STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065368	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Greeley	4800 W 25th St Greeley, CO 80634

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 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** 37166 Based on record review and interviews, the facility failed to provide services in accordance with currently accepted professional principles for one resident (#44) of three residents reviewed for blood pressure management out of 32 sample residents. Specifically, the facility failed to assess and document Resident #44's blood pressure consistently prior to administering blood pressure medications. Findings include: I. Facility policy and procedure The Oral Medication Administration policy, revised 9/22/21, was provided by the nursing home administrator (NHA) on 7/17/24. It read in pertinent part, The facility will provide oral medication administration in accordance with professional standards of practice, as outlined by [NAME] through the procedures below: -Assess parameters, such as blood pressure and pulse, as needed, before administering a medication with dose-holding parameters. II. Resident #44 A. Resident status Resident #44, age 70, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included diabetes, encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), ascites (fluid build up) and cirrhosis (liver damage). The 5/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS assessment indicated he had a fluid build up (ascites) and was prescribed a diuretic medication. B. Record review (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065368	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The July 2024 CPO revealed a physician's order for furosemide (a diuretic medication) 40 milligrams (mg), give one tablet by mouth two times a day for fluid build up due to cirrhosis. Hold for a systolic blood pressure less than 90 millimeters of mercury (mmHg) and a diastolic blood pressure less than 60 mmHg, ordered 6/6/24. Resident #44's medication administration record (MAR) was reviewed for June 2024 and 7/1/24 to 7/16/24. The MAR revealed the resident was administered the medication on all days reviewed. -However, the resident's blood pressure was not recorded on the MAR and there was no documentation on the MAR to indicate the resident's blood pressure was assessed prior to the administration of the medication. The blood pressure (BP) records were reviewed from the vital signs section of the resident's electronic medical record (EMR) and revealed the following: On 6/21/24 at 9:49 a.m. the resident's BP was 89/58 mmHg. -However, according to the June 2024 MAR, the medication had been administered. On 6/15/24 at 4:23 p.m. the resident's BP was 83/57 mmHg. -However, according to the June 2024 MAR, the medication had been administered. On 6/11/24 at 3:24 p.m. the resident's BP was 90/52 mmHg. -However, according to the June 2024 MAR, the medication had been administered. On 6/9/24 at 2:47 p.m. the resident's BP was 92/58 mmHg. -However, according to the June 2024 MAR, the medication had been administered. On 7/1/24, 7/2/24, 7/3/24, 7/5/24, 7/6/24, 7/7/24 and 7/8/24, the resident's blood pressure was documented one time in the vital signs section. -However, the resident's blood pressure was to be obtained two times per day prior to the administration of the furosemide. On 7/4/24 the resident's BP was not documented in the vital sign section of the EMR. -However, according to the June 2024 MAR, the medication had been administered. II. Staff interviews (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #3 was interviewed on 7/15/24 at 2:45 p.m. LPN #3 reviewed Resident #44's EMR and said the resident's blood pressure was not consistently documented or taken. She said the resident was scheduled to receive medication at 8:00 a.m. and 1:00 p.m. every day, however the blood pressure on some days was documented only once. She said it was important to check blood pressure prior to the administration of furosemide to ensure that it was safe to administer the medication. She said if the blood pressure was too low and the medication was given, the resident's blood pressure could get critically low. LPN #3 said she would communicate the findings to the unit manager. She said she would correct the record to ensure the resident's blood pressure was documented on the MAR so all the nurses would have to document the resident's blood pressure before administering medications. The director of nursing (DON) was interviewed on 7/16/24 at 3:50 p.m. The DON said she was not aware that Resident #44 received furosemide when his blood pressure was below normal. She said the nurses should follow the physician's order and check the resident's blood pressure prior to medication administration. She said if the resident's blood pressure was below the recommended parameters, the medication should not be administered. The DON said she would provide education to all the licensed nursing staff to remind them about following the holding parameters for medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50690

Based on observations, record review and interviews, the facility failed to ensure one (#67) of three residents reviewed for pressure-related skin conditions out of 32 sample residents received care consistent with professional standards of practice to prevent pressure ulcers from developing.

Resident #67, who was at risk for developing pressure injuries due to paraplegia, weakness and the inability to move both legs, was admitted on [DATE]. The facility provided a pressure reducing mattress and wheelchair pad upon admission. The resident was able to make small movements to reposition herself, however, the staff did not provide the resident with consistent repositioning per the resident's needs

On 7/4/24, a wound was observed on the resident's sacral area (bony area just above the tailbone). The nurse who observed the wound on 7/4/24 failed to notify the unit manager or the physician of the wound.

On 7/11/24, the wound was again noted by a nurse and a specialty mattress was ordered for the resident (seven days after the initial identification of the wound).

On 7/12/24 and 7/15/24, the facility's nurse practitioner (NP) and the resident's physician documented the resident had what appeared to be an early stage wound to her coccyx which would continue to be monitored, however, neither the NP nor the physician observed the resident's wound.

On 7/15/24 (11 days after the initial identification of the wound) Resident #67's wound was observed by the wound team for the first time. The wound was classified as a Stage 3 pressure injury to the sacrum and wound care orders for treatment of the wound and nutritional supplement orders were obtained from the physician (11 days after the initial identification of the wound).

Due to the facility's failures to implement timely interventions and obtain wound care orders after the initial identification of the wound, Resident #67 developed a Stage 3 pressure wound to her sacrum.

The findings include:

I. Professional reference

According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: (2019), retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://static1.squarespace.com/static/6479484083027f25a6246fcb/t/6553d3440e18d57a550c4e7e/1699992399539/CPG2019edition-digital-Nov2023version.pdf on 7/17/24,

Pressure ulcer classification is as follows:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed. Suspected Deep Tissue Injury: Depth Unknown (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Injuries policy, revised on 7/9/24, was provided by the nursing home administrator (NHA) on 7/17/24 at 4:35 p.m. It read in pertinent part, Residents will receive a comprehensive skin assessment upon admission or readmission to the facility. The Braden Scale (a tool used for determining pressure ulcer risk) will be completed for each resident upon admission or readmission, weekly for four weeks, quarterly, and as needed based upon each resident's specific needs. Resident skin assessments will be performed weekly by a licensed nurse. Any changes or open areas noted by a certified nurse aide (CNA) will be reported to the nurse. CNAs will report to the nurse if a topical dressing is soiled, saturated or dislodged. The nurse will complete further inspection and provide treatment if needed. Measures to maintain and improve the resident's tissue tolerance to pressure will be implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development. Upon admission and throughout, a pressure redistribution surface mattress will be used with turning and repositioning as needed with care, assistance, and incontinent care. Skin barriers will be applied as needed and a preventative wheelchair cushion used if indicated. Measures to protect the resident against the adverse effects of pressure, friction, and shear will be implemented in the plan of care, including repositioning at least every two to four hours (per NPIAP standards) as consistent with overall patient goal and medical condition, utilizing positioning devices to keep bony prominences from direct contact, placing a pressure redistribution mattress under the resident and placing the resident on a pressure reduction device and repositioning the resident when in a wheelchair. Staff will educate the resident and significant others regarding the preventive skin care plan. If skin breakdown occurs, it requires attention and a change in the plan of care if indicated. III. Resident #67 A. Resident status (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Resident #67, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included acute infarction of the spinal cord (interruption of blood flow to the spinal cord), incomplete paraplegia (paralysis of the lower body), generalized muscle weakness, difficulty in walking and osteoarthritis.

The 6/24/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She was dependent on staff for bed mobility and transfers, needed substantial assistance with toileting and moderate assistance with bathing.

The assessment indicated the resident was at risk for developing pressure ulcers but had none upon admission.

B. Resident interview

Resident #67 was interviewed on 7/10/24 at 10:37 a.m. Resident #67 said she woke up at 5:00 a.m. and waited for about three hours until someone could help her out of bed. She said at night, she spent a lot of time in her wheelchair before getting help transferring to bed. The resident said she had a wound on her bottom that was being treated with cream and a bandage. She said she thought the wound happened because she sat in her wheelchair so much and laid on her back when she was in bed while waiting for staff to get her up.

On 7/11/24 at 1:16 p.m., the resident was overheard telling an unidentified therapist that staff did not get around to getting her out of bed until after 9:00 a.m.

C. Observations

On 7/15/24 at 3:10 p.m., Resident #67's wound was visualized with CNA #2 and LPN #2. CNA #2 and LPN #2 rolled Resident #67 onto her left side. LPN #2 peeled away the corner of the resident's dressing to reveal a sacral wound approximately the size of a nickel, which was red at the base and had slough (white, dead tissue) in the upper portion of the wound. The wound had no odor or drainage.

D. Record review

A Braden Scale assessment dated [DATE] at 9:54 p.m. revealed Resident #67 was at high risk for developing pressure ulcers due to very limited sensory perception, occasional moisture, being confined to bed and completely immobile and having the potential for friction and shear.

A care plan, initiated 6/20/24, revealed Resident #67 was at risk for a break in skin integrity. Interventions to reduce risk of skin breakdown included cleaning and drying the resident's skin after incontinent episodes, using a pressure reducing mattress, providing treatments as ordered and conducting weekly skin checks.

A care plan initiated 7/12/24 by registered nurse (RN) #2 and updated by the NHA on 7/15/24 (during the survey), revealed that the resident had a Stage 3 pressure ulcer to her sacrum. Weekly skin checks were already in place, and the resident had a specialty air mattress and gel wheelchair cushion placed on 7/11/24.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Additional interventions, which were added to the care plan on 7/15/24 (during the survey) included encouraging the resident to offload her buttocks while in the wheelchair and providing the resident with supplements as ordered to promote wound healing. From 6/28/24 to 7/15/24, CNA documentation revealed that bed mobility assistance was given to Resident #67 between two and three times per 24- hour period. From 6/28/24 to 7/15/24, CNA documentation revealed Resident #67 was provided one or two-person transfer assist between the bed, chair, or wheelchair. The time stamps on the documentation indicated the resident received two to three transfers per day, in combination with assistance given to her while in bed. A weekly skin assessment, dated 6/27/24 at 11:09 p.m. by LPN #2, did not reveal any pressure injuries. A weekly skin assessment, dated 7/4/24 at 9:36 p.m. by LPN #2, revealed an open area to Resident #67's coccyx. It documented the resident was repositioned frequently for skin integrity and comfort, a dryness lotion was applied, and the finding was not new. -However, the 6/27/24 weekly skin assessment documented the resident did not have any open areas (see above). -No progress note was written and there was no documentation that a physician or unit manager was notified of the open area. A weekly skin assessment, dated 7/11/24 at 9:37 p.m. by LPN #2, revealed an area of blanchable redness to the coccyx (tailbone). A skilled nursing note, dated 7/6/24 at 9:29 p.m. revealed the resident had an open slit above the coccyx (tailbone). A nurse practitioner (NP) note, dated 7/12/24 at 8:31 a.m., revealed the NP had not seen the resident's wound, but noted it appeared to be an early stage coccyx wound. The wound development status was reviewed with the resident, the resident was educated on offloading, was to utilize the new mattress and seat cushion and the wound would be monitored. The resident informed the NP that she received the new mattress and gel seat cushion for her wheelchair. A skilled nursing note, dated 7/12/24 at 10:44 p.m., revealed the resident had an open slit above the coccyx that was covered with an intact, mepilex (a kind of foam) dressing. A physician's progress note, dated 7/15/24 at 10:33 a.m., revealed the physician (MD) had not seen the resident's wound, but noted it appeared to be an early stage coccyx wound. The resident was educated on offloading, utilizing the new mattress and seat cushion and the wound would continue to be monitored. A skilled nursing note, dated 7/15/24 at 1:36 p.m., revealed there were dressing changes ordered for a sacral wound. There were no signs of wound infection and the resident was now followed by the wound care team. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The note was documented during the survey investigation. A nursing progress note, dated 7/15/24 at 8:32 p.m. revealed that staff would continue to turn and reposition the resident frequently to prevent skin breakdown. An NP progress note dated 7/16/24 at 9:18 a.m., revealed the NP had not seen the resident's wound, but noted it appeared to be an early stage coccyx wound. The resident was educated on offloading. She was using the new mattress and seat cushion, and the wound would be monitored. The July 2024 CPO revealed the following physician's orders: Ensure air mattress is on and functioning every shift, ordered 7/12/24. Monitor the open area to the resident's sacrum and notify the physician for signs and symptoms of infection, ordered 7/13/24. Apply santyl ointment (to remove dead tissue from pressure wound) 250 units per gram to the sacrum, ordered 7/15/24. Cleanse the small open area to the sacrum with normal saline and pat dry. Apply nickel thick santyl and cover with mepilex. Change daily and as needed, ordered 7/15/24. Two Cal med pass oral nutritional supplement, ordered 7/15/24. -The dressing orders and the nutritional supplement orders were not obtained until 11 days after the initial identification of Resident #67's wound. A Wound Observation Tool was completed by the director of nursing (DON) on 7/15/24 at 6:24 p.m. (during the survey). It documented Resident #67 had a Stage 3 pressure injury to the sacrum. The wound was documented as round, with 70% slough tissue (yellow, tan, white, stringy) and dimensions of 1.2 centimeters (cm) length by 0.5 cm width by 0.2 cm depth. The wound had no drainage or signs of infection and was not painful to the resident. The DON documented that the NP, the resident, and the resident's representative were previously notified of the wound, on 7/12/24. The DON further documented that the current treatment plan included cleansing the wound with normal saline and patting dry, [NAME] Nickel thick Santyl, covering the wound with mepilex, and changing daily and as needed. Special equipment and preventive measures included a pressure reducing specialty air mattress and pressure reducing wheelchair cushion. The resident was to be repositioned as tolerated to reduce pressure on her buttocks and both heels. Daily skin care was to be provided. D. Staff interviews RN #1 was interviewed on 7/15/24 at 4:10 p.m. RN #1 said she treated residents'pressure related wounds. She said the wound team, which consisted of herself, RN #2, the registered dietitian (RD), and the NP, rounded on wounds every Wednesday. She said the NP measured the wounds and wrote the more complicated wound orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	RN #1 said residents at high risk for skin breakdown (and all residents upon admission), received a dietitian consultation and weekly skin assessments. She said those were standard interventions for residents who did not currently have a wound. RN #1 said all residents were originally given pressure-reducing mattresses. She said residents with a pressure wound or redness received a low-air loss mattress which had a pump to intermittently inflate and deflate. RN #1 said she did not know about Resident #67's wound because the resident was not on her assigned hallway. She said RN #2, who was on vacation, knew more about the resident. RN #1 said she had not seen the resident yet but the resident was on the list to be seen by the wound care team on Wednesday (7/17/24). She said RN #2 must have completed a referral form for the wound team to assess the wound the previous Friday, before she left. RN #1 said if a nurse noticed an open area on a resident's skin, they would let the unit manager know and they would proceed with notifying the physician and wound team. RN #1 said she did not know why wound care treatments for Resident #67 had not been initiated when the wound was initially identified. She said taking two weeks to get treatments into place after noticing an open wound was not good practice. CNA #2 was interviewed on 7/16/24 at 2:48 p.m. CNA #2 said upon admission, Resident #67 had a deficit in her right leg and needed two staff members to assist her with a mechanical lift. She said the resident moved around in bed and had, to some extent, been able to reposition both legs in bed, but she needed some help moving the right leg. She said the resident was consistent in pressing the call light to let staff know she wanted to be moved or repositioned. CNA #2 said Resident #67 never complained of pain at the site of the wound. She said since the wound developed, the resident had gotten a new air mattress, they repositioned her even more often than before, and were more diligent about making sure the site of the wound and the dressing were clean, especially after changing her brief. LPN #1 was interviewed on 7/16/24 at 3:02 p.m. LPN #1 said she was not usually on Resident #67's unit and had only known the resident for the past two days. She said the resident could move her left leg some, but not the right one. She said she needed a mechanical lift for transfers but she could move around on her own in her wheelchair using her upper body. She said the resident could not really roll in bed on her own. LPN #1 said if a new opening was noticed on a resident's skin, it would be documented in the skin assessment and the unit manager and wound care team would be notified for new interventions to be placed. She said, usually, the wound team nurse would stage and measure the wound. LPN #1 said since the wound developed, Resident #67 had received a new air mattress, they did daily dressing changes and she was on a supplement for wound healing. She said the resident did not complain of pain from the wound. The DON was interviewed on 7/16/24 at 4:44 p.m. The DON said upon admission Resident #67 could not do much. She said interventions to prevent wound development for Resident #67 had included offloading her bottom and repositioning the resident at least every two hours and whenever the resident requested repositioning. She said rounds for more independent residents were every two hours, so staff should round even more frequently for residents who could not reposition independently. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON said residents at high risk for pressure injuries on the Braden assessment would have certain interventions in place, such as a specialty air mattress, a gel cushion for the wheelchair, and they would be placed on a check-and-change or frequent repositioning schedule. The DON said on 7/4/24 Resident #67's wound was open and on 7/11/24 it was closed again and had blanchable redness. She said the resident's mattress was changed and the treatments were changed as soon as the blanchable redness was noticed. The DON said she talked to LPN #2 about the wound. She said LPN #2 told her she had put barrier lotion on the wound and covered it with mepilex but she did not tell anyone about the wound when it originally developed. The DON said education about wound care documentation began on 7/15/24 (during the survey) for the nursing staff.

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Greeley		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 W 25th St Greeley, CO 80634	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47151

Based on record review and interviews, the facility failed to ensure one (#6) of nine residents reviewed for accidents out of 32 sample residents remained as free from accident hazards as possible.

The facility failed to prevent Resident #6's fall from a mechanical (hoyer) lift while transferring her. On [DATE] two certified nurse aides (CNA) #1 and #3 attempted to transfer Resident #6 from her bed to her wheelchair. During the transfer, Resident #6 fell from the sling attached to the mechanical lift's sling bar (a bar with two safety latches on each end the sling attaches to), onto the floor and hit her head on the mechanical lift. As a result, Resident #6 sustained head trauma (laceration) to the back of her head.

Immediately after Resident #6's fall staff observed that one (right upper body) of the four sling handles had disconnected from the mechanical lift sling bar. Resident #6 was assessed at the facility and transported to the hospital where she was treated and received staples for the head laceration. She returned to the facility the same day at 9:00 p.m.

On [DATE] Resident #6 complained of pain to her right shoulder. New orders for an x-ray for her right shoulder and arm were obtained. Imaging showed a fracture to Resident #6's right clavicle.

The facility was unable to identify during their investigation how the sling could have come unhooked from the mechanical lift resulting in Resident #67 ' s fall.

Due to the facility's failure to adequately supervise Resident #6 during her mechanical lift transfer, Resident #6 fell and sustained head trauma and a fractured right clavicle. The facility failed to identify during the course of their investigation a specific procedural failure that occurred during the transfer of Resident #6 on [DATE].

Findings include:

Record reviews, observations and interviews confirmed the facility corrected the deficient practice related to Resident #6's fall prior to the onsite investigation on [DATE] to [DATE]. The deficiency was cited as past non-compliance with a correction date of [DATE].

I. Incident on [DATE]

The nursing home administrator (NHA) provided an investigation on [DATE] at 9:15 a.m. regarding Resident #6's fall from the mechanical lift while being transferred by CNA #1 and CNA #3.

A. Investigative report

An investigative timeline that documented the initial reported incident on [DATE] and follow up actions of interviews, assessments, mechanical lift inspections, education and reporting. The investigation, action plan and facility wide education was completed [DATE].

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility concluded Resident #6 fell from the sling attached to the mechanical lift's sling bar (a bar with two safety latches on each end the sling attaches to), onto the floor and hit her head on the mechanical lift. She sustained a laceration to her head requiring staples and a fractured right clavicle. B. Investigation timeline and mechanical lift inspection history On [DATE]: At 4:08 p.m. a CNA reported to the nurse that Resident #6 fell from the mechanical lift and the resident was assessed by two registered nurses (RN). At 4:15 p.m. the physician, the director of nursing (DON) and the resident's representative were all notified. At 4:18 p.m. orders were received from the physician to transfer Resident #6 to the emergency department for evaluation and treatment. At 4:35 p.m. Resident #6 transferred out to a local hospital via ambulance. At 9:00 p.m. Resident #6 returned from the local hospital emergency department. On [DATE]: At 9:00 a.m. staff and resident interviews were conducted, Resident #6 was assessed by a physician and she denied having pain. At 9:05 a.m. the interdisciplinary team (IDT) met to discuss the fall and interventions. On [DATE]: Resident #6 had no complaints of pain. On [DATE]: At 10:43 a.m. Resident #6 refused to use her right arm. Orders for immediate imaging were obtained. At 4:00 p.m. Resident #6's x-ray results were received and the physician was notified the resident had a right clavicle fracture. The facility's work history report documented monthly inspections of all facility mechanical lifts for the prior year from [DATE] to [DATE]. C. Resident and staff interviews (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #3 provided a written witness statement on [DATE]. The statement read in pertinent part, CNA #1 and myself were getting Resident #6 up for dinner. While transferring her from her bed to her wheelchair, the sling slipped out of the hook of the hoyer (mechanical lift) and before we could realize, the resident slipped out of the sling and hit her head on the leg of the hoyer (mechanical lift). CNA #1 provided a written witness statement on [DATE]. The statement read in pertinent part, My coworker and I were getting Resident #6 ready to go down to the dining room. We were transferring her from the bed to the wheelchair with the hoyer lift. She was on the hoyer lift off the bed when one arm of the sling came off and she (Resident #6) fell on the floor. -Neither statement documented what kind of safety checks CNA #1 and CNA #3 performed prior to transferring Resident #6 from her bed to her wheelchair. Seven residents throughout the facility were interviewed on [DATE] by the social services director (SSD), two of which were transferred utilizing the mechanical lift. All of the residents denied concerns regarding their transfers during daily care. Nine CNA's were interviewed on [DATE] and [DATE] and they all denied concerns or issues with the mechanical lift and falls and knew what steps to take if a resident fell . The maintenance supervisor (MS) provided a written statement on [DATE]. It read in pertinent part, The NHA and I immediately went and found the lift (used for Resident #6's transfer) for an inspection to rule out a failure of the equipment in any way. The hoyer (mechanical) lift was working properly, wheels rolled, brakes locked, legs open and closed, mast went up and down, emergency stop was working, remote functioned and the sling safety latches were present on the swivel bar. This was corroborated by multiple department heads. We (the staff) tried to recreate the incident on our own as the staff members were present. We (the staff) could not recreate any failures. Out of an abundance of caution I (the MS) removed the lift from service until such time that the staff could show what happened. The lift was removed from use on the floor at around 10:00 a.m. on [DATE]. All other mechanical lifts were inspected at this time as well to assure all safety features are present and lifts are indeed in working order. The mechanical lift was out of service until the staff involved could show how the incident occurred. II. Facility plan of correction A. Immediate action to correct the deficient practice for Resident #6 Both CNA #1 and CNA #3 demonstrated the use of appropriate mechanical lift procedures on [DATE] immediately following Resident #6's fall. Both CNA's correctly demonstrated use of the lift separately and then together showing the procedure they used to transfer Resident #6. B. Identification of other residents The NHA reviewed care plans and assessments of all residents who required assistance with transferring via mechanical lifts first, and expanded the care plan review and examined residents with recliners in their rooms that might be a fall risk. C. Systematic changes (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

All nursing staff were re-educated on proper mechanical lift procedures and provided a return demonstration of knowledge by [DATE].

D. Monitoring

The NHA was interviewed on [DATE] at 5:41 p.m. The NHA said the facility discussed the [DATE] hoyer lift incident in the quality assurance program improvement (QAPI) meeting and were continuing to monitor.

Interviews and record review during the investigation revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place.

III. Facility policy and procedure

The Limited Lift Program (Safe Patient Handling) policy, revised [DATE], was provided on [DATE] at 11:00 a.m. by the nursing home administrator (NHA). The policy read in pertinent part, The facility will assess residents for the need for assistance with transfer activities, mobility or repositioning utilizing a validated mobility assessment by either nursing or therapy. Associates will be responsible for utilizing mechanical lifting devices, transferring devices, proper body mechanics to lift, transfer and/or pivot non-ambulatory patients as indicated.

The facility must ensure that the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance devices to prevent accidents. The facility will provide education to residents and resident representatives on the use of a mechanical lifting device to ensure the safety of the resident and associate.

IV. Mechanical lift manual

The user manual for the Golvo 7000ES/7007ES mechanical lift was provided by the NHA on [DATE] at 11:00 a.m. It read in pertinent part, Before using always make certain that:

-Persons using the equipment have received appropriate instructions and training;

-All manuals have been carefully studied and understood;

-The sling is securely locked into position on the sling bar and cannot accidentally unlock;

-All lift components, material and seams are intact and show no signs of damage or wear;

-The patient is positioned firmly and securely so that no part of the body can be injured; and,

-The safety split or pin or nut is securely fastened in the bolt that holds the sling bar or other accessories.

V. Resident status

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #66, over the age of 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included metabolic encephalopathy (chemical imbalance in the blood affecting the brain), chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, dementia, weakness and difficulty walking. The [DATE] minimum data set (MDS) assessment revealed the resident had a memory problem and was severely impaired in her decision making abilities for everyday life based on the staff interview for mental status. She was dependent on care for toileting hygiene, transfers and rolling from left to right/right to left in bed, needed substantial assistance with dressing, bathing and personal hygiene and moderate assistance with oral hygiene and set up help only with eating. The MDS assessment did not indicate the resident had a fall. VI. Record review The fall care plan, revised [DATE], documented Resident #6 was at risk for falling and injuring herself due to her diagnoses of muscle weakness, difficulty walking and dementia. She required extensive assistance for most of her daily care. She used her wheelchair as her primary mode of locomotion in the facility. The care planned intervention on [DATE] included the use of a mechanical lift with the assistance of two staff members to transfer Resident #6. Resident #6's progress notes documented the following: On [DATE] two CNAs transferred Resident #6 with the mechanical lift. Resident #6 was in the sling and the CNAs proceeded to lift the resident off her bed and into her wheelchair when one of the sling's handles came off of the mechanical lift sling bar. Resident #6 then fell to the floor and hit her head. There was a laceration to the back of her head. The resident was transported by ambulance to a local hospital at 4:40 p.m. On [DATE] Resident #6 returned to the facility from the hospital at approximately 9:00 p.m. with a scalp laceration closed by staples. On [DATE] Resident #6's fall interventions were reviewed and remained unchanged. She was re-assessed for the correct sling size which also remained unchanged for the resident and she remained appropriate for the mechanical lift. On [DATE] Resident #6 refused to use her arm in a full range of motion and immediate x-rays were ordered. On [DATE] Resident #6 was non weight bearing on her right arm due her right clavicle (collarbone) fracture diagnosis. VII. Staff interviews The NHA and MS were interviewed together on [DATE] at 10:36 a.m. The MS said, on [DATE], the day after Resident #6's fall, he and the NHA utilized the same mechanical lift staff used during Resident #6's fall multiple times to complete a transfer with the mechanical lift and the sling stayed secure each time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The NHA said CNA #1 and CNA #3 demonstrated separately how to use the mechanical lift and the sling after Resident #6's fall and both CNAs provided a correct demonstration on how to use the lift for a resident transfer. The NHA said Resident #6's sling hung on the back of her bathroom door and was kept in her room. CNA #1 was interviewed on [DATE] at 3:15 p.m. CNA #1 said she assisted in Resident #6's transfer on [DATE] from the resident's bed to the resident's wheelchair. CNA #1 said she used the sling hanging on the back of Resident #6's door for the transfer. CNA #1 said she was trained to use the lift during her CNA training at the facility, and there was ongoing training and a reeducation after Resident #6's fall. CNA #1 said one of the four sling handles came off the lift itself and she noticed this after the resident fell . CNA #1 said she and CNA #3 placed the sling under Resident #6 while she was in bed. CNA #1 said Resident #6 fell from the lift during her transfer off her bed, and when the resident fell , she and CNA #3 noticed a sling handle was not secured on the hook. She said she did a visual inspection to ensure the sling was in the correct place prior to Resident #6's transfer. CNA #1 said she and CNA #3 followed the correct mechanical lift procedures during Resident #6's transfer. Registered nurse (RN) #1 was interviewed on [DATE] at 3:15 p.m. RN #1 said the right shoulder side of the sling detached from the mechanical lift during Resident #6's transfer. RN #1 said ongoing assessment occurred for CNA #1 and CNA #3 for four weeks and the staff were assessed at random five times a week for 12 weeks. She said staff monitoring started immediately after the fall on [DATE]. The DON and RN #1 were interviewed together on [DATE] at 11:00 a.m. RN #1 said when she entered the resident's room after Resident #6 fell , CNA #1 and CNA #3 had already unhooked the sling from the mechanical lift. RN #1 said one sling handle came unhooked and Resident #6 slipped out of the sling and fell , which resulted in a laceration on the back of her head. RN #1 said Resident #6 was transported to the hospital and assessed. RN #1 said the CNAs reported Resident #6 was in the mechanical lift and was lifted from her bed when she fell . RN #1 said the facility ordered and replaced all the mechanical lift slings in the facility. RN #1 said she did not work on the recreation of Resident #6's fall with the MS and the NHA. The DON and RN #1 said based on their interviews with CNA #1 and CNA #3, Resident #6's sling was connected correctly to the lift during her transfer. RN #1 said if the sling was not attached to the lift correctly Resident #6 would have fallen back onto her bed immediately after the staff began lifting her. RN #1 said Resident #6 was already lifted off the bed and was mid-transfer off the bed when she fell from the sling. The DON said she interviewed both CNA #1 and CNA #3 after Resident #6's fall. The DON said CNA #1 and CNA #3 both demonstrated the correct use of the mechanical lift to her and the MS after Resident #6's fall. The DON said if a sling was broken, frayed or staff were unsure if it was intact, the staff could bring the sling to a nurse on duty. She said the nurse on duty could then assess the sling. The DON said the facility assessed the sling used during Resident #6's fall and the sling was intact and had no deformities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #4 was interviewed on [DATE] at 1:35 p.m. CNA #4 said she received mechanical lift training prior to starting work as a CNA. CNA #4 said two staff members should always be present to use the mechanical lift while transferring a resident. CNA #4 said after Resident #6's fall on [DATE], the staff were required to demonstrate their knowledge on how to use the mechanical lift. CNA #4 said before the mechanical lift slings were utilized in the facility, the slings were inspected by a nurse. CNA #4 said she knew the size of a resident's sling because there was a posted sign listing all residents' correct sling sizes which all staff had access to. CNA #4 said she checked the slings prior to use to see if the sling was frayed or torn and would tell a nurse if she observed damage to a sling. CNA #4 said while using a mechanical lift to transfer a resident, one staff member controlled the lift while the second staff member guided the resident. CNA #4 said guiding the resident involved holding the sling or the resident's legs to keep the resident from moving. CNA #4 said she was trained how to the lift's emergency button and, if the mechanical lift malfunctioned, the emergency button stopped the mechanical lift immediately. CNA #5 was interviewed on [DATE] at 1:40 p.m. CNA #5 said he had extensive training on how to use the mechanical lift and sit to stand hoyer lift. CNA #5 said mechanical lifts were always operated with two staff members attending. CNA #5 said he was shown how to use the mechanical lift, had demonstrated how to use the lift with a coworker and he himself had been in a lift for training. CNA #5 said he was trained and knew how to use the emergency button on a lift but had not had to use it. CNA #5 said the staff member guiding the resident during a transfer steadied the resident while in the sling. CNA #5 said one person operated the lift and both staff members should both be watching the resident during the transfer. CNA #5 said if he ever determined a lift was not safe to use he would tell a nurse for assistance. He said he had received training to use a mechanical lift prior to working as a CNA and received ongoing training and was observed using a mechanical lift. The NHA, DON and RN #1 were interviewed together on [DATE] at 1:45 p.m. The NHA said CNA #3's written statement (see above) indicated Resident #6 fell and then the CNAs looked up and saw a sling handle had come off the sling bar hook. The NHA said Resident #6 fell quickly. The NHA said the facility was unsure how the resident fell and the sling came unhooked if all the procedures were followed correctly. The DON said CNA #1 and CNA #3 reported all the sling hooks were attached to the mechanical lift prior to Resident #6's transfer on [DATE]. The DON said the resident was not over the chair but lifted and being transferred over the floor when she fell . The DON said when CNA #1 and CNA #3 demonstrated how they used the mechanical lift to recreate Resident #6's lift prior to her fall, she did not take notes or write down what the staff said or what they demonstrated. RN #1 said the sling was intact immediately after Resident #6's fall and it was not frayed or torn. CNA #3 was interviewed on [DATE] at 3:15 p.m. CNA #3 said she was one of two CNAs who transferred Resident #6 with the mechanical lift on [DATE]. CNA #3 said Resident #6 fell from the sling attached to the lift very quickly. CNA #3 said CNA #1 attached the sling to the hooks prior to the transfer and she (CNA #3) guided the resident by her legs. She said both she and CNA #1 gave a quick glance to ensure the sling was connected correctly and it was. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #3 said Resident #6 was lifted out of the bed and the CNAs started to turn the lift when Resident #6 slid out of the sling. CNA #3 said Resident #6 slid all the way out of the sling onto the floor. She said immediately after the resident fell , both CNAs saw the right shoulder sling handle was disconnected from the sling bar. CNA #3 said she went to get a nurse while CNA #1 stayed with the resident. CNA #3 said the additional training post-fall helped assure her that she used the right sling size for Resident #6 during her transfer on [DATE]. CNA #3 said she and CNA #1 transferred Resident #6 correctly. The NHA said the facility identified the incident, investigated, and put in place a plan of correction that included facility wide education that was fully completed by [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37166 Based on observations and staff interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one of two units. Specifically, the facility failed to: -Ensure licensed practical nurse (LPN) #3 followed proper infection control during medication administration; and, -Follow proper infection control procedures by sanitizing scissors pulled from a nurses pocket prior to their use for Resident #21's wound care. Findings include: I. Facility policy and procedure The Infection Prevention and Control Program policy, revised 5/19/23, was provided by the nursing home administrator (NHA) on 7/17/24 at 4:35 p.m. The policy read in pertinent part, General procedures include: Ensure staff follow the Infection Prevention and Control Program policy and procedures such as hand hygiene and appropriate use of PPE (personal protective equipment) and to the degree possible/consistent with the resident's capacity, provide supplies necessary to adhere to recommended infection prevention and control practices such as hand hygiene supplies, respiratory hygiene and cough etiquette, PPE and environmental cleaning and disinfection. Implementing strategies to achieve the goals include methods to reduce the risks associated with procedures, medical equipment and medical devices, including the following: appropriate storage, cleaning, disinfection and/or disposal of supplies and equipment, no resume of equipment designated by the manufacturer as disposable in a manner that is consistent with regulatory and professional standards, and the appropriate use of PPE. II. Failure to follow proper infection control during medication administration A. Observations On 7/15/24 at 9:59 a.m. licensed practical nurse (LPN) #3 was observed as she was administering morning medications to residents. LPN #3 dropped one pill on the medication cart. -LPN #3 picked the pill up with her ungloved hands and put it back in the medication cup. At 10:08 a.m. LPN #3 was observed administering topical medications in a resident's room. LPN #3 applied lotion to the resident's ankle using her left gloved hand. She was not wearing gloves on her right hand which she had used to remove the resident's sock. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN #3 did not wash her hands after touching the resident's ankle and before offering the resident the oral medications from a medication cup. B. Staff interviews The infection preventionist (IP) was interviewed on 7/16/24 at 11:45 a.m. The IP said all medications that came in contact with the medication cart surface should be disposed of because the medication cart surface was considered unclean. The IP said nurses should wash their hands when they removed gloves. She said LPN #3 should have washed her hands after she was finished applying lotion, after she removed her gloves and prior to offering the resident her medications. She said LPN #3's hands were not considered clean since they came in contact with the resident's feet when she helped the resident remove her sock. 47151 III. Failure to follow proper infection control procedures during wound care A. Observations On 7/15/24 at 10:50 a.m. registered nurse (RN) #1 and RN #3 were observed providing wound care to Resident #21 in his room. Resident #21 was seated in his chair while wound care was provided to his right lower leg. Resident #21's wound care supply container was set on his bedside table next to his chair. At 10:53 a.m. RN #3 began to unwrap the top of Resident #21's ace bandage from his right calf. RN #3 reached into her right pants pocket and removed a pair of medical grade bandage scissors with her hand. -Without cleaning or sanitizing the scissors, RN #3 cut the top of Resident #21's wound bandage around his right calf, touching the scissors to his skin. RN #3 then placed the scissors on the resident's bedside table and continued with Resident #21's wound care. -At 11:05 a.m. RN #3 placed the scissors back in her right pants pocket without cleaning or sanitizing the scissors. RN #1 was interviewed at 11:07 a.m. after the completion of Resident #21's wound care. RN #1 said RN #3 used her own personal scissors to perform wound care on Resident #21, but the facility had scissors in each resident's individual wound care supply container. B. Staff interviews RN #4 was interviewed on 7/16/24 at 10:39 a.m. RN #4 said if personal scissors were used to provide wound care, the scissors should be on top of the medication cart and not in a clothing pocket. RN #4 said if scissors were kept in a staff member's pocket, the scissors would need to be cleaned and sanitized prior to providing wound care and then cleaned again after use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065368	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER: Life Care Center of Greeley		STREET ADDRESS, CITY, STATE, ZIP CODE: 4800 W 25th St Greeley, CO 80634	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed again on 7/16/24 at 11:00 a.m. RN #1 said scissors were kept in each residents' container of supplies for wound care. RN #1 said if a nurse used their personal scissors for wound care, the scissors should be sanitized before and after providing a resident's wound care, and the scissors should also be kept in their own holster or package. RN #1 said she corrected RN #3 after completing Resident #21's wound care and told RN #3 that she should have sanitized her scissors prior to using them to cut the resident's wound dressing. RN #1 said RN #3 did sanitize her scissors after RN #1 instructed her to do so. RN #1 said RN #3 used her own scissors because the scissors usually in Resident #21's wound supply container were not present for his wound care on 7/15/24. The infection preventionist (IP) was interviewed on 7/16/24 at 4:10 p.m. The IP said wound care scissors pulled from a pocket in a nurse's clothing should be cleaned and sanitized before and after each use and the scissors should have their own holster to carry them in.