STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065397	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Cont Care Sr Campus, Skilled Nursing	1919 68th Ave Greeley, CO 80634

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents had adequate supervision and assistive devices to prevent accidents for one (#3) of five residents reviewed out of five sample residents. Resident #3, who was admitted on [DATE], required the assistance of two staff members when transferring. On the morning of 7/17/25, Resident #3 was found to have a bruise on her right lower extremity. Certified nurse aide (CNA) #4, who discovered the bruise, went and alerted the day shift nurse. Upon assessment, Resident #3 grimaced when the bruise was touched. On 7/17/25, Resident #3's primary care physician (PCP) examined her bruise and ordered an Xray, which revealed the resident sustained a nondisplaced acute proximal tibia fracture (a break of the shinbone towards the upper part of the shin bone). Interviews during the survey revealed multiple staff members said Resident #3 was very rigid and stiff. The staff said they were using multiple different methods to transfer Resident #3 and none of the staff members knew how she had obtained the bruise and the fracture. Due to the facility's failure to ensure staff closely monitored the resident during transfers, Resident #3 sustained a right tibia fracture. Additionally, on 10/2/25, Resident #3 slid out of the Hoyer lift (mechanical lift) and landed on her back and shoulders while two CNAs were transferring her from her wheelchair to her bed. Specifically, the facility failed to ensure Resident #3 was consistently transferred correctly. Findings include:I. Facility policy and proceduresThe Incidents/Accidents Nursing Procedures, undated, was provided by the nursing home administrator (NHA) on 10/21/25 at 1:40 p.m. It read in pertinent part, All incidents/accidents are to be documented. These include skin tears and bruises. Document the date, time and location of the incident/accident such as, in the resident's room, bathroom or hall, etc. Document a full description of any injuries giving measurements of wounds. If the resident is memory impaired and is found to have a bruise or skin tear of unknown origin, the facility should proceed to conduct and document an investigation for post-bruise/skin tear unrelated to a fall, along with an incident report. The following list describes most causes of skin tears and bruising. when the cause is unknown, consider the following when conducting a investigation: falls, medications - Coumadin, steroids, aspirin, and non-steroidal anti-inflammatory drugs make residents more susceptible to skin tears and/or bruising. Staff assistance to residents during toileting, baths, transfers to/from the bed and wheelchair, and assistance with positioning, and while using mechanical lifts. During physical and occupational therapy. Staff may be rushed and careless and then tired, frustrated and impatient.The Transfer policy and procedure, undated, was provided by the NHA on 10/20/25 at 2:37 p.m. It read in pertinent part, Determination of the method of transfer is made with evaluation of therapy or nursing management. Mechanical lifts, gait belts or other transfer techniques may be appropriate for a resident as indicated in their care plan. II. Resident #3A. Resident statusResident #3, age greater than 65, was admitted [DATE]. According to the October 2025 computerized physician orders (CPO) diagnoses included unspecified fracture of upper end of right tibia, adult failure to thrive, Alzheimer's disease and type two diabetes. The 9/29/25 minimum data set (MDS) assessment revealed the resident was rarely or never understood through staff assessment. The resident had short-term and long-term memory deficits and was severely impaired in daily decision-making through staff assessment. The resident was dependent on staff for all activities of daily living (ADL) and all mobility.B. Observations On 10/21/25 at 10:06 a.m. Resident #3 was in an activity, listening to the daily chronicle being read. She was sitting in a high-back wheelchair, leaning heavily to the left side. Her legs were stiff, not fully bent at the knees. Her feet were resting on the outer edge of her foot pedals. On 10/21/25 at 10:08 a.m. observations of Resident #3's room revealed the bathroom door was on the left at the entrance of her room. Her bed was pushed up against the wall and the foot of the bed was towards the entrance of the room. A dresser was against the opposite side of the wall next to the entrance of her room. The foot of the bed and the edge of the dresser were approximately three feet apart. She had a recliner in her room. The space in the middle of her room was approximately six feet by six feet. C. Injury of unknown origin1. Facility investigation The facility investigation, dated 7/18/25, documented four CNAs were interviewed. All of the CNAs denied knowing how the bruise happened. All of the CNAs denied seeing Resident #3 showing any signs of pain. Three of the CNAs said they thought it could have happened when they used the sit-to-stand (mechanical lift) with her or when she was in her wheelchair, because she would keep her legs out in front of her and there was not a lot of room in her room. The investigation documented they spoke to licensed practical nurse (LPN) #1 who the bruise was reported to. The investigation documented the LPN