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	11/13/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on observation and interviews, the facility failed to ensure that professional standards of practice were followed during medication administration for two (#9 and #8) of three residents out of nine sample residents. Specifically, the facility failed to ensure Resident #9 and Resident #8 received medications as scheduled according to the physician's orders. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, page 606-607, retrieved on 11/21/24, It read in pertinent part, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Facility policy and procedure The Administering Medication policy, revised 2019, was received from the nursing home administrator (NHA) on 11/13/24 at 9:08 a.m. It documented in pertinent part, Medications are administered in a safe and timely manner and as prescribed. Medication errors are documented, reported and reviewed by the quality assurance and performance improvement (QAPI) committee to inform process changes and or the need for additional staff training. Medications are administered within one hour of their prescribed time, unless otherwise specified. III. Resident #9 A. Resident status (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included Alzheimer's dementia and hypertension (high blood pressure). The 11/11/24 minimum data set (MDS) assessment the resident had short term and long term memory deficits and was severely impaired with daily decisions per staff assessment. The assessment indicated Resident #9 was receiving an antidepressant, opioid (pain medication) and hypoglycemic medications (used to lower blood sugar). B. Observations Licensed practical nurse (LPN) #1 was observed during medication administration on 11/13/24 at 9:35 a.m. She was preparing medications for Resident #9. She put two 500 milligrams (mg) tablets of Tylenol and squirted Voltaren gel into another cup. She approached the resident at the table near the nurses station and administered the medications at 9:50 a. m. C. Record review The November 2024 medication administration record (MAR) for Resident #9 revealed that all of Resident #9's medications were scheduled for 8 a.m. -Resident #9 received her medications one hour and 50 minutes past its scheduled time and 50 minutes after the allowed medication administration window (see observations above). IV. Resident #8 A. Resident status Resident #8, age greater 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included osteomyelitis (bone infection) and type 2 diabetes. The 10/10/24 MDS assessment revealed Resident #8 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment indicated Resident #8 was receiving an antipsychotic (class of drugs used to treat mental disorders), an antibiotic and an antiplatelet medication (used to prevent blood clots). B. Observations LPN #1 was observed during medication pass on 11/13/24 at 10:00 a.m. S was preparing medications for Resident #8. She put the following medications in the cup: -B-complex vitamin one tablet; -Finasteride (urinary retention medication) five mg one tablet; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Aspirin 81 mg one tablet; -Lactobacillus tablet (probiotic); -Quetiapine (antipsychotic medication) 12.5 mg; and, -Omeprazole (used to treat gastroesophageal reflux disease) 20 mg. She administered the medications at 10:06 a.m. C. Record review The November 2024 MAR for Resident #8, revealed that the B-complex, Finasteride and aspirin were scheduled for 8:00 a.m. The lactobacillus, quetiapine and the omeprazole were scheduled to be administered at 9:00 a.m. -Resident #8 received the B-complex, Finasteride and Aspirin two hours and six minutes past the scheduled time and one hour after the medication administration window. -Resident #8 received the lactobacillus, quetiapine and the omeprazole one hour and six minutes past the scheduled time and six minutes after the medication administration window. V. Staff interviews The director of nursing (DON) and the regional clincial resource (RCR) were interviewed together on 11/13/24 at 4:30 p.m. The RCR said the nursing staff had a one hour window (one hour before and one hour after scheduled time) to administer medications. She said she reviewed the time stamps on the morning medications for Resident #9 and Resident #8 and said their morning medications were administered late. She said the medications were administered late because the morning nurse called off and did not come to work.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and interviews, the facility failed to ensure the resident environment was free from accident hazards and adequate supervision was provided for one (#3) of three residents reviewed out of nine sample residents. Resident #3 was admitted to the facility on [DATE] for rehabilitation after surgery on her back. Upon admission, the resident was assessed for fall risk and was identified as a high risk for falls. However, the baseline care plan, initiated on 10/11/24, failed to identify the resident was at risk for falls and person-centered interventions were not put in place to prevent falls for Resident #3. On 10/12/24 Resident #3 sustained a fall which resulted in a laceration to her head and required transportation to the emergency department for further evaluation and staples to close the laceration. Findings include: I. Facility policy and procedure The Fall Management policy, reviewed September 2012, was provided by the nursing home administrator (NHA) on 11/13/24. The policy revealed the facility would identify each resident who was at risk for falls, would plan the care and implement interventions to manage falls. Residents who were at risk for falls, would have interventions to manage falls. The facility would manage falls by providing an environment that was free from potential hazards. II. Fall investigation The 10/12/24 fall investigation for Resident #3 was provided by the NHA on 11/13/24 at 11:00 a.m. Review of the fall investigation revealed Resident #3 was found on the floor near her bathroom. The resident said she walked to the hallway and asked for help but the girl told me to do it myself. The resident returned to her room where she later was found on the floor with a laceration to her head. Resident #3 was transported to the emergency department for further evaluation. The investigation included an interview with certified nurse aide (CNA) #2 who said she assisted Resident #3 to the bathroom and back to her room. CNA #2's written statement indicated Resident #3 continued to say that she was going to fall while CNA #2 was in the bathroom with her. The investigation did not include an interview with the nurse or manager on duty at the time of the incident. The investigation included interviews with three other staff members who were not present during the incident. III. Resident #3 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #3, age greater than 65, was admitted on [DATE] and discharged home on 11/3/24. According to the November 2024 computerized physician orders (CPO), diagnoses included compression fracture of the fourth thoracic vertebrae, diabetes, difficulty walking, communication deficit, lack of coordination and congestive heart failure. The 10/15/24 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) score was not conducted. The resident did not display any behaviors or rejection of care. A 10/12/24 nurse progress note revealed the resident was alert and oriented to person, time, place and situation. The assessment documented Resident #3 was independent with all activities of daily living (ADL). B. Record review Per the functional assessment completed on 10/11/24, Resident #3 required assistance with ambulation to the bathroom. The 10/11/24 fall risk assessment revealed Resident #3 was at risk for falls. -However, the baseline care plan, initiated on 10/11/24, failed to identify the resident was at risk for falls and person-centered interventions were not put in place to prevent falls for Resident #3. Per the 10/12/24 daily skilled note, the resident had difficulty walking due to compression fracture. The 10/12/24 nurse progress note documented Resident #3 was found sitting on the floor at 6:05 a.m. and the resident was noted to have a laceration 2 centimeters (cm) by 0.5 cm by 0.1 cm bleeding down her hair and onto her chest. When the resident was asked what happened, Resident #3 said she asked a girl (CNA #2) for help and was told she could do it herself. Resident #3 said she took the walker and went to the bathroom. The resident did not know what happened and said she just fell backwards. A physician's order was obtained to send the resident out to the emergency department for evaluation. The 10/12/24 emergency department records revealed Resident #3 was admitted after a fall at the nursing facility where she asked for help and was refused. The resident sustained a head trauma with a laceration that was secured with two staples and a dressing. The resident was discharged back to the nursing facility the same day (10/12/24). IV. Staff interviews The director of nursing (DON), the assistant director of nursing (ADON) and the regional clincial resource (RCR) were interviewed together on 11/13/24 at 3:30 p.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The ADON said she received a call from the floor nurse on 10/12/24. She said the floor nurse reported to her that Resident #3 had a fall. She said the floor nurse told her that Resident #3 was assisted to the bathroom by CNA #2. The ADON said she was told Resident #3 later approached CNA #2 again when she was giving a report to another CNA. She said the resident was told to return to her room where she was later found on the floor in the bathroom. The ADON said she did not participate in the formal investigation of the incident. The DON said she did not recall the incident on 10/12/24 and she was not sure if she was included in the investigation. She said every resident was assessed upon admission for fall risk and baseline care plans were initiated to ensure the safety of residents. -The DON was unable to say why Resident #3's baseline care plan initiated on 10/11/24 did not identify the resident was at risk for falls or include person-centered interventions to prevent falls for the resident. The RCR said Resident #3's initial assessment for fall risk should have triggered the baseline care plan for falls and should have included person-centered interventions for the resident. The physical therapist (PT) was interviewed on 11/13/24 at 4:15 p.m. The PT said Resident #3 participated in therapy and reached her full potential at the time of her discharge from the facility on 11/3/24. He said, upon admission, the resident required one-person assistance with transfers. He said the resident was admitted after back surgery and it was very difficult for the resident to get up. He said she required maximum assistance getting off the bed or chair and assistance of one person when ambulating. The NHA was interviewed on 11/13/24 at 4:45 p.m. The NHA said he completed the investigation for the 10/12/24 incident involving Resident #3. He said CNA #2 was suspended from her duties during the investigation and later was dismissed as she did not return the facility's calls. The NHA said he could not substantiate that neglect had occurred for Resident #3 because he could not prove that CNA #2 refused to provide assistance to the bathroom for the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on record review and interviews, the facility failed to ensure one (#4) of three residents out of nine sample residents were free of significant medication errors. Specifically, the facility failed to ensure Resident #4 was administered his Parkinson's medication per the physician orders. Findings include: I. Professional reference According to the carbidopa/levodopa dosing instructions, retrieved from https://www.goodrx.com/carbidopa-levodopa/dosage on 11/21/24, A combination of two medications: carbidopa and levodopa. Levodopa replaces dopamine, which improves symptoms of Parkinson's disease. And carbidopa helps levodopa stick around longer in the body. If you miss a dose of carbidopa/levodopa, take the medication as soon as you remember. But if you remember when you' re already close to taking your next dose, skip the missed one. Don' t take more than one carbidopa/levodopa dose at a time. Doubling up on doses can be dangerous and lead to more side effects, such as movement problems and mood changes. Taking too much carbidopa/levodopa can be dangerous and increase your risk of side effects. These side effects may include low blood pressure, a fast heartbeat and confusion. According to the carbidopa-levodopa dosing guidelines, retrieved from https://www.drugs.com/medical-answers/carbidopa-levodopa-3562239/ on 11/21/24, It is important to adhere to the schedule closely, and it is recommended that you take the medication at the same time each day. II. Facility policy and procedure The Administering Medication policy, revised 2019, was received from the nursing home administrator (NHA) on 11/13/24 at 9:08 a.m. It documented in pertinent part, Medications are administered in a safe and timely manner and as prescribed. Medication errors are documented, reported and reviewed by the quality assurance and performance improvement (QAPI) committee to inform process changes and or the need for additional staff training. Medications are administered within one hour of their prescribed time, unless otherwise specified. III. Resident #4 A. Resident status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4, age 73, was admitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease (brain disease causing uncontrollable movements and difficulty with motor function), acute respiratory failure and difficulty in walking. According to the 7/21/24 minimum data set (MDS) assessment Resident #4 was cognitively intact with a brief interview for mental status score of 15 out of 15. She required partial/moderate assistance with hygiene, dressing and transferring. B. Record review Review of Resident #4's July 2024 CPO revealed the following physician order: Carbidopa-Levodopa oral tablet disintegrating 25-100 milligrams (mg), give one tablet by mouth four times a day for Parkinson's, ordered on 7/15/24, administer at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. A review the July 2024 medication administration record (MAR) revealed on 7/30/24Resident #4 did not receive Carbidopa-Levodopa at 8:00 a.m., 12:00 p.m., or 4:00 p.m. per the physician's order. The MAR was marked with the number nine for those times, which indicated other and to see the nursing progress note. A nursing progress note from 7/30/24 at 7:24 a.m. revealed Resident #4 was noted to be out of Carbidopa-Levadopa. The nurse called the pharmacy and the pharmacy noted it was in process and would be delivered to the facility that day. The nurse urged the importance of the medication to the pharmacist due to the amount of medication the resident took. A nursing progress note from 7/30/24 at 3:23 p.m. revealed the medication delivery made to the facility did not contain Resident #4's Carbidopa-Levadopa. The nurse spoke to the pharmacy and the pharmacy said they would send it out as STAT (immediately). The nursing unit manager was made aware of the concern at this time. -The nursing staff failed to audit the cart and reorder the medication before the medication ran out. -The nursing staff failed to order the medication as STAT once they noticed it was missing. -There was no documentation that the resident's physician was notified after Resident #4 missed three doses of the Carbidopa-Levadopa. -There was no documentation that the nurse monitored Resident #4 for symptoms that she may have experienced while missing the medication. IV. Staff interviews (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 11/13/24 at 1:50 p.m. RN #1 said it was the responsibility of the floor nurses to audit the medication cart each shift and order medications as needed. She said if a medication was due to run out within two to three days, she would reorder it. She said the pharmacy the facility worked with delivered the medications the day after ordering. RN #1 said the medication could also be ordered as STAT and it would arrive within an hour and a half. She said Parkinson's medications should be administered per the physician order. She said if the medication was missed, she would notify the provider and monitor the resident for increased Parkinson's symptoms such as agitation and tremors. She said the number nine on the MAR indicated other and to see the nursing progress note. The director of nursing (DON), the assistant director of nursing (ADON) and the regional clincial resource (RCR) were interviewed together on 11/13/24 at 3:10 p.m. The ADON said it was the expectation for the nursing staff to audit the medication carts on the night shift and reorder any medication that was due to run out in the next five days. She said the pharmacy had a four hour window to deliver medications orders as STAT, but they typically came within an hour. She said if a medication administration was missed for a resident, the process was to notify the provider, notify the unit manager and DON and order the medication as [NAME] She said the nurse should monitor the resident for any symptoms the resident had due to missing the medication. She said the symptoms should be documented in the resident's medical record. She said the number nine on the MAR indicated other and to see the nursing progress note. She said there should be a nursing progress note associated with each documentation of a nine in the MAR. The RCR said there was no documentation that the nurse notified the provider of Resident #3's three missing doses of Carbidopa-Levadopa. The consultant pharmacist was interviewed on 11/13/24 at 4:09 p.m. The pharmacist said the medication was important to take according to the physician's orders unless the resident was experiencing any clinical side effects. She said if the resident missed doses, it could worsen the Parkinson's effect and the resident's motor abilities could not have been managed.