STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065282	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Longmont	2451 Pratt St Longmont, CO 80501

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident's representative when there was a significant change in the resident's condition for one (#3) of four residents out of four sample residents. Specifically, the facility failed to notify the designated representative for Resident #3 when he had a fall in the facility.Findings include:I. Facility policy and procedure The Change in Resident's Condition or Status policy and procedure, revised [DATE], was provided by the director of nursing (DON) on [DATE] at 4:47 p.m. It read in pertinent part, A facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there is an accident or a significant change in the resident's physical, mental or psychosocial status.II. Resident #3A. Resident status Resident #3, age [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included transient ischemic attack (a mini stroke when there is a temporary interruption of blood flow to the brain), cerebral infarction (a stroke), acute respiratory failure, spinal stenosis (the spinal canal becomes narrow), bilateral osteoarthritis of the knee and a history of falling. According to the [DATE] minimum data set (MDS) assessment, the resident was moderately cognitively intact with a brief interview for mental status (BIMS) score of 12 out of 15. He required a walker. He required set up assistance for eating, supervision for oral hygiene and toileting, and partial assistance with personal hygiene. B. Resident representative interviewResident #3's representative was interviewed on [DATE] at 12:15 p.m. via telephone. The representative said the facility did not notify her when the resident fell on [DATE]. She said she was notified on [DATE] at around 8:30 a.m. that the resident needed to go to the hospital because he was unresponsive. She said no one at the facility could explain what happened to cause the resident to become unresponsive and need to go to the hospital. She said at the hospital, the resident was discovered to have a large hematoma (a localized collection of blood outside the circulatory system) on the right side of his head, and the doctors at the hospital said he was not a surgical candidate. She said he was placed on hospice care at the hospital and died four days later. Resident #3's representative said when the resident fell, the facility was supposed to call her because she was the resident's power of attorney (POA). She said it was really frustrating because the facility did not always call her and she had family members telling her what happened to the resident. She said the facility knew they could call her at any time, including in the middle of the night, when the resident fell or something else happened to him. She said although the resident's death happened three months ago ([DATE]), the death and experience with the facility was still fresh. The resident's representative was tearful throughout the phone call. C. Record reviewThe [DATE] at 12:38 a.m. nurse progress note revealed Resident #3 was found on the floor by a certified nurse aide (CNA). The resident was sitting on the floor with his back against his bed and his legs towards the closet. His legs were bent at the knees. He had grippy socks and slippers on his feet. His call light was within reach but not on. The resident's floor and clothes were wet. The resident denied hitting his head and said he hit his shoulder on the heater vent. The resident's four-wheeled walker was tipped over onto the heater. The registered nurse (RN) assessed the resident and no injuries were found. The physician was notified. The resident was encouraged to use the call light and wait for assistance. The call light was within reach.-There was no documentation to indicate the resident's representative was notified of the resident's fall. The [DATE] at 8:15 a.m. nurse progress note revealed Resident #3 remained on neurological checks and the checks were within normal limits. The CNA reported to the nurse that the resident was gasping when breathing. The nurse went to the resident's room, vital signs were obtained and the resident was noted to be unresponsive to verbal, physical or sternal rub stimuli. The resident was warm and moist to the touch and his breathing continued with gasps. The resident's right pupil was slightly smaller than the left pupil, which was a change for the resident as he was alert and was able to place his breakfast order this morning ([DATE]). Resident #3 had denied any pain earlier that same morning. The resident was incontinent. The unit manager was notified and emergency medical services (EMS) was called. The resident was a full code status. The unit manager placed phone calls to the resident's family and to the physician The resident was transferred to the emergency room to evaluate and treat. The [DATE] fall incident report revealed the POA was notified on [DATE] at 8:47 a.m. (eight hours after the resident's fall). The [DATE] history and physical trauma surgery report from the hospital revealed Resident #3 had a large left subdural hematoma (a collection of blood that accumulates between the tough outer layer of the brain and the middle