Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065431	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	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)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and staff interviews, the facility failed to maintain accurate minimum data set (MDS) assessment for one (#18) of five residents out of 22 sample residents. Specifically, the facility failed to accurately complete the minimum data set (MDS) assessment and submit a timely assessment for Resident #18. Findings include: I. Resident status Resident #18, age 68, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease, psychotic disorder with hallucinations, major depressive disorder and neuropathy (damage to the nerves outside the spinal cord and brain). The 2/29/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. II. Record review A review of Resident #18's electronic medical record (EMR) revealed the following: Resident #18's admission note documented he was admitted to the facility on [DATE] with an admitting diagnosis of hospice and Parkinson's disease for a long term stay. A review of Resident #18's previously submitted MDS assessments revealed the following: The 11/9/23 admission assessment did not indicate that Resident #18 was receiving hospice care. -However, Resident #18 was admitted to the facility on hospice care services. -The quarterly assessment with a target date of 2/9/24 was not submitted until 3/21/2024. which was greater than the required 92 day submission timeframe for a quarterly assessment. (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: 065431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
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)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The functional abilities section of Resident #18's 11/9/23 admission assessment and the 2/9/24 quarterly assessment were incomplete. III. Staff interviews The nursing home administrator (NHA) was interviewed on 4/25/24 at 11:30 a.m The NHA said the MDS assessments for Resident #18 should have been completed for functional abilities and hospice. The MDS coordinator (MDSC) was interviewed on 4/25/24 at 12:20 p.m. The MDSC said she was told if the resident did not receive therapy, the functional abilities section of the resident's MDS should not be completed. The MDSC said she submitted Resident #18's quarterly assessment late. -However, a 12/19/23 note written in Resident #18's EMR at 6:03 p.m. documented the following skilled services were being provided: management/evaluation of the resident, observation/assessment of resident, and teaching/training to manage and monitor fluid intake to prevent dehydration therapy (physical therapy, occupational therapy, speech therapy). Additional information included the resident participated in therapy.

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 04/25/2024
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)

F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47151

Based on observations, record review and interviews, the facility failed to ensure two (#12 and #138) of five residents who required respiratory care received the care consistent with professional standards of practice out of 22 sample residents.

Specifically, the facility failed to:

-Ensure a physician's order was in place to include the appropriate care of a continuous positive airway pressure (CPAP) machine for Resident #12 and Resident #138;

-Implement a routine cleaning schedule for the care of Resident #12 and Resident #138's CPAP machines;

-Ensure the distilled water was used in Resident #138's CPAP machine instead of tap water; and,

-Ensure a care plan was in place and implemented for Resident #12 and Resident #138's CPAP machines to include route of administration, oxygen supplementation, storage, cleaning and machine settings.

Findings include:

I. Professional reference

The Controlling Legionella in Other Devices (2/3/21), was retrieved on 4/29/24 from https://www.cdc.gov/legionella/wmp/control-toolkit/index.html, and read in pertinent part,

In the absence of control, Legionella can grow in almost any system or equipment containing non sterile water, such as tap water, at temperatures favorable to Legionella growth. Devices that may grow Legionella in the absence of control include the following: Dental and medical equipment such as scalers, CPAP, bronchoscopes, and heater-cooler units. Dental and medical equipment should be cleaned regularly per manufacturer recommendations; and use distilled water in respiratory equipment such as CPAP machines, heater-cooler units, and bronchoscopes.

II. Facility policy and procedure

The CPAP/BiPAP policy and procedure, revised 2/8/21, was provided by the nursing home administrator (NHA) on 4/29/24 at 10:53 a.m. The policy read in pertinent part,

Continuous positive airway pressure (CPAP) is a non-invasive ventilation machine that involves the administration of air usually through the nose by an external device at a predetermined level of pressure. The patient will receive necessary respiratory care and services in accordance with professional standards of practice, the patient's care plan, and the patient's choice. The patient will have an order that includes settings for CPAP/BiPAP and the CPAP/BiPAP will be cleaned per the manufacturer's guidelines.

(continued on next page)

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 04/25/2024
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The manufacturer's guidelines for cleaning the CPAP machines was requested and not provided by the end of the survey on 4/25/24. III. Resident#12 A. Resident status Resident #12, age 77, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included a compression fracture of the second lumbar vertebrae, repeated falls, osteomyelitis, weakness, obstructive sleep apnea and dependence on other enabling machines and devices. The 3/25/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The resident was dependent with care for showering and putting on and taking off footwear, he needed substantial assistance with toileting hygiene, partial assistance with dressing and set up help only with eating and oral hygiene. The assessment documented the resident used a CPAP machine. B. Resident interview and observation Resident #12 was interviewed on 4/22/24 at 11:00 a.m. Resident #12 said his CPAP machine did not get cleaned at the facility and he used his CPAP every night. Resident #12's CPAP mask and tubing was on his bed during the interview on 4/22/24. C. Record review A review of the nurse practitioner progress notes for Resident #12 revealed the nurse practitioner documented that Resident #12 had obstructive sleep apnea (OSA)-CPAP on 3/25/24, 4/1/24, 4/8/24, 4/15/24 and 4/22/24. -However, further review of the resident's electronic medical record (EMR) revealed Resident #12 did not have a physician's order for the use of a CPAP or a physician's order that included the route of administration, frequency, oxygen supplementation, storage and/or settings of the device. -The use of a CPAP was not on Resident #12's care plan as an active problem area, and the care plan did not have goals and interventions listed for the CPAP to include route of administration, frequency, oxygen supplementation, storage and/or settings and a cleaning schedule. IV. Resident #138 A. Resident status (continued on next page)

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 04/25/2024
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #138, age 77, under age 65 was admitted on [DATE] and discharged home on 4/23/24. According to the April 2024 CPO, diagnoses included enterocolitis (colon inflammation) due to clostridium difficile (a bacteria), type II diabetes mellitus, chronic kidney disease, morbid obesity, adjustment disorder with anxiety and depression. The resident's BIMS score had not been completed at the time of the survey. The resident's care plan documented the resident was confused at times. The 4/10/24 daily skilled nursing note documented Resident #138 was independent with oral hygiene, toileting hygiene, transfers and eating. B. Resident interview and observation Resident #138 was interviewed on 4/22/24 at 2:15 p.m. Resident #138 said the facility was out of distilled water for her CPAP machine and instead had used regular tap water in her CPAP machine for two days. Resident #138 said a certified nurse aide (CNA) told her facility staff looked for distilled water in the facility but were unable to locate distilled water for the CPAP. She said the CNA told her the facility would order distilled water but was unsure when the distilled water would be delivered. Resident #138's CPAP mask was observed on the nightstand by her bed during the interview. C. Record review Resident #138's respiratory care plan, initiated 4/8/24 and revised 4/25/24 (during the survey), documented she was at respiratory risk related to respiratory conditions and/or deficiencies and abnormalities in pulmonary function. Interventions included to administer and provide respiratory therapy and respiratory treatment interventions as per physician's orders, wash mask with CPAP cleanser and warm water, and place on a paper towel to air dry and use the CPAP per physician's orders (initiated 4/8/24 and revised on 4/25/24). -However, further review of the resident's EMR revealed Resident #138 did not have a physician's order for the use of a CPAP or an order that included the route of administration, frequency, oxygen supplementation, storage and/or settings of the device and a cleaning schedule. V. Staff interviews The director of nursing (DON) and the NHA were interviewed on 4/25/24 at 1:00 p.m. The NHA said if the facility ran out of distilled water, staff were able to purchase distilled water from a local store until more distilled water could be ordered. The NHA and the DON said a resident should have a physician's order for a CPAP machine that included cleaning instructions. (continued on next page)

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 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The rehabilitation aide (RA) was interviewed on 4/25/24 at 2:30 p.m. The RA said she worked as a CNA at the facility and a resident's CPAP machine should be cleaned daily. The RA said CNAs cleaned the CPAP machines at the facility and the cleaning task should show in the CNA task list to complete. The RA said if the facility was out of distilled water for a resident's CPAP machine she would notify a nurse. Licensed practical nurse (LPN) #4 was interviewed on 4/25/24 at 2:45 p.m. LPN #4 said a CNA would clean or change the water in a CPAP machine, although it could depend on how the physician's order was written. LPN #4 said a resident should have a physician's order for a CPAP machine that included cleaning instructions.

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 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	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)
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** 37166 Based on interviews and record review, the facility failed to ensure residents were free from significant medication errors for one (#89) of 11 residents reviewed for medication errors out of 22 sample residents. Specifically, the facility failed to ensure Resident #89 was administered blood pressure medications according to the physician's order. Findings include: I. Facility policy The Medication Administration policy, revised 8/22/22, was provided by the nursing home administrator (NHA) on 4/29/24. It read in pertinent part, It is the policy of this facility that medications are to be administered as prescribed by the attending physician. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medications. Medications must be administered in accordance with the written orders of the attending physician. II. Resident status Resident #89, age less than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included heart disease and high blood pressure. The 4/3/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status score (BIMS) score of 11 out of 15. The resident was on medications for high blood pressure. III. Record review According to the medication administration record (MAR) for March 2024 and April 2024, Resident #89 was receiving the following medications: Lisinopril 40 milligrams (mg) for high blood pressure. Hold medication if systolic blood pressure less than 110 milligrams per deciliter (mg/dl). The medication was administered on 4/5/24 when the resident's recorded blood pressure was 104/40. -The medication should have been held per the physician's order because the resident's systolic blood pressure was less than 110 mg/dl. Carvedilol 25 mg for high blood pressure. Hold medication when systolic blood pressure was below 100 mg/dl or heart rate below 60 beats per minute (bpm). The medication was administered on the following dates: (continued on next page)

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 04/25/2024
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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/31/24 with a recorded blood pressure of 107/37; -4/3/24 with a recorded heart rate of 57 bpm; -4/11/24 with recorded heart rate of 59 bpm and a blood pressure of 89/36 mg/dl; and, -4/12/24 with a recorded blood pressure of 98/49 mg/dl. -The medication should have been held per the physician's orders on the above dates because the resident's heart rate and/or systolic blood pressure were below the physician specified parameters for holding the medication. -Review of the progress notes between March 2024 and April 25, 2024 revealed no supporting progress notes on the above dates for why the nurse gave the medications despite the resident's heart rate and systolic blood pressures being below the physician specified parameters for holding the medication. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 4/25/24 at 10:05 a.m. LPN #2 said prior to administration of blood pressure medications, a resident's blood pressure should be checked to make sure it was above the recommended parameters. She said if the blood pressure was below the recommended parameters, the medication should be held. LPN #2 said for carvedilol it was important to monitor the resident's heart rate as the medication affected the frequency of heart rate, and if the heart rate was below 60 beats per minute, the medication should not be administered. The nurse practitioner (NP) was interviewed on 4/25/24 at 10:20 a.m. The NP said the parameters when to hold medications were put in place for safety. She said since medication would lower blood pressure and reduce the heart rate, it was important not to administer the medication when the resident already had low blood pressure and/or a reduced heart rate. She said administering the medications when the heart rate and/or blood pressure were below the parameters to hold the medication was a significant medication error as it could have lowered the blood pressure or heart rate further and resulted in an emergency situation. The NP said, in addition, Resident #89 was on two different medications that had the same effect of lowering blood pressure. She said in situations when medication was given by mistake, she should have been notified and she would have instructed the staff on how the resident should have been monitored due to the error. The NP said she did not recall that she was notified and she was not aware that medications were administered to Resident #89 incorrectly. The director of nursing (DON) was interviewed on 4/25/24 at 11:21a.m. The DON said the medications should have been held when Resident #89's blood pressure and/or heart rate were below the recommended parameters for holding the medication. She said the physician should have been notified when the medications were administered when they should not have been. She said she would provide education to the nurses immediately to ensure medications were administered correctly.

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 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to: -Ensure a process was in place which enabled staff to identify residents who were on enhanced barrier precautions (EBP) when a sign was not posted outside the residents' rooms; -Ensure staff donned (put on) appropriate personal protective equipment (PPE) for residents on enhanced barrier precautions (EBP); -Ensure staff followed appropriate infection control procedures while administering a medication intravenously; and, -Ensure staff donned appropriate PPE and performed hand hygiene during medication administration. Findings include: I. Ensure staff followed proper infection control procedures for residents on enhanced barrier precautions (EBP) A. Facility policy and procedure The Enhanced Barrier Precautions policy and procedure, dated 3/27/24 (to be implemented by 4/5/24), was provided by the nursing home administrator (NHA) on 4/29/23 at 10:53 a.m. The policy read in pertinent part, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Per the Centers for Disease Control and Prevention (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 a multidrug resistant organism (MDRO). EBP are indicated for residents with any of the following: 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. Enhanced barrier precautions involve staff utilizing gown and gloves during specified high-contact activities with the patient. Enhanced barrier precautions include use of gown and gloves during the high-contact patient care activities below: 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 with toileting, device care or use, and wound care. (continued on next page)

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 04/25/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident status Resident #140, age 74, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included fournier gangrene (infection of the genital and perineal areas), morbid obesity and diabetes mellitus type II. The 4/17/24 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. He was dependent for bathing, toileting hygiene, lower body dressing and putting on footwear, all transfers and mobility in bed. He required supervision or touching assistance with personal hygiene, upper body dressing and oral hygiene, and set up help with eating. The assessment documented Resident #140 had an indwelling catheter and received some medications through a central intravenous line. C. Observations On 4/22/24 and 4/23/24 Resident #140's room did not have a sign on the door to his room notifying staff the resident had orders for enhanced barrier precautions. -However, Resident #140's MAR documented the EBP signage on the door to his room was in place on 4/22/24 and 4/23/24 during the survey (see record review below). On 4/23/24 at 10:39 a.m. Resident #140 was assisted to his room by two staff members. A contact precautions sign was posted on Resident #140's door. An unidentified staff member pushed Resident #140 through the hallway in his wheelchair and into Resident #140's room.A second staff member followed them into the room. Both staff members entered Resident #140's room and failed to don the appropriate PPE of a gown and gloves. One of the two staff members in Resident #140's room asked him if he preferred to get into bed. While in Resident #140's room, Resident #140 was assisted into bed. -On 4/24/24 at 10:39 a.m. the contact precautions sign on Resident #140's door was removed and replaced with an EBP sign. D. Physician orders and care plan The physician orders documented an order starting 4/13/24 for enhanced barrier precautions and personal protective equipment (PPE) with high contact care activities due to numerous wounds and to ensure signage was in place every shift for Resident #140. Review of Resident #140's medication administration record (MAR) from 4/13/24 through 4/23/24 (during the survey) revealed staff was documenting that an EBP sign was in place outside the resident's room. -However, observations revealed Resident #140 did not have any EBP signage in place on 4/22/24 and 4/23/24 but did have a contact precautions sign on his door on 4/23/24 (see observations above). (continued on next page)

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 04/25/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #140's care plan for EBP due to wounds and his PICC line was initiated on 4/22/24 (during the survey). Pertinent interventions included staff were to wear PPE during high contact resident care and designated precautions signs were to be placed outside the door. E. Staff interviews The rehabilitation aide (RA) was interviewed on 4/25/24 at 2:30 p.m. The RA said she received various types of training on enhanced barrier precautions that included videos and in person training. The RA said she was trained how to don and doff (remove) PPE and PPE should be used to transfer a resident on EBP in their room. The RA said she did not have a way to know if a resident was on enhanced barrier precautions unless there was a sign posted on the resident's door. Licensed practical nurse (LPN) #4 was interviewed on 4/25/24 at 2:45 p.m. LPN #4 said nurses were to do a complete visual inspection to ensure the sign for enhanced barrier precautions was posted on a resident's door before marking the order complete in the resident's MAR. She said staff were trained annually on infection control practices and when a resident was admitted with precautions. She said the training included why the resident was on a specific precaution. LPN #4 said the training did provide instructions for donning and doffing PPE. LPN #4 said a resident who needed to be transferred with the assistance of one or two people should wear PPE if the resident was on EBP. The director of nursing (DON) was interviewed on 4/25/24 at The DON said a staff member informed her a contact precautions sign was posted on a resident's doors when an EBP sign should be posted instead. The DON said she was not aware the sign on Resident #140's door was incorrect. The DON said the sign had been changed from a contact precautions sign to an EBP sign on the afternoon of 4/23/24 (during the survey). The DON said staff were to ensure the correct sign was posted before marking the task complete in the resident's MAR. The DON said the facility staff should put on a gown and gloves for any transfers with contact with a resident on EBP. 50219 II. Resident #188 A. Resident status Resident #188, age 73, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included cystitis (an infection of the bladder), bacteremia (presence of bacteria in the blood), and discitis (an infection of the intervertebral disc space). The 4/20/24 MDS assessment revealed that the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. The assessment documented the resident was receiving intravenous (IV) medications. B. Observations On 4/22/24 at 11:03 a.m. no sign was observed on Resident #188's door. (continued on next page)

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 04/25/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/24 at 2:29 p.m. registered nurse (RN) #1 entered Resident #188's room and donned gloves prior to IV medications to the resident via his PICC line. RN #1 did not don a gown at any point during the medication administration. On 4/23/24 at 10:32 a.m. no sign was observed on Resident #188's door. On 4/24/24 at 9:52 a.m. no sign was observed on Resident #188's door. On 4/25/24 at 10:00 a.m. an EBP sign was observed on Resident #188's door and drawers containing PPE were placed outside his room. C. Record review A review of the April 2024 CPO revealed the following physician orders: -Cefazolin sodium solution 2 grams intravenously three times a day, ordered 4/13/24, discontinued 4/16/24, and re-ordered 4/16/24; -Normal saline flush 10 milliliters after each IV medication administration, ordered 4/14/24; and, -EBP and PPE with high contact care activities due to the resident's PICC line, ordered 4/24/24 (during the survey). D. Staff interviews LPN #2 was interviewed on 4/25/24 at 10:07 a.m. LPN #2 said nursing staff needed to wear gloves and a gown to maintain infection control when entering a room that was on EBP. LPN #2 said any time nursing staff were touching or working with an indwelling line, such as a PICC, it required EBP. The DON and the regional clinical resource (RCR) were interviewed on 4/25/24 at 12:18 p.m. The DON said nursing staff needed to wear gloves and a gown when administering IV medications to residents with PICC lines. The RCR said she was unsure if the staff needed to wear a gown too. 37166 III. Failure to wear proper PPE during blood glucose checks and complete proper hand hygiene. A. Observations On 4/23/24 at 12:08 p.m. LPN #1 was administering medications to Resident #140. The sign on Resident #140's door read contact precautions. LPN #1 entered the room, put gloves on without washing her hands, approached the resident and tested his blood glucose prior to exiting the resident's room. (continued on next page)

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 04/25/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN #1 did not don a gown, which was indicated it was required on the contact precautions sign hanging on the resident's door. -LPN #1 did not perform hand hygiene prior to putting on gloves. In a few minutes, LPN #1 returned to Resident #140's room to administer insulin. LPN #1 donned clean gloves without performing hand hygiene and administered the insulin to the resident. -LPN #1 did not don a gown and did not sanitize her hands prior to administering the insulin. At 12:18 p.m. LPN # 1 was administering medications to Resident #191. The sign on the door read enhanced barrier precautions. LPN #1 entered the room, put gloves on without performing hand hygiene, approached the resident and tested his blood glucose prior to exiting the resident's room. -LPN #1 did not don a gown, which was indicated it was required on the enhanced barrier precautions sign hanging on the resident's door. -LPN #1 did not perform hand hygiene prior to putting on gloves. In a few minutes, she returned to the room to administer insulin to Resident #191. LPN #1 donned clean gloves without performing hand hygiene and administered the insulin. -LPN #1 did not don a gown and did not sanitize her hands prior to administering the insulin. At 12:26 p.m. LPN #1 was administering medications to Resident #195. The sign on the door read contact precautions. LPN #1 entered the room, put gloves on without performing hand hygiene, approached the resident and tested her blood glucose prior to exiting the resident's room. -LPN #1 did not don a gown, which was indicated it was required on the enhanced barrier precautions sign hanging on the resident's door. -LPN #1 did not perform hand hygiene prior to putting on gloves. In a few minutes, she returned to the room to administer insulin to Resident #195. LPN #1 donned clean gloves without washing her hands and administered the insulin. -LPN #1 did not don a gown and did not sanitize her hands prior to administering the insulin. On 4/25/24 at 10:00 a.m. LPN #3, was administering medications to Resident #18. Upon entering the room, the resident was observed sitting in a wheelchair and leaning over with his hand touching the floor. LPN #3 repositioned the resident by moving his hands to the table. She did not offer hand hygiene to the resident. She poured the medications into the resident's palm and the resident took the medications by licking them off his palm. B. Staff interviews (continued on next page)

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 04/25/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 4/23/24 at 12:40 p.m. LPN #1 said a gown was not required for glucose checks and insulin administration. LPN #3 was interviewed on 4/25/24 at 10:15 a.m. LPN #3 said she should have offered resident hand hygiene to Resident #18 but forgot to do so. The DON was interviewed on 4/25/24 at 11:40 a.m. The DON said Resident #140, #191 and #195 were on enhanced barrier precautions. She said gown and gloves must be worn during blood glucose checks and insulin administration. She said nurses were in close contact with resident's clothes and body fluids when doing injections and therefore should have followed enhanced barrier precautions by wearing a gown and gloves. She said Resident #18 should have been offered hand hygiene prior to medication administration.