STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to ensure consent was obtained for the use of psychotropic medications for one (#226) of five residents reviewed for unnecessary medications out of 60 sample residents. Specifically, the facility failed to ensure informed consent, which included the risks associated with taking a psychotropic medication, were obtained for Resident #226 prior to the administration of a psychotropic medication. Findings include: I. Facility policy and procedure The Psychotropic Medication Use policy and procedure, revised 2/8/21, was provided by the nursing home administrator (NHA) on 11/22/24 at 8:38 a.m. It revealed in pertinent part, Psychotropic consent will be obtained from the resident and or family on admission or within 72 hours of admission. II. Resident #226 A. Resident status Resident #226, age 74, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included adjustment disorder with mixed anxiety and depressed mood and depression. The 11/17/24 brief interview for mental status (BIMS) assessment revealed the resident was moderately cognitively impaired with a score of 10 out of 15. B. Record review The antidepressant medication care plan, initiated 11/15/24, revealed Resident #226 received an antidepressant medication due to her depression and adjustment disorder diagnoses. Pertinent interventions included administering the medication as ordered and observing for side effects and effectiveness of the medication each shift. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #226's November 2024 CPO revealed the following physician's order related to psychotropic medications: Venlafaxine (antidepressant) oral capsule extended release. Give 225 milligrams (mg) by mouth in the morning for depression, ordered 11/15/24. Review of Resident #226's electronic medical record (EMR) revealed a psychoactive medication therapy consent form for Venlafaxine dated 11/14/24. -However, the form was not signed by the resident and the staff member that obtained the consent until 11/18/24, four days after the resident's admission to the facility. Resident #226's November 2024 medication administration report (MAR) revealed the following Venlafaxine was marked as administered once a day from 11/15/24 through 11/20/24 and antidepressant monitoring was marked as completed each shift from 11/14/24 through 11/20/24. -However, the psychoactive medication therapy consent form was not signed by the resident until 11/18/24 (see above). III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 11/21/24 at 12:47 p.m. LPN #2 said the nurses at the facility were the ones who went over the medication consents with the residents along with the rest of their admission paperwork. LPN #2 said there had been times where agency staff had missed the consent forms and not had the resident sign them, or missed the medication orders and did not realize the resident needed a consent form. LPN #2 said the unit manager went through and checked to make sure the admissions packets were signed appropriately. LPN #1 was interviewed on 11/21/24 at 1:17 p.m. LPN #1 said the nurse that admitted the resident was responsible for ensuring all of the medication consents were signed. LPN #1 said there was sometimes a delay in getting the consents signed if the resident wanted a family member to read through it. LPN #1 said the nursing staff could not administer an antidepressant or other psychoactive medication until the resident had signed the respective consent form. LPN #1 said the unit manager followed up the next day after a resident was admitted to ensure all of the consent forms were signed appropriately on admission, and if they were not signed, the unit manager would follow up with the resident and try to answer any questions the resident might have. Registered nurse (RN) #2 was interviewed on 11/21/24 at 3:44 p.m. RN #2 said Resident #226 admitted to the facility with a physician's order for an antidepressant medication on 11/14/24. RN #2 said the facility had a consent form that the resident was supposed to sign prior to receiving the medication. RN #2 said sometimes the nurses missed the medication consent forms or the residents refused to sign them. RN #2 said she was not sure what happened in Resident #226's case, but thought that the agency nurse that admitted the resident may have missed the consent form for that medication. RN #2 said she, or one of the other unit managers, usually reviewed the admission paperwork to ensure all the paperwork was filled out correctly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The director of nursing (DON) was interviewed on 11/21/24 at 5:56 p.m. The DON said antidepressant medications had a consent form that the resident needed to sign immediately when they went through the admission packet with the admitting nurse, or have a family member come in to sign it. The DON said the resident was not supposed to receive psychotropic medication prior to signing the consent form. The DON said the hospital sent the facility a list of medications which the resident's practitioner then had to approve before it was ordered from the pharmacy. The DON said usually by the time the facility received the medication from the pharmacy, the consent form had been signed. The DON said RN #2 was the one that wrote the consent form so she guessed the form was dated incorrectly. The DON said she had not heard anything about Resident #226 not wanting to sign the medication consent form. The DON said consent forms were needed for any high risk medications to ensure the resident knew what they were taking, why they were taking it and what the side effects could be. D. Facility follow up A signed statement from Resident #226 was provided by the NHA on 11/22/24 at 11:29 a.m. (after the survey exit) The statement revealed Resident #226 signed all of her consent forms upon admission on 11/14/24, including her psychoactive medication therapy consent form for Venlafaxine. The statement was undated and also signed by a member of the staff. -However, the medication consent form in Resident #226's EMR during the survey was signed by Resident #226 and a staff member on 11/18/24, not 11/14/24 (see record review above).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51163 Based on record review and interviews, the facility failed to honor resident choices for one (#53) of one resident out of 60 sample residents. Specifically, the facility failed to ensure Resident #53's preference to have her bed bath completed during the day shift was honored. Findings include: I. Resident #53 A. Resident status Resident #53, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included fracture of left femur, end stage renal disease, type two diabetes and morbid obesity. The 10/10/24 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 was dependent on staff for toileting, bathing, and lower body dressing and was partially dependent on staff for all other activities of daily living (ADL). The assessment indicated that it was very important that she was able to choose between a tub bath, shower, bed bath or sponge bath. B. Resident interview Resident #53 was interviewed on 11/18/24 at 11:27 a.m. Resident #53 said bathing was scheduled based on the room the resident resided in. She said the certified nurse aide (CNA) would come to give her a bed bath at night. She said she had asked to be put on the day shift bathing schedule since she was admitted and the facility still had not accommodated her request. She said her hair had only been washed once since being admitted to the facility. Resident #53 was interviewed again on 11/20/24 at 8:56 a.m. Resident #53 said she was unable to sit in the shower chair comfortably, which was why she received bed baths. She said she had refused her bed bath because the CNA would come to give her a bed bath between 7:00 p.m. to 8:00 p.m. She said it was too late to receive a bed bath as she was starting to wind down for the evening. She said she requested to be moved to the day shift for her baths, but it still had not been done. Cross reference F684: The facility failed to prevent the development and worsening of Resident #53's abdominal wounds. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADL care plan, revised 10/5/24, documented Resident #53 required assistance with ADLs due to her recent injury. It documented Resident #53 preferred to get up around 6:00 a.m. and preferred bed baths on her scheduled bath days. -The care plan did not address Resident #53's preference to receive bed baths during the day. The Kardex (a nursing tool that summarizes resident information regarding daily schedules and interventions) documented Resident #53 was scheduled to receive a bed bath on Wednesday and Saturday nights. Resident #53's preference sheet documented Resident #53 should receive a bed bath on Tuesdays, Thursday and Saturdays. -It did not document the resident preference of day or night. The shower documentation from 10/4/24 to 11/17/24 documented Resident #53 refused all of her bed baths except for one, on 11/3/24. It documented Resident #53 had requested to be changed from the night schedule to the day schedule and on days in which she did not receive dialysis on 10/12/24 and 11/16/24 II. Staff interviews CNA #6 was interviewed on 11/21/24 at 9:59 a.m. CNA #6 said she never assumed a resident wanted a certain type of bath or shower and would ask them each time. She said she asked each resident when each resident preferred to have their bath or shower. She said if a resident refused, the resident had to sign a sheet of paper, but they would try and reschedule their bath or shower for another day and time. The director of nursing (DON) was interviewed on 11/21/24 at 5:38 p.m. The DON said the preferences sheet was completed upon admission and should identify when the resident preferred a shower or bath. She said showers were split between the day shift and the evening shift. She said if a resident communicated they wished to have their bathing day or time moved, then the residents preference should be honored. The DON said she was not made aware by the floor staff that Resident #53 had been refusing her bed baths because of the time of day they were being offered. She said she would change Resident #53 to the day shift immediately. The DON confirmed Resident #53's preference had been documented on 10/12/24 and 11/16/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to prevent misappropriation of property for three (#228, #46 and #229) of three residents reviewed for personal property out of 60 sample residents. Specifically, the facility failed to prevent the loss of property for Resident #228, Resident #46 and Resident #229 during their time in the facility. Findings include: I. Facility policy and procedure The Dignity policy and procedure, revised 8/15/22, was provided by the nursing home administrator (NHA) on 11/22/24 at 8:38 a.m. It revealed in pertinent part, Residents' private space and property shall be respected at all times. Staff will not handle or move a resident's personal belongings (including radios and televisions) without the resident's permission. II. Resident #228 A. Resident status Resident #228, age less than 65, was admitted on [DATE] and discharged home on 7/29/24. According to the November 2024 computerized physician orders (CPO), diagnoses included muscle weakness and hypotension (low blood pressure). The 7/23/24 brief interview for mental status (BIMS) assessment revealed the resident was cognitively intact with a score of 14 out of 15. B. Resident interview Resident #228 was interviewed on 11/21/24 at 6:29 p.m. via telephone. Resident #228 said her daughter had brought her some money to get her hair done while she was at the facility but she had not been able to get her hair done the day her daughter brought the money. Resident #228 said her sister visited her the next day and took her outside, but before they went outside, Resident #228 put her money into her bag inside her closet. Resident #228 said when she came back inside, the money was no longer in her bag. Resident #228 said an unidentified facility staff member was standing across the hallway from her room and when she told the staff member what happened, the staff member said she had not seen anything. Resident #228 said she spoke with the police but had not heard any updates about the investigation. Resident #228 said the facility never offered her a lockbox or a safe, and if they had, she would have given them all her belongings to secure. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's misappropriation investigation, dated 7/29/24, was provided by the NHA on 11/20/24 at 12:50 p. m. It documented Resident #228 stated she was missing $200. She said she had the money because she was scheduled to have her hair done yesterday (7/28/24) but the beautician was not able to get it done. She said her daughter came today (7/29/24) to pick up the $200 but when she went to get her money from her bag, she noticed her $200 was missing. The resident thought that the money went missing when she went outside with her sister at approximately 3:00 p.m. The police were notified and the resident was re-educated to lock her valuables in the business office manager's (BOM) safe or the director of nursing's (DON) office. The staff was educated about the incident. Based upon the interviews and review of documentation, the facility determined that Resident #228 did have the money and that the money was misplaced while the patient was staying at the facility. The facility would reimburse Resident #228 the full amount of $200. The staff were educated about the incident that occurred and the policy on locking items away for safety. A review of Resident #228's progress notes and electronic medical record (EMR) did not reveal any other information regarding the incident. A grievance for Resident #228, dated 7/25/24, was provided by the DON on 11/21/24 at 3:53 p.m. It revealed Resident #228 was crying because she wanted to have her hair done but the beautician at the facility told her it would be almost $200. Resident #228 was crying because she did not have enough money to pay for that. The resolution listed in the grievance was that the DON spoke with the beautician and determined she charged based on time and that it would take the beautician a long time to brush out Resident #228's hair. -However, both the interview with Resident #228 and the facility's investigation revealed the resident's family member brought her the money to have her hair done (see above). III. Resident #46 A. Resident status Resident #46, age 83, was admitted on [DATE] and discharged home on 11/2/24. According to the November 2024 CPO, diagnoses included muscle weakness and right femoral fracture. The 10/24/24 BIMS assessment revealed the resident was cognitively intact with a score of 15 out of 15. B. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's misappropriation investigation, dated 10/31/24, was provided by the NHA on 11/20/24 at 12:50 p.m. It documented Resident #46 had a smart watch on the charger in her room on Friday 10/25/24. The resident noticed the next morning (10/26/24) that the watch was missing. Resident #46's daughter called the DON on 10/26/24 and reported the watch may have been missing but she wanted to verify before officially reporting. Resident #46's daughter called the DON again on Friday 11/1/24 and officially reported the watch missing. The watch was tracked electronically to a residential address. The police were notified. The facility staff and residents were interviewed immediately, without resolution. Education was completed for residents and staff to secure valuables in the BOM's safe or DON's office. The facility additionally educated the residents and staff to report any suspicious occurrences immediately. Based on interviews and review of documentation, the facility determined the watch could have been taken from the facility. The facility would reimburse the family the cost of the same make and model of the missing watch. A review of Resident #46's progress notes and EMR did not reveal any other information regarding the incident. IV. Resident #229 A. Resident status Resident #229, age 71, was admitted on [DATE] and discharged home on 9/11/24. According to the November 2024 CPO, diagnoses included infection following a surgical procedure and disruption of an external surgical wound. The 8/28/24 BIMS assessment revealed the resident was cognitively intact with a score of 15 out of 15. B. Record review The facility's misappropriation investigation, dated 9/9/24, was provided by the NHA on 11/20/24 at 12:50 p.m. It documented the alleged assailant was identified as certified nurse aide (CNA) #4. Resident #229 stated that she was missing $40. Resident #229 looked in her wallet and noticed the money was missing. Resident #229 thought the money went missing on 9/9/24 but was unsure. The DON and the NHA interviewed all of the residents residing on the same hallway that Resident #229 was residing on. The DON and the NHA interviewed the staff member identified by Resident #229. The police were notified and Resident #229 was re-educated on locking her valuables in the BOM's safe or the DON's office. The identified staff member was immediately suspended pending an investigation. The staff were educated about the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #229 reported she last saw the money on 9/7/24. Resident #229 said she had the money in her wallet, had wrapped the wallet in a towel and placed the towel in a drawer in her bathroom. She said she noticed that the wallet had been unwrapped and that the money was missing on 9/9/24 and reported it to management on 9/10/24. Resident #229 was interviewed by the facility staff and reported that CNA #4 had asked her questions about the wallet. Resident #229 hid the wallet out of caution by wrapping it in a towel and placing it in a drawer in her bathroom. Resident #229 said she was 90% sure that CNA #4 had taken the money but was not 100% certain. CNA #4 was interviewed privately by the facility's administration staff. CNA #4 reported he was not aware that Resident #229 had money in her room. Based upon the interviews and review of documentation, the facility determined that Resident #229 did have the money and that the money was misplaced while she was staying at the facility. The facility would reimburse Resident #229 the full amount of $40. Re-education was provided to Resident #229 on how and where to keep valuable or personal items locked in the DON's office or the BOM's safe. Resident #229 was resistant to locking up her wallet. An interview with CNA #4, dated 9/10/24, was included with the investigation. It revealed CNA #4 was asked about the missing money from Resident #229's room. CNA #4 said he knew nothing about the money. CNA #4 then said he was upset and did not want to talk with the interviewer anymore. A review of Resident #228's progress notes and EMR did not reveal any other information regarding the incident. V. Staff interviews The NHA was interviewed on 11/20/24 at 1:37 p.m. The NHA said the facility did not have the police reports for the incidents but that he requested the reports from the local police department. CNA #2 was interviewed on 11/21/24 at 9:50 a.m. CNA #2 said he had not heard anything about any residents having their property misplaced. CNA #2 said he had not received any training about what to do when residents' property went missing, but that he would go tell the DON if he heard anything about missing property. CNA #3 was interviewed on 11/21/24 at 10:33 a.m. CNA #3 said she had heard about residents having property go missing on other hallways but did not know much about the situations. CNA #3 said she had received training on what to do about residents reporting missing property and that the facility staff had meetings about it once a month. Licensed practical nurse (LPN) #2 was interviewed on 11/21/24 at 12:47 p.m. LPN #2 said she had not personally received any training or education about what to do when residents reported missing property. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON, the NHA, and the chief operating officer (COO) were interviewed together on 11/21/24 at 2:16 p.m. The DON said if a resident reported something missing, the facility staff filed a grievance, reviewed the grievance with the NHA and the DON and then filed a police report. The DON said the facility was trying to investigate CNA #4's role in the incidents, since CNA #4 had been involved in caring for both Resident #228 and Resident #229. The DON said they had suspended CNA #4 but he later quit. The DON said Resident #46's smart watch had been tracked to a residential address. The DON said the facility administrators had cross-referenced the residential address with their employees' home addresses but did not identify any potential suspects among the staff. The DON said the police also investigated the incident, including looking at the employees' families' home addresses and could not identify any connection to the facility staff. The NHA said the police department denied his request for Resident #229's police report as it was an ongoing investigation. The NHA said he had not heard back from the police department yet regarding the other two residents' investigations. The DON said the police had reached out with updates in the past regarding any ongoing investigations. The COO said the facility staff received training on missing property upon hire, annually, and if an incident occurred. The DON said an all-staff meeting on misappropriation of resident property was conducted on 11/4/24. The NHA said they had educated the staff on misappropriation and that the residents could secure their items in the BOM safe or the DON offices. The NHA said the CNAs and nurses should have been informing residents where they could secure their valuables and that the information on that subject was also in the residents' admissions agreement. The COO said the facility would be keeping in contact with the police department more regularly going forward. The NHA said if a resident declined to secure their valuables in the BOM safe or the DON office, the facility would encourage the resident's family to take their valuables home with them. The DON said she had discussed Resident #228's hair appointment with the resident and Resident #228 said she did not have enough money for the hair appointment and complained about how expensive it was. The DON said they filed a grievance with Resident #228 related to this prior to the incident in which Resident #228 reported having money go missing. The COO said Resident #228's daughter had visited the resident and that he thought the resident's daughter may have taken the money home. The COO said from a customer service standpoint, the facility generally just reimbursed any money residents report missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, resident reports of missing property continued to occur at the facility and the facility had not implemented a process to effectively prevent misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on interviews and record review, the facility failed to develop an acute/baseline care plan for four (#380, #376, #382 and #225) of four residents reviewed for baseline care plans out of 60 sample residents. Specifically, the facility failed to ensure Resident #380, #376, #382 and #225 were provided a copy of their baseline care plan with 48 hours of admission to the facility. Findings include: I. Facility policy and procedure The Baseline Care Plan policy and procedure, revised March 2020, was provided by the nursing home administrator (NHA) on 11/22/24 at 8:33 a.m. It read in pertinent part, It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan and manage resident care as evidenced by documentation from admission through discharge for each resident. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the patient's strengths, limitations, and goals. The care plan will be specific and appropriate to the individual needs for each resident. The interdisciplinary care plan will be developed through collaborative efforts of the IDT and other health care professionals. The care plan will be patient centered emphasizing the resident's and/or family's goals. The facility will develop, implement, and provide care in accordance with a comprehensive person-centered care plan for the resident consistent with regulatory requirements. The care plan is to include measurable objectives and timeframes to meet a resident's medical, nursing, psycho-social, and functional needs identified with completion of the comprehensive assessment. To the extent that is practical, the resident and/or family will be involved in the development of their care plan. The care plans will be modified when needed to meet the resident's current needs, problems, and goals. Any revision, additions, or deletion to the plan of care will be dated and initiated. II. Resident #380 A. Resident status Resident #380, age 76, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included aftercare following joint replacement surgery and presence of bilateral artificial knee joint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/18/24 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 moderate assistance with activities of daily living (ADL). B. Resident interview Resident #380 was interviewed on 11/19/24 at 11:41 a.m. Resident #380 said she was not aware of her plan of care other than she had been receiving physical and occupational therapy. She said she had not been provided a written copy of her plan of care when she was admitted to the facility. She said she was frustrated that she did not know what was happening. C. Record review The 11/14/24 care conference progress note documented an initial care conference meeting was held with the case manager, therapy, the resident and the resident's family. It documented the resident was oriented to the role of the case manager, how to contact the case manager, discussed discharge planning processes, services and guidelines. The progress note indicated a copy of the resident's medication list and care plan were provided to the resident. -However, a review of Resident #380's electronic medical record (EMR) on 11/21/24 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident and/or responsible party were provided a copy of the baseline care plan, which was identified by the director of nursing as the facility's process (see DON interview below). III. Resident #376 A. Resident status Resident #376, age 76, was admitted on [DATE]. According to November 2024 CPO, diagnoses included encounters for other orthopedic aftercare, difficulty in walking, muscle weakness and right and left foot drop. The 11/13/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She required maximum assistance with all ADLs. B. Resident interview Resident #376 was interviewed on 11/18/24 at 4:03 p.m. Resident #376 said she was visiting from another state when she ended up in the hospital for lumbar surgery. She said she had not received her care plan in writing since she was admitted to the facility. She said she had not received any communication from the case manager since she was admitted . C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/14/24 care conference progress note documented an initial care conference meeting was held with the case manager, therapy, resident, and family. It documented the resident was oriented to the role of the case manager, how to contact the case manager, discussed discharge planning processes, services and guidelines. The progress note indicated a copy of the resident's medication list and care plan were provided to the resident. -However, a review of Resident #376's EMR on 11/21/24 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident and/or responsible party were provided a copy of the baseline care plan, which was identified by the DON as the facility's process (see DON interview below). IV. Resident #382 A. Resident status Resident #382, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included fracture of left femur, history of falls, muscle weakness and gout. The 11/15/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She required maximum assistance with all ADLs. B. Resident interview Resident #382 was interviewed on 11/18/24 at 4:52 p.m. Resident #382 said she had not been given a copy of her care plan since her admission to the facility. She said she had not received any communication regarding her discharge plan. C. Record review The 11/6/24 care conference progress note documented an initial care conference meeting was held with the case manager, therapy, resident, and family. It documented the resident was oriented to the role of the case manager, how to contact the case manager, discussed discharge planning processes, services and guidelines. The progress note indicated a copy of the resident's medication list and care plan were provided to the resident. -However, a review of Resident #382's EMR on 11/21/24 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident and/or responsible party were provided a copy of the baseline care plan, which was identified by the DON as the facility's process (see DON interview below). V. Resident #225 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #225, age 71, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included surgical aftercare and local infection of the skin and subcutaneous tissue. The 11/5/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. B. Record review A progress note dated 11/5/24 at 1:47 p.m. revealed the activities department completed an activities assessment of Resident #225. The activity care plan had been updated to reflect Resident #225's interests. A progress note dated 11/7/24 at 2:42 p.m. revealed a care conference had been completed with Resident #225, her family, the therapy team and Resident #225's case manager. The care conference notes revealed the team discussed discharge planning, processes, services and guidelines. The note documented a copy of Resident #225's medications and her care plan were provided to the resident. -However, a review of Resident #225's EMR on 11/21/24 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident and/or responsible party were provided a copy of the baseline care plan, which was identified by the DON as the facility's process (see DON interview below). VI. Staff interviews Case manager (CM) #2 and the DON were interviewed together on 11/21/24 at 3:46 p.m. CM #2 said she met with residents three to five days after their admission to the facility for an initial care conference. She said during the care conference, the resident's goals, preferences and initial discharge plan was determined with the resident and/or their family. CM #2 said she was not responsible for developing the discharge plan of care. She said the MDS nurse was responsible for developing the baseline care plan and providing each resident a copy within 48 hours of their admission to the facility. The DON was interviewed again on 11/21/24 at 3:57 p.m. The DON said all residents signed the Acknowledgement of Care Plan form upon receiving a copy of the baseline care plan. She said the form was then uploaded into the resident's EMR. The DON confirmed the facility did not have signed Acknowledgement of Care plan forms for Residents #380, #376, #382 and #225. 50219

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on observations, record review and interviews, the facility failed to develop and implement an effective discharge plan for nine (#376, #378, #380, #371, #388, #382, #10, #185 and #225) of 10 residents reviewed for discharge planning out of 60 sample residents. Specifically, for Residents #376, #378, #380, #371, #388, #382, #10, #185 and #225, the facility failed to: -Ensure residents and their representatives were involved in the development of the discharge plan; -Ensure the discharge plan of care was updated with the residents' discharge goals; and, -Ensure the discharge planning process was documented in the residents' electronic medical records (EMR). Findings include: I. Facility policy and procedure The Admissions, Readmission, Transfers, and Discharge Process policy and procedure, revised February 2023, was provided by the nursing home administrator (NHA) on 11/22/24 at 8:33 a.m. It read in pertinent part, It is the policy of this facility to permit each resident to remain in the facility, and not mandate a transfer out of the facility or discharge for the resident from the facility, except in limited circumstances. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be provided at the facility or the mandated transfer out of the facility or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. Staff involved in the move in, transfer and move out process will ensure that the focus is the resident and their family and their needs and concerns. II. Resident #376 A. Resident status Resident #376, age 76, was admitted on [DATE]. According to November 2024 computerized physician orders (CPO), diagnoses included encounters for other orthopedic aftercare, difficulty in walking, muscle weakness and right and left foot drop. The 11/13/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for a mental status (BIMS) score of 12 out of 15. She required maximum assistance with all activities of daily living (ADL). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview and observation Resident #376 was interviewed on 11/18/24 at 4:03 p.m. Resident #376 said she was visiting from another state when she ended up in the hospital for lumbar surgery. She said she had not received any communication regarding discharge planning. She said she felt she was forced to stay at the facility until the case manager deemed she was able to go home. She said she had not received any communication from the case manager since she was admitted to the facility. On 11/20/24 at 10:19 a.m., Resident #376 and certified occupational therapy assistant (COTA) #1 were in Resident #376's room. Resident #376 told COTA #1 that she was being discharged but she had not received any information. COTA #1 asked Resident #376 if she had received a Notice of Medicare Non-Coverage (NOMNC) and Resident #376 responded she had not received anything. COTA #1 told the resident she had not been told the resident was discharging and would go find out more information. Resident #376 refused therapy saying she was being discharged . C. Record review The discharge care plan, initiated 11/11/24, documented Resident #376 wanted to be involved in her discharge planning. The interventions included communicating with the resident and/or family as needed related to the resident's progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and continuing to encourage the resident to make an effort toward achieving their goals. -Upon review, the care plan was not person-centered, had similar wording for every resident and did not document Resident #376's specific discharge goal or include any revisions or updates. The 11/18/24 physician's progress noted documented the resident's discharge date was to be determined. The 11/20/24 daily skilled nursing progress note documented Resident #376 had a projected discharge date of the following week. -However, a review of the resident's EMR did not reveal documentation of an active discharge planning process. Resident #376 was discharged on [DATE]. III. Resident #378 A. Resident status Resident #378, age 80, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included difficulty in walking, muscle weakness, infection and inflammatory reaction due to internal right knee prosthesis, sepsis due to methicillin resistant staphylococcus aureus (MRSA) and adjustment disorder with mixed anxiety and depressed mood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/30/24 MDS assessment revealed the resident had moderate cognitive impairment with a brief interview for a mental status score of nine out of 15. She required substantial to maximum assistance with all (ADLs. B. Resident interview Resident #378 was interviewed on 11/18/24 at 3:48 p.m. Resident #378 said the facility had not discussed discharge plans with her. She said she had concerns about getting to out-patient physical therapy because she did not have any transportation. She said she had not been informed of any potential options for once she went home from the facility. She said she had not received any communication from the case manager since her initial care conference the first week she was admitted . C. Record review The discharge care plan, initiated 11/11/24, documented Resident #378 wanted to be involved in her discharge planning. The interventions included communicating with the resident and/or family as needed related to the resident's progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and continuing to encourage the resident to make an effort toward achieving their goals. -Upon review, the care plan was not person-centered, had similar wording for every resident and did not document Resident #378's specific discharge goal or include any revisions or updates. -The daily nursing progress notes from 11/5/24 to 11/20/24 did not reveal documentation of any active discharge planning for Resident #378. -A review of the resident's EMR did not reveal documentation of an active discharge planning process. IV. Resident #380 A. Resident status Resident #380, age 76, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included aftercare following joint replacement surgery and presence of artificial knee joint, bilateral The 11/18/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required moderate assistance with ADLs. B. Resident interview Resident #380 was interviewed on 11/19/24 at 11:41 a.m. Resident #380 said she had not received any communication regarding her discharge plan or options for when she returned home. She said she felt like she was at the facility until they decided she could go home and she did not have any input. Resident #380 was interviewed again on 11/21/24 at 11:13 a.m. Resident #380 said a case manager came into her room and had her sign a document indicating she would be discharging on 11/22/24. She said prior to this meeting, she had not received any information or updates on her discharge status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The discharge care plan, initiated 11/11/24, documented Resident #380 wanted to be involved in her discharge planning. The interventions included communicating with the resident and/or family as needed related to the resident's progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and continuing to encourage the resident to make an effort toward achieving their goals. -Upon review, the care plan was not person-centered, had similar wording for every resident and did not document Resident #378's specific discharge goal or include any revisions or updates. The 11/18/24 physician progress note documented Resident #380's discharge date was to be determined. The 11/20/24 social services progress note documented a NOMNC was issued to the resident on 11/20/24 for a planned discharge of 11/23/24. -However, a review of the resident's EMR did not reveal documentation of an active discharge planning process since her admission. V. Resident #371 A. Resident status Resident #371, age 77, was admitted on [DATE]. According to the November 2024 CPO, diagnoses aftercare following joint replacement surgery, presence of left artificial knee, muscle weakness and post hemorrhagic anemia. The 11/15/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She required moderate assistance with upper body activities and is dependent for walking/transfers that require lower body function. B. Resident and resident's representative interview Resident #371 and the resident's representative were interviewed together on 11/21/24 at 10:12 a.m. Resident #371 said her goal was to return home when she was ready. She said she had not received any communication since her admission regarding her discharge planning until two days prior, when the facility had her sign a document that indicated she was discharging. Resident #371's representative said they did not know if she was ready to return home, so he hired a private caregiver to assist with caring for the resident's ADLs. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The discharge care plan, initiated 11/3/24, documented Resident #371 wanted to be involved in her discharge planning. The interventions included communicating with the resident and/or family as needed related to the resident's progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and continuing to encourage the resident to make an effort toward achieving their goals. -Upon review, the care plan was not person-centered, had similar wording for every resident and did not document Resident #371's specific discharge goal or include any revisions or updates. The 11/20/24 daily skilled nursing progress note documented there was no projected discharge date for Resident #371. However, the 11/20/24 social services progress note documented a NOMNC was issued to Resident #371 on 11/20/24 with the appeal rights explained. -Additionally, a review of the resident's EMR did not reveal documentation of an active discharge planning process. VI. Resident #388 A. Resident status Resident #388, age 80, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, morbid obesity, bilateral primary osteoarthritis and difficulty in walking. The 11/17/24 24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required moderate assistance with ADLs. B. Resident interview Resident #388 was interviewed on 11/19/24 at 9:12 a.m. Resident #388 said she had concerns regarding her discharge process. She said she was told when she was first admitted to the facility that she would be at the facility for two to three weeks. She said it had been two weeks since her admission and she had yet to receive any communication regarding her progress and discharge plan. Resident #388 said she was concerned about discharging home because she lived alone and her home was not set up for wheelchair access, as she was currently confined to a wheelchair. She said she did not have any assistance at home and had not been given any information or options for help when she did return home. C. Record review The discharge care plan, initiated 11/5/24, documented Resident #388 wanted to be involved in her discharge planning. The interventions included communicating with the resident and/or family as needed related to the resident's progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and continuing to encourage the resident to make an effort toward achieving their goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Upon review, the care plan was not person-centered, had similar wording for every resident and did not document Resident #388's specific discharge goal or include any revisions or updates. -The nursing progress notes from 11/5/24 to 11/20/24 did not reveal documentation of discharge planning. -A review of the resident's EMR did not reveal documentation of an active discharge planning process. VII. Resident #382 A. Resident status Resident #382, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included fracture of left femur, history of falls, muscle weakness and gout. The 11/15/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She required maximum assistance with all ADLs. B. Resident interview Resident #382 was interviewed on 11/18/24 at 4:52 p.m. Resident #382 said she had not received any communication about discharge planning since her admission to the facility. She said all she thought about was going home, but she did not know where she stood in that process. C. Record review The discharge care plan, initiated 11/3/24, documented Resident #382 wanted to be involved in her discharge planning. The interventions included communicating with the resident and/or family as needed related to the resident's progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and continuing to encourage the resident to make an effort toward achieving their goals. -Upon review, the care plan was not person-centered, had similar wording for every resident and did not document Resident #388's specific discharge goal or include any revisions or updates. -A review of the resident's EMR did not reveal documentation of an active discharge planning process. VIII. Staff interviews COTA #1 was interviewed on 11/20/24 at 1:29 p.m. COTA #1 said the therapy team was not aware of the discharge for Resident #376. She said the therapy department felt she had not progressed enough and was not ready to discharge from the facility. She said the ankle foot orthosis (AFO - medical device that supports the foot and ankle) had not been delivered yet and was needed in order for Resident #376 to discharge safely. She said they were working on re-routing the AFO to the resident's home instead of the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Case manager (CM) #2 was interviewed on 11/21/24 at 3:46 p.m. CM#2 said she met with each resident she was assigned within three to five days of their admission to the facility. She said the meeting was required at the facility and was called the admission care conference. She said during the meeting, she explained her role, the discharge planning process and discussed any equipment needs of the resident. She said discharge planning should begin on the first day of each resident's admission to the facility and should be documented. She said she was responsible for issuing a NOMNC letter when the resident was ready for discharge, according to the interdisciplinary team (IDT). CM #2 said she did not document any active discharge planning in the resident's EMR. She said she kept it on a log in a binder on her desk. She said each resident had notes regarding their progress with therapy, but did not contain any documentation where the resident and/or family were spoken with or apprised of each resident's progress and movement toward discharge. She said her notes contained updates from the therapy department. She acknowledged updates from the therapy department did not show active discharge planning. CM #2 confirmed Resident #380 was issued a NOMNC. She said she could not recall if she had met with the resident or done any active discharge planning prior to the NOMNC being issued. CM#2 said she had not met with Residents #376, #388 and #382 to discuss any discharge planning. CM #1 and the director of nursing (DON) were interviewed together on 11/21/24 at 4:05 p.m. CM #1 said discharge planning was only documented on a log she kept in her office and not in the residents' EMRs. She said she was not required to document anything in the residents' EMRs other than the NOMNCs being issued and care conference notes. CM#1 said she was not responsible for developing the discharge care plan and making revisions throughout the resident's stay at the facility. She confirmed she was responsible for discharge planning for assigned residents at the facility. She said she was not responsible for identifying barriers for a resident's discharge. CM#1 said she had not met with or discussed resident progress or discharge planning with Resident #378 and #371 since their initial care conferences. 51163 IX. Resident #10 A. Resident status Resident #10, age 80, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included fracture of the T9-T10 (thoracic) vertebra, bipolar disorder and Parkinson's disease. The 11/1/24 MDS assessment revealed that the resident was cognitively intact with a BIMS score of 14 out of 15. She required partial assistance with most of her activities of daily living (ADL) and was dependent on staff for bathing and lower body dressing. The assessment indicated the resident's overall goal was to be discharged back into the community or to go back home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview Resident #10 was interviewed on 11/18/24 at 10:50 a.m. Resident #10 said she had asked the facility staff several times if she could go home. She said the facility staff seemed more interested in completing physical therapy, however, she was admitted because of clostridioides difficile (C-diff - a bacteria that causes diarrhea). She said the case manager told her she would not be able to go home until she could dress herself, shower herself and go to the bathroom by herself. She said she lived at home with her spouse and son who had been assisting her with all of her ADLs for a long time. Resident #10 said she told the case manager she would not be able to do all those things by herself because she had Parkinson's disease. She said the case manager seemed kind of cold and she felt the case manager thought she was lazy. Resident #10 was interviewed a second time on 11/20/24 at 9:53 a.m. Resident #10 said the facility staff had not updated her on her discharge plan or how she was progressing toward her discharge goals. She said no one would give her a straight answer and she felt like a prisoner at the facility. She said the case manager seemed angry when she told her that she wanted to go home. She said she did not think the case manager fully understood that she would never be fully independent because of her Parkinson's disease. Resident #10 was interviewed a third time on 11/20/24 at 3:13 p.m. with a family member present. Resident #10 said the facility held a care conference the first week she was at the facility, but she could not remember what was discussed. She said she was under the impression she would be discharged on ce the C-diff was no longer an issue. Resident #10's family member said he had not been apprised of the progress that had been made toward the resident's discharge. He said he was given a folder of papers upon her admission to the facility, but no one ever explained the discharge process. The family member said he went and spoke to the case manager and she said she would let him know what was going on but he said she had never followed up with him. Resident #10's family member said the facility had not done any discharge planning that he was aware of and he felt like the facility was keeping Resident #10 at the facility for the insurance money. He said Resident #10 had not been able to do any ADLs on her own for the last twenty years due to her diagnosis of Parkinson's disease. Resident #10 said she felt intimidated by the case manager because she was the one who controlled when she got to go home. C. Record review The discharge care plan, revised 11/19/24 (during the survey process), documented Resident #10 wanted to be involved in her discharge planning. The interventions included communicating with the resident as needed related to progress, goals and plans, contacting the appropriate community agencies as needed when the resident was ready to discharge and encouraging the resident to make an effort toward achieving their goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Prior to the care plan being updated on 11/19/24, which was during the survey process, there were no new goals or interventions added to the care plan since 10/25/24, the date of the resident's admission. -The discharge care plan did not include Resident #10 lived at home with her spouse and son who provided assistance with her ADLs or any person-centered interventions or barriers to her discharge. The 10/28/24 discharge progress note documented Resident #10's plan for discharge was to increase her strength, mobility and ADL participation and return to her home with her spouse. The 10/29/24 discharge progress note documented the facility conducted a care conference. It documented the resident was welcomed to the facility and the discharge planning process was reviewed and a copy of her medications and care plan were given to the resident. It documented that case management would monitor for changes and needs and provide additional support throughout her stay. The review of the care plan summary revealed that the interdisciplinary team (IDT) met weekly to discuss and assess the progress of the resident's physical and medical status in determining the resident's date of discharge. -However, the resident's electronic medical record (EMR) did not reveal any documentation of the IDT meetings or the progress that the resident was making towards discharge. -The EMR failed to include any documentation that the resident and her family were involved in the discharge planning process or that a discharge planning process had occurred since Resident #10's admission to the facility. -The EMR did not reveal documentation that the resident's discharge goals had been identified and developed throughout her stay at the facility. D. Staff interviews CM #1, the DON and the chief operations officer (COO) were interviewed together on 11/21/24 at 3:05 p.m. CM #1 said she kept all the discharge documentation on the residents she was assigned to in a binder that was kept in her office. She said the documentation contained updates from therapy on each resident's progress. She said each time she documented in the binder did not mean she had met with the resident and/or their family to discuss their discharge progress, just that she had written down what the therapy department had communicated. CM #1 said Resident #10 had not had a formal care conference since her admission to the facility. She said she had not documented any of her interactions with the resident or her family. The COO said that he did not think anyone would tell a resident they could not go home if they were unable to complete certain ADLs. The COO said, based on the assistance level Resident #10 and her family described, he did not see any difference between her prior level of function and her current level of function. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CM#1 said she had not met with Resident #10 or her family to discuss her discharge planning. She said she would be meeting with them tomorrow (11/22/24) because therapy had set a discharge date that day (11/21/24) to issue the notice of medicare non-coverage (NOMNC). CM #1 said discharge planning should occur prior to the NOMNC being issued. 47064 X. Resident # 185 A. Resident status Resident #185, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included right knee prostheses complication (artificial knee), vascular access device (device to access the blood vessel), dysphagia (difficulty swallowing) and hypertension (high blood pressure). The 11/11/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She required partial staff assistance with toileting, dressing and transfers. She was independent with eating.The resident was on antibiotics intravenous (IV) medications. The assessment revealed the resident wanted to be discharged to the community B. Resident interview Resident #185 was interviewed on 11/18/24 at 11:36 a.m. Resident #185 said she was very concerned about her stay in the facility because she required at least six weeks of IV antibiotic treatment and no one had discussed with her what would happen if the insurance company did not allow her to stay in the facility that long. Resident #185 expressed financial concerns if her insurance did not cover her whole stay for the duration of her IV treatment. Resident #185 said her husband and son had been trying to communicate with the insurance company about her coverage and they had not been able to get any information on what could happen. Resident #185 said she was not able to care for IV lines and administer IV medication at home because it was a complicated system. Resident #185 said no one in the facility had discussed her discharge planning with her since her admission on 11/4/24 when they asked her what her plan was for discharge. She said her plan was to return home. C. Record review -Review of the 11/4/24 comprehensive care plan did not reveal a discharge planning care area focus for Resident #185. The care conference note dated 11/7/24 revealed the resident's discharge plan was to return home with her husband and son. The note indicated Resident #185 had 17 steps to go upstairs in her home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A social service note dated 11/7/24 revealed a care conference was held on 11/7/24. The note indicated the case manager discussed the resident and family discharge planning process, services and guidelines. -However, Resident #185 said she did not know what was occurring with her discharge plan (see resident interview above). D. Staff interview Case manager (CM) #1 was interviewed on 11/21/24 at 3:04 p.m. CM #1 said she did not document discharge planning in the residents' electronic medical records (EMR). CM #1 said she only documented the initial care conference with residents and when a Notice of Medicare Non-Coverage (NOMNC) was given. CM #1 said Resident #185's plan was to discharge home with her husband and son but she needed to work therapy to ensure she could manage the 17 stairs within her home. CM #1 said she had not discussed any discharge planning, such as home health services, with Resident #185. CM #1 said she had not given Resident #185 any information about her discharge. 50219 XI. Resident #225 A. Resident status Resident #225, age 71, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included surgical aftercare and local infection of the skin and subcutaneous tissue. The 11/5/24 brief interview for mental status (BIMS) assessment revealed the resident was cognitively intact with a score of 15 out of 15. B. Resident interview Resident #225 was interviewed on 11/20/24 at 2:37 p.m. Resident #225 said she had met the day prior (11/19/24) with her insurance representatives to discuss her discharge and she was going to discharge home from the facility on 11/24/24. Resident #225 said the facility staff had been coming in recently to talk to her about her upcoming discharge, and the occupational therapist had just been in to speak with her. -However, there was no documentation in Resident #225's EMR regarding updates to her discharge or changes in her discharge plan. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The discharge care plan, initiated 11/2/24 and revised 11/3/24, revealed Resident #225 established appropriate goals for herself and wanted to be involved in her discharge planning. Pertinent interventions included communicating with the resident as needed related to progress, goals and plans, contacting appropriate community agencies as needed when the resident was ready to discharge and encouraging the resident to make an effort toward achieving their goals. A progress note dated 11/7/24 at 2:42 p.m. revealed a care conference had been completed with Resident #225, her family, the therapy team and Resident #225's case manager. The care conference notes revealed the team discussed discharge planning, processes, services and guidelines. The progress note documented a copy of Resident #225's medications and her care plan were provided to the resident. A progress note dated 11/21/24 at 4:32 p.m. revealed on 11/19/24 the case manager discussed with Resident #225 and her family that a discharge date had been set by her insurance company. The case manager confirmed with Resident #225 that she would be discharging home with her family member and that the nursing staff would educate the resident and her family on how to administer intravenous (IV) medications and management of the indwelling IV line. The case manager told Resident #225 that home health services had been set up for her and a new wound vacuum had been ordered for her. -However, the progress note note was not added to Resident #225's EMR after the interview with the case manager on 11/21/24, two days after the discharge discussion with Resident #225. (see interview below). -Review of the care plan and Resident #225's EMR did not reveal any further documentation related to discharge planning or discussion of the discharge plan with the resident. D. Staff interviews The DON and CM #2 were interviewed together on 11/21/24 at 1:42 p.m. CM #2 said Resident #225 was going to discharge on 11/24/24. CM #2 said the facility conducted caregiver training with Resident #225's spouse and the nursing staff did IV training for the resident. CM #2 said Resident #225 was discharging home with a wound vacuum and an IV line and was to receive home health services. -However, there was no documentation in Resident #225's EMR regarding the caregiver training for the resident's spouse or the IV training conducted by the nursing staff (see record review above). CM #2 said the facility staff had a care conference with Resident #225 on 11/7/24. CM #2 said she had talked with Resident #225 on 11/19/24 and 11/21/24. CM #2 said she had discussed with Resident #225 the wound vacuum the facility had ordered, the home health services the facility had arranged and the training the resident's husband would receive. CM #2 said she had documented these conversations in a binder. XII. Facility follow up On 11/22/24 at 11:29 a.m., the NHA provided the logs for CM #1 and CM #2 for Resident #378, #376, #225, #388, #380, #10 and #382. -A review of the logs revealed therapy information on each resident's functional status but no discharge planning or coordination/communication with residents and or their representatives. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The information was not documented in the EMR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on observations, record review and interviews the facility failed to ensure activities were designed to support residents physical, mental and psychosocial well-being were provided for two (#373 and #36) of two residents out of 60 sample residents. Specifically, the facility failed to identify and meet the socialization needs for Resident #373 and #36. Findings include: I. Facility policy and procedure The Activities policy and procedure, revised February 2024, was received by the nursing home administrator (NHA) on 11/22/24 at 8:33 a.m. It read in pertinent part, The resident has the right to choose activities and participate in activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility will ensure and implement an ongoing resident-centered activity program that incorporates the resident's hobbies and culture preferences, which is integral to maintaining and or improving a resident's physical, mental and psychosocial well-being and independence. The facility will support and create meaningful life by supporting his/her domain of wellness. Activities Procedures: The resident will make choices about the activities they would like to participate in. The facility will promote one to one visits in the resident's room as needed. Activities will be provided seven days a week on days and evenings. The activity room will have self-directed activities 24 hours a day available to the resident. II. Resident #373 A. Resident status Resident #373, age 75, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included spinal stenosis to the cervical region (when the spinal canal narrows putting pressure on the spinal cord and nerves) and muscle weakness. The 10/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 15 out of 15. She required maximum assistance with activities of daily living (ADL) B. Resident and resident's representative interviews and observations Resident #373 was interviewed on 11/19/24 at 9:39 a.m. Resident #373 said she was lonely and just wanted someone to sit with her and watch The Price is Right (television show). She said she wanted someone to talk with and share her stories about her children and grandchildren. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #373 said she had asked facility staff to take her outside for a walk, but she was always told they were too busy. She said she wanted to get some fresh air. On 11/19/24 at 2:00 p.m. the facility had a scheduled group activity of painting. -Resident #373 was not invited to attend the group activity. During a continuous observation on 11/20/24, beginning at 8:50 a.m. and ending at 11:30 a.m., Resident #373 activated her call light five times for non-care related reasons from 8:50 a.m. to 9:56 a.m. At 11:00 a.m. the facility held a group activity of Monopoly. -Resident #373 was not invited to attend the group activity. At 1:30 p.m. Resident #373's representative was observed wheeling the resident out of her room and down the hallway. Resident #373's representative was interviewed on 11/20/24 at 1:57 p.m. The representative said he had just taken Resident #373 for a walk outside. He said Resident #373 was happy to go outside and have someone to talk to and tell her stories to. On 11/20/24 from 1:30 p.m. to 3:00 p.m. the facility had a group activity of pet visits. -Resident #373 was not invited to participate. C. Record review The activities care plan, initiated 10/24/24, documented Resident #373 expressed interest in participating in group activities and enjoyed watching television. It indicated the resident required one-to-one activities to be coordinated by the activities director (AD). The interventions included activity calendar to be available for resident's review, encourage participation in expressed individual and/or group activities of interest, AD will remind, encourage/assist and/or transport resident to activities of interest as needed, AD will encourage maximum participation according to functional capacity, and provide supplies as needed such as books, newspapers, magazines, batteries, craft supplies, word games, etc . A review of the November 2024 treatment administration record (TAR) revealed Resident #373 should have activities available as requested for both day and night shifts. The TAR documented Resident #373 was only offered activities on 11/4/24 at 4:09 p.m. and 11/13/24 at 3:48 p.m. III. Resident #36 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #36, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included fracture of the left femur (broken bone of the upper leg), kidney failure, major depressive disorder (disorder affecting how someone feels) and hypertension (high blood pressure). The 10/21/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She was dependent on staff for toileting, dressing and transfers. She required moderate assistance for eating and personal hygiene. B. Observations On 11/18/24 at 4:22 p.m. Resident #36 was observed to be calling out to anyone who walked by her room. -Staff did not enter the resident's room to see what she needed or offer to provide her with any activities of interest. On 11/19/24 at 10:00 a.m. Resident #36 was observed to be calling out from her room saying help me. -Staff did not enter the resident's room to see what she needed or offer to provide her with any activities of interest. On 11/19/24 at 3:34 p.m. Resident #36 said good morning to an unidentified certified nurse aide (CNA) who was sitting at the nurses station. Resident #36 called out three times before the CNA went to her room. The unidentified CNA remained in the resident's room for 30 seconds then returned to the nurses station. -The CNA did not offer to provide the resident with any activities of interest. On 11/20/24 at 11:40 a.m. Resident #36 was awake in her bed looking out the door towards the nurses station. The television was not on and no books were observed in her room. C. Record review The activity care plan, initiated 10/14/24, revealed Resident #36 enjoyed watching television, reading (historical fiction) and spending time with her family. An activities progress notes dated 10/16/24 revealed an initial activities assessment was completed for Resident #36. The progress note documented Resident #36 would be involved in leisure activities as desired and the activity care plan had been developed to reflect these interests. Staff would monitor for any problems or concerns that might inhibit Resident #36's participation in leisure activities. Furthermore, staff would support the leisure needs of Resident #36 by offering reminders, encouragement, assistance and supplies as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A late entry activities progress note dated 11/1/24 revealed Resident #36 was offered a monthly activities calendar. The calendar identified times and locations of future activities. Resident #36 was told to contact activities at the activities extension number for any additional supplies or if she had an interest in any group activities. -However, according to Resident #36's 10/21/24 MDS assessment (see resident status above), the resident was severely cognitively impaired and therefore would not have been able to call the activities extension number for activities supplies. An activities progress note dated 11/4/24 documented Resident #36 refused the daily chronicle which had an educational short read and an engaging puzzle. -However the comprehensive care plan identified Resident #36 liked to read but the daily chronicle was not a topic she enjoyed (see record review above). There was no other documentation to indicate Resident #36 had been provided with individual activities of interest or been invited to group activities. The activities log identified several days where one-to-one visits occurred for Resident #336. -However, the one-to-one visits were with the resident's family members and not members of the facility's activities staff (see interviews below). IV. Staff interviews CNA #5 was interviewed on 11/20/24 at 3:16 p.m CNA #5 said Resident #373 was lonely and wanted someone to sit and talk with her. She said most of the time, Resident #373 wanted the CNAs to sit on her bed and watch television with her. The AD and the NHA were interviewed together on 11/21/24 at 5:03 p.m. The AD said she did not actually conduct the one-to-one activities for each resident, but instead relied on each residents' family and friends. She said she did not take residents outside during this time of the year because of the cold weather. The AD said she provided a monthly calendar of activities to all residents on admission and monthly. The AD said she relied on floor staff to encourage residents to attend activities the day before the activity and to help her identify any residents who may need help to attend activities. The AD said, because the facility had a large census, it was difficult for her to meet with all residents prior to the activity but she had her CNA license which helped her transport residents to the activities. The AD said each resident's participation in group activities was based on their physical and cognitive abilities. She said the nursing staff should notify her of any residents asked to attend activities. She said the activities staff did not personally invite residents to group activities. She said there was not usually a high turnout for regular group activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The AD said each resident's activity preferences were established upon admission and she did not re-evaluate those preferences throughout their stay at the facility. She said she was the only one that provided activities to all residents in the facility and it was a lot for one person to handle. The AD said she had not been informed that Resident #373 was lonely or wanted to attend activities. She confirmed she had documented the resident wanted to attend group activities and required one-to-one visits during Resident #373's admission activity assessment. She said she had not personally provided Resident #373 with any one-to-one activities but relied on the resident's family for that. The AD said Resident #36 had a cognitive impairment and made communication difficult for the resident. The AD said Resident #36 had a strong family involvement and the one-to-one visits documented on the resident's activities log were when the resident's family visited with her. The AD said she did not conduct one-to-one activities visits with Resident #36. The AD said she had not checked in with Resident #36 about needing any books or other leisure activities supplies. The AD said she did not think she needed to make any changes to the activity program at the facility. The NHA said Resident #36 enjoyed visits from family members. He said Resident #36 seemed to like familiar faces over strangers. The NHA said the housekeeping staff would remove books from residents' rooms when they were cleaning and return them to the library. He said that might be the reason no books were observed in Resident #36's room (see observations above). The NHA said the activities department needed to change their approach with residents in order to build rapport with residents to ensure their needs were being met. The NHA said, going forward, the activity staff would check in with the residents more often and determine if their preferences had changed throughout their stay at the facility. He said he would put a system in place to ensure residents were being invited to group activities every day. The director of nursing (DON) was interviewed on 11/21/24 at 5:47 p.m. The DON said she did not have any involvement in activities other than directing residents to seek out the activities staff for something to do or to review the calendar with a resident. The DON said the AD, along with all other staff, were responsible for inviting residents to group activities 30 minutes prior to the start of the activity. The DON said the AD should be completing one-to-one visits with residents and should be inviting residents to all planned/scheduled activities. 47064

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on record review, observations, and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for one (#53) one resident out of 60 sample residents. Resident #53 was admitted to the facility for rehabilitation services on 10/4/24 with a diagnosis of fracture of the left femur, end stage renal disease, type two diabetes and morbid obesity. The 10/5/24 admission skin assessment indicated the resident had a surgical incision on her left hip, multiple scattered bruises to both upper extremities and a chest port for dialysis. The assessment did not indicate that the resident had any abdominal wounds. On 10/24/24 the resident was noted to have two facility acquired moisture associated skin disorder (MASD) wounds to her abdominal folds. The facility failed to provide the resident with showers per her preferences. Due to the facility's failures, observations revealed the resident had developed three MASD wounds to her abdomen. Through observations, the facility failed to follow infection control practices when providing wound care and failed to document the third MASD wound. Additionally, the facility also failed to communicate the worsening of the abdominal wounds to the primary care physician and ensure a timely referral to a wound physician. Findings include: I. Resident #53 A. Resident status Resident #53, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included fracture of left femur, end stage renal disease, type two diabetes, and morbid obesity. The 10/10/24 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 was dependent on staff for toileting, bathing, and lower body dressing and was partially dependent for all other activities of daily living (ADL). The assessment indicated that the resident did not have any skin conditions. B. Resident interview Resident #53 was interviewed on 11/18/24 at 11:24 a.m. Resident #53 said she had wounds underneath her abdominal fold that she had developed when she was admitted to the facility. She said the abdominal wounds were very painful. She said the pain was what caused her to ask the staff to look under her abdominal fold. She said she did not understand how the wounds developed so quickly and when she asked the nurse they said that they did not know either. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #53 was interviewed again on 11/20/24 at 8:06 a.m. She said the facility gave her bed baths instead of showers because she was unable to sit in the shower chair comfortably. She said she preferred to receive a bed bath in the morning, however she often refused her bed bath because the certified nurse aide (CNA) would come between 7:00 p.m. and 8:00 p.m., which she had told them repeatedly was too late. She said she had requested to be moved to the day shift for her bed baths to ensure she received it during the day, but her request had still not been honored. Resident #53 said when the facility the staff did give her a bed bath, they did not lift up her abdominal fold and clean underneath. She said she had full feeling in her abdominal fold and underneath it, and she would have felt if they had cleaned underneath it. Cross reference F561: The facility failed to ensure Resident #53's preference to have her bed bath done during the day shift was honored. C. Observations On 11/21/24 at 8:40 a.m. the certified wound nurse (CWN) and the director of nursing (DON) were observed providing Resident #53's wound care and dressing change. The CWN cleared off the resident's bedside table and wiped it down with a disinfectant wipe, applied a barrier pad and placed her bag of resident wound care supplies on top. The DON entered the room as well and put a clean chucks pad (disposable absorbent pad) under the resident's abdominal fold but below the wounds. Three dressings were observed on the resident, one on the right, one in the middle and one on the left. All of the dressings had the date 11/20/24 with a nurse's signature. Both the DON and the CWN completed hand hygiene and put on clean gloves. The CWN removed all three dressings, the right and left sides had moderate serosanguineous drainage (a thin watery fluid), the middle had a small amount of bloody drainage. The wound on the right was the largest of the three wounds. It was noted to have a ring of redness around it and the center had 20% eschar and 10% yellow slough the remaining tissue was red and it had no odors. The middle wound was the size of a nickel and had red tissue throughout and did not have an odor. The wound on the left was noted to be about the size of a quarter and had 80% slough and 20% red tissue and did not have an odor. The CWN changed her gloves to set up her supplies for the wound care. She set up a stack of gauze, a continuous spray can of saline solution and a lidocaine spray. She started on the left wound by taking one gauze she sprayed it with saline and wiped the wound, folded it over and wiped again three times with the same gauze, the wound was noted to have bloody drainage. The CWN then threw the gauze away and with her dirty glove touched the saline bottle and then re-sprayed all three wounds with lidocaine per the resident's request due to pain, with contaminated gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Using the same gloved hands the CWN then took another piece of gauze and sprayed it with the saline solution and moving from the left wound to the middle wound she wiped twice with the same piece of gauze. The CWN then moved to the wound on the right and wiped the wound three times with the same piece of gauze. She then collected a second piece of gauze moistened it with saline and wiped eight times over the wounds with the same piece of gauze, she then took another piece of gauze moistened it with saline solution and proceeded to wipe six more times over the wound areas. She took a third piece of gauze and dabbed the area three times due to bloody drainage. She threw away the gauze and changed her gloves and performed hand hygiene. The CWN conducted a wound culture to the right wound. She took the culture tubing out of the sterilized package. She swabbed the right wound. She then inserted the sample into the test tube. The CWN then changed her gloves, performed hand hygiene. She started on the left side of the wound, using gauze and saline to wipe, applied skin prep to the peri-wound and cut calcium alginate (highly absorbent dressing) sheet to size and applied it. She applied Medihoney (antimicrobial gel) and covered the wound with a border foam dressing. The CWN moved to the middle wound and used a saline-soaked gauze to wipe the wound four times, using the same gauze to apply the skin prep to the peri-wound. She cut another piece of calcium alginate and Medihoney and applied both to the resident's wound and covered it with the foam dressing. Using the same gloved hands, the CWN moved to the right wound, using saline soaked gauze, she wiped the wound four times with noted serosanguinous drainage coming out of the wound as she applied skin prep. She measured the right wound at this time 3.5 centimeter (cm) length by 9 cm width by 0.1 cm depth and said the wound was larger than last week. She took calcium alginate and Medihoney and applied it to the wound and covered it with a foam dressing. Cross-reference F880: the facility failed to follow proper infection control practices for wound care. D. Record review The potential for skin breakdown care plan, revised on 10/5/24, documented Resident #53 had a surgical incision on her left hip, brace to the left knee, double right chest port, folded abdomen and a hard abdomen. The interventions included applying antifungal powder beneath the pannus (abdominal fold) every shift, completing a Braden scale every week per protocol, providing prophylactic skin treatments as ordered, performing skin assessments as needed, wound nurse to evaluate and treat and the wound physician to evaluate and provide treatment as needed. -The comprehensive care plan did not include Resident #53's actual skin breakdown of three abdominal wounds. The 10/4/24 hospital discharge summary documented Resident #53's skin was warm, dry, intact and had no rashes. The 10/5/24 admission skin assessment documented Resident #53 had a surgical incision on her left hip, multiple scattered bruises to both upper extremities and a chest port for dialysis. -It did not document Resident #53 had abdominal wounds upon admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 10/10/24 and 10/17/24 skin assessments documented the resident had a surgical incision on her left hip, multiple scattered bruises to both upper extremities and a chest port for dialysis. -It did not indicate Resident #53 had sustained any abdominal wounds. The 10/24/24 skin assessment documented the previously identified skin concerns and additionally a wound to the abdomen. It did not include any information regarding the wound to the abdomen. The 10/24/24 wound progress note documented the floor nurse requested the wound nurse to come and assess the abdominal wounds. The note indicated that there were two moisture-associated skin damage (MASD) wounds underneath the pannus. The right wound measured 2.5 cm in length by 4 cm in width by 0.5 cm depth with 50% granulation tissue (new connective tissue) and 50% slough (dead tissue) with little signs or symptoms of drainage. The wound was debrided with no complications. The left wound measured 1 cm length by 1.5 cm width by 0.2 cm depth with 70% granulation tissue and 30% slough with little signs or symptoms of drainage. The wound dressing order read: cleanse with wound cleaner, apply skin prep to peri-wound (skin surrounding a wound), apply collagen to the wound bed, cover with a foam border dressing every other day or as needed, replace the Interdry sheets (fabric to absorb moisture) beneath the abdomen every three days or as needed and monitor placement of the Interdry sheets every shift. The 10/31/24 wound note documented that the size of both wounds had not changed, however the right wound now had 20% gran and an increase of 80% slough with little signs or symptoms of drainage. The left wound was unchanged with 70% granulation tissue and 30% slough with little signs or symptoms of drainage. The wound dressing order was changed and read as: cleanse with wound cleaner, apply skin prep to the peri-wound, apply medihoney and then collagen to the wound beds, cover the wound with a foam border dressing everyday and as needed, replace the Interdry sheets beneath abdomen every three days or as needed and monitor placement of the Interdry sheets every shift. The 11/13/24 provider note documented that the nurse practitioner (NP) saw Resident #53 to follow up on her abdominal wound and her lab work. It documented the NP saw the wounds via picture. It documented that the wound team was following the MASD open wounds. The 11/14/24 wound progress note documented there were no changes to both wounds. -The wound progress notes did not reveal accurate documentation of the wounds in describing the eschar (scab-like dead tissue covering the wounds) observed to the right wound and that Resident #53 had three abdominal wounds (see observations above of wound care during the survey process), not only two wounds. Review of the record revealed that the resident's primary care physician or her nurse practitioner did not physically see the abdominal wounds except for via photograph which was noted on 11/13/24 (see NP interview below). II. Staff interviews The CWN was interviewed on 11/21/24 at 9:11 a.m. The CWN said Resident #53 had abdominal wounds upon admission and were caused from moisture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-However, according to the facility admission skin assessment, Resident #53's she had a surgical incision on her left hip and scattered bruises on her upper extremities upon admission to the facility. The CWN said the wound physician had not been referred to see Resident #53's wounds, but she had referred the resident that week, during the survey process, since the wounds had gotten worse and were not healing. She said she observed Resident #53's wounds weekly. The CWN said she was notified from the floor nurse yesterday (11/20/24), that Resident #53's wound had deteriorated. She said she contacted the wound physician and received an order to culture one of the wounds. The CWN said her cleaning technique with the gauze was to move from clean to dirty and then discard the gauze. She said she had not realized she had used the same gauze up to eight times to wipe the wound. She said she should have changed the gauze in between each wipe to decrease the risk of infection. She said she should have changed her gloves in between each wound site to decrease the risk of infection. Primary care physician (PCP) #1 was interviewed on 11/21/24 at 11:55 a.m. PCP #1 said she was the PCP for Resident #53. PCP #1 said Resident #53's skin was clear from any wounds upon admission, except for the surgical incision. She said she observed the wounds on 10/25/24, but had not observed the wounds since because the wound nurse was following and she expected the wound nurse to provide her with updates. She said the NP was following the wounds more closely for this resident. She said she had not been informed Resident #53's wound had deteriorated to include eschar and slough. She said she would assume the wound physician ordered a wound culture because there was concern about a potential infection of the wound. She said she would have expected the CWN to have referred Resident #53's wounds to the wound physician sooner, who was an expert in that area. NP #1 was interviewed on 11/21/24 at 12:21 p.m. NP #1 said she was the NP for Resident #53. She said she had not directly observed Resident #53's abdominal wounds. She said she hated to take off the bandage to look at the wound because of Resident #53's pain and creating more work for the floor nurse. She said she had asked the CWN for pictures of the wounds. She said she was not informed Resident #53's wounds had deteriorated to include eschar and slough, just that they had increased in size. NP #1 said an increase in measurements did not necessarily mean the wounds were deteriorating. She said if she had been provided more information and informed of the eschar and slough, she would have acted differently, to ensure the wound physician was involved sooner. NP #1 said the presence of eschar and yellow slough meant the wound was deteriorating. She said that using the same gauze to wipe the wound multiple times could spread bacteria as well as not changing gloves, which had potential to lead to an infection. She also said that by not debriding the wound before getting a culture of the wound could potentially cause inaccurate test results. NP #1 said she was unaware the wound physician was not already following and involved in the wound care for Resident #53's abdominal wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The CWN was interviewed again on 11/21/24 at 4:32 p.m. The CWN said she was not concerned about Resident #53's abdominal wounds until yesterday (11/20/24), when the floor nurse informed her the wound had gotten worse. She said by the time she had been notified of the worsening of the wounds, the wound physician had already left for the day. The CWN said it was up to her discretion as to when a wound required the wound physician's expertise. She said the wound physician would see Resident #53's abdominal wounds next week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0686 Level of Harm - Minimal harm or potential for 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** 47064 Based on observations, record review and interviews, the facility failed to ensure one (#174) of one resident reviewed for pressure ulcers out of 60 sample residents received the necessary treatment and services according to professional standards of practice. Specifically, the facility failed to ensure Resident #174's physician ordered heel protection boots were consistently implemented as an intervention to prevent potential pressure wounds. Findings include: I. Professional reference According to the International Wound Journal's Summary of Best Evidence For Prevention and Control Of Pressure Ulcers on Support Surfaces (3/9/23), retrieved on 12/2/24 from https://pmc.ncbi.nlm.nih.gov/articles/PMC10332999/#:~:text=Therefore%2C%20this%20study%20included%20heel,in%20a%20%E2%80%9Cfloating%E2%80%9D%20position.&text=This%20means%20keeping%20the%20heel,risk%20assessment%20in%20the%20future, A pressure ulcer is a localized injury caused by continuous pressure on the skin and/or subcutaneous soft tissues, usually located at a bony prominence, or involving a medical device or other instrument. Pressure redistribution is important in pressure ulcer prevention and control strategies. The ideal way to prevent heel pressure ulcers is to ensure that the heel does not touch the bed to avoid all pressure, that is, to keep the heel in a 'floating' position. For patients with established pressure ulcers and those who are bedridden, heel support devices are recommended, but there are many different types, such as heel suspension boots. II. Facility policy and procedure The Pressure Ulcer policy and procedure, reviewed on 3/14/24, was received from the nursing home administrator (NHA) on 11/22/24 at 8:38 a.m. It revealed in pertinent part The facility will provide the necessary requirements to ensure that a resident receives the treatment and care in accordance with professional standards of practice. Upon admission, the nursing staff will complete a full skin evaluation and examine for any ulcerations or alterations in skin. The physician will assist with identifying factors contributing to or predisposing residents to skin breakdown. III. Resident #174 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #174, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included cerebral hemorrhage (brain bleed) affecting the right side, dysphagia (difficulty swallowing), aphasia (difficulty speaking), hypertension (high blood pressure) and pre-diabetes (abnormal glucose). The 11/20/24 minimum data set (MDS) assessment revealed the resident had short and long term memory issues. She required maximal assistance from staff for transfers, toileting, personal hygiene and dressing. The resident required minimal staff assistance with bed mobility and eating. B. Observations On 11/18/24 at 10:50 a.m. Resident #174 was sleeping in bed. A right foot heel protection boot was hanging off the bed and not on the resident's foot in order to protect the heel. Resident #174's right heel was resting directly on the mattress. On 11/20/24 at 10:42 a.m. Resident #174 was in her wheelchair visiting with her family. She was not wearing her heel protection boots while in the wheelchair. Resident #174's feet were resting directly on the foot pedals of the wheelchair. On 11/20/24 at 11:34 a.m. Resident #174 was transferred back into bed. Her heel protection boots were not put on when she was transferred back into bed. On 11/20/24 at 11:48 Resident #174's was laying in bed with her feet resting directly on the mattress. The resident's heel protection boots were lying on the desk in the room. On 11/20/24 at 3:02 p.m. Resident #174 was laying in bed with three visitors in her room. Resident #174 did not have her heel protection boots on and the boots were still lying on the desk in the room. On 11/20/24 at 3:26 p.m. Resident #174 was sleeping in her bed with her feet resting directly on the bed. The resident's heel protection boots were lying on the desk in her room. On 11/20/24 at 4:04 p.m. registered nurse (RN) #1 entered Resident #174's room and observed that the resident's heel protection boots were not on the resident's feet but were instead lying on the desk approximately five feet from the resident. RN #1 completed a skin check of Resident #174's bilateral feet and applied the heel protection boots to both feet. RN #1 said one of the boots was broken because it was missing a strap which would help ensure the boot remained on the resident's foot. On 11/21/24 at 10:22 a.m. Resident #174 was laying in bed. The resident's heel protection boots were on her bed but were not on the resident's feet. Resident #174's feet were resting directly on the mattress. C. Resident family member interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #174's family member was interviewed on 11/19/24 at 10:08 a.m. The family member said Resident #174 could not move her right hand or her right leg due to her medical condition. The family member said the resident had been wearing heel protection boots to both feet since her hospital stay but the family member was not sure why the resident needed them. The family member said no one in the facility had informed the family when the resident should or should not be wearing the heel protection boots. D. Record review The 11/13/24 admission Braden Scale assessment (a tool used to calculate the risk of pressure injuries) revealed Resident #174 was at high risk for skin breakdown. The resident's high risk factors contributing to skin breakdown included limited sensory response, bedfast (confined to bed), completely immobile and required maximum assistance in moving. Review of Resident #174's November 2024 CPO revealed the following physician's order: Turn and reposition throughout shift, as tolerated. Offload bilateral heels while in bed, as tolerated. Foam boots to be worn at all times as tolerated. May remove during ambulation, ordered 11/14/24. The 11/13/24 comprehensive care plan revealed Resident #174 had potential for skin breakdown related to pressure points, immobility and incontinence. Resident #174 was admitted with redness under bilateral breasts and bruises on her abdomen from medication injections. Her heels and coccyx were intact. Resident #174 had heel protection boots on bilateral feet. The goal was for Resident #174's skin to remain intact. Interventions included conducting a Braden Scale assessment every week per protocol, encouraging the resident to turn and reposition throughout the shift, offloading bilateral heels while in bed every shift for skin integrity, providing pressure reduction devices as needed for mattress and wheelchair, prophylactic skin treatments as ordered and skin assessments as needed. IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 11/20/24 at 3:15 p.m.CNA #1 said, on admission, a resident's care plan would document any special care the resident may need so staff was aware of their needs. CNA #1 said if a resident required heel protection boots, the therapy department would assess the resident and order the correct size or style of heel protection boots needed. CNA #1 said Resident #174 did not wear any heel protection boots and her heels could be floated off the bed with pillows. -However, Resident #174 had a physician's order for heel protection boots to be worn on her bilateral feet at all times, except when she was ambulating (see record review above). CNA #1 said Resident #174 required assistance with transfers and bed mobility because she was weak on the right side of her body due to her medical condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed on 11/20/24 at 4:04 p.m. RN #1 said the nursing staff was to conduct an assessment on residents to determine their risk of skin breakdown and interventions would be implemented based on the outcome of the assessment. RN #1 said pressure areas were considered to be any bony areas that had direct contact with a surface, such as a mattress. RN #1 said Resident #174 had a physician's order for heel protection boots to her bilateral feet. RN #1 said Resident #174 had right-sided weakness and limited mobility to her right side, which increased her risk of skin breakdown. RN #1 said heel protection boots were important to prevent skin breakdown for Resident #174. RN #1 said Resident #174 should have been wearing her heel protection boots per the physician's order. The director of nursing (DON) was interviewed on 11/21/24 at 5:37 p.m.The DON said heel protection boots were implemented to prevent skin breakdown on a resident who was at an increased risk of skin breakdown. The DON said the admitting nurse was to complete a Braden Scale assessment to determine the risk a resident had for the development of pressure injuries. The DON said it was up to the nurses to check to ensure that Resident #174's heel protection boots were on every shift if there was a physician's order for them. The DON said if a resident had a physician's order for heel protection boots, it was important for the intervention to be used to help prevent skin breakdown. The DON said the nurses would be educated on the importance of ensuring heel protection boots were in place when ordered to help prevent skin breakdown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on observations, record review and interviews, the facility failed to ensure one (#382) of one resident reviewed for pain out of 60 sample residents had an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans and resident preferences. Specifically, the facility failed to ensure Resident #382, who experienced an acute episode of pain, was provided pain relief and had an effective pain management program to address her continuous pain. Findings include: I. Facility policy and procedure The Analgesia policy and procedure, revised August 2022, was provided by the nursing home administrator (NHA) on 11/22/24 at 8:38 a.m. It read in pertinent part, Pain management procedure: based on the assessment, the facility, in collaboration with the attending physician, or medical director, and the resident initiated interventions to prevent or manage the resident's pain, beginning at admission. These interventions may be integrated into components of the comprehensive care plan, but at minimum will be evaluated at admission and every shift thereafter. Once a patient expresses the perception of pain or makes a request for pain medication, the patient will be provided with a dose of analgesic pain medication or non-pharmacological intervention will be initiated. The facility will address/treat the underlying causes of the pain, to the extent possible. Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both. It is the responsibility of the staff member to address the complaint of pain and make sure some intervention (pharmacological or otherwise) is initiated. In the event the resident does not have an order for pain medications, contact the physician immediately to obtain an order for analgesia. In the interim, attempt non-pharmacological modalities for pain control such as repositioning, touch therapy, biofeedback, distraction (television, conversation). II. Resident #382 A. Resident status Resident #382, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), the diagnoses included left femur fracture status post closed reduction, muscle weakness, history of falls, heart disease and peripheral vascular disease (chronic condition that occurred when blood vessels outside of the brain and heart narrow or become blocked). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 11/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. She required moderate to maximum assistance with all activities of daily living (ADLs). The MDS assessment indicated the resident received scheduled pain medications and as needed opioids. The resident did not receive as needed pain medications or non-pharmacological interventions for pain on three days of the five days during the assessment period. Of these three days the resident reported a pain level of 5 or greater on a pain scale of 1 to 10, with an identified acceptable pain level of 5 out of 10 on the pain scale. B. Resident interview and observations Resident #382 was interviewed on 11/19/24 at 10:37 a.m. Resident #382 was sitting up in her bed, grimacing and appeared in distress. Resident #382 said she was in a lot of pain and needed pain medication. She said she had told a facility staff member she was in extreme pain, but had been waiting for two hours. She said no one ever returned to address her pain. Licensed practical nurse (LPN) #3 was immediately informed of the resident's verbal and non-verbal expressions of pain. LPN #3 entered Resident #382's room, however, did not administer the resident any pain medication (see record review and interviews below). Resident #382 was interviewed on 11/19/24 at 1:20 p.m. Resident #382 was sitting up in her bed, eating fast food and visiting with a family member. Resident #382 said her pain was okay for now but would like her pain medications to be given on time so her pain does not get out of control. She said the nurse took her catheter out the night before, it was very painful, and was not given pain medication prior to the procedure. Resident #382 was interviewed on 11/21/24 at 6:34 p.m. with the director of nursing (DON) and infection preventionist (IP) present. Resident #382 said she was very hesitant to talk as she did not want to get LPN #3 in trouble. The resident was reassured by all that this was not the case, but wanted to ensure that her needs were addressed. Resident #382 said she was always in pain and that some position changes made her feel better. She said her pain was not being managed effectively. She said she was only being given acetaminophen (Tylenol) prior to physical and occupational therapy. She said the Tylenol was not enough to address her pain and felt it did not work. She said it was difficult to participate in physical and occupational therapy to the best of her ability because she was in pain. She said her pain was throughout her right leg. She said the pain was throbbing all the time. Resident #382 said the tramadol was sometimes effective but not all the time. The DON said they would plan to meet with the physician in the morning to make adjustments to address her pain. C. Record review The opioid use care plan, initiated on 11/4/24, documented Resident #382 was on opioid pain medication therapy. The goal was to be free of any discomfort or adverse side effects from the pain medication. The interventions included administering analgesic medication as ordered by the physician and observing for side effects and effectiveness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The pain management care plan, initiated on 11/4/24, documented Resident #382 expressed pain related to pressure points, decreased mobility related to a fall, a left intertrochanteric hip fracture status post closed reduction and gout. It indicated the resident's pain was alleviated/relieved by rest, repositioning and medication. The interventions included anticipating the resident's need for pain relief by monitoring her pain level at every shift and as needed, notifying the physician of any changes in condition as needed, administering pain medication per physician orders and note the effectiveness, administering Biofreeze Gel 4% during therapy services observing, giving pain medications as needed for breakthrough pain per physician orders and note the effectiveness, acknowledging the resident's presence of pain and discomfort, listening to the patient's concerns as needed, and implementing non-pharmacological interventions when able such as: positioning/support, assistive devices/braces, exercise/stretching, ice packs/moist hot pack application, relaxation. etc. The November 2024 (11/4/24 to 11/21/24) medication administration record (MAR) revealed Resident #382 reported her pain greater than her acceptable level of pain rating of a 5 out of 10 on the pain scale, a total of 10 times since her admission on 11/3/24. A level 9 out of 10 pain on the pain scale was the highest pain level reported. Record review of the November 2024 (11/4/24 to 11/20/24) treatment administration record (TAR) and medication administration MAR confirmed that on 11/19/24, Resident #382 expressed pain and requested pain medication, however the facility failed to administer a dose of analgesic pain medication from the hours of 10:37 a.m. when it was verbally requested by Resident #382 until the scheduled acetaminophen dose was administered at 2:00 p.m. -A review of the narcotic log on 11/21/24 at 10:02 a.m. and MAR with registered nurse (RN) #3 confirmed the findings. The 11/7/24 pain assessment revealed that Resident #382 responded almost constantly when asked the question: Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain. Resident # 382 also rated her highest pain level at a 9 out of 10 over the previous five days. The 11/14/24 pain assessment revealed no change in response to the same question and rated her pain level an 8 out of 10 over the past five days. The November 2024 CPOs documented the following: -Oxycodone 5 milligrams (mg) four times per day as needed for pain, ordered on 11/12/24 and discontinued on 11/17/24. -Tramadol 50 mg three times per day as needed for pain, ordered on 11/3/24 and discontinued on 11/4/24. -Tramadol 50 mg three times per day (every 8 hours) as needed for pain, ordered on 11/5/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-Lidocaine Patch 4% (percent) apply two patches to the affected area topically in the morning for discomfort/pain, remove at hour of sleep, ordered on 11/4/24. -Oxycodone 5 mg every four hours as needed for pain level 1-10 for 14 days, order to be held for dates of 11/4/24 to 11/12/24 and was discontinued on 11/15/24. -Voltaren External Gel 1% apply topically in the morning for discomfort/pain, ordered on 11/3/24. -Acetaminophen 1000 mg given three times per day for pain, not to exceed 3 grams daily, ordered on 11/3/24. The 11/19/24 daily skilled nursing progress note identified Resident #382 had a new area of pain to the left great toe and right ankle, with increased edema, and rated her pain level as a 4 out of 10 on the pain scale with her maximum acceptable rating of 5. LPN #3 documented she administered scheduled Tylenol and Gabapentin, as the resident had reported this was effective for pain. It indicated that Resident #382 declined repositioning or elevating her bilateral lower extremities as a form of non pharmacological intervention, and tubi grips were applied to bilateral lower extremities. -However, Gabapentin was not a physician's order documented in the CPO or MAR and according to a review of the narcotic log with RN #3 confirmed Gabapentin was not administered to Resident #382. -The progress note failed to identify any person centered non-pharmacological or medication interventions that were attempted or how Resident #382's pain was addressed when LPN #3 was informed the resident was in acute pain on 11/19/24 at 10:37 a.m. III. Staff interviews RN #3 was interviewed on 11/21/24 at 10:02 a.m. RN #3 said acetaminophen was administered as scheduled on 11/19/24 at 8:00 a.m., 2:00 p.m. and 10:00 p.m., and Tramadol was administered once at 9:00 a.m. RN #3 said that no other pain medications were administered to Resident #382 on 11/19/24 after 10:37 a.m., when LPN #3 was informed the resident was in acute pain. RN #3 confirmed the resident did not have an order to receive Gabapentin for pain. LPN #3 and the DON were interviewed together on 11/21/24 at 2:30 p.m. LPN #3 said the Gabapentin that was documented on the daily nursing note on 11/19/24 was an error. She said she did not administer Gabapentin to Resident #382. LPN #3 said she administered acetaminophen as ordered at 8:00 a.m. and 2:00 p.m. LPN #3 said she recalled the events from 11/19/24. She said she used non-pharmacological interventions with Resident #382 by repositioning, asked the resident if she needed to go to the restroom and that she folded and placed tubi grips in the drawer while she was in the resident's room. She said she remembered exactly what she did because the resident was eating fast food brought in by the resident's daughter. -However, according to observations made during the survey process, the resident's family member did not bring Resident #382 fast food until later that afternoon, three hours after LPN #3 was informed of the resident's acute pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-Additionally, record review showed LPN #3 had documented in the daily nursing note on 11/19/24 at 4:00 p. m. that the resident had a 4 out of 10 pain level, the resident declined repositioning or elevating to her bilateral lower extremities and that she had applied the tubi grips to the resident's bilateral lower extremities. The DON was interviewed on 11/21/24 at 3:56 p.m. The DON said if a resident's pain regimen was not effective, the facility should review the medications and call the physician. She said it was the facility's goal to always keep residents comfortable and free of pain. She said acute pain should be addressed immediately either by providing non-pharamacological interventions or medication to alleviate the resident's pain. She said any acute pain should be documented in the resident's medical record at the time the resident expressed pain and interventions provided. She said all documentation should be accurate and should pertain to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50219 Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable and attractive. Specifically, the facility failed to consistently ensure foods were appealing and palatable in temperature and seasoning. Findings include: I. Facility policy and procedure The Food Palatability policy and procedure, revised 8/22/22, was provided by the nursing home administrator (NHA) on 11/22/24 at 8:38 a.m. It revealed in pertinent part, Food and drink each resident receives and the facility provides foods prepared by methods that conserve nutritive value, flavor, and appearance. In addition, the food is palatable, attractive, and served at a safe and appetizing temperature. The dietary staff prepares foods according to the menu and recipes available in the dietary department. Foods are sampled daily by designated staff to ensure the taste and quality of the foods remain at a high level. Use of seasonings and proper cooking methods are followed to ensure the food is appealing and palatable. II. Resident interviews Resident #221 was interviewed on 11/18/24 at 9:30 a.m. Resident #221 said some of the food at the facility tasted okay. Resident #221 said she had received a thick slice of turkey for dinner that she could not even cut into, much less chew. Resident #224 was interviewed on 11/18/24 at 10:05 a.m. Resident #224 said the food at the facility was served cold and that he had yet to be served a hot meal. Resident #226 was interviewed on 11/18/24 at 10:13 a.m. Resident #226 said the food at the facility was not good. Resident #226 said the food at the facility was tasteless and that they served the same things over and over again. Resident #234 was interviewed on 11/18/24 at 10:19 a.m. Resident #234 said breakfast at the facility was always served cold. Resident #225 was interviewed on 11/18/24 at 11:14 a.m. Resident #225 said the food at the facility was bland. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #231 was interviewed on 11/18/24 at 11:21 a.m. Resident #231 said the food could be a bit warmer when served. Resident #53 was interviewed on 11/18/24 at 11:33 a.m. Resident #53 said the food served by the facility was not great. Resident #53 said the meat was very overcooked and the mixed vegetables seemed like they were microwaved too long. Resident #233 was interviewed on 11/18/24 at 1:42 p.m. Resident #233 said the food at the facility could be better and that it was served cold. Resident #232 was interviewed on 11/18/24 at 1:51 p.m. Resident #232 said the food at the facility was for the most part always cold and barely edible. Resident #232 said by the time the meals were served they were already cold. Resident #190 was interviewed on 11/18/24 at 2:04 p.m. Resident #190 said the food at the facility was cold and yucky. Resident #190 said it was especially cold if your room was at the last place on the delivery list. Resident #322 was interviewed on 11/18/24 at 2:20 p.m. Resident #322 said the food was awful when she first got to the facility. Resident #322 said her husband had to heat up her lunch in the microwave sometimes because the food arrived cold. Resident #322 said her coffee was rarely served hot and that the food was tepid in temperature. Resident #52 was interviewed on 11/18/24 at 3:25 p.m. Resident #52 said most of the meals at the facility were bland. Resident #52 said the meals at the facility were unseasoned. Resident #324 was interviewed on 11/18/24 at 3:44 p.m. Resident #324 said the food at the facility was served at room temperature. Resident #378 was interviewed on 11/18/24 at 3:48 p.m. Resident #378 said the food at the facility did not look good and that they had to have the staff reheat it a few times because it was served cold. Resident #126 was interviewed on 11/18/24 at 4:08 p.m. Resident #126 said he was not impressed with the food at the facility and that it did not taste right. Resident #388 was interviewed on 11/19/24 at 9:18 a.m. Resident #388 said their dinner a few days prior was a pork chop that was very thin and so overcooked and tough they could not eat it. Resident #388 said the pork chop hurt to chew. Resident #388 said they were supposed to be eating a lot of protein, and when they received protein that was inedible they were not able to have enough intake to help their wounds heal or help with their constipation issues. Resident #382 was interviewed on 11/19/24 at 10:27 a.m. Resident #125 said the quality of the meals at the facility had declined since his last stay. Resident #125 said the meals he received were barely warm. Resident #33 was interviewed on 11/19/24 at 10:30 a.m. Resident #33 said the food at the facility was not great and was served at room temperature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #379 and their family member were interviewed on 11/19/24 at 1:42 p.m. Resident #379 ' s family member said the meals Resident #379 was served looked terrible and turned the resident ' s stomach. Resident #379 said she ordered over-easy eggs for breakfast but received overcooked and cold eggs. Resident #221 was interviewed a second time on 11/20/24. Resident #221 said her breakfast that morning was okay. Resident #221 said her eggs were so rubbery she could barely eat them. Resident #221 said eating the eggs was comparable to eating a rubber bouncy ball. III. Resident council minutes Resident council minutes, dated 11/11/24 at 2:00 p.m., revealed an unidentified resident reported the food at the facility lacked seasoning and that the portions of the desserts were too small. -However, there was no documentation that indicated these concerns were addressed by the facility staff. Resident council minutes, dated 10/7/24 at 2:00 p.m,. revealed an unidentified resident said the texture of the food at the facility was not good and that the food lacked flavor and seasoning. -However, there was no documentation that indicated these concerns were addressed by the facility staff. Resident council minutes, dated 9/9/24 at 2:00 p.m., revealed an unidentified resident said the food was sometimes served cold. -However, there was no documentation that indicated these concerns were addressed by the facility staff. Resident council minutes, dated 7/8/24 at 2:00 p.m., revealed an unidentified resident said the meal temperatures were sometimes cold. -Notes in the margins of the 7/8/24 resident council meetings revealed the facility staff recommended that the residents could have their food reheated. IV. Test tray observations A test tray for a regular texture diet was evaluated by six surveyors immediately after the last round of room trays were delivered at 12:37 p.m. The test tray consisting of beef fajitas served on a corn tortilla, fajita vegetables, refried beans, and cilantro lime rice: -The rice was overcooked. The rice had no flavor or seasoning and was gluey to chew. -The refried beans were dry in texture. -The beef was dry. The beef l had no seasoning or flavor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The fajita vegetables were bland. -The tortilla was hard and gluey in texture. V. Staff interviews The executive chef (EC) was interviewed on 11/20/24 at 11:45 a.m. The EC said she was looking into getting different plate warmers, as the food was served hot on her line but was cold by the time it was served to the residents. The EC said some of the residents had complained about food temperature, especially with breakfast. The EC said she individually delivered meals for residents that complained about food temperature so the food had a chance of being served hot. The EC was interviewed a second time on 11/20/24 at 3:53 p.m. The EC said she only ever received complaints about the temperatures of the eggs served for breakfast. The EC said some of the residents had complained about the palatability of the food served at the facility because they wanted salt in their food and that they could not use salt in the food at the facility. The EC said the dietary staff did not really follow specific recipes but would look up recipes on their phones or find a recipe if their food provider had one. The EC said the plate warmers used at the facility were able to hold temperatures but that the EC was looking for better solutions. The EC said there were a few complaints about breakfast temperatures but said it was for no more than five residents. The EC said the food delivery carts were new and closed so there was less air-flow that could cool the food down. Certified nurse aide (CNA) #2 was interviewed on 11/21/24 at 12:23 p.m. CNA #2 said the dietary aides and a few other facility staff members usually came to help him pass out meal trays. CNA #2 said it only took a few seconds to get all of the meal trays on his hallway passed out when other staff members came to help, and even when it was only him passing out trays it still only took a few minutes. CNA #2 said some of the residents thought the food was very bland and would ask him to get them seasoning packets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen and two of two nourishment refrigerators. Specifically, the facility failed to: -Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross contamination in the main kitchen; and, -Ensure safe and appropriate storage of food items in the kitchen and nourishment room refrigerators. Findings include: I. Failed to ensure ready-to-eat foods were handled in a sanitary manner A. Professional reference The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. B. Facility policy and procedure The Use of Gloves/Hairnets/Covering of Food policy and procedure, revised [DATE], was received from the nursing home administrator (NHA) on [DATE] at 8:38 a.m. It revealed in pertinent part, Single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. C. Observations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continuous observation of the lunch meal service on [DATE], beginning at 10:30 a.m. and ending at 12:37 p.m. the following was observed: At 11:07 a.m. cook (CK) #1 retrieved a plastic bag containing heads of lettuce. With his bare hands, CK #1 reached into the plastic bag and grabbed the lettuce and put it onto the cutting board. CK #1 washed his hands, then using his bare hands held the lettuce as he cut it. CK #1 then used his bare hands to move the lettuce to a steam table bin. -The lettuce was placed into a steam table bin on the line and was added to the carnitas without any further washing or modification. At 11:09 a.m. dietary aide (DA) #1 was wearing a pair of gloves. With her gloved hands, DA #1 handled a plastic bag of bread and the buttons on a toaster. Using the same gloved hands, DA #1 pulled two pieces of bread out of the toaster. DA #1 grabbed the handle and opened the lid for the cold storage preparation area and retrieved several condiment packets. DA #1 squeezed the contents out of the condiment packets and used the same gloved hands to stabilize the pieces of toast while applying the condiments. With the same gloved hands, DA #1 retrieved the plastic bread bag and took out two more pieces of bread and put them in the toaster. With the same gloved hands DA #1 grabbed pieces of lettuce and put them on the toasted bread with the condiments applied. DA #1 repeated this process with several slices of tomato while wearing the same gloves. DA #1 then pressed buttons on the toaster with her gloved hand. DA #1 then used her gloved hands to sort through a plate of bacon, select several pieces, then put them on top of the lettuce and tomato. With the same gloved hands, DA #1 grabbed the pieces of bread out of the toaster and put them on top of the sandwiches. At 11:22 a.m. CK #1 was wearing a pair of gloves. Using his gloved hands, CK #1 retrieved a plastic bag of tortillas, opened it, and placed several tortillas onto the grill. Using the same gloved hand, CK #1 held the stack of tortillas as he took them off the grill and placed them into a steam table bin. At 11:34 a.m. CK #2 used his bare hand to grab a handful of lettuce and place it onto a plate containing pork carnitas. The executive chef (EC) told CK #2 to use tongs when performing that task. -However, the plate was still served. At 11:36 a.m. CK #1 used tongs to place two tortillas onto a plate. CK #1 then used his bare hands to separate the tortillas, then used his bare hand to stabilize the tortillas as he scooped beef into them. At 11:40 a.m. CK #1 was handling tongs and serving utensils with his bare hands. Using his same bare hands, CK #1 reached into a container of parsley, grabbed a pinch of the herb, and sprinkled it onto a plate containing mashed potatoes. CK #1 then used his bare hand to stabilize two tortillas on the same plate as he ladled pork into them. -CK #1 used his bare hands to sprinkle herbs onto several plates prepared during the lunch service. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:51 a.m. CK #2 donned (put on) a pair of gloves. Using his gloved hands, CK #2 used tongs and serving utensils. CK #2 used the same gloved hands to grab lettuce and shredded cheese and put them onto a plate containing carnitas. CK #2 then used the same gloved hands to adjust two halves of a grilled cheese sandwich on a plate prior to setting it into the window to be served. At 12:01 p.m. a pea sized amount of mashed potatoes landed on the bare forearm of CK #1. Using his bare hands, CK #1 grabbed the piece of mashed potatoes and flung it back into the steam table bin of mashed potatoes. At 12:08 p.m. CK #2 donned a pair of gloves and retrieved a plastic bag of bread. Using his gloved hands, CK #2 opened the bag of bread, grabbed two pieces of bread and put them onto a cutting board. CK #2 grabbed a knife that was previously used to cut fish, retrieved a towel from a sanitizer bucket, and wiped the knife off. Using the same gloved hands, CK #2 opened several packets of peanut butter and held the pieces of bread to stabilize them as he spread peanut butter onto the bread with the knife. Using the same gloved hands, CK #2 pressed the two pieces of bread together. At 12:11 p.m. CK #1 used his bare hands to handle serving utensils. Using the same bare hands, CK #1 reached into the container of shredded cheese and sprinkled it onto the pork carnitas. At 12:16 p.m. the EC was wearing a pair of gloves and handling serving utensils and the lid to a pot. Using the same gloves, the EC grabbed two pieces of toast out of the toaster and set them onto a plate. At 12:18 p.m. CK #2 was wearing gloves and handling serving utensils and tongs. Using the same gloved hands, CK #2 grabbed a handful of shredded lettuce and placed it onto pork carnitas. CK #2 used the same gloved hands to repeat this process with shredded cheese. At 12:19 p.m. CK #1 was handling serving utensils and tongs with his bare hands. Using his bare hands, CK #1 grabbed a stack of five plates and laid them out along the food service line. CK #1 then placed the entirety of his bare hand onto the top of one of the five plates prior to putting food onto the plate and serving it. At 12:21 p.m. CK #2 took the same knife that was used to cut cooked fish and spread peanut butter onto bread and wiped the knife with the same rag that was used to wipe the knife prior. CK #2 then used the knife to cut a veggie burger into bite-sized pieces. -The towel had been left on the counter between uses and had not been replaced in the sanitizer bin. D. Staff interviews The EC was interviewed on [DATE] at 11:45 a.m. The EC said the dietary staff were not allowed to use gloves during food service. The EC said she told her dietary staff not to use gloves. The EC said she told CK #2 to wear gloves if that was what felt more comfortable for him but that CK #2 needed to change his gloves whenever he left the food service line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The EC was interviewed a second time on [DATE] at 3:53 p.m. The EC said ready to eat foods should be handled with clean gloves and only after hands had been washed. The EC said gloves should only be used for one task before being changed. The EC said whenever the dietary staff left the line they needed to remove their old gloves and perform hand hygiene before donning new gloves. II. Failed to store food items correctly in the refrigerators A. Professional reference The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees celsius (41 degrees fahrenheit (F)) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. B. Facility policy and procedure The Kitchen Sanitation policy and procedure, revised [DATE], was received from the NHA on [DATE] at 8:38 a.m. It revealed in pertinent part, The staff shall maintain the sanitation of the kitchen through compliance with an established cleaning schedule. Cleaning and sanitation tasks for the kitchen will be defined. Frequency of cleaning for each task will be defined. C. Observations On [DATE] at 8:50 a.m. an initial tour of the kitchen revealed the following in the refrigerator by the food service line: -A pitcher of tea, unlabeled and undated; -A pitcher of fruit punch, dated [DATE]; -A cup of juice, dated [DATE]; and, -A boat shaped reusable container with meat in it, unlabeled and undated. At 4:48 p.m. observations of the nourishment refrigerator on the 200 unit revealed the following: -An open carton of milk with a name written on it, with an expiration date of [DATE]; -A carton of yogurt, with an expiration date of [DATE]; -A container with an apple-based dessert with a room number written on it but no date; and, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A container of noodles with a room number and resident name but no date. At 4:52 p.m. observations of the nourishment refrigerator on the 300 unit revealed the following: -A milk carton, with an expiration date of [DATE]; -A milk carton, with an expiration date of [DATE]; -A protein shake, with an expiration date of [DATE]; -A protein shake, with an expiration date of [DATE]; -A protein shake, with expiration date of [DATE]; -Two yogurt containers, with an expiration date of [DATE]; -A bowl of an unidentified food substance, dated [DATE]; -A container of food from a fast food restaurant , unlabeled and undated; -A cup of juice, unlabeled and undated; -A cup of milk, unlabeled and undated; -A container of ranch, dated [DATE]; -A container of red liquid, dated [DATE]; -A bottle of lemon juice, with an expiration date of [DATE]; and, -A packet of sour cream, with an expiration date of [DATE]. -The freezer had a foul odor. On [DATE] at 10:25 a.m., the nourishment refrigerator on the 300 unit was reviewed again. The same contents listed above remained in the refrigerator. During the observation period, an unidentified resident and unidentified staff member were walking by. The resident said it smelled like something died in the freezer. The staff member then replied to the resident and said they needed to clean it out more. D. Staff interview The EC was interviewed on [DATE] at 9:05 a.m. The EC said the pitcher of tea was hers from that morning. The EC said the boat shaped container was the staff's personal food from yesterday. The EC said the staff brought in food every Sunday to share among the staff. The EC said she told her staff to make sure they took their personal food containers home with them but they had forgotten it. The EC said the pitchers of juice were good for seven days once prepared, so the [DATE] and [DATE] containers needed to be thrown out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The EC was interviewed a second time on [DATE] at 3:53 p.m. The EC said the nourishment refrigerators were cleaned out twice a week on both units by the dietary staff. The EC said the process for cleaning out the refrigerators was to throw away any food without a name or date on it. The EC said the third floor refrigerator was last cleaned out the Tuesday ([DATE]) prior to observations taking place, and the second floor refrigerator was cleaned out that Wednesday ([DATE]) prior to observations taking place. The EC said food items prepared by the facility needed to be thrown out three days after the date written on them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	Provide and implement an infection prevention and control program. 47064 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of three units. Specifically, the facility failed to: -Ensure staff wore the appropriate personal protective equipment (PPE) in COVID-19 positive resident rooms; -Ensure proper infection control practices were followed for wound care; -Identify an effective process to ensure staff were aware of which residents required enhanced barrier precautions (EBP); and, -Ensure staff wore the appropriate PPE for residents on EBP. Findings include: I. Failure to ensure staff wore the appropriate personal protective equipment (PPE) in COVID-19 positive resident rooms A. Professional reference According to the Center for Disease Prevention and Control (CDC) Infection control Guidance: SARS-CoV-2, (9/23/22) retrieved on 11/26/24 from https://www.cdc.gov/covid/hcp/infection-control/, Healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (goggles or a face shield that covers the front and sides of the face). Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. B. Observations On 11/18/24 at 8:54 a.m. an unidentified housekeeper entered Resident #32's room. Resident #32 was on isolation precautions for COVID-19. The unidentified housekeeper was wearing a surgical mask. -The unidentified housekeeper did not put on a N95 mask, gown, gloves, or protective eyewear prior to entering Resident #32's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	On 11/20/24 at 2:52 p.m. a bin containing PPE was sitting outside the doorway to Resident #32's room. There were three signs on the resident's door. The first sign identified the room as requiring droplet precautions and instructed everyone entering the room to sanitize their hands and wear masks and face shields. The second sign said EBP and instructed everyone to sanitize their hands when entering the room and providers and staff must also wear a gown, gloves, mask and face shield when providing care. The third sign was a stop sign which instructed people to check with the nurse before entering the room. On 11/20/24 at 4:50 p.m. an unidentified certified nurse aide (CNA) put on a N95 mask, gown and gloves and delivered Resident #32's dinner tray. -The unidentified CNA did not perform hand hygiene or put on protective eyewear prior to entering the resident's room. On 11/20/24 at 5:57 p.m. a visitor was walking down the hallway and stopped at Resident #32's room. The visitor turned and spoke with registered nurse (RN) #4. RN #4 informed the visitor that Resident #32 was still on isolation precautions until the next day (11/21/24). The visitor proceeded to enter Resident #32's room without applying PPE. -RN #4 failed to educate the visitor on the appropriate PPE and precautions that should be taken when entering Resident #32's COVID-19 positive room. C. Staff interviews Housekeeper (HSK) #1 was interviewed on 11/19/24 at 11:18 a.m HSK #1 said housekeepers were to wear PPE, including gloves, gown, mask when cleaning a COVID-19 positive room or any room with isolation precautions. HSK #1 said it was important to wear PPE to protect the residents and to protect herself/staff. The infection preventionist (IP) was interviewed on 11/21/24 at 3:39 p.m The IP said COVID-19 was considered to be droplet transmission. The IP said droplet transmission meant the virus had to be inhaled to be transmitted to someone else and it could not be picked up off a surface. The IP said housekeepers were to wear PPE when cleaning rooms when residents were on droplet or contact isolation precautions in order to prevent the spread of an infection. 51163 II. Failure to ensure proper infection control procedures were following during wound care A. Observations On 11/21/24 at 8:40 a.m. the CWN and the DON were observed providing Resident #53's wound care and dressing change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	The CWN cleared off the resident's bedside table, wiped it down with a disinfectant wipe, applied a barrier pad and placed her bag of resident wound care supplies on top. The DON placed a clean chucks pad (disposable absorbent pad) under the resident's abdominal fold but below the wounds. Three dressings were observed on the resident, one on the right, one in the middle and one on the left. All of the dressings had the date 11/20/24 with a nurse's signature. Both the DON and the CWN completed hand hygiene and put on clean gloves. The CWN removed all three dressings. The right and left wounds had moderate serosanguineous drainage (a thin watery fluid), the middle wound had a small amount of bloody drainage. The wound on the right was the largest of the three wounds. It was noted to have a ring of redness around it and the center had 20% eschar and 10% yellow slough (dead tissue). The remaining tissue was red and it had no odors. The middle wound was the size of a nickel and had red tissue throughout and did not have an odor. The wound on the left was noted to be about the size of a quarter and had 80% slough and 20% red tissue and did not have an odor. The CWN changed her gloves to set up her supplies for the wound care. She set up a stack of gauze, a spray can of saline solution and a lidocaine (used for pain control) spray. She started with the left wound by taking one gauze, sprayed it with saline and wiped the wound. She folded over the gauze and wiped the wound bed again three times with the same piece of gauze. The wound was observed with bloody drainage. The CWN threw the gauze away, and with her dirty glove, touched the saline bottle and then re-sprayed all three wounds with lidocaine per the resident's request due to pain. -The CWN did not change gauze pads after each wipe of the wound. -The CWN did not change her gloves or perform hand hygiene after cleaning the left wound, which had bloody drainage, and before picking up the saline and lidocaine spray bottles. Using the same dirty gloves, the CWN took another piece of gauze, sprayed it with the saline solution and moved to the middle wound. She wiped the wound bed twice with the same piece of gauze. The CWN moved to the wound on the right and wiped the wound bed three times with the same piece of gauze. She collected a second piece of gauze, moistened it with saline and wiped eight times over the wound. She disposed of that piece of gauze, took another piece of gauze, moistened it with saline solution and proceeded to wipe six more times over the wound bed. She disposed of the piece of gauze, grabbed another and dabbed the area three times due to bloody drainage. She threw away the gauze, changed her gloves and performed hand hygiene. The CWN used the same dirty gloves throughout the entire process. -The CWN did not change her gloves and perform hand hygiene after cleaning the left wound and before proceeding to clean the middle wound. -The CWN did not change gauze pads after each wipe of the wound. -The CWN did not change her gloves or perform hand hygiene after cleaning middle wound, which had bloody drainage, and before picking up the saline and lidocaine spray bottles. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	The CWN then conducted a wound culture to the right wound based on the wound physician's recommendation. She took only the culture tubing out of the sterilized package. She swabbed the right wound. She did not perform debridement of the wound prior to the wound culture. She inserted the sample into the test tube, closed it and used a resident label, placing it directly over the test tube so the sample could be identified. The CWN changed her gloves and performed hand hygiene. She started on the left wound, using gauze and saline to wipe the wound bed, applied skin prep to the peri-wound and cut calcium alginate (highly absorbent dressing) sheet to size and applied it. She applied medihoney (type of antimicrobial gel) and covered the wound with a border foam dressing. Using the same gloves, the CWN moved to the middle wound and used a saline-soaked gauze to wipe the wound four times. using the same gauze to apply the skin prep to the peri-wound. She cut another piece of calcium alginate and medihoney and applied both to the resident's wound and covered it with the foam dressing. Using the same gloves, the CWN moved to the right wound, using saline soaked gauze, she wiped the wound four times with noted serosanguinous drainage coming out of the wound as she applied skin prep. She measured the right wound which was 3.5 cm (centimeters) length by 9 cm width by 0.1 cm depth and said the wound was larger than last week. She took calcium alginate and medihoney and applied it to the wound and covered it with a foam dressing. -The CWN did not change her gloves or perform hand hygiene in between performing the treatment for each wound. All supplies were cleaned up, trash was removed, PPE was doffed and hand hygiene was performed by all parties prior to leaving the room. B. Staff interviews The CWN was interviewed on 11/21/24 at 9:11 a.m. The CWN said her cleaning technique with the gauze was to move from clean to dirty and then discard the gauze. She said she did not realize she had used the same gauze up to eight times to wipe the wound bed. She said the gauze should be changed in between each wipe to decrease the risk of infection. She said gloves should be changed in between each wound. She said she should have changed her gloves in between each wound site to decrease the risk of infection. NP #1 was interviewed on 11/21/24 at 12:21 p.m. NP #1 said the presence of slough in a wound could mean a wound had a potential infection. She said using the same gauze to wipe the wound multiple times could spread bacteria throughout the wound. She said not changing gloves in between cleaning each wound had the potential to spread a possible infection to the other wounds. The IP was interviewed on 11/21/24 at 3:39 p.m. The IP said each piece of gauze used to clean wounds should only be used for one wipe over the wound to prevent the spread of infection. The IP said the CWN should have changed her gloves between each wound site to prevent the spread of infection from one site to another. 50219 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	III. Failure to identify an effective process to ensure staff were aware of which residents required EBP and ensure staff wore appropriate PPE for residents on EBP A. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 11/25/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care: any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy and procedure, dated 3/27/24, was received from the nursing home administrator (NHA) on 11/22/24 at 8:38 a.m. It read in pertinent part, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. Per the CDC, EBP are recommended (when contact precautions do not otherwise apply) during high-contact care activities with residents who are at higher risk of acquiring or spreading an MDRO. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Residents with MDROs, wounds, or indwelling medical devices will be placed on proper precautions when at the facility. Residents will be put on EBP when contact precautions do not otherwise apply. EBP involves staff utilizing gown and gloves during specified high-contact activities with the resident. Residents are not restricted to their room and can participate in group activities. EBP are intended to be in place for the duration of a resident's stay in the facility or until a resolution of wound or discontinuation of the indwelling medical device that placed them at higher risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	EBP are required for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO during high contact activities, including wounds that are chronic with drainage, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers. High contact care activities: EBP include use of gown and gloves during the high contact patient care activities, including dressing, bathing/showering, transferring, when working with patients in the therapy gym that need mobility assistance and/or transfers that require a longer duration, providing hygiene, changing linens, changing briefs or assisting toileting and with device care or use of a central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care. C. Resident #225 1. Observations On 11/19/24 at 9:57 a.m. RN #2 entered Resident #225's room. Resident #225 was receiving antibiotics via a peripherally inserted central catheter (PICC) line. -There were no signs on the resident's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). RN #2 donned gloves after entering the room, flushed Resident #225's PICC line with normal saline, disconnected the PICC line, wiped the connection points on the PICC line and removed her gloves. -RN #2 did not don a protective gown prior to performing care of Resident #225's PICC line -On 11/19/24 at 2:06 p.m. an EBP sign was observed on Resident #225's door and a bin containing PPE had been placed outside the resident's room. 2 Resident interview Resident #225 was interviewed on 11/19/24 at 9:55 a.m. Resident #225 said the nurses at the facility wore gloves to connect and disconnect her PICC line. Resident #225 said the nurses at the facility did not wear gowns when they handled her PICC line. D. Resident #231 1. Observations On 11/19/24 at 10:08 a.m. RN #2 entered Resident #231's room. Resident #231 had a PICC line and a wound vacuum (a treatment device that uses suction to help wounds heal). -There were no signs on the resident's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	RN #2 performed hand hygiene and donned gloves after entering the room, flushed Resident #231's PICC line with normal saline, disconnected the PICC line, wiped the connection points on the PICC line and removed her gloves. RN #2 offered to hold Resident #231's wound vacuum as the resident readjusted in bed. -RN #2 did not don a protective gown prior to performing care of Resident #231's PICC line or while holding the wound vacuum. -On 11/19/24 at 2:06 p.m. an EBP sign was observed on Resident #231's door and a bin containing PPE had been placed outside the resident's room. E. Resident #40 1. Resident observation and interview On 11/20/24 at 8:52 a.m. Resident #40 said he had a port (a small, disk-shaped device that's surgically implanted under the skin to provide access to a vein for medical treatments and blood draws) on his chest and a fistula (a surgically created connection between an artery and a vein that allows for hemodialysis treatments) in his left arm. -There were no signs on the resident's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). On 11/21/24 at 1:26 p.m. an unidentified nurse said Resident #40 should have a sign on his door and a bin containing PPE outside his door so staff was aware PPE was required when working with the resident. The nurse went to obtain the items. 2. Staff interview Licensed practical nurse (LPN) #1 was interviewed on 11/21/24 at 1:17 p.m. LPN #1 said EBP was used for any residents that had any indwelling device in their body and were used when doing any care related to that indwelling device. LPN #1 said residents were identified for EBP on admission or if a new indwelling device was implemented. LPN #1 said since Resident #40 had a dialysis port and should be on EBP. LPN #1 said if Resident #40 should have EBP put in place immediately. F. Resident #224 1. Resident observations and interview On 11/18/24 at 10:05 a.m. a PICC line was observed in Resident #224's arm. -There were no signs on the resident's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). -At 12:04 p.m. an unidentified member of the activities staff went into Resident #224's room without performing hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	At 2:42 p.m. Resident #224 said the nursing staff administered medications through his PICC line in the evenings. Resident #224 said he could not recall whether the nursing staff wore gowns while caring for his PICC line. On 11/19/24 at 8:41 a.m. an EBP sign was observed on Resident #224's door and a bin containing PPE had been placed outside the resident's room. At 10:05 a.m. two unidentified members of the therapy staff were preparing to enter Resident #224's room. The therapy staff members were overheard discussing whether or not they needed to don gowns before entering the room.The therapy staff members said that since Resident #224 did not have COVID-19, they only needed to wear gloves while working with the resident. -The therapy staff members proceeded to enter the resident's room without putting on gowns. G. Resident #222 1. Observations On 11/19/24 at 3:00 p.m. there were no signs on the Resident #222's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). Resident #222's electronic medical record (EMR) identified the resident had bilateral extremity wounds. On 11/21/24 at 1:11 p.m. LPN #2 posted an EBP sign on Resident #222's door and a bin containing PPE inside or outside of the resident's room. 2. Staff interviews CNA #2 was interviewed on 11/21/24 at 9:50 a.m. CNA #2 said EBP were for residents with PICC lines or other indwelling devices. CNA #2 said the nursing staff needed to wear PPE for more high contact care, including a gown, gloves, and a mask. CNA #2 said the different signs on the residents' doors told the nursing staff what PPE they needed to wear for that specific resident. -However, EBP required a gown and gloves, but not a mask (see professional reference above). CNA #2 was interviewed again on 11/21/24 at 12:23 p.m. CNA #2 said he did not have to wear any gown, gloves, or other PPE when working with Resident #222 because the resident did not have any catheters or indwelling lines. -However, Resident #222 had bilateral lower extremity wounds which required the implementation of EBP (see professional reference above and facility follow up below). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	LPN #2 was interviewed on 11/21/24 at 12:47 p.m. LPN #2 said EBP were for residents with devices such as PICC lines, foley catheters and wound vacuums. LPN #2 said EBP was implemented so that when the nursing staff worked with the resident, it protected the nursing staff, the resident indicated and other residents from the spread of infection. LPN #2 said EBP meant staff needed to don a gown, gloves, and a mask. LPN #2 said EBP were identified when the resident arrived from the hospital when the nurses doing the admission identified the resident had an indwelling medical device. LPN #2 said EBP were only used for residents with wound vacuums and were not used for residents with more general open wounds. LPN #2 said staff did not need to use EBP for residents with open wounds. -However, EBP required a gown and gloves, but not a mask (see professional reference above). -Additionally, according to the CDC, EBP should be implemented for all residents with wounds or indwelling devices, regardless of their MDRO status (see professional reference above). LPN #2 there were were no signs or materials for EBP for Resident #222 because the resident did not have any indwelling lines or catheters, but she said the resident might be put on EBP by the wound nurse if he had some sort of infection in his wounds. LPN #2 said the nursing staff had not been using EBP during Resident #222's care because there were no signs or PPE outside his door to indicate EBP was required for the resident. LPN #2 said she thought he may have had an EBP sign up on his door at one time but she was not sure where it went. H. Resident #226 1. Observations On 11/18/24 at 10:13 a.m. there were no signs on Resident #226's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). Resident #226's EMR identified the resident had venous stasis wounds (open sores that develop on the lower legs or ankles due to poor blood circulation) on both lower extremities. 2. Staff interviews RN #2 was interviewed on 11/21/24 at 3:44 p.m. RN #2 said the IP had been putting residents on EBP if they had open and draining wounds, PICC lines or other indwelling lines. RN #2 said staff members only needed to wear PPE when working with the specific area that the resident needed EBP for. She said if staff was providing foley catheter care or working with a resident's PICC line, the staff should put on PPE. RN #2 said residents on EBP should have a sign on their door and a bin with PPE outside of their room. RN #2 said Resident #226 had wounds on both legs, however, she was not aware if the resident required EBP. RN #2 said she needed to clarify with the IP to see what constituted a wound that required EBP. -However, Resident #226 had venous stasis wounds on both legs which required the implementation of EBP (see professional reference above and facility follow up below). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	I. Resident #53 1. Observations On 11/21/24 at 8:40 a.m. the CWN and the DON were observed providing Resident #53's wound care and dressing change. -There were no signs on the resident's door or a bin containing PPE inside or outside of the resident's room, which was identified as the facility's process for EBP (see staff interviews). On 11/21/24 at 11:40 a.m. an EBP sign was observed on Resident #53's door and a bin containing PPE had been placed outside the resident's room. 2. Staff interviews LPN #4 was interviewed on 11/21/24 at 11:48 a.m. LPN #4 said Resident #53 was on EBP because she had a dialysis port and an open wound. She said an EBP sign had been on the door and a PPE bin had been outside the resident's room previously, but she did not know who removed them or when. She said she replaced the EBP sign and put a bin outside the resident's room after the wound care was performed (on 11/21/24). J. Additional staff interviews CNA #3 was interviewed on 11/21/24 at 10:33 a.m. CNA #3 said the different signs on the residents' doors meant different things. CNA #3 said the EBP signs meant the resident had an intravenous (IV) line. CNA #3 said for EBP, the nursing staff needed to wear PPE, including a mask, gown, and gloves. -However, EBP required a gown and gloves, but not a mask (see professional reference above). The IP was interviewed on 11/21/24 at 3:39 p.m.The IP said the facility used signs on resident doors to indicate which residents were to be on EBP precautions and placed bins containing PPE outside the residents' doors. She said floor staff were not great at putting EBP in place. The IP said when she reviewed residents or became aware of an infection/illness, usually at morning meetings, which required isolation precautions ,she would complete an audit to ensure a bin with PPE supplies and a precaution sign on the resident's door was in place. The IP said she also ensured the residents met the criteria for EBP or any other infection precautions needed. The IP said it was the floor staff's responsibility to ensure the PPE carts outside of a residents room were stocked with all of the needed PPE. The IP said EBP were put into place when a resident had a MDRO infection and had devices such as ports, urinary catheters or chronic non-healing wounds and wounds showing signs of infection. The IP said when EBP were required, all caregivers/staff providing care needed to sanitize hands, apply gloves, gown and a mask. -However, according to the CDC, EBP should be implemented for all residents with wounds or indwelling devices, regardless of their MDRO status (see professional reference above). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065403	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lincoln, Llc, The	12230 Lioness WY Parker, CO 80134

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 - Some	The director of nursing (DON) was interviewed on 11/21/24 at 5:56 p.m. The DON said that EBP was used for PICC lines, draining wounds, chronic wounds, foley catheters, and dialysis ports. The DON said EBP was used by the nursing staff when handling the resident and providing high-contact care. The DON said they used the PPE bins and EBP signs as indicators and thought the housekeeping staff may have been moving the PPE bins away from resident rooms. The DON said EBP was used to protect the residents and the nursing staff from infection. The DON said staff providing care to residents with those devices should be wearing PPE, including gloves, gown and a mask. -However, EBP required a gown and gloves, but not a mask (see professional reference above). The DON said a sign for EBP should have been placed on the doors and a PPE cart should have been placed outside the rooms for Residents #225, #231, #40, #224, #222, #226 and #53. K. Facility follow up The NHA provided CDC guidelines on EBP via email on 11/22/24 at 11:29 a.m. (after the survey). The guidelines revealed in pertinent part, In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of EBP is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds and not those with only shorter-lasting wounds. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers and chronic venous stasis ulcers. -However, observations and interviews revealed the facility had not implemented EBP for residents with wounds (see above).