STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065391	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorado Veterans Community Living Ctr at Homelake	3749 Sherman Ave Monte Vista, CO 81144

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide services for two (#15 and #7) of two residents reviewed out of 23 sample residents according to professional standards of practice. Specifically, the facility failed to ensure Resident #15's and Resident #7's vital signs, specifically the resident's blood pressure and pulse, were monitored and assessed prior to the administration of a blood pressure medication. Findings include: I. Professional reference According to Kizior, R. J. [NAME], K. J. (2023). Metoprolol. [NAME] Nursing Drug Handbook. Elsevier. p. 770. Assess B/P (blood pressure), heart rate immediately before drug administration. If pulse in 60 beats per minute or less or systolic B/P is less than 90 mmHg (millimeters of mercury) withhold medication and contact physician. According to Kizior, R. J. [NAME], K. J. (2023). Amlodipine. [NAME] Nursing Drug Handbook. Elsevier. P. 60. Assess B/P, if systolic B/P is less than 90 mmHg, withhold medication, contact physician. According to Kizior, R. J. [NAME], K. J. (2023). Lisinopril. [NAME] Nursing DrugHandbook. Elsevier. p. 703. Obtain B/P, apical pulse immediately before each dose in addition to regular monitoring, be alert to fluctuations. II. Facility policy and procedure The Medication Administration policy and procedure, revised 10/20/23, was provided by the nursing home administrator (NHA) on 10/16/24 at 4:56 p.m. It read in pertinent part, Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the provider's prescribed parameters. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #15 A. Resident status Resident #15, age [AGE], was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), the diagnoses included Parkinson's disease (brain disorder that causes tremors), orthostatic hypotension (low blood pressure after standing or sitting up) and syncope (fainting). The 7/18/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 13 out of 15. He was dependent with toileting, personal hygiene, required substantial/maximal assistance with bed mobility, transfers and required supervision with eating. B. Observations On 10/16/24 at 7:35 a.m. registered nurse (RN) #2 was observed dispensing and administering Metoprolol 12.5 milligrams (mg) to Resident #15. RN #2 checked the certified nurse aide (CNA) 10/16/24 vital sign record sheet for that morning (10/16/24), which indicated the resident's blood pressure was 93/60 mmHg. -RN #2 did not check the vital sign record sheet or the resident's medical record for a pulse rate. -RN #2 did not check the order for blood pressure or pulse parameters prior to the administration of the Metoprolol medication to Resident #15. C. Record review The October 2024 CPO documented a physician's order of Metoprolol succinate ER (extended release), give 12.5 mg once a day for heart rate, ordered on 11/3/22. -The October 2024 CPO did not document any vital signs parameters for when to hold the Metoprolol medication or when to notify the physician of irregular vital sign results for that medication. The October 2024 (10/1/24 to 10/16/24) vital signs summary revealed Resident #15's pulse was only assessed on 10/4/24, 10/5/24, 10/7/24, 10/11/24, 10/12/24, 10/13/24 and 10/14/24 and not daily at the time the resident was given the prescribed Metoprolol tablets. IV. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the October 2024 CPO, the diagnoses included diabetes mellitus (DM) and hypertension. The 7/25/24 MDS assessment revealed the resident had cognitive impairment with a BIMS score of five out of 15. She required partial/moderate assistance with personal hygiene, transfers, supervision with toileting, set up assistance with eating and was independent with bed mobility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 10/16/24 at 8:00 a.m. RN #2 was observed dispensing and administering: -Amlodipine 10 mg (blood pressure medication); and, -Lisinopril 40 mg (blood pressure medication). -RN #2 did not assess the resident vital signs, including the resident's blood pressure and pulse, check the order for blood pressure parameters or review the resident's record for the resident's most recent vital signs prior to the administration of Almodipine or Lisinopril. C. Record review. The October 2024 CPO documented a physician's order of Amlodipine 10 mg once a day for hypertension (high blood pressure), ordered on 9/18/24. The October 2024 CPO documented a physician's order of Lisinopril 40 mg once a day for hypertension, ordered on 9/6/23. -The October 2024 CPO did not document any vital sign parameters for when to hold the Amlodipine or Lisinopril or when to notify the physician of irregular vital sign results. -The October 2024 (10/1/24 to 10/16/24) medication administration record (MAR) and treatment administration record (TAR) did not document how often the resident's vital sign should be checked. The September 2024 (9/1/24 to 9/30/24) and October 2024 (10/1/24 to 10/16/24) vital sign summary revealed Resident #7's blood pressure was only assessed on 9/5/24, 9/16/24, 9/19/24, 9/20/24, 9/21/24, 9/27/24, 10/9/24 and 10/16/24. The September 2024 (9/1/24 to 9/30/24) and October 2024 (10/1/24 to 10/16/24) vital sign summary revealed Resident #7's pulse was only assessed on 9/5/24, 9/12/24, 9/19/24, 9/20/24, 9/21/24 and 9/26/24. V. Staff interviews RN #2 was interviewed on 10/16/24 at 8:15 a.m. RN #2 said if a physician's order did not indicate parameters to hold the medication he would only check the blood pressure if the resident was symptomatic. He said a blood pressure of 93/60 mmHg was normal for Resident #15. He said vital signs were not routinely checked unless there were ordered parameters for medications. RN #1 was interviewed on 10/16/24 at 11:00 a.m. RN #1 said residents that were on a new medication had their vital signs checked daily. She said certain medications had ordered parameters to check vital signs. She said when residents were on medications and did not have parameters she would decide on her own whether or not to take the resident's vital signs. The director of nursing (DON) was interviewed on 10/16/24 at 12:00 p.m. The DON said vital signs were taken by certified nurse aides (CNA) and the nurses when there were parameters ordered. She said blood pressure medications should have blood pressure and pulses taken before administration, even (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if there were no parameters ordered. The DON was interviewed again on 10/16/24 at 2:00 p.m. The DON said she was working on nursing education regarding checking vital signs before administering blood pressure medications and knowing when to hold and consult the physician if there were no parameters in place, according to standards of practice. V. Facility follow up The Hypertensive Medication Parameters, dated 10/16/24, was received from the NHA on 10/17/24 at 1:33 p.m. It documented nursing education was provided on 10/16/24 (during the survey) to include when receiving physician's orders for hypertensive medication to notify physician to obtain orders for parameters. It documented the DON did a chart audit for all residents on medications affecting blood pressure and heart rate and their associated parameters on 10/16/24 (during the survey). It documented a weekly audit would be done of blood pressure medications with parameters for compliance. It documented audit reports to quality assurance and performance improvement (QAPI) every month to start 10/31/24.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain complete and accurate resident resuscitation choices in the medical record for three (#141, #13 and #32) of fourteen residents out of 23 sample residents. Specifically, the facility failed to: -Ensure a physician's order was in place for a do not resuscitate (DNR) for Resident #141, who wished to be a DNR per the resident's Medical Orders for Scope of Treatment (MOST) form; -Ensure documentation of a MOST form was in place for Resident #13; and, -Ensure the MOST form was discussed with and signed by Resident #32, who was cognitively intact. Findings include: I. Facility policy and procedure The Advanced Directives and Resident Rights to Refuse Treatment policy and procedure, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 8:00 a.m. It read in pertinent part, On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Copies of living wills or advanced directives will not be scanned into the medical record but instead, kept in a binder in a designated area. Physician order will be entered in the electronic medical record (EMR) that reflects the resident's wishes and corresponds to the MOST form or other legal documents related to advanced directives or living will. II. Resident #141 A. Resident status Resident #141, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included chronic kidney disease (CKD), macular degeneration (eye disease that causes vision loss) and bilateral cataracts. The[DATE] 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. He required setup assistance with eating and was independent with toileting, personal hygiene, bed mobility and transfers. B. Record review Review of Resident #141's EMR revealed a MOST form which was signed on [DATE] and documented (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #141's wishes for DNR status. -Review of the [DATE] CPO failed to reveal documentation of a physician's order for the resident's DNR status. III. Resident #13 A. Resident status Resident #13, age [AGE], was admitted on [DATE]. According to the [DATE] CPO, diagnoses included traumatic brain injury, hemiplegia (paralysis of one side of the body) and abdominal aortic aneurysm (AAA). The [DATE] MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of four out of 15. He required substantial/maximal assist personal hygiene, partial/moderate assistance with toileting, transfers, setup assistance with eating and was independent with bed mobility. B. Record review A review of Resident #13's [DATE] CPO revealed the following physician's order: DNR, see MOST form, ordered [DATE]. -A comprehensive review of the facility's MOST form binder failed to reveal a completed MOST form for Resident #13. IV. Resident #32 A. Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included traumatic ischemia of muscle (direct tissue damage with decrease in blood supply), Parkinson's disease (degenerative movement disorder) and chronic respiratory failure. The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required substantial/maximal assistance with one person for shower/bathing, upper/lower body dressing, personal hygiene, sit to stand transfers, and chair to chair transfers. B. Record review A review of Resident #32's [DATE] CPO revealed the following physician's order: Do Not Resuscitate (DNR), see MOST form, ordered [DATE]. According to the resident's MOST form, the resident was marked as No CPR: do not attempt resuscitation. The MOST form was signed by Resident #32's medical power of attorney (MPOA). The area on the MOST form that revealed if the decision was discussed with the resident was marked no. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, Resident #32 was cognitively intact with a BIMS score of 15 out of 15 indicating the resident was capable of making his own decision about his resuscitation status and therefore should have signed his own MOST form. The care plan, initiated [DATE], revealed the resident planned to stay at the facility for short term care. -The care plan did not identify the resident's resuscitation wishes according to the MOST form. V. Staff interviews The director of nursing (DON) and the NHA were interviewed together on [DATE] at 2:59 p.m. The DON said the facility used the MOST forms for the residents' resuscitation wishes. She said the admitting nurse initiated the MOST form when the residents were admitted and the form was reviewed quarterly and when the residents' chose to change their resuscitation wishes. She said the physician was at the facility a minimum of once a week and would sign the MOST forms. She said residents that came to the nursing home from the domiciliary (the independent resident cottages) brought their MOST forms with them. The DON said Resident #141 was admitted on [DATE]. She said a physician's order for DNR status had not been obtained for Resident #141 until [DATE] (during the survey) because it was caught during a MOST form audit the facility conducted. She said, in an emergency situation, staff referred to the MOST form binder to check for residents' resuscitation statuses. She said it was important to have MOST forms filled out and physician's orders documented timely in case of any emergency situations. The DON said she did not know why Resident #13's original MOST form was missing out of the facility's MOST binder. She said there was a MOST form for Resident #13 uploaded into the EMR, but she said the facility's process during an emergency situation was to check the MOST binder and the original MOST form. She said the original MOST form was where the staff would document when a review of the MOST form was conducted and document with residents that the MOST form continued to accurately reflect their wishes. She said the facility would create a new MOST form for Resident #13 and verify if the DNR status was still his wish for resuscitation.