said she enjoyed drinking a soda from time to time but the facility did not allow residents to have soda with their dinner anymore. She said the only time residents have a soda was at lunch time. She said if residents wanted to have soda with dinner, they had to order two sodas at lunch and save one for dinner time. She said this made her feel sad and like no one cared about what the residents wanted. III. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included stage 3 chronic kidney disease, right knee effusion and hypertension. The 9/5/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She required maximum staff assistance with transfers, toileting, showering and dressing. B. Resident interview Resident #2 was interviewed on 11/12/24 at 12:40 p.m. Resident #2 said she enjoyed drinking a soda but she could not get soda at dinner. She said the facility recently stopped allowing residents to have soda at dinner. She said the only time she was able to request a soda was at lunch. Resident #2 said it made her very upset to not be able to get a soda with dinner and it made her feel like a scolded child. IV. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes and hypertension. The 10/3/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required maximum staff assistance with toileting and showering. B. Resident interview Resident #3 was interviewed on 11/13/24 at 8:54 a.m. Resident #3 said she was not able to ask for soda at dinner. Resident #3 said if she wanted to have a soda at dinner she had to order two sodas at lunch and save one for dinner. She said the facility was very strict about soda consumption and it made her angry. She said she was an adult and should be able to have soda whenever she wanted to. V. Observations On 11/12/24 at 1:20 p.m. the menu post for the day was observed. The breakfast and lunch menu offered beverages of choice for breakfast and lunch. The dinner beverage options were lemonade, tea, agua pomegranate water, apple juice, coffee and milk. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 11/13/24 at 9:20 a.m. the menu post for the day was observed. The breakfast and lunch menu offered beverages of choice for breakfast and lunch. The dinner beverage options were lemonade, tea, agua pomegranate water, apple juice, coffee and milk. VI. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 11/12/24 at 2:49 p.m. CNA #1 said residents were asked to order soda on their meal tickets at lunchtime. She said she was not sure if residents could get soda outside of lunch. The food service director (FSD) was interviewed on 11/13/24 at 9:05 a.m. The FSD said the facility made a decision to reduce the amount of soda the residents were drinking because it was not nutritious. She said residents could ask for soda anytime and soda was available on the beverage carts. -However, according to resident interviews, they were unable to get soda at the dinner meal (see resident interviews above). The activities director (AD) was interviewed on 11/13/24 at 9:13 a.m. The AD said she did not know how the residents would go about getting a soda once the kitchen closed for the day. She said the kitchen was locked after it closed for the day. The nursing home administrator (NHA) was interviewed on 11/13/24 at 10:20 a.m. The NHA said the soda was not easily accessible anymore and the facility needed to get control of how much soda was being used due to some residents hoarding the soda. He said soda was always available to the residents but he did ask them to order it on their meal tickets.