STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065427	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Park West Llc, The	3727 Parker Blvd Pueblo, CO 81008

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48112 Based on observations, record review and interviews, the facility failed to keep medical records in a secure and confidential manner. Specifically, the facility failed to ensure nursing staff logged off their workstation when leaving the work area to protect the confidentiality of resident information. Findings include: I. Facility policy and procedure A request for a protected health information policy was requested on 8/1/24, but was not received. II. Observations On 7/30/24 observations were made on the second and third floor units. The second and third floors each had a nurses station in the middle of the unit with five to seven computer monitors. The second and third floor units had three hallways with resident rooms. Each hallway had a computer at a workstation in the middle of the hallway. The second and third floor units had three medication carts with a computer. Residents, visitors and families frequently walked down the hallways and by the nurses station, which enabled the computers to be visible to anybody walking by. At 2:42 p.m. an unidentified nurse left her computer screen, with a resident's electronic medical record (EMR) open, at the third floor nurses station. At 2:47 p.m. an unidentified certified nurse aide (CNA) left her computer screen, with a resident's EMR open, in the hallway at the third floor nurses station. At 3:00 p.m. a computer screen was left unattended, with a resident's EMR open, on a second floor medication cart. At 3:00 p.m. a computer screen was left unattended, with a resident's EMR open, on the second floor hallway desk workstation. An unidentified resident was sitting in a wheelchair next to an unidentified CNA. The unidentified resident was looking at the computer monitor. On 7/31/24 the following observations were made on the third floor unit: (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:18 a.m. licensed practical nurse (LPN) #1 left her computer screen open, with a resident's EMR visible, at the nurses station. At 11:15 a.m. LPN #1 left her computer screen open, with a resident's EMR visible, at the nurses station. Two family members walked by the nurses station and Resident #99 came out of her room to the nurses station. At 12:41 p.m. LPN #1 left her computer screen open, with a resident's EMR visible, at the nurses station. On 7/31/24 observations were made on the third floor unit with the nursing home administrator (NHA) and the director of nursing (DON). At 2:46 p.m. a computer screen was left open, with a resident's EMR visible, in the hallway. The DON locked the computer screen. At 2:47 p.m. a computer screen was left open, with a resident's EMR visible, at the third floor nurses station. The DON locked the computer screen. III. Staff interviews CNA #5 was interviewed on 8/1/24 at 10:40 a.m. CNA #5 said residents' EMRs should not be left open on the computers where they were easily accessible to non-staff members. She said she needed to log off her workstation when she left the work area. LPN #2 was interviewed on 8/1/24 at 8:54 a.m. LPN #2 said the residents' EMRs with personal health information should not be left open and easily accessible to non-staff members. She said the nurses needed to log off their workstations when leaving the work area. LPN #1 was interviewed on 8/1/24 at 9:26 a.m. LPN #1 said the resident's EMRs with personal health information should not be left open and easily accessible to non-staff members. She said the nurses needed to log off their workstations when leaving the work area. The NHA was interviewed on 7/31/24 at 2:44 p.m. The NHA said the staff needed to log off their workstation when they left their workstation. He said the residents should not sit right next to nurses or CNAs who had resident medical record information visible on the computer monitor. The NHA said it was important to not leave the monitors unattended to keep resident medical information private.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goal for one (#32) of two residents out of 40 sample residents. Specifically, the facility failed to, for Resident #32: -Ensure a pain assessment was completed that identified the type of pain, the effects of pain on the resident, the aggravating factors and the relieving factors; -Ensure person centered non-pharmacological interventions for pain management were offered and monitored for effectiveness; and, -Ensure the administration of pain medications was documented consistently. Findings include: I. Resident #32 A. Resident status Resident #32, age 83, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes, interstitial pulmonary disease (inflammation and scarring that made it hard for lungs to get oxygen), heart failure, atrial fibrillation (irregular and often rapid heart rhythm), morbid obesity and unsteadiness on her feet. The 6/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial assistance for toileting. She was dependent on staff for showering, dressing and transfers. She required supervision for oral hygiene and personal hygiene. The assessment revealed the resident did not have a pain management regimen. The resident took pain management as needed and received non-medication interventions for pain. The MDS assessment documented the resident had pain frequently, which occasionally affected her sleep and her day-to-day activities. The resident reported her pain as moderate. B. Resident interview Resident #32 was interviewed on 7/29/24 at 2:28 p.m. Resident #32 said she sometimes had pain in different locations on her body. Resident #32 said she did not like to take pain medications. She said the facility did not offer non-pharmacological interventions when she experienced pain. She said if the lighting in her room was lowered, it would help her pain. C. Record review (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32's pain care plan, revised 8/1/24 (during the survey), revealed the resident had acute and chronic pain related to joint pain, peripheral vascular disease (blood circulation is reduced to a body part), interstitial lung disease and diabetes. She did not want to take pain medications and preferred non-pharmacological interventions. Interventions included acknowledging the presence of pain and discomfort, administering pain medications and monitoring for effectiveness, implementing non-pharmacological interventions, monitoring for pain every shift and notifying the physician as needed. Resident #32's opioid medication care plan, revised 6/17/24, revealed the resident took opioid medication for pain relief. The intervention was to monitor for side effects of dependence, nausea, vomiting, constipation, itching, respiratory depression and addiction. Resident #32's comfort care plan, revised 6/25/24, revealed the resident was at the facility for comfort care with minimal therapy. She received pain medications as ordered to keep her comfortable. Interventions included administering pain medication as ordered, notifying the physician if pain continued, providing a calm dimly lit environment, providing incontinence care and repositioning throughout the shift. -The care plan did not identify the location of her pain. The 6/13/24 admission pain assessment revealed the resident reported her pain was a 5 on a scale of 1 to 10. Her pain level, based on a verbal scale, was moderate. Her acceptable pain level was a 3 out of 10. She said she had pain in her knees, left arm and shoulders. The assessment documented the pain started years ago and the pain was constant and sharp. Voltaren gel and Advil helped her pain and movement made her pain worse. The 6/17/24 comprehensive pain assessment revealed the resident's pain, based on a verbal scale, was moderate. She had pain in her abdomen. -The type of pain, effects of pain on the resident's life, aggravating factors, relieving factors and associated symptoms portions of the assessment were not documented. The 7/27/24 comprehensive pain assessment revealed the resident's pain, based on a verbal scale, was moderate. She had pain in her abdomen. -The type of pain, effects of pain on the resident's life, aggravating factors, relieving factors and associated symptoms were marked as unable to determine. The August 2024 CPO revealed the following physician's orders: Voltaren gel 1%. Apply two grams transdermally every six hours as needed for chronic joint pain, ordered 6/13/24. Oxycodone five milligrams (mg). Take one tablet by mouth every four hours as needed for a pain level of 6 to 10 on a scale of 1 to 10, ordered 6/14/24. Tramadol 50 mg. Take one tablet by mouth every six hours as needed for a pain level of 1 to 5 on a scale of 1 to 10, ordered 6/14/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate pain every shift and document, ordered 6/13/24. -A review of the resident's August 2024 CPO did not reveal a physician's order for non-pharmacological pain interventions and non-pharmacological interventions were not monitored for effectiveness. On 6/28/24, 6/29/24, 6/30/24, 7/3/24, 7/4/24, 7/5/24, 7/6/24 7/7/24, 7/8/24, nurse progress note revealed the resident had pain. She had a pain level of 2 out of 10 on a scale of 1-10. The location of the pain was generalized. The action taken was repositioning, immobilization of the affected area and pain medication. -A review of the resident's electronic medical record (EMR) did not reveal documentation indicating if the non-pharmacological pain interventions were effective. The 7/10/24 nurse progress note revealed the resident had pain. She reported her pain as a 7 out of 10. The location of the pain was generalized. The action taken was repositioning, immobilization of the affected area and pain medication. -A review of the resident's EMR did not reveal documentation indicating if the non-pharmacological pain interventions were effective. On 7/11/24, 7/12/24, 7/14/24, 7/15/24, 7/16/24, 7/18/24, 7/21/24 the nurse progress notes revealed the resident had pain. She had a pain level of 2 out of 10. The location of the pain was generalized. The action taken was repositioning, immobilization of the affected area and pain medication. -A review of the resident's EMR revealed repositioning and immobilization were not determined as a personalized pain management intervention. -A review of the resident's EMR did not reveal the facility followed up to see if the repositioning and immobilization interventions were effective. -A review of the resident's July 2024 medication administration record (MAR) revealed pain medication was not administered. The narcotic log book was reviewed on 7/31/24. Oxycodone and tramadol were not administered in July 2024. -However, the nursing progress notes indicated pain medication was administered (see above). II. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 8/1/24 at 10:40 a.m. CNA #5 said if a resident reported they were in pain, she would ask them what their pain was based on a scale of 1 to 10. CNA #5 said she told the nurse and then the nurse told her what the nurse planned to do. CNA #5 said she told the resident what the nurse's plan was to alleviate the pain. CNA #5 said she provided non-pharmacological interventions if the resident could not have pain medication. CNA #5 said the nurse told her what pain relieving interventions to provide for the resident. CNA #5 said Resident #32's pain plan was not documented. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #5 was familiar with Resident #32. She said the resident did not have pain at the moment. CNA #5 said the resident sometimes refused pain medication and the family representative, who was frequently present, helped encourage the resident to take the pain medication. Licensed practical nurse (LPN) #1 was interviewed on 8/1/24 at 9:26 a.m. LPN #1 said she completed pain assessments for residents at admission, during shift change and during medication pass. LPN #1 said she asked the resident where the pain was located, what the level of pain was, if it was acute or chronic pain and what helped the resident's pain improve. Registered nurse (RN) #1 was interviewed on 8/1/24 at 10:32 a.m. RN #1 said a pain assessment was completed every morning during medication pass and as needed throughout the day. She said the residents who had chronic pain told her when they had pain. RN #1 said a pain assessment was completed at admission. She said the pain assessment included what an acceptable pain level was for the resident, where the pain was located and what medication and non-medication interventions relieved the pain. RN #1 said if the resident reported they only wanted pain medications, she documented that in the assessment. RN #1 said she encouraged the residents to use non-pharmacological interventions, such as ice and elevation. RN #1 said typical interventions included ice, elevating, resting and limiting movement. She said she knew if pain medication or non-pharmacological interventions were effective because she followed up with the resident an hour after the medication was administered or an intervention was offered. She said she documented the effectiveness in the progress note. RN #1 said Resident #32 had generalized pain. RN #1 said Resident #32 had pain in her neck, chest and back. RN #1 said the resident used to have little to no pain. She said since the resident received a skin tear on 7/27/24, she had pain more frequently. RN #1 said Advil and tramadol helped the resident when she had pain. She said a calm, quiet and dark environment helped her. The director of nursing (DON) was interviewed on 8/1/24 at 11:01 a.m. The DON said a pain assessment was completed at admission, every seven days and quarterly. The DON said the pain assessment covered the resident's pain level and if the pain was managed. She said non-pharmacological interventions were not personalized to the resident. The DON said the pain assessments were documented in a progress notes. The DON said if the assessment sections were marked as unable to determine, it meant the resident was unable to answer because they were confused. -However, Resident #32 was cognitively intact and was able to answer questions regarding her pain The DON was not aware Resident #32's assessments were marked as unable to determine because the resident was able to answer the questions. The DON said she did not know why the pain assessments revealed the resident had pain in her abdomen. The DON said she was not aware the nurse progress notes documented the resident was administered pain medication but the MAR showed no pain medication was administered. The DON said Resident #32's care plan should have included monitoring if the resident's non-pharmacological interventions were effective and indication that the resident would refuse pain medication. IV. Facility follow up The DON provided the following information on 8/2/24 at approximately 1:54 p.m. (after the survey): (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 had a comprehensive pain evaluation every seven days per protocol. The DON said the pain evaluation addressed the location of pain, if the pain was tolerable and if the pain impacted her day-to-day activities. The 8/1/24 nurse progress note revealed the resident said her pain level was a four. The resident said once pain medication was administered, the pain level decreased. The resident had tramadol available as needed. Non-pharmacological interventions were discussed. The resident said she usually dealt with it or took Advil. The resident was asked if repositioning, distraction, music, or cold helped the pain. The resident said the cold made it worse for her and repositioning did not help. -However, the facility did not update the resident's EMR to identify Advil was an effective intervention for the resident. -The facility did not update the pain assessment to demonstrate the resident was able to answer questions in the pain assessment, specifically the quality of pain, effects of pain on the resident's life, aggravating factors, relieving factors and associated symptoms. -The facility did not update the resident's EMR to monitor if non-pharmacological interventions were offered and if the interventions were effective.