STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065284	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Manor Care Center	465 5th St Burlington, CO 80807

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, record review and interviews the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (#19) of 12 residents out of 15 sample residents.

Specifically, the facility failed to have a wound care order in place prior to treatment being provided for Resident #19.

Findings include:

I. Facility policy and procedure

The Care of Skin Tears, Abrasions and Minor Breaks policy, revised September 2013, was provided by the director of nursing (DON) on 4/10/24 at 2:31 p.m. It read in pertinent part, The purpose of the procedure was to guide the prevention and treatment of abrasions, skin tears and minor breaks in the skin. An abrasion is an area of the skin that has been damaged by friction, scraping, rubbing or trauma.

Preparation:

-Obtain a physician's order as needed;

-Check the treatment record; and,

-Generate a non-pressure form and complete it.

II. Resident #19

A. Resident status

Resident #19, age above 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included a history of falling, neoplasm of uncertain behavior of skin (a skin growth that could not be predicted), chronic kidney disease, hypertension (high blood pressure) and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls).

The 1/29/24 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of nine out of 15. He required moderate

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with toilet transfers, chair to bed transfers, sit to stand and lying to sitting. The resident was at risk of developing pressure injuries. B. Resident observations and interviews Resident #19 was observed on 4/9/24 at 11:37 a.m. with a soiled border foam dressing to his right elbow. The dressing had dried blood on it and no date to indicate when it was changed or nurse initials. Resident #19 was observed a second time on 4/10/24 sitting in his recliner. His right elbow was open to air and scabbed over. Resident #19 said he received the wound on his right elbow when he fell a couple of weeks ago. He said a staff member put the dressing on because it was bleeding but it had not been changed since the fall. He said he took it off that morning (4/10/24) himself. C. Record review -Review of the March 2024 and April 2024 CPO revealed no treatment orders for the right elbow wound. A progress note dated 3/31/24 documented the resident received the abrasion to his right elbow following an unwitnessed fall. -However, the progress note did not document a dressing had been ordered and applied to the resident's elbow. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/10/24 at 12:54 p.m. LPN #1 said Resident #19 had a skin tear to his right elbow from a previous fall. She said there was not a physician's order in place for the treatment of the wound. She said there should be a physician's order in place on what to treat the wound with and for monitoring for infection. The DON was interviewed on 4/10/24 at 1:30 p.m. The DON said Resident #19 had an abrasion to his right elbow from a previous fall. She said she overheard LPN #1 and the unit manager discussing there was no physician's order for a treatment and it was left open to the air. She said the nurse should have called the physician for an order to treat the abrasion and to monitor for infection.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly in two of two medication carts and one of one medication rooms. Specifically the facility failed to: -Ensure medications were not loose in medication carts; and, -Ensure expired medications were not stored with current medications in the medication storage room. Findings include: I. Facility policy and procedure The Storage of Medications policy and procedure, revised November 2020, was received from the director of nursing (DON) on 4/10/24 at 2:40 p.m. It documented in pertinent part, The facility stores all drugs and biologics in a safe, secure, and orderly manner. Drugs and biologicals are stored in packaging, containers or other dispensing systems in which they were received. Nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Discontinued, outdated, or deteriorated drugs and biologicals are returned to the dispensing pharmacy or destroyed. II. Observations and staff interviews On 4/10/24 at 1:57 p.m. medication cart #1 was reviewed with licensed practical nurse (LPN) #1. -The medication cart had 28 whole medication tablets and one half medication tablet loose in the medication drawers. On 4/10/24 at 2:09 p.m. medication cart #2 was reviewed with LPN #1. -The medication cart had 16 whole medication tablets loose in the medication drawers. LPN #1 was interviewed on 4/10/24 at 2:11 p.m. LPN #1 said there was no formal cleaning schedule but it was the nurses responsibility to keep medication carts clean. LPN #1 siad medication carts were to be kept clean to prevent contamination and aid in medication stocking. On 4/10/23 at 2:15 p.m. the medication room was observed with LPN #1. -The medication room contained two boxes of 50 Tylenol 650 milligram (mg) suppositories that (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired in February 2024. LPN #1 was interviewed on 4/10/24 at 2:17 p.m. LPN #1 said the medications were expired and should have been removed from the medication room for destruction. LPN #1 said expired medications had the potential for the full dose of the medications not to be administered to a resident. III. Additional staff interview The DON was interviewed on 4/10/24 at 2:31 p.m. The DON said medication carts were to be cleaned daily by the charge nurse. The DON said the pharmacy consultant came into the facility monthly to perform inspections on medication carts. The DON said nurses working the floor were expected to check the cart every day for expired medications and cleanliness. The DON said the facility did not have a schedule that identified a certain day or shift the medication carts were to be cleaned. The DON said if a nurse dropped a medication tablet into the drawer they should go looking for it and destroy it. The DON said it was important for medications to be stored in their dispensing containers so they did not get mixed up, creating a potential for medication errors. The DON said her nurse manager was to check the medication room for expired medications every two weeks. The DON said if a medication was used past the expiration date it could alter the strength and effectiveness of the medications.