STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065269	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF PUEBLO	2118 CHATALET LN PUEBLO, CO 81005

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#3) of one out of five sample residents were provided prompt efforts by the facility to resolve a grievance. Specifically, the facility failed to: -Have documentation of Resident #3's complaint investigation findings with the resolution to family (complaint); and, -Ensure Resident #3's family was informed of the steps taken to resolve her complaint. Findings include: I. Facility policy and procedure The Grievance Procedure and Concern & Comment Program, reviewed 5/19/2020, was provided by the executive director (ED) on 6/30/2020 at 4:30 p.m. It read, in pertinent part, Use of the Concern & Comment Program in response to a reported concern: -Fosters a timely and quality response to the concern and/or comment. -Allows for identification of possible trends and patterns. -Identifies special needs of families and/or residents. -Ensures appropriate follow-up and systemic analysis . -The Social Services Staff and/or the Executive Director are responsible for the following. -Maintaining a recordkeeping system of all complaints reported via the Concern & Comment Program or any other means of reporting that includes the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. -Following up with the resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction. -Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision . -The associate completing the form will take adequate time to record the concern comprehensively or allow the concerned individual to record their comments on the form. Complete information will facilitate appropriate & prompt follow-up. Resolve the concern, if possible. If the resolution is not possible at that time, explain to the individual that another staff member will be assigned to investigate the concern and will contact them as soon as possible . -Executive Director and/or Designee is responsible for the following: Ensuring that all grievances and concern & Comment Reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated, achieved and maintained. II. Resident status Resident #3, was admitted on [DATE] and readmitted on [DATE]. According to June 2020 computerized physician orders [REDACTED]. The 4/6/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She did not exhibit behaviors or resist care. She required extensive one-person assistance with bed mobility, transfers, dressing, hygiene, and toilet use. She was always continent of her bowel and bladder. A. Family interview Resident #3's family member was interviewed on 6/29/2020 at 11:50 a.m. She said Resident #3 had two hospitalization s on 6/4/2020 and 6/22/2020 and she did not return after 6/22/2020 because the facility did not follow-up on her concerns. She said the facility called her on 6/4/2020 at 6:30 a.m., and told her that Resident #3 had a fall and it had just happened, but it happened around 4:30 a.m. She said the nurse told her that her mom rolled out of bed, but her mom told her she was reaching for her wheelchair because it was placed out of reach. She said Resident #3 got up on her own because she needed to go to the bathroom and did not call for help. -She said it took over six hours before they obtained an x-ray on 6/4/2020 at 12:00 p.m. She said she requested the facility send her mother to the hospital right after her fall but they would not send her until after the x-ray was completed and she missed [MEDICAL TREATMENT] because she was waiting for the x-ray. She said her mom told her that they would not give her anything for pain until the x-ray was completed. -She said she also voiced concerns about a certified nurse aide (CNA) #5 who yelled at Resident #3 and told her she was using the call light too much, so they took the call light away from my mom and yelled at her and told her she could not do that. She said she spoke with the unit manager UM #1, social services director (SSD) and the social services assistant (SSA) #1 on 6/22/2020 and all three of them said they would look into it. She said she also called the director of nursing (DON) and left her a message about her concerns of staff not managing her mother's pain and monitoring her mother's glucose levels, but the DON never called her back. -She said the second time Resident #3 was sent to the hospital was because they were not managing her pain. She said on 6/22/2020 at 8:30 a.m., she called to check on Resident #3 and while she was talking with her she could hear that Resident #3 was gasping for air. She said I called the nurse and told her to check on my mom. The nurse said she checked on her and she said my moms lungs were clear. She said Resident #3 was sent to a local hospital; however, there were no intensive care units (ICU) beds, so she was flown to the closest hospital. She said Resident #3 was in fluid overload due to not receiving [MEDICAL TREATMENT] treatment a few days before, because they were not managing her pain for her to go to [MEDICAL TREATMENT] treatment. She said that day (6/22/2020) she asked them to send her to the hospital in the morning and they did not send her until 4:30 p.m. in the afternoon. B. Record review The facility grievance form was provided by the ED on 6/30/2020 at 4:21 p.m. The grievance was completed by SSD dated 6/22/2020, it documented Resident #3's daughter contacted the facility and stated CNA #5 told her mother that she was using her call light too much. This was reported to SSD and UM #1. The grievance further documented the following: -Under investigation steps: spoke with resident's daughter earlier in the afternoon, unable to speak with the resident due to being transferred out, called the accused CNA #5. -Investigation findings: Resident #3's daughter stated a CNA #5 told her mother not to use her call light so much because she was busy. Not able to be confirmed with resident due to being transferred out. -The grievance was signed off as being completed by the ED on 6/25/2020; however, there was no documentation of Resident #3's family member being notified of the outcome. Additionally there was no documentation on the grievance form about Resident #3's daughter's complaints of Resident #3 not receiving glucose monitoring or having her pain managed. III. Staff interviews The executive director (ED) and director of nursing (DON) and staff development coordinator (SDC) were interviewed on 6/30/2020 at 4:05 p.m. The DON said she had a conversation with Resident #3's daughter. She said Resident #3's daughter had concerns they were not managing her mother's pain and she did not have blood sugar checks so she reviewed her administration of pain medication which was documented as effective and she also started education with the nursing staff about implementing glucose monitoring for all diabetic residents. The ED, SSD, and SSA #1 were interviewed on 6/30/2020 at 4:45 p.m. The SSD said he did recall speaking with Resident #3's on 6/22/2020. He said Resident #3's daughter told him CNA #5 told her mother that she was using the call light too much. He said he immediately went to talk with UM #1 and documented a grievance. He said UM #1 told him that she had just received a call from Resident #3's daughter and was aware the daughter had concerns about CNA #5 and she told him she was taking care of it. SSA #1 said she did not receive a call from Resident #3's daughter about any recent concerns. She said the last time she received a call from Resident #3's daughter was three to four weeks ago. She said Resident #3's daughter stated the resident's roommate was mean to her. She said on that day she went to interview Resident #3 and Resident #3 said she had no complaints about her roommate. SSA said she did not document the

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

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.

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F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) conversation she had with Resident #3's daughter or the resident in the clinical record or document the concern on a grievance form. She said she should have documented her discussion with the resident and Resident #3's daughter in the clinical record or on a grievance form. The ED said the staff felt the concern was a customer service issue. He said the SSD and UM #1 handled the concern appropriately. He said he was unaware Resident #3's daughter expressed concerns that her mother was yelled at by the CNA #5 until 6/24/2020 and that day they started their investigation which was unsubstantiated. He said he tried reaching out to the daughter on 6/24/2020 about her concerns, but she would not respond to him. He acknowledged this was the only time he tried to reach out to Resident #3's daughter. They acknowledged Resident #3's daughter's complaint findings were not relayed to them with resolution to their satisfaction and were not followed-up with timely.
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** Based on observations, record review and interviews, the facility failed to ensure professional standards of practice were followed for two (#2, #3) diabetic residents out of three sample residents. Specifically, staff failed to: -Obtain physician orders [REDACTED].#2's and Resident #3's diabetes. Cross-reference F585-failed to ensure grievances were completed Findings include: I. Resident #3 A. Resident status Resident #3, was admitted on [DATE] and readmitted on [DATE]. According to June 2020 computerized physician orders [REDACTED]. The 4/6/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She did not exhibit behaviors or resist care. She required extensive one-person assistance with bed mobility, transfers, dressing, hygiene, and toilet use. She received insulin injections seven days out of seven days. B. Record review The care plan, initiated 1/2/19 and revised 1/21/2020, revealed the resident had diabetes mellitus and interventions included to administer medications as ordered and obtain blood sugar checks as ordered. The June 2020 Medication Administration Record [REDACTED]. The June 2020 MAR indicated [REDACTED]. C. Family interview Resident #3's family member was interviewed on 6/29/2020 at 11:50 a.m. She said she called the director of nursing (DON) on 6/22/2020 and left her a message about her concerns of staff not monitoring her mother glucose levels, but the DON never called her back. II. Resident #2 A. Resident status Resident #2, age 73, was admitted on [DATE] and readmitted on [DATE]. According to the June 2020 CPO, [DIAGNOSES REDACTED]. The 6/15/2020 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She did not exhibit behaviors or resist care. She required limited one-person assistance with most activities of daily living (ADLs). She received insulin injections seven days out of seven days. B. Record review The care plan, initiated on 7/24/19 and revised on 2/6/2020, revealed the resident had diabetes mellitus and interventions included to administer medications as ordered and obtain blood sugar checks as ordered. The April, May and June 2020 MAR indicated [REDACTED]. The April, May and June 2020 MAR indicated [REDACTED]. III. Staff interviews The executive director (ED) and director of nursing (DON) and staff development coordinator (SDC) were interviewed on 6/30/2020 at 4:05 p.m. The DON said she had a conversation with Resident #3's daughter. She said Resident #3's daughter had concerns they were not managing her mother's pain and she did not have blood sugar checks so she reviewed her administration of pain medication which was documented as effective and she also started education with the nursing staff about implementing glucose monitoring for all diabetic residents. She said residents who received insulin should have orders for blood sugars monitoring, unless a specific resident preferred not to have their blood sugars monitored. The DON and SDC were interviewed a second time on 6/30/2020 at 5:10 p.m. They acknowledged there was no orders for blood glucose monitoring for Resident #2 or Resident #3. They said Resident #2 refused some medications and treatments at times. The DON said if a resident refused to have their blood sugar taken it should have been documented in the resident's record and on the care plan which it was not for Resident #2 or Resident #3. The DON said the nurses were monitoring resident's blood sugars and documenting it on their report sheets; however, they did not have evidence of the monitoring as they shredded them after their shift and were only able to retrieve documentation of blood glucose for Resident #3 on 6/11/2020, 6/14/2020 and 6/22/2020. IV. Facility follow-up The DON provided staff education for blood glucose monitoring on 6/30/2020 at 5:10 p.m. The education titled Checking Blood Glucose Before Insulin Administration was dated 6/24/2020. It documented that all insulin orders need to have supplementary blood glucose levels and all blood glucose levels needed to be checked 30 minutes prior to administration of insulin. A total of twenty five licensed nurses signed off that they had received the education.