STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065219	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Health and Rehabilitation Center	850 27th Ave 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to honor resident choices for one (#2) of three residents reviewed for self-determination out of five sample residents. Specifically, the facility failed to provide bathing for Resident #2 per her preference. Findings include: I. Facility policy and procedure The Promoting/Maintaining Resident Self-Determination policy, undated, was provided by the nursing home administrator (NHA) on 2/24/25 at 4:16 p.m. It read in pertinent part, It is the practice of this facility to protect and promote resident rights by facilitating resident self-determination through support of resident choice. The facility will ensure that each resident has the opportunity to exercise his/her autonomy regarding those things that are important in his/her life such as interests and preferences. All staff members involved in providing care to residents will promote and facilitate resident self-determination. It is the residents' right to determine what, if anything, they would prefer to do or not to do each day in accordance with physician orders and resident's abilities. Each resident has the right to choose their schedules (including sleeping, eating, bathing and waking times), consistent with their interests, assessments, and plans of care. Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. The Resident Showers policy, undated, was provided by the NHA on 2/24/25 at 3:14 p.m. It read in pertinent part, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. Partial baths may be given between regular shower schedules as per facility policy. The CNA (certified nurse aide) will assess the skin for any changes while performing bathing and inform the nurse of any changes. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included enterocolitis due to clostridium difficile-recurrent (inflammation of the intestines and infection of the colon), heart failure, chronic obstructive pulmonary disease (progressive lung disease) and type 2 diabetes mellitus. The 2/10/25 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 required supervision or touching assistance with showers, sit to stand and chair to chair transfers. The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period. B. Resident interview Resident #2 was interviewed on 2/24/25 at 1:25 p.m. Resident #2 said she had been missing a lot of her showers/bathing. Resident #2 said the hospice staff never forgot to give her showers and gave her one every Wednesday. Resident #2 said however the CNAs at the facility had not given her regular showers and it made her feel like the staff did not care about her. Resident #2 said it made her mad that the facility staff tried to offer her a shower one time at midnight and that woke her up. Resident #2 said a shower at 9:00 p.m. would be nice and help her to relax before bedtime. Resident #2 said the facility had not provided her a shower the whole month of February 2025. Resident #2 said she felt better and cleaner when she got a shower. Resident #2 said she felt dirty when she did not get regular showers. She said she wanted regular and consistent showers. Resident #2 said she was not used to not having regular showers. She said when she lived at home she could have a shower every day if she wanted and was tired of being treated like this. Resident #2 said having a shower twice a week would be the minimum for her. C. Record review A review of Resident #2's activity of daily living (ADL) care plan, initiated 9/2/24, did not address the resident's specific shower/bathing preferences or needs. The hospice care plan, initiated 10/25/24, did not reveal the plan for shower/bathing assistance. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's bathing shower task records were reviewed from 1/1/25 to 2/24/25. The records revealed the resident preferred to receive a shower twice per week on Wednesday and Saturday in the morning. The bathing task records further revealed the following: According to review of Resident #2's bathing task records from 1/1/25 to 1/31/25, the resident received a shower on 1/8/25, 1/11/25, 1/15/25 and 1/29/25. The resident received a sponge bath on 1/22/25. The hospice records revealed Resident #2 received a tub bath on 1/8/25, 1/15/25, 1/22/25 and 1/29/25. -The resident received a total of five showers/baths out of nine opportunities. According to review of Resident #2's bathing task records from 2/1/25 to 2/24/25, the resident received no showers from the facility. The resident received one full body bath on 2/12/25. The hospice records revealed Resident #2 received a tub bath 2/5/25, 2/12/25 and 2/19/25. -The resident received a total of three baths out of seven opportunities. III. Staff interviews The director of nursing (DON) was interviewed on 2/24/25 at 11:10 a.m. The DON said she had worked at the facility for three years. The DON said the staff development coordinator had held a recent CNA training, on 2/11/25, regarding completing shower documentation in the EMR. The DON said the CNAs were trained to document completed showers under the shower task in the electronic medical record (EMR). The DON said the CNAs should document the type of shower and it should always be documented in the EMR. The DON said the facilities had a bath sheet at the nurse's station that indicated the showers schedule. The DON said the units were divided into two nurse managers and they should be auditing if the showers were completed. The DON said she also got an EMR dashboard alert if showers were not taken. The NHA and the clinical resource (CR) were interviewed on 2/24/25 at 2:07 p.m. The NHA reviewed the shower documentation and said it looked like there could have been a documentation issue by the CNAs because she thought the residents were getting their showers by looking at the bath sheets. The NHA said the bath sheets were not part of the resident's EMRs and the facility did not utilize paper charts. The NHA said she would look for documentation of the recent CNA education on documenting showers. The NHA acknowledged that the education did not appear to have been effective. The NHA said there was a documentation issue that needed to be addressed. The NHA said that the purpose of the shower sheets was to communicate the shower schedule. The NHA said the shower sheets were also used as a skin care check list and a communication tool between the CNAs and the nurses. The NHA said the CNAs should be documenting the showers in the EMR. -The CNA shower education documentation was not provided. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed again on 2/24/25 at 2:24 p.m. The DON said she would recommend a shower one or two times per week for cleanliness and to prevent skin breakdown. The DON said showers were also a good time for a skin assessment and if the CNA saw a skin issue they would notify the nurse. The DON said the shower bath sheets at the nurse's station had a body sketch so that the CNA could circle the location of any skin issues observed during the bathing. The DON said she could not remember what the instructions were to the CNAs during the education that was recently provided, except that it was related to documentation of showers. The DON said she was at the CNA education class but she was not the instructor. She said the instructors were the staff development coordinator and the infection preventionist. The DON said the lack of showers appeared to be a documentation issue. The DON said the shower preferences and needs should be on the care plan in order to share information on the residents' care. The DON said they updated Resident #2's care plan today (2/24/25). The NHA said she would complete a thorough shower audit and complete education on documentation on showers and education of the staff and review daily to see that charting/documentation was matching up. Licensed practical nurse (LPN) #1 was interviewed on 2/24/25 at 4:30 p.m. LPN #1 said showers should be given to the residents at least twice a week. LPN #1 said some of the refused showers but were asked three times and then the CNAs would write if they refused on the bath sheet and also document in the EMR. LPN #1 said the nurses could also chart in the progress notes if the resident refused and what they did to encourage them, the reason and look for a pattern. LPN #1 said regular showers were important to maintain good skin health, proper hygiene and infection control. CNA #1 was interviewed on 2/24/25 at 4:35 p.m. CNA #1 said had worked at the facility for one year. CNA #1 said residents got a shower about two times per week. CNA #1 said showers were important to prevent rashes and skin breakdown. CNA #1 said she wrote the showers down on the bath sheet and charted them in the EMR. CNA #1 said the bath sheet communicated with the nurse at the station in case they needed to do a skin assessment. CNA #1 said in the EMR she documented the type of shower the resident received, their transfer ability, and how much assistance the resident supplied.