STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review and interviews, the facility failed to promote and maintain resident dignity by providing care in a dignified, respectful and individualized manner for three (#1, #5 and #6) of three residents out of 12 sample residents. Specifically, the facility failed to: -Ensure Resident #1 and Resident #6 were treated with dignity and respect when they asked for care assistance; and, -Ensure Resident #5, a resident with a diagnosis of Alzheimer's disease, was provided a dignified experience of receiving sufficient care to maintain good personal health and hygiene. Findings included: I. Facility policy The Dignity policy, revised February 2021, was provided by the corporate nurse consultant (CNC) on 8/27/24 at 11:10 a.m. It read in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. Individual needs and preferences of the resident are identified through the assessment process. Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with this facility. When assisting with care, residents are supported in exercising their rights. For example, residents are; groomed as they wish to be groomed (hairstyles, nails, facial hair). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Coal Creek Post Acute & Assisted Living		STREET ADDRESS, CITY, STATE, ZIP CODE 329 Exempla Cir Lafayette, CO 80026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Rights policy, revised December 2016, was provided by the CNC on 8/27/24 at 11:10 a.m. It read in pertinent part, Employees shall treat all residents with kindness, respect and dignity. The residents' rights include a dignified experience. The Activities of Daily Living (ADL), Supporting policy, dated 2001, was provided by the CNC on 8/27/24 at 11:10 a.m. It read in pertinent part, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. II. Resident #1 A. Resident status Resident #1, age 74, was admitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included diabetes and congestive heart failure. The minimum data set (MDS) assessment was not completed. The nursing admission assessment dated [DATE] documented Resident #1 was alert and oriented to person, place, time and situation and was calm and cooperative. The resident was motivated to participate in rehabilitation services and needed assistance with ADLs, including transferring, toileting, dressing and hygiene. The resident was incontinent of bladder and usually had daily bowel movements. B. Record review A review of Resident #1's electronic medical record (EMR) revealed the resident's baseline care plan had not yet been started and there was no CNA task record or Kardex (abbreviated plan of care for the CNA). -The CNC confirmed the facility did not have a Kardex for Resident #1. A social services note, dated 7/29/24 at 11:18 p.m., documented Resident #1 said he wanted to leave the facility due to the caregiver neglecting to provide timely assistance for him to use the bathroom. The facility investigation dated 7/29/24 documented that the resident asked his certified nurse aide (CNA) #2 for assistance to use the bathroom to have a bowel movement and CNA #2 told him to remain in bed, go to the bathroom in his brief and she would clean him up afterward. The resident insisted he be taken to the bathroom. CNA #2 finally took the resident to the bathroom. Staff interviews revealed Resident #1 waited so long for the staff to act that he thought he was not going to make it to the bathroom. The resident was unhappy with the way he was treated and told staff that he was leaving and going home. Resident #1 called the police, rolled himself outside of the facility and was taken to the hospital by ambulance transport. The facility's investigation concluded CNA #2 did not respond to Resident #1 in a dignified and respectful manner when she told him to go to the bathroom in his brief instead of providing him timely assistance to use the toilet as he asked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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

F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

III. Resident #5

A. Resident status

Resident #5, age greater than 65, was admitted on [DATE] and discharged on [DATE]. According to the August 2024 CPO, diagnoses included Alzheimer's disease, overactive bladder and depression.

The MDS assessment was not completed.

The nursing admission summary dated 7/26/24 revealed the resident was alert and oriented to person only. The resident was incontinent of bowel and bladder and dependent on staff to complete ADLs and used a mechanical lift for transfers.

B. Resident representative interview

Resident #5's legal representative was interviewed on 8/26/24 at 10:33 a.m. The representative said she had talked to the facility during Resident #5's admission and several times afterward about the resident's care choices. The representative said Resident #5 spent a lot of time in bed but had requested that staff get her up before lunch so she could spend time with family when they visited. The representative said the resident also requested staff get her up so she could participate in Sunday church services, the one activity she enjoyed. She said there were several occasions when the family would visit and find Resident #5 with poor hygiene and wearing the same clothing as the day before. She said this was out of character for Resident #5.

The resident's representative said she was in the facility to see the resident every day at different times of day and she found her mom in poor condition on several occasions making her fear for the resident's health. She said Resident #5 had a pressure injury when she admitted and it started worsening. She said if Resident #5 did not get proper hygiene and hydration assistance, her wounds would worsen.

The resident's representative said Resident #5 had always had good hygiene and it was important to her. The representative said Resident #5 was in a total state of helplessness and was dependent on staff to provide good care for her overall wellbeing and happiness. She said staff did not take the time to change soiled linens, provide timely incontinence care or remove the resident's soiled clothing to be laundered. The representative said this left Resident #5 and her room with a foul odor. The resident's representative said it was disappointing to see the resident in a soiled state.

The resident's representative said, on 8/4/24, she provided the facility a detailed letter of the family's observations and concerns with action items (interventions) that she and Resident #5 would like to have provided for the resident but she said things still were not corrected by the facility.

The resident's representative said her concerns for the resident's well-being deepened when she learned that the nursing home administrator (NHA) had not been provided a copy of her grievance letter and was not informed of her request to meet with the leadership team to discuss the details of her grievance letter.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative said it was not long after she gave the facility the letter that the family decided to remove Resident #5 from the facility's care. She said they moved Resident #5 out of the facility on 8/11/24, 16 days after she was admitted to the facility. C. Record review A care conference summary dated 8/2/24 revealed the resident and her legal representative were in attendance at the care conference, as were the facility's interdisciplinary team (IDT) members, including the director of nursing (DON) and the social services director (SSD). The summary documented the family planned for Resident #5 to remain in the long-term care setting and for the resident's husband to move to the facility's on-site assisted living community. The psychosocial mood care plan initiated on 8/2/24 revealed Resident #5 was at risk for decreased psychosocial well-being adjustment issues and emotional distress. The goal was for the resident to have no decline in mood or behavior that prevented her from functioning in her daily activities. Interventions included assessing the resident's preferences and choices with activities and encouraging involvement and encouraging friends and family support/visits. A nursing note dated 8/4/24 documented the resident's legal representative voiced concerns about the resident's care. The representative voiced concerns that, despite a request at a care conference, the resident was not up for church that morning (8/4/24) and she had the same shirt on from 8/2/24 (Friday). The representative was additionally concerned because the resident had not had a shower since her admission to the facility on [DATE] and soiled laundry was left on the shower floor. A care conference summary dated 8/8/24 revealed Resident #5, her legal representative and another family member were in attendance at the care conference, as were the facility's IDT members, including the DON, the SSD and the activities director (AD). The care conference summary documented the resident's representative and the other family member brought up concerns about the resident's personal and environmental hygiene. The representative said she had arrived at the facility to assist Resident #5 with the noon meal and found the resident in a darkened room and still in bed. The representative said she had asked the facility staff, upon the resident's admission to the facility, to make sure the resident was up and dressed by 11:00 a.m. so she could eat her meal while seated in her chair and not in bed. According to the care conference summary note, the representative's concerns included finding Resident #5 being left in heavily soiled undergarments and smelling strongly of urine. The sheets of the resident's bed were also stained and soiled with urine. The representative said the resident's bedding was covered with food crumbs from the resident being assisted to eat while in bed. Additionally, the representative was concerned because the resident had not been showered. The IDT's plan for the resident's care was to schedule management follow-up to make an observation of Resident #5 every morning at 9:00 a.m. to ensure the resident was provided assistance to meet her care needs. A comprehensive skin evaluation assessment dated [DATE] documented the resident was placed on a two-hour check and change schedule. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER: Coal Creek Post Acute & Assisted Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 329 Exempla Cir, Lafayette, CO 80026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The care plan was not updated to reflect the two-hour check and change intervention. The facility investigation dated 8/14/24 documented that, after investigating the resident's legal representative's concerns, the facility substantiated that CNA #1 failed to provide the resident with a hygienic environment when they left soiled laundry in and around the resident's room. The facility separated from CNA #1 and did not schedule her for additional shifts. CNA #1 was interviewed on 8/14/24. CNA #1 said she checked on Resident #5 in the morning assisted her with breakfast and changed the resident. She did not prove the time that the care was completed. CNA #1 said she continued with rounds assisting her other residents and came back to Resident #5's room to find the family present. CNA #1 said the family was very upset by the condition of Resident #5 and by the presence of a soiled laundry being found on the floor of the resident's shower. -The facility's interview with CNA #1 did not provide answers and details about the exact nature of why the family was upset, the complaint the family voiced and the exact condition of how the resident was found. The investigation did not establish a timeline of events with CNA #1 and failed to provide any substantial evidence about CNA #1's knowledge of the resident's routine or care needs. IV. Resident #6 A. Resident status Resident #6, age less than 65, was admitted on [DATE] and discharged on [DATE]. According to the July 2024 CPO, diagnoses included amputation between the left hip and knee, diabetes and pressure-induced deep tissue injury. The 6/10/24 MDS assessment documented the resident had intact cognition with a BIMS score of 15 out of 15. The resident was dependent on staff for toileting hygiene and bathing and substantial assistance with dressing. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. B. Record review The facility investigation dated 7/10/24 documented Resident #6 filed a grievance on 7/3/24 that when she asked her assigned CNA (CNA #3) to assist her in changing her soiled brief, CNA #3 told her You do not need me to change your diaper, you can do it your (expletive word) self. CNA#3 was removed from the care of Resident #6 and another CNA took over the resident's care and provided ADL assistance and emotional support. The investigation documented there were no witnesses to the exchange between CNA #3 and Resident #6 and the facility concluded it was a He said, she said situation. -However, the facility terminated CNA #3 when the investigation revealed there were four other times in the prior two weeks that CNA #3's conduct caused several other residents to request CNA #3 not to provide care for them. V. Interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER: Coal Creek Post Acute & Assisted Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 329 Exempla Cir, Lafayette, CO 80026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A frequent visitor (FV) to the facility was interviewed on 8/26/24 at 2:47 p.m. The FV said she had concerns about the way residents in the facility were treated. She said residents complained that they were not always treated respectfully and others had to wait a long time for care to be completed. The FV said residents had reported that staff did not address them directly and walked away from them in the middle of a conversation when they were asking for staff assistance. The FV said she brought resident-voiced concerns, as well as her observed concerns, to the leadership team and found that it took a long time for the facility to address resident grievances. The FV said the new NHA seemed to be taking things more seriously than the previous NHA and some things had improved. She said several of the problematic staff were no longer working in the facility. Resident #9 was interviewed on 8/26/24 at 3:41 p.m. Resident #9 said she had just filed a grievance concern earlier today (8/26/24) because of the disrespectful way one of the CNAs made her feel. Resident #9 said she never knew how she would be treated from day to day. She said there were good CNAs and then other CNAs were disrespectful and rough with care assistance. Resident #9 said some CNAs would drop off her meal tray and walk out quickly; never speaking to her to see if she needed anything. She said other CNAs would walk away mid-conversation and she did not get what she needed. Resident #9 said today (8/26/24), a CNA came in to take her to the bathroom and she hurriedly assisted her to the toilet. The CNA never apologized or said anything about it. The NHA was interviewed on 8/27/24 at 8:12 a.m. The NHA said he was new to the facility and started working as the NHA on 7/10/24. The NHA said, after becoming familiar with the facility's operating practices, he implemented several quality measures and improvement projects. He said a couple of areas of focus included developing an orientation binder for agency staff that they were to read before working in the facility. He said the binder would provide agency staff information on basic facility policy, expectations for resident care and following the resident care plan. The NHA said. initially, agency staff were not provided access to the resident's plan of care. He said the DON and assistant director of nursing (ADON) would be responsible for reviewing admission intake information and providing a report to staff on the day of admission to ensure appropriate care was provided for all residents. The NHA said he recognized the need for staff to be better educated on the importance of treating every resident with dignity and respect while meeting the resident-assessed care needs and preferences. The NHA said he was saddened when he learned about the care concerns brought forward by several residents and their families. He said poor quality of care should not be the resident experience. The NHA said it frustrated him that members of leadership had not brought the concerns of Resident #5's family members to him when they first voiced grievances because he believed the concerns could have been fixed and the resident could have been happy living in the facility. The NHA said he did not learn of the family's concerns until a few days before the resident was discharged . The NHA said once he started to investigate resident care concerns and grievances, he realized the leadership team needed to make some changes in the staff's approach to resident care and staff's understanding of the facility's expectations to ensure that all resident care needs were met in a dignified and respectful manner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Coal Creek Post Acute & Assisted Living		STREET ADDRESS, CITY, STATE, ZIP CODE 329 Exempla Cir Lafayette, CO 80026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said he called a mandatory all-staff meeting last night (8/26/24) and early this morning (8/27/24), which was the first of many training sessions where staff would be educated on the importance of customer service and resident care. The NHA said that staff who did not follow facility policies for resident care would be removed from employment. The DON, the unit manager (UM) and the CNC were interviewed on 8/27/24 at 10:56 a.m. The UM said every unit had a nurse-to-nurse report sheet that was updated each shift and the CNAs had access to the residents' Kardex. The UM said the floor nurse should have updated the CNA assigned to Resident #1 about his care needs, especially since the resident had been newly admitted . The DON said she expected the nursing staff to be compassionate, provide good customer service and treat the residents like family. The DON said the facility would be educating staff on the expectations of good customer service.