

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#40) resident out of 53 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure Resident #40 was assessed for the appropriateness and safety of self-administration of topical medications; and,</li> <li>-Ensure there was a physician order for self-administration of topical medications.</li> </ul> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Vicks Vaporub drug fact, retrieved on 2/26/24 from: <a href="https://assets.ctfassets.net/nvoox4konz4a/2UQyJBdjHzFWUzLsLPELjn/efb8f4729c2477450e30c1defa14e144/VapoRub-Topical-Ointment-Drug-Facts.pdf">https://assets.ctfassets.net/nvoox4konz4a/2UQyJBdjHzFWUzLsLPELjn/efb8f4729c2477450e30c1defa14e144/VapoRub-Topical-Ointment-Drug-Facts.pdf</a>, Do not use by mouth, in nostrils, on wounds or damaged skin.</p> <p>II. Facility policy and procedure:</p> <p>The Self Administration of Medication policy and procedure, revised on 11/28/16, was received from the NHA on 2/27/24 at 11:26 a.m. It revealed in pertinent part, The facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medication was safe and clinically appropriate, based on residents functionality and health condition.</p> <p>To ensure safe and appropriate self-administration, the facility should educate resident to ensure that the resident was able to: state name, dose, strength, frequency, and purpose of his/her medications; understand the possible side effects of his/her medications and that he/she should notify facility staff if he/she experiences any such side effects; correctly administer, inject or apply his/her medications; correctly store his/her medications in a locked compartment.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility should document in the residents care plan whether the resident or facility staff were responsible for storage of the residents medications. If the resident was responsible for the storage of his/her medications, the facility should provide a secured compartment for storage of such medications. The medication storage compartments should be located in the residents room so that another resident was not able to access the medications. The storage compartment should be locked when not in use.</p> <p>The facility staff should document the self administration of medications on the resident's medication administration record (MAR) according to the medication administration schedule.</p> <p>III. Resident #40</p> <p>A. Resident status</p> <p>Resident #40, older than 65, admitted on [DATE]. According to the February 2024 CPO, diagnoses included multiple sclerosis (disease affecting the central nervous system), peripheral vascular disease (disease affecting circulation of the lower body), dependent on oxygen, hypertension (high blood pressure) and dysphagia (difficult swallowing).</p> <p>The 2/7/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. She required two person assistance with bed mobility, transfer, dressing and needed set up assistance for personal hygiene and eating.</p> <p>B. Observations and resident interview</p> <p>On 2/21/24 at 10:13 a.m. a container of Vicks Vaporub, a box of Icy Hot lidocaine 4% patches with one patch in the box were on the residents night stand and one bottle of saline nasal spray was on the resident's bedside table</p> <p>Resident #40 said she used the saline nasal spray for her dry nose because she wore oxygen and it dried it out. Resident #40 did not know how many times a day she could use the saline nasal spray. Resident #40 said the Icy Hot patches help her with shoulder or neck pain but had not used them in a while. Resident #40 said she applied the Vicks Vaporub to her dry cracked lips at least twice a day but sometimes more than that.</p> <p>On 2/26/23 at 12:09 p.m. a saline nasal spray, container of Vicks Vaporub and Icy Hot lidocaine patches were in Resident #40's room.</p> <p>C. Record review</p> <p>Review of February 2024 revealed an order for:</p> <ul style="list-style-type: none"> <li>-Lidocaine external patch 4% to be applied to the right shoulder topically every 12 hours as needed.</li> <li>-There were no orders for saline nasal spray or the Vicks Vaporub.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Review of the Resident #40's care plan did not identify the resident ability to self administer medications.</p> <p>-Resident #40 was not assessed to self administer medications.</p> <p>IV. Staff interviews</p> <p>LPN #1 was interviewed on 2/26/24 at 12:12 p.m. She said residents were not to have medications in their rooms. LPN #1 said if a resident wanted to self administer medications they need to have an order from the physician, ensure the pharmacy knows about the medications to ensure no drug-to-drug interactions and the resident ability to self administer the medications hdto be evaluated.</p> <p>LPN #1 reviewed Resident #40's CPO and identified there was only an order for the lidocaine patches and it did not indicate Resident #40 was able to self administer. LPN #1 said there was no order for the Vicks Vaporub or the saline nasal spray.</p> <p>LPN #1 reviewed assessments for Resident #40 and there was no assessment for self administration of medications completed. LPN #1 was unaware of the hazards of using vicks vaporub and oxygen.</p> <p>LPN #1 was interviewed again at 1:59 p.m. She said she went into Resident #40's room and located the three medications. LPN #1 said Resident #40 told her she used the nasal spray for dry nose from oxygen use and she kept it on her bedside table for easy access. LPN #1 reported Resident #40 threw the box of lidocaine patches in the trash can as she had not used them in a long time after she was questioned about them. LPN #1 said she tried to educate Resident #40 about cracked lips was a sign of dehydration and should drink more fluids instead of using the vicks vaporub on her lips. LPN #1 said Resident #40 refused to give up her medications and she would contact the physician for orders and complete an assessment for self administration of medications for Resident #40.</p> <p>The DON was interviewed on 2/26/24 at 2:51 p.m. He said there were to be no medications in a resident room unless they have been assessed for self administration and the physician has approved self administration. The DON was unaware of the risks of using Vicks Vaporub and oxygen.</p> <p>The NHA was interviewed on 2/26/24 at 2:54 p.m. She said Vicks Vaporub should not be used when oxygen was in use due to risks of injury.</p> <p>The DON was interviewed on 2/27/24 at 10:41 a.m. He said Resident #40 had been assessed for self administration of the Vicks Vaporub and saline nasal spray and the physician approved the medications for use. The DON said he spoke with Resident #40 in the morning to educate on the medications and risks. Resident #40 wished to continue use of the vicks despite her use for oxygen. The DON said it would be the responsibility of nursing staff to monitor for the storage of medication in resident rooms but should be kept in a secure place like a drawer to prevent other residents from having access to them.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for one (#33) of five residents reviewed out of 53 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #33 received her scheduled showers, who was dependent on staff for bathing.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Activities of Daily Living (ADL) policy, revised 8/23/23, was provided by the nursing home administrator (NHA) on 2/26/24 at 2:19 p.m. It read in pertinent part: The resident will receive assistance with ADLs (bathing, dressing, grooming, and oral care).</p> <p>II. Resident #33</p> <p>A. Resident status</p> <p>Resident #33, age below 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis, muscle weakness, abnormalities of the gait and mobility, dependence on a wheelchair, contracture of the right hand, major depressive disorder and a history of falling.</p> <p>The 2/2/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She was dependent on staff for toileting and bathing.</p> <p>B. Resident interview</p> <p>Resident #33 was interviewed on 2/21/24 at 11:27 a.m. She said she usually did not receive her shower on Sundays. She said the previous Sunday she did not get her shower because the facility was short staffed. She said she finally received a shower the following Tuesday because she had vomited all over herself.</p> <p>C. Record review</p> <p>Review of the January and February shower logs revealed she received only 11 showers and refused one time out of 16 opportunities.</p> <p>-The missing showers were on a Sunday.</p> <p>The ADL care plan, revised on 7/18/22, revealed Resident #33 had a self care performance deficit related to her disease process of multiple sclerosis. Interventions included the resident required assistance by two staff members with bathing/showering twice weekly and as necessary.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Review of the medical record failed to show the resident received her two showers a week according to her care plan.</p> <p>III. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 2/26/24 at 1:57 p.m. She said the CNA was responsible for giving the residents their showers. She said if staff did not have time to complete the scheduled shower, they would be offered a bed bath or wait until their next scheduled shower. She said showers should be given on the scheduled days to keep the resident clean and odor free.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 2/26/24 at 2:06 p.m. She said the CNA was responsible for completing scheduled showers. She said the shower was then logged into the medical record. She said if the shower was missed, staff needed to document why it was missed. She said showers should be given on the scheduled days for skin integrity and to keep the resident free from infections.</p> <p>The assistant director of nursing (ADON) was interviewed on 2/26/24 at 2:24 p.m. She said showers should be given on their scheduled days and as needed. She said it was very important for skin integrity and infections.</p> <p>The director of nursing (DON) was interviewed on 2/26/24 at 2:27 p.m. He said management conducted weekly audits and the results were discussed weekly on Thursdays. He said he did not know why Resident #33 had missing showers. He said showers should be given on the scheduled days and as needed for skin integrity.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to assist residents with making appointments and arranging transportation for one (#89) of three residents reviewed for vision/ancillary services out of 53 sample residents.</p> <p>Specifically, the facility failed to offer and make an appointment for optometry services for resident #89.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Podiatry policy and procedure, revised 9/8/23, was provided by the nursing home administrator (NHA) on 2/27/24 at 11:26 a.m. It revealed in pertinent part, The facility will ensure residents receive proper treatment and assistive devices to maintain vision abilities.</p> <p>II. Resident status</p> <p>Resident #89, age greater than 65, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included non-pressure chronic ulcer of the left calf with unspecified severity, history of falling and adult failure to thrive.</p> <p>The 12/21/23 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 was independent with eating. She required setup help with oral hygiene, and partial/moderate assistance with toileting. She required substantial/maximal assistance with showers.</p> <p>The 11/29/23 MDS assessment revealed the resident had impaired vision but did not wear any corrective lenses.</p> <p>III. Resident observation and interview</p> <p>Resident #89 was interviewed on 2/22/24 at 8:50 a.m. The resident was not wearing glasses at the time of the interview.</p> <p>Resident #89 said she had a hard time seeing. She said she could barely read anything on the television and she was unable to read any documents. She said she typically wore glasses, however, she said she did not have any. She said she had contacts with her but they were dried out and the prescription on them needed to be updated.</p> <p>Resident #89 said she had told nursing staff she needed to see the eye doctor a few months ago but no one had followed up with her about an appointment. She said her vision had gotten worse since she was admitted and she would love to see the eye doctor and get a new prescription or updated glasses in order to see again.</p> <p>IV. Record review</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The February 2024 CPO revealed the following physician's order:</p> <p>Resident may have dental, podiatry, audiology and optometry care as needed. Ordered 11/28/23</p> <p>The nursing progress note dated 11/28/23 at 3:45 p.m. documented in pertinent part, The resident's vision was impaired for regular print. She can see large print without glasses. She does not have her contacts with her, they are at home. Said she needs to see her eye doctor for a new eye exam.</p> <p>Review of Resident #89's care plan, revised 12/11/23, revealed the resident had impaired visual function related to the aging process. Interventions included: arrange consultation with eye care practitioner as required, observe and report as needed any signs and symptoms of acute eye problems: change in ability to perform activities of daily living (ADL), decline in mobility, sudden visual loss, pupils dilated, gray or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision and tell the resident where you are placing their items and to be consistent.</p> <p>Review of Resident #89's electronic medical record (EMR) did not reveal the resident was offered or provided access to optometry services until 2/27/24 (during the survey).</p> <p>V. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 2/26/24 at 2:04 p.m. RN #1 said she was not aware that Resident #89 had any issues with her vision since she was new to the wing the resident resided on. She said if the resident complained of vision problems she would notify the social services director (SSD) so she could put the resident on the list to be seen by the eye doctor.</p> <p>The SSD was interviewed on 2/26/24 at 2:27 p.m. She said residents and/or the residents' responsible party should be offered ancillary services upon admission and every quarter during the care plan conference. She said it should be documented in the progress notes that ancillary services were offered. She said she was unable to find documentation to indicate Resident #89 and/or her representative were offered optometry services since the resident's admission on [DATE].</p> <p>Certified nurse aide (CNA) #2 was interviewed on 2/27/24 at 9:58 a.m. CNA #2 said she was unsure if Resident #89 wore glasses or if she had impaired vision. She said if the resident complained to her about impaired vision she would let the nurse know. She said sometimes it was hard to remember to tell the nurse if she got busy and had to provide care to other residents.</p> <p>RN #2 was interviewed on 2/27/24 at 10:05 a.m. RN #2 said Resident #89 could see without any issues and she wore glasses sometimes. She said she had worked with the resident since her admission to the facility and it was never reported on the nursing report sheet that the resident had impaired vision.</p> <p>The director of nursing (DON) was interviewed on 2/27/24 at 10:46 a.m. The DON said if a resident experienced changes in their vision or had impaired vision the nursing staff should contact the physician for orders. He said nursing staff should notify the SSD in order to place the resident on the ancillary services list to ensure the resident was seen by the optometrist. The DON said he needed to provide an all staff education related to ancillary services.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nursing home administrator (NHA) was interviewed on 2/27/24 at 11:55 a.m. The NHA said the Resident #89 should have been offered all ancillary services which included vision. She said if the resident complained of any vision impairment, nursing care staff should have notified the SSD and the resident would have been placed on a list to be seen by the eye doctor in order to receive vision care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews the facility failed to ensure one (#89) of three residents reviewed for ancillary services, such as podiatry services, out of 53 sample residents received proper foot care and treatment according to standards of practice.</p> <p>Specifically, the facility failed to ensure podiatry care was provided timely and as requested by Resident #89.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Nail Care policy and procedure, revised 9/8/23 was provided by the nursing home administrator (NHA) on 2/27/24 at 11:26 a.m. It revealed in pertinent part The facility will provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical conditions and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.</p> <p>I. Resident status</p> <p>Resident #89, age greater than 65, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included non-pressure chronic ulcer of the left calf with unspecified severity, history of falling and adult failure to thrive.</p> <p>According to the 12/21/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was independent with eating. She required setup help with oral hygiene, and partial/moderate assistance with toileting. She required substantial/maximal assistance with showers.</p> <p>II. Resident observation and interview</p> <p>On 2/22/24 at 8:49 a.m., Resident #89 was in her room. The toenails on both of the resident's feet were thick and approximately three inches long.</p> <p>Resident #89 said she liked to keep her toenails cleaned and trimmed. She said she maintained regular visits with the podiatrist before she was admitted to the facility. Resident #89 said she had asked nursing staff to cut her toenails, however, she said the nursing staff told her they are unable to cut her toenails. She said the nursing staff had not told her why they were unable to cut her toenails. She said she did not know why she could not see a podiatrist. Resident #89 said her toenails bothered her and she would love to get them cut.</p> <p>III. Record review</p> <p>The February 2024 CPO revealed the following physician's order:</p> <p>Resident may have dental, podiatry, audiology and optometry care as needed. Ordered 11/28/23.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #89's care plan, revised 12/11/23, revealed the resident had an activity of daily living (ADL) self-care performance deficit related to weakness, pain and decreased mobility. Interventions included: checking the resident's nail length and trimming and cleaning nails on bath days and as necessary and t reporting any changes to the nurse.</p> <p>Review of Resident #89's electronic medical record (EMR) did not reveal the resident was offered or provided access to podiatry services until 2/27/24 (during the survey).</p> <p>IV. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 2/26/24 at 2:04 p.m. RN #1 said she was not aware that Resident #89 had any issues with her toenails since she was new to the wing the resident resided on. She said if the resident complained of long toenails then nursing staff were able to cut them unless the toenails were too thick and/or too long. RN #1 said nursing staff should not cut a resident's toenails if the resident was a diabetic. She said if the resident had toenail issues that could not be addressed by nursing staff she would notify the social services director (SSD) so she could put the resident on the list to be seen by the podiatrist.</p> <p>The SSD was interviewed on 2/26/24 at 2:27 p.m. The SSD said residents and/or the residents' responsible party should be offered ancillary services upon admission and every quarter during the care plan conference. She said it should be documented in the progress notes that ancillary services were offered. She said she was unable to find documentation to indicate Resident #89 and/or her representative were offered podiatry services since the resident's admission on [DATE].</p> <p>Certified nursing assistant (CNA) #2 was interviewed on 2/27/24 at 9:58 a.m. CNA #2 said she was unsure if Resident #89 had long toenails because showers occurred during the evening time. She said if the resident complained to her about long toenails she would let the nurse know. She said sometimes it was hard to remember to tell the nurse if she got busy and had to provide care to other residents.</p> <p>RN #2 was interviewed on 2/27/24 at 10:05 a.m. RN #2 said she did not know if Resident #89 had long toenails because it was never reported to her by CNA staff and it was never passed on to her through nursing report sheets. RN #2 observed the resident's toenails and said she would need to have her seen by a podiatrist to get her toenails cut because the resident's toenails had become too thick and long.</p> <p>The director of nursing (DON) was interviewed on 2/27/24 at 10:46 a.m. The DON said if a resident had long toenails then CNA staff should have informed the nurse. He said nurses were supposed to document long nails on the skin check form. He said nurses were the only staff members allowed to cut nails. He said if a nurse was uncomfortable cutting a resident's nails and/or the resident had toenail issues staff should notify him and contact the physician for podiatry orders. The DON said nursing staff should notify the SSDI in order to place the resident on the ancillary services list to ensure the resident was seen by the podiatrist. The DON said he needed to provide an all staff education related to ancillary services and documentation expectations for the skin check forms.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	

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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nursing home administrator (NHA) was interviewed on 2/27/24 at 11:55 a.m. The NHA said the resident should have been offered all ancillary services which included podiatry. She said if the resident complained of any nail issues nursing staff should attempt to cut them only if there were no complex comorbidities such as diabetes. She said the staff should have notified the SSD and the resident would have been placed on a list to be seen by the podiatrist in order to receive foot care.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> III. Resident #76</p> <p>A. Resident Status</p> <p>Resident #76, age [AGE], was admitted on [DATE] and readmitted [DATE]. According to the February 2024 CPO, diagnoses included fracture of the sacrum, fracture of the left pubis (pelvis), multiple fractures of the ribs, history of falling, muscle weakness, unsteadiness on feet, fracture of the fifth metacarpal bone (pinky) and thumb on the right hand, depression, and anxiety.</p> <p>The 12/29/24 MDS assessment revealed, the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. She had impairment to both sides of her lower extremities. She used a walker and wheelchair. She had falls prior to admission as well as falls in the facility. She had a fall with a fracture. She required partial assistance with toileting, bathing, and sitting to standing.</p> <p>B. Resident interview</p> <p>Resident #76 was interviewed on 2/21/24 at 11:15 a.m. She said she had many falls. She said she fell and broke her thumb and pinky when she tripped over the wheel on her wheelchair. She said she also slid off the mattress and asked staff for a different one. She said staff told her all the mattresses were the same. She said when she stood up, she had nothing to hold onto. She asked staff if she could have a side rail and was told facilities were not allowed to put side rails on a resident's bed.</p> <p>C. Record review</p> <p>A physician's order, dated 10/20/23, instructed staff to send the resident to the hospital for abnormal x-ray results.</p> <p>A physician's order, dated 10/27/23, documented a fractured right fifth digit (pinky finger). Put the fourth digit together with the fifth digit as a guardian, apply a long cast from the fifth digit to the forearm, secure with ace wrap from finger to forearm. Let the thumb, middle, and ring finger be free from the ace wrap. Leave in place at all times every shift for a right fifth digit fracture.</p> <p>A physician's order, dated 10/27/23, documented a right thumb fracture. Apply an aluminum cast, U shaped and secure with coban. Leave in place at all times for thumb fracture.</p> <p>The hospitalization care plan, initiated 10/16/23, revealed Resident #76 was at risk for rehospitalization due to a history of injurious falls in the past 12 months. The interventions included labs as ordered, provide medications as ordered, registered dietician to evaluate and staff to provide timely communication to the physician regarding any change in resident condition.</p> <p>The fall risk care plan, initiated on 9/30/23 and revised on 10/16/23 revealed Resident #76 had a history of falls with injuries. Interventions included:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Assess if the resident wanted her bed made frequently and place the bed against the wall, initiated 2/12/24;</p> <p>-Assess toileting needs frequently, initiated 1/2/24;</p> <p>-Assist with activities of daily living as needed, initiated 9/30/23;</p> <p>-Bathroom lights to remain on at all times and remind resident to turn overhead light on when walking around the room, initiated 10/20/23;</p> <p>-Keep call light, reacher, and frequently used items within reach, initiated 9/30/23;</p> <p>-Complete a fall risk assessment, initiated 9/30/23;</p> <p>-Provide appropriate footwear/non-skid socks when ambulating, initiated 1/19/24; and,</p> <p>-Physical therapy to evaluate and treat, initiated 1/19/24.</p> <p>Review of Resident #76's falls were reviewed from 10/20/23 to 2/9/24.</p> <p>1. 10/20/23 fall</p> <p>An event progress note, dated 10/20/23 at 11:15 a.m., revealed Resident #76 was found lying on her right side next to her bed. Her call light was within reach but not activated. The room had poor lighting and the resident did not turn on the light. The resident stated she was trying to get clothes from her closet and tripped. The resident expressed pain to her right wrist and bruising was noted to the left wrist. The physician was notified and x-rays of both wrists were ordered.</p> <p>The intervention was to educate the resident to remember to turn the overhead light on before movement in the room.</p> <p>-There was no fall investigation provided for the 10/20/23 fall.</p> <p>2. 11/17/23 fall</p> <p>A health status progress note, dated 11/17/23 at 7:45 p.m., revealed the registered nurse (RN) supervisor was called to the unit because Resident #76 was on the floor. She required maximum assistance of two staff members to be lifted off the floor. An abrasion was found to the resident's mid lower back.</p> <p>The fall investigation dated 11/17/23 revealed the resident was found sitting on the floor after losing her balance at bedside. The resident stated she was reaching for an item near her bedside night stand. The intervention was to place frequently used items in reach of the resident.</p> <p>3. 12/1/23 fall</p> <p>A health status progress note, dated 12/1/23 at 7:08 p.m., revealed Resident #76 had a fall. She was found while eating her dinner. She was sitting in a chair. There was no complaint of pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The fall investigation dated 12/1/23 revealed the resident's roommate was able to activate the call light and call the nurses station from her cell phone. Resident #76 said she was seated in front of her bedside table and stood up to retrieve her purse. She said she felt she might fall and backed up to her bed. The resident assisted herself up from the floor. She had no injuries.</p> <p>-The intervention was to continue to remind the resident to use her call light to get items at a distance, which was the same intervention implemented for the fall on 11/17/23.</p> <p>-There were no new fall interventions put into place.</p> <p>4. 12/22/23 fall</p> <p>An event progress note, dated 12/22/23 at 1:14 p.m., revealed Resident #76 was found on the floor next to her bed in a sitting position. The resident stated she had tried to reach for her grabber and slid off the bed.</p> <p>The fall investigation dated 12/22/23 revealed the resident had no injuries. The intervention was to make sure her grabber and belongings were within reach. All the staff were aware to check the resident regularly. The resident was reminded to use her call light.</p> <p>-Despite the fall investigation documenting that all staff were aware to check the resident regularly, frequent checks were not implemented as a fall intervention on the resident's care plan.</p> <p>5. 1/2/24 fall</p> <p>An event progress note, dated 1/2/24 at 12:33 a.m., revealed Resident #76 was found on the floor by a certified nurse aide (CNA). The resident was lying prone (face down) between the bathroom and the foot of her bed. She had pillows beneath her face. The call light was not activated. The resident's walker was approximately one foot away from her. The bed was soaked with urine. She had a small scratch to her left knee and complained of pain to her left leg and buttocks. The resident stated she exited the bathroom and her weakened hands led to a fall. She was assisted back to bed by three staff members.</p> <p>The fall investigation dated 1/2/24 revealed the resident fell after exiting the bathroom. The intervention was to assess the residents' toileting needs frequently.</p> <p>-The intervention did not document how frequently the resident should be offered toileting.</p> <p>6. 2/9/24 fall</p> <p>An event progress note, dated 2/9/24 at 8:50 p.m., revealed Resident #76 was found on the floor at her bedside. She acknowledged she fell while trying to reach the call button as she was making her bed. There were no injuries noted.</p> <p>The fall investigation dated 2/9/24 revealed the resident was found on the floor and initially denied falling. The intervention was to have staff offer to make her bed when it was untidy or upon the resident's request. She was currently working with therapy to improve strength.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>D. Staff interviews</p> <p>CNA #1 was interviewed on 2/26/24 at 1:55 p.m. CNA #1 said Resident #76 was a stand by assist (SBA) for transfers and ambulation. She said the resident used her call light when she needed help. She said she did not know what interventions were put into place to help her from falling.</p> <p>LPN #2 was interviewed on 2/26/24 at 2:07 p.m. LPN #2 said she had worked with Resident #76 a couple weeks ago but was not told what fall interventions were put into place. She said if a resident had a fall, a new intervention should be put into place for each fall.</p> <p>The DON was interviewed on 2/26/24 at 2:29 p.m. The DON said Resident #76 liked to be independent. He said interventions that had been put into place were making sure the bathroom light was on, making her bed regularly, and making sure her grabber was in reach. He said he had thought about placing a bed cane on her bed but was afraid she would hit her head. He said he had not thought about placing a transfer pole at her bedside.</p> <p>Based on record review and interviews, the facility failed to ensure the residents' environment remained as free from accident hazards as possible and prevent falls with major injury for two (#46 and #76) of four residents reviewed for falls out of 53 sample residents.</p> <p>Resident #46, who had a known history of falls, had a diagnosis of obesity which required the use of a bariatric (to support substantial weight) bed with extensions to enable the bed frame to be made larger. On 1/29/24, the resident sustained a witnessed fall from her bed when she was being rolled on her side with the assistance of staff during a bed bath.</p> <p>Resident #46 was sent to the hospital for evaluation of left knee pain following the fall where she was discovered to have a fracture of her left femur (thigh bone), which was surgically repaired on 1/30/24. The resident returned to the facility on 2/1/24 and was placed in the same bed she fell from on 1/29/24. The facility did not inspect the bed to ensure the extensions were pulled out appropriately and the mattress fit correctly prior to placing the resident back in the bed.</p> <p>On 2/5/24 (4 days after Resident #46's readmission to the facility), a rental supply company came to the facility to install bed canes (a device which can be utilized to assist a person to reposition themselves in bed). The rental supply company's personnel discovered the extensions on Resident #46's bed had not been pulled out prior to the resident's fall from the bed and the facility had failed to pull the extensions out prior to the resident's readmission to the facility.</p> <p>Additionally, Resident #76, who had diagnoses of muscle weakness and unsteadiness on her feet, was admitted to the facility on [DATE]. The resident had a history of falls with injuries in the 12 months prior to her admission to the facility. She required partial assistance with her toileting, bathing and moving from a sitting position to a standing position. The facility failed to implement appropriate person-centered fall interventions for the resident upon her admission to the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/20/23, Resident #76 sustained a fall after tripping while she was attempting to get clothes from her closet. The resident complained of pain in her right wrist and x-rays were obtained which revealed she sustained a fracture to her right pinky finger and right thumb. The facility put an intervention in place to educate the resident to remember to turn on the overhead light before moving around in her room, however, the resident sustained five more falls following the 10/20/23 fall. The facility failed to put new and effective interventions into place after each fall to prevent the resident from sustaining further falls.</p> <p>Due to the facility's failure to properly evaluate Resident #46's bed frame and mattress for appropriate functionality and fit and the failure to implement timely and effective person-centered fall interventions for Resident #76, both residents sustained falls with major injury and experienced pain.</p> <p>I. Findings include</p> <p>A. Policy and procedure</p> <p>The Fall Management policy and procedure, reviewed 11/30/22, was provided by the nursing home administrator (NHA) on 2/26/24 at 2:19 p.m. It read in pertinent part: To promote patient safety and reduce patient falls by proactively identifying, care planning and monitoring of patients' fall indications.</p> <p>The facility must ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Residents will be assessed for fall indications upon admission, readmission, quarterly, change in condition, and with any fall utilizing the Fall Risk Assessment.</p> <p>II. Resident #46</p> <p>A. Resident status</p> <p>Resident #46, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses include chronic respiratory failure, insomnia, chronic pain, bed confinement, colostomy, low back pain, muscle weakness, lack of coordination, history of falling and body mass index of 45.0 to 49.9 (obesity).</p> <p>The 2/2/24 minimum data set (MDS) assessment revealed the resident had normal cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required two person assistance with dressing, toileting, bathing/showering, bed mobility and use of a mechanical lift with two staff members for transfers. The resident required one person assistance with personal hygiene and was independent for eating.</p> <p>B. Resident interview</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #46 was interviewed on 2/21/24 at 11:26 a.m. The resident said she had fallen out of bed on 1/29/24. The resident said the problem was the bed. She said she felt as if she were sliding out of the bed when being turned onto her side. She said the staff had not pulled the slide outs/extensions out so the mattress fit correctly. She said she had been in the center of the bed, had started slipping and was unable to catch herself before falling to the floor. She said when she returned from the hospital the bed rental company personnel came to install bed canes and discovered the extensions had not been pulled out.</p> <p>C. Record review</p> <p>A nursing note dated 1/29/2024 at 6:51 p.m. documented a witnessed fall. A certified nurses aide (CNA) had yelled for help due to a resident falling from her bed while receiving a bed bath. Upon entering the room the resident was found on the left side of the bed on the ground. The resident was screaming in pain. The resident had swelling and a scrape on her left knee and was not able to move it. The resident was sent to the hospital for evaluation of her left knee.</p> <p>An emergency department (ED) note, dated 1/29/24, documented the resident fell out of bed during a bed bath landing on her left knee which was bruised with joint effusion (swelling).</p> <p>A diagnostic radiology (x-ray) note, dated 1/29/24, documented Resident #46 sustained a comminuted (broken in three or more places) mildly displaced and impacted (a break where the ends are driven into each other) distal (near the knee) femoral fracture.</p> <p>The operative report, dated 1/30/24, documented the operation/procedure of an open reduction (repositioning of pieces of fractured bone) and nailing of the femur fracture. A [NAME] 13 by 1340 millimeter (mm) nail locked the knee with three advanced locking screws and locked proximally (nearer the body) with one screw.</p> <p>Hospital discharge documentation, dated 2/1/24, documented the resident was discharged back to the facility.</p> <p>A facility readmission note, dated 2/1/24, at 3:35 p.m. documented the resident returned to the facility by stretcher.</p> <p>A bed rental company report, dated 2/5/24, documented the service to Resident #46's bed for placement of assist bars (bed canes).</p> <p>D. Staff interviews</p> <p>Licensed practice nurse (LPN) #2 was interviewed on 2/26/24 at 1:21 p.m. LPN #2 said the staff should check the bed before residents were admitted to ensure the bed was working properly and the mattress fit correctly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>LPN #1 was interviewed on 2/26/24 at 2:06 p.m. LPN #1 said the bariatric (large size) beds, which was the type of bed Resident #46 used, had extensions to make the bed frame larger. She said the bariatric beds with the extensions were delivered to the residents' rooms from the facility's central supply (CS). She said CS personnel were supposed to check the bed to ensure the bed was working properly and the extensions were pulled out to accommodate the mattress. She said the mattress should fit inside the bed frame. LPN #1 said the extensions could be adjusted while the resident was in the bed, however, she said it was better to adjust them before the resident got into the bed. She said if a resident felt something was wrong with the bed, nursing staff should call maintenance to check the bed.</p> <p>The central supply director (CSD) was interviewed on 2/26/24 at 3:03 p.m. The CSD said Resident #46's bed had not been checked due to the resident being readmitted on [DATE] to the facility after she had left work for the day. She said the nursing staff should check the frame if the CSD was not available. She said the bed rental personnel had reported the extension bars were not all the way out on one side on 2/5/24 when they came to install the bed canes.</p> <p>The CSD said the extensions were not hard to pull out. She said the staff should report if the mattress was too small for the bed. She said there was no report of problems with the bed until the bed canes were put on by the service provider on 2/5/24.</p> <p>The director of nursing (DON) was interviewed on 2/27/24 at 11:33 a.m. The DON said if a resident was reporting a feeling of slipping in the bed it should be reported and the facility should look into the cause. He said the admissions staff and the CSD ensured the resident had the correct size bed. He said nursing staff was responsible for ensuring the extensions on the bed frame were pulled out and the mattress fit the bed appropriately. He said nurses should look at the frame. He said Resident #46 slipping from the bed could have been a bed frame problem.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and interviews, the facility failed to ensure residents with a gastrostomy tube received appropriate treatment and services to prevent complications for one (#18) of three residents reviewed for tube feeding management out of 53 sample residents.</p> <p>Specifically, the facility failed to label Resident #18's tube feeding bag with the date and time the tube feeding bag was hung, the initials of the nurse hanging the tube feeding bag, the type of tube feeding the resident was receiving and the flow rate for the tube feeding administration.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Enteral Nutrition Therapy (Bolus) policy, dated 8/8/23, was provided by the nursing home administrator (NHA) on 2/27/24 at 12:35 p.m. It read in pertinent part, The facility will provide bolus enteral nutrition therapy in accordance with physician orders and professional standards of practice. The facility will utilize the Lippincott procedure.</p> <p>II. Resident status</p> <p>Resident #18, age greater than 65, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included pressure ulcer of sacral region, stage 4, pressure ulcer of right buttock, stage 4, pressure ulcer of left buttock, stage 4, unspecified severe protein-calorie malnutrition, encounter for attention to gastrostomy, multiple sclerosis and dependence on wheelchair.</p> <p>According to the 12/27/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required setup help with oral hygiene and required substantial/maximal assistance with showers and toileting.</p> <p>The assessment revealed the resident had a feeding tube.</p> <p>III. Observations</p> <p>On 2/22/24 at 8:05 a.m., the resident's tube feeding pump was observed connected to her while she laid in bed. The tube feeding pump was connected to an intravenous (IV) pole with one tube feeding bag hanging from the pole. The tube feeding formula bag was transparent without any labels. The tube feeding appeared to be a brown colored liquid that was not identified.</p> <p>-The tube feeding bag was not labeled with the date and time the tube feeding was hung, the initials of the nurse that hung the tube feeding bag, the type of tube feeding the resident was receiving and the flow rate for the tube feeding administration.</p> <p>III. Record review</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 12/27/23 physician's order documented in pertinent part, Enteral Feed at bedtime for PEG (percutaneous endoscopic gastrostomy) tube Jevity 1.5 (tube feeding formula) at 70 ml (milliliters) per hour for 12 hours, on at 9:00 p.m. and off at 9:00 a.m Water 100 ml every four hours for 12 hours. Total of 840 ml tube feeding and 300 ml free water flush.</p> <p>IV. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 2/22/24 at 8:15 a.m. RN #1 said she had not connected Resident #18's enteral nutrition since she came on shift at 6:00 a.m. She said when the tube feeding formula was hung a label should be placed on the bag with the nurse's initials, time it was initiated, the formula and rate. She said she was unable to identify the fluid that was inside the tube feeding bag. She said when she disconnected the tube feeding connector from the PEG tube she ensured the connector was cleaned and stored away covered with no residual left on it.</p> <p>The assistant director of nursing (ADON) was interviewed on 2/22/24 at 8:30 a.m. The ADON said she identified the unlabeled tube feeding bag and relabeled it. She said she was able to identify the liquid was Jevity 1.5 because she called the nurse that hung it and verified that she poured Jevity 1.5 but she forgot to label the tube feeding bag.</p> <p>The director of nursing (DON) was interviewed on 2/27/24 at 3:20 p.m. The DON said the tube feeding should have been paused once the day shift nurse identified the unlabeled bag and then contacted the physician to notify them and followed the physician's instructions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure two (#62 and #68) of four residents who required respiratory care received care consistent with professional standards of practice out of 53 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Follow manufacturer recommendations to maintain, clean, sanitize and store Resident #62 and Resident #68's continuous positive airway pressure (CPAP) mask and machine;</li> <li>-Accurately complete section O in the minimum data set (MDS) assessment under respiratory treatments for Resident #62 and Resident #68;</li> <li>-Ensure a care plan was in place to include settings, cleaning, disinfecting and storage of the CPAP for Resident #62; and,</li> <li>-Ensure Resident #68's CPAP mask sealed properly because it was torn.</li> </ul> <p>Findings include:</p> <p>I. Facility policy and procedures</p> <p>The BiPAP/CPAP Administration policy, revised 9/26/23, was provided by the nursing home administrator (NHA) on 2/26/24 at 11:01 a.m. The policy revealed in pertinent part: The reservoir should be filled daily with sterile or distilled water to the fill line. Each day when the resident is removed from the machine the reservoir should be emptied and left to air dry. To clean the face mask, alcohol prep pads or warm soapy water can be used as needed. If the mask/tubing is washed with warm soapy water, they should be air dried completely.</p> <p>II. Resident #62</p> <p>A. Resident status</p> <p>Resident #62, age above 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included congestive heart failure, atrial fibrillation (abnormal heart beat), pulmonary hypertension (affects arteries in the lungs), dependence on supplemental oxygen, shortness of breath and obstructive sleep apnea.</p> <p>The 12/4/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She was dependent on staff for toileting, showering, and personal hygiene. She used oxygen.</p> <ul style="list-style-type: none"> <li>-The use of the CPAP was not triggered/coded on the MDS assessment under section O.</li> </ul> <p>B. Resident interview</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #62 was interviewed on 2/21/24 at 2:20 p.m. She said she did not know how often her CPAP mask was supposed to be cleaned by staff. She said she cleaned the mask herself daily. She said she cleaned the mask with a skin wash towelette that she kept in a Styrofoam cup on her overbed table. She said the mask was always stored on top of her CPAP machine but not in a plastic bag.</p> <p>C. Observations</p> <p>The CPAP was observed on 2/21/24, 2/22/24 and 2/26/24 on the resident's night stand next to her bed. The CPAP mask was attached to the tubing and placed on top of the night stand laying across the CPAP machine.</p> <p>D. Record review</p> <p>Review of the February 2024 treatment administration record (TAR) revealed the following orders:</p> <ul style="list-style-type: none"> <li>-Clean mask with warm soapy water, rinse, set out to dry every day shift. The order was dated 12/5/23.</li> <li>-Clean reservoir with warm soapy water, rinse, set out to dry everyday shift on Saturday. The order was dated 12/2/23.</li> <li>-There was not a care plan addressing the use of the CPAP.</li> </ul> <p>III. Resident #68</p> <p>A. Resident status</p> <p>Resident #68, age above 65, was admitted on [DATE] and readmitted [DATE]. According to the February 2024 CPO, diagnoses included severe morbid obesity, acute and chronic respiratory failure, dependence on supplemental oxygen, anxiety disorder and obstructive sleep apnea.</p> <p>The 1/5/24 MDS assessment revealed the resident was cognitively intact with a BIMS of 15 out of 15. She required maximum assistance with transfers. She used oxygen.</p> <ul style="list-style-type: none"> <li>-The use of the CPAP was not triggered/coded on the MDS assessment under section O.</li> </ul> <p>B. Resident interview</p> <p>Resident #68 was interviewed on 2/21/24 at 10:53 a.m. She said she did not know when or if her CPAP tubing had been changed. She said she did not know how often the mask should be cleaned or cleaned with. She said she had not seen staff clean her mask. She said her mask had been torn for a while and did not seal properly. She said she was embarrassed because it made so many noises from not sealing properly. She said she had let staff know she needed a new mask.</p> <p>C. Observations</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CPAP was observed on 2/21/24, 2/22/24, and 2/26/24 before noon on the resident's night stand next to her bed. The CPAP mask was attached to the tubing and placed on top of the night stand laying across the CPAP machine.</p> <p>D. Record review</p> <p>Review of the February 2024 TAR revealed the following orders:</p> <ul style="list-style-type: none"> <li>-Clean mask with warm soapy water, rinse, set out to dry every day shift. The order was dated 12/5/23.</li> <li>-Clean reservoir with warm soapy water, rinse, set out to dry every seven days. The order was dated 11/13/23.</li> </ul> <p>The CPAP care plan, revised on 12/5/23, revealed Resident #68 used a CPAP for obstructive sleep apnea. The interventions included:</p> <ul style="list-style-type: none"> <li>-Assess for signs and symptoms of hypoxia (low oxygen).</li> <li>-BiPAP on when sleeping and off while awake</li> <li>-BiPAP with following settings: AVAPS, Tidal volume 500mL, FiO2% 40, Measured IPAP 23 cmH2O, set EPAP/CPAP 10 cmH2O, set rate 24, P max 25 cmH2O, P min 15 cmH2O, I-time 0.9 sec, rise time 3 sec.</li> <li>-Wash BIPAP mask with warm soapy water, rinse and air dry.</li> <li>-Wash BIPAP Reservoir with warm soapy water, rinse and air dry.</li> </ul> <p>IV. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 2/26/24 at 1:50 p.m. She said the nurse was responsible for cleaning and storing the CPAP mask. She said she did not know how the mask should be stored.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 2/26/24 at 2:05 p.m. She said the nurse was responsible for cleaning the CPAP mask daily. She said the mask should be stored in a clear plastic bag.</p> <ul style="list-style-type: none"> <li>-LPN #2 observed the CPAP mask for Resident #62 and Resident #68 not stored in a plastic bag.</li> </ul> <p>LPN #2 said if a mask had a tear in it, or did not fit properly, the nurse would call the physician and get an order for the resident to be refitted for a new mask.</p> <p>The assistant director of nursing (ADON) was interviewed on 2/26/24 at 2:12 p.m. She said the nurses were responsible for cleaning and storing the CPAP and mask. She said the mask should be cleaned daily according to the physician's order. She said the reservoir should be cleaned weekly on Sunday with warm soapy water. She said the tubing should be changed weekly. She said the mask should fit properly to avoid leaks.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The ADON said Resident #68 last had a respiratory visit in November 2023. She said the mask should be cleaned daily and stored in a clear plastic bag to avoid respiratory infections.</p> <p>The director of nursing (DON) was interviewed on 2/26/24 at 2:22 p.m. He said the nurses were responsible for cleaning and storing the CPAP and mask. He said the mask should be cleaned daily according to the physician's order. He said the mask should fit properly to avoid leaks. The DON said the mask should be cleaned daily and stored in a clear plastic bag to avoid respiratory infections.</p> <p>V. Facility follow up</p> <p>A progress note dated 2/24/24 at 5:06 p.m. documented the respiratory company was notified of the torn mask and a new mask would be sent overnight for Resident #68.</p> <p>A progress note dated 2/26/24 at 3:09 p.m. documented the respiratory company was notified a second time of the torn mask and a new mask would be sent overnight for Resident #68.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent.</p> <p>Specifically, the facility had a medication error rate of 14.29%, which was five errors out of 35 opportunities for error.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:</p> <ol style="list-style-type: none"> <li>1. The right medication</li> <li>2. The right dose</li> <li>3. The right patient</li> <li>4. The right route</li> <li>5. The right time</li> <li>6. The right documentation</li> <li>7. The right indication.</li> </ol> <p>According to the Instructions for use Alvesco Inhalation Aerosol, retrieved on 2/27/24 from: <a href="https://www.alvesco.us/_resources/Alvesco-InstructionsForUse.pdf">https://www.alvesco.us/_resources/Alvesco-InstructionsForUse.pdf</a>. It revealed in pertinent part, Rinse your mouth out with water and spit it out. Do not swallow.</p> <p>II. Facility policy and procedure</p> <p>The Administration of Medications policy, revised 7/14/21, was received from the nursing home administrator (NHA) on 2/26/24 at 11:01 a.m. It revealed in pertinent part, All medications were administered safely and appropriately per physician order to address residents' diagnosis and signs and symptoms.</p> <p>Medication error means the observed or identified preparation for administration of medication or biologicals which is not in accordance with the prescribers order.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>III. Observations and staff interviews</p> <p>On 2/26/24 at 8:03 a.m. licensed practical nurse (LPN) #2 was observed preparing and administering medications to Resident #23. LPN #2 dispensed a 100 milligram (mg) tablet of Seroquel (antipsychotic) to the medication cup and checked off Glipizide (used for high blood glucose) 10 mg.</p> <p>The order indicated Glipizide 10 mg to be administered twice daily and according to the resident's medication administration record (MAR) administered at 7:30 a.m. and 4:30 p.m.</p> <p>The Seroquel 100 mg was ordered twice daily and ordered to be administered at 6:00 a.m. and 8:00 p.m. according to the resident's MAR.</p> <p>LPN #2 dispensed Sertraline (antidepressant) 100 mg into the medication cup and checked off Losartan (blood pressure medication).</p> <p>The MAR documented Losartan 100 mg daily at 8:00 a.m. and Sertraline 100 mg daily at 8:00 p.m.</p> <p>LPN #2 dispensed one Senna (used for constipation) 8.6 mg tablet into the medication cup and checked off Senna plus (used for constipation) 50-8.6 mg in the resident's MAR.</p> <p>LPN #2 dispensed three medications ordered incorrectly. LPN #2 said she was ready to go administer the medication in the cup to Resident #23. LPN #2 reviewed the medications in the medication cup after being prompted. LPN #2 failed to identify what the medications were in the cup and had to be prompted to identify the medication using the tablet identifiers engraved on the tablets.</p> <p>The Seroquel, Sertraline and Senna were removed from the medication cup and replaced with the correct medications ordered one Glipizide 10 mg tablet, one Losartan 100 mg and one Senna plus 50-8.6 mg tablet.</p> <p>LPN #2 entered Resident #23 room for medication administration. LPN #2 started with an Alvesco inhalation aerosol solution that instructed the resident to take two puffs/inhalations of the medication. Resident #23 completed the two inhalations and then took all other medications to complete her morning medications.</p> <p>-LPN #2 failed to have Resident #23 rinse and spit after the administration of the Alvesco inhaler.</p> <p>LPN #2 was interviewed directly after administration of the medication. She said Resident #23 should have rinsed out her mouth after the inhaler to help prevent the resident from developing thrush (a yeast infection in her mouth).</p> <p>LPN #2 said she should have looked at the MAR and the cards she dispensed the medication from more closely to ensure she was dispensing and administering the correct medications to the residents. LPN #2 said it was her responsibility to follow the seven rights of medication administration.</p> <p>LPN #2 was observed administering medications on 2/26/24 at 8:43 to Resident #102. LPN #2 applied a Lidocaine 4 % patch to the resident's right hip.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	

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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The order documented the Lidocaine 4% patch was to be applied to Resident #102 right ribs.</p> <p>-LPN #2 applied the lidocaine patch to the incorrect location on the resident.</p> <p>LPN #2 went back to Resident #102 room at 9:05 a.m. and informed the resident she applied the patch to the wrong location. LPN #2 then removed the patch from the resident's right hip and placed it on her right side ribs.</p> <p>LPN #2 said it was important to place a topical medication in the correct place on a resident's body to ensure it was being used correctly.</p> <p>The director of nursing (DON) was interviewed on 2/27/24 at 10:21 a.m. He said nurses were to follow the seven rights of medication administration otherwise a medication error could occur. The DON said if a medication error occurred it placed a resident at risk for interactions or complications. The DON said if a medication error occurred the resident, power of attorney and physician needed to be notified and the resident was to be monitored for side effects.</p> <p>The DON said some inhalers require the resident mouth be rinsed out to prevent thrush.</p> <p>The DON said medication orders for topicals should indicate the location it was to be applied and should only be applied to the indicated site to be effective for the resident's needs.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly on one of four medication carts.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure medication was not left unattended on the medication cart; and,</li> <li>-Ensure tuberculin (medication to test for tuberculosis, a lung bacteria) vials were dated with open dates.</li> </ul> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Tubersol package insert, retrieved [DATE] from: <a href="https://www.fda.gov/media/74866/download">https://www.fda.gov/media/74866/download</a>, A vial of Tubersol which has been entered and in use for 30 days should be discarded.</p> <p>II. Facility policy and procedures</p> <p>The Storage and Expiration Dating of Medications and Biologics policy and procedures, revised [DATE], received from the nursing home administrator (NHA) on [DATE] at 11:01 a.m. It revealed in pertinent part, The facility should ensure that all medications and biologics, including treatment items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors.</p> <p>Once any medication or biologic package was opened, the facility should follow manufactures/suppliers guidelines with respect to expiration dates for opened medications. The facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened.</p> <p>If a multiple dose vial of an injectable medication has been opened or accessed (needle puncture), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial.</p> <p>III. Observations and staff interviews</p> <p>On [DATE] at 12:27 p.m. the second floor medication room was reviewed with registered nurse (RN) #4. There was one vial of Tubersol open and undated.</p> <p>RN #4 was not sure when the vial was opened and she was unsure how many days the vial was good for before expiring after it was opened. RN #4 said vials should be dated once opened because they did expire before the expiration date the manufacturer places on the vial.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 8:20 a.m. licensed practical nurse (LPN) #2 one 100mg tablet of Seroquel (antipsychotic) and one 100 mg tablet of sertraline (antidepressant) on her medication cart unattended. An unidentified certified nurse aide (CNA) walked by the unattended medication.</p> <p>LPN #2 was interviewed on [DATE] at 8:30 a.m. She said she should have not left the medication on the cart. LPN #2 said she should have locked up the medications until she could place them in the drug buster for destruction. LPN #2 said a resident could have picked up the medication left on the cart and taken it. LPN #2 said if a resident took a medication not ordered for them they could have a medication interaction and sustain side effects.</p> <p>The director of nursing (DON) was interviewed on [DATE] at 10:21 a.m. He said he was not aware of the tuberculin expiration date once the vial was opened. He said multi-dose vials should be dated so nurses know when it expired because a medication may not be as effective if used past the expiration date.</p> <p>The DON said medications should not be left unattended because a resident could get ahold of them and take them leading to possible side effects if not prescribed to them. The DON said the facility had residents, who had cognitive impairment, that could potentially get ahold of medications if left unattended.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	
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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure one (#89) of three residents reviewed for ancillary services, such as dental services, out of 53 sample residents received routine dental care obtaining routine and 24-hour emergency dental care.</p> <p>Specifically, the facility failed to refer Resident #89 to the dentist to replace lost dentures and repair loose fitting dentures.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Dental Services policy and procedure revised 8/23/23, was provided by the nursing home administrator (NHA) on 2/27/24 at 11:26 a.m. It revealed in pertinent part, The facility will assist residents in obtaining routine and 24-hour emergency dental care. The facility will provide and obtain routine and emergency dental services to meet the needs of each resident. The facility will assist the resident as necessary or as requested in making appointments; and by arranging for transportation to and from the dental services location; and promptly refer residents with lost or damaged dentures for dental services.</p> <p>I. Resident status</p> <p>Resident #89, age greater than 65, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included non-pressure chronic ulcer of the left calf with unspecified severity, history of falling and adult failure to thrive.</p> <p>According to the 12/21/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was independent with eating. She required setup help with oral hygiene, and partial/moderate assistance with toileting. She required substantial/maximal assistance with showers.</p> <p>II. Resident observation and interview</p> <p>On 2/22/23 at 8:49 a.m., Resident #89 was in her room. The resident was missing her bottom set of dentures and her top dentures were loose and moved as she talked.</p> <p>Resident #89 said she lost her dentures before she was admitted to the facility. She said she needed to get her bottom dentures replaced and have her top denture readjusted because they were loose. Resident #89 said she was unaware the facility was able to assist her with dental care.</p> <p>III. Record review</p> <p>The February 2024 CPO revealed the following physician's order:</p> <p>Resident may have dental, podiatry, audiology and optometry care as needed. Ordered 11/28/23.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE  14101 E Evans Ave Aurora, CO 80014	

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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 11/28/23 at 3:45 p.m., documented in pertinent part, The resident was missing her bottom dentures, has the top dentures. Eating softer food here. Denied swallowing problems, answered all swallowing questions with a no.</p> <p>Review of Resident #89's care plan, revised 12/11/23, revealed the resident had oral/dental health problems related to the aging process. Interventions included: the resident will comply with mouth care at least daily, administer medications as ordered, coordinate arrangements for dental care, transportation as needed/as ordered, diet as ordered and consult with dietitian as needed.</p> <p>Review of Resident #89's electronic medical record (EMR) did not reveal the resident was offered or provided access to dental care.</p> <p>IV. Staff interviews</p> <p>The social services director (SSD) was interviewed on 2/26/24 at 2:27 p.m. The SSD said residents and/or the residents' responsible party should be offered ancillary services upon admission and every quarter during the care plan conference. She said it should be documented in the progress notes that ancillary services were offered. She said she was unable to find documentation to indicate Resident #89 and/or her representative were offered dental services since the resident's admission on [DATE].</p> <p>Certified nursing assistant (CNA) #2 was interviewed on 2/27/24 at 9:58 a.m. CNA #2 said she was unsure if Resident #89 had issues with her dentures.</p> <p>Registered nurse (RN) #2 was interviewed on 2/27/24 at 10:05 a.m. RN #2 said she was aware Resident #89 had lost her bottom dentures prior to being admitted to the facility. She said the resident's diet had been changed to a mechanical soft texture (diet which needs very little chewing) to help her eat. RN #2 said she did not refer the resident to the dentist and Resident #89 did not complain of any issues about her top dentures.</p> <p>The director of nursing (DON) was interviewed on 2/27/24 at 10:46 a.m. The DON said Resident #89 should have been referred to the dentist upon admission to replace her bottom dentures and to ensure the top dentures were not loose. The DON said it was not an appropriate intervention to change her diet in lieu of replacing her dentures. The DON said the nursing staff should notify the SSD in order to place the resident on the ancillary services list to ensure the resident was seen by the dentist if she had any dental complaints. The DON said he needed to provide an all staff education related to ancillary services.</p> <p>The nursing home administrator (NHA) was interviewed on 2/27/24 at 11:55 a.m. The NHA said Resident #89 should have been offered all ancillary services which included dental services. She said if the resident complained of any dental issues nursing staff should have notified the SSD and the resident would have been placed on a list to be seen by the dentist in order to have her dentures readjusted and replaced.</p>