

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/22/2025
NAME OF PROVIDER OR SUPPLIER  Center at Centerplace, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE  4356 24th St Rd Greeley, CO 80634	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure each resident had the right to formulate an advanced directive for one (#1) out of three residents reviewed out of three sample residents. s out of three sample residents. Resident #1 was admitted on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia (lungs struggle to get enough oxygen into the blood), interstitial pulmonary disease (a condition that causes inflammation and scarring in the lungs), pulmonary hypertension (high blood pressure in the arteries connecting the heart to the lungs), chronic obstructive pulmonary disease with acute exacerbation (sudden worsening of respiratory symptoms like shortness of breath and coughing), and pneumonia (a lung infection).The hospital referral information had conflicting information regarding the resident's cardio-pulmonary resuscitation (CPR) wishes. Upon admission, the resident's representative and a nurse practitioner (NP) signed the resident's Colorado Medical Orders for Scope and Treatment (MOST) form. The form indicated the resident's wishes were to have CPR. However, the facility failed to correctly transcribe the resident's wishes into the resident's electronic medical record (EMR). Progress notes, the care plan and the nurses' report sheet indicated the resident as do not resuscitate, which conflicted with the MOST form, signed by the resident's representative and the NP upon admission.On [DATE] at approximately 4:00 a.m. a certified nurse aide (CNA) found the resident deep in sleep. The CNA asked licensed practical nurse (LPN) #1 to check on the resident. LPN #1 promptly checked on the resident and found her without vital signs. LPN #1 called registered nurse (RN) #1 to assess the resident at approximately 4:25 a.m. RN #1 confirmed the resident did not have vital signs. The on-call physician was called and pronounced the death of the resident at 4:30 a.m. At no point, did the staff attempt to contact emergency medical services or initiate CPR.Serious harm to Resident #1 occurred due to the facility not having clear documentation of the resident's advanced directives. Specifically, the facility failed to ensure Resident #1's wishes of receiving CPR were initiated when the staff found the resident without vital signs. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE].I. Situation of serious [NAME] [DATE] at approximately 4:00 a.m., a CNA found the resident deep in sleep. The CNA asked LPN #1 to check on the resident. LPN #1 promptly checked on the resident and found her without vital signs. LPN #1 called RN #1 to assess the resident at approximately 4:25 a.m. RN #1 confirmed the resident did not have vital signs. The on-call physician was called and pronounced the death of the resident at 4:30 a.m. According to the MOST form Resident #1 wished to have CPR. However, the facility transcribed the resident's code status as DNR into the resident's EMR. The facility staff did not contact emergency medical services or initiate CPR when the resident was unresponsive. Due to the facility's failure to clarify Resident #1's advanced directives wish, the staff did not attempt to resuscitate the resident or contact emergency medical services once the resident was found to be non-responsive.II. Facility plan of correctionA. Immediate action:LPN #1 was suspended pending investigation and was immediately given education on correctly implementing MOST forms and referencing code status correctly.The in-service education document was provided by the director of nursing (DON) on [DATE] at 6:41 p.m. On [DATE] the facility held a nursing in-service which educated all relevant staff on CPR, code status and MOST form policies and procedures. The in-service informed staff that resident code status would no longer be listed on the report sheet. Staff were strictly to review code status according to the MOST form found in the MOST binder at each nurses' station. B. Identification of other residents On [DATE] an audit was initiated to identify all residents residing in the facility who were at risk for inconsistencies between MOST forms and the EMR. Audits were completed by the DON and the second floor unit manager. Audits compared MOST forms and EMRs to ensure completion and consistency between the two. For each resident, MOST forms were compared to care plans, physicians orders/MARs and the top of resident's charts to ensure code status was correct.C. Systemic changes and monitoringOn [DATE] audits were completed for each unit and MOST forms and EMRs were updated and accurate. Hospital referrals are no longer used as a resource to determine the code status of a new admission. Only hospital discharges will be used as a resource to determine the code status of a new admission. Upon admission, once a MOST form is completed, the facility will reference this form in emergency situations.D. MonitoringAudits will be conducted with any change in MOST form/code status and with new or returning admissions. The DON, MDS coordinator, and unit manager rotate on-call and are</p>		