STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48458 Based on record review and interviews, the facility failed to ensure quality of care and address needed communication for one (#45) of six residents reviewed out of 26 sample residents. Specifically, the facility failed to: -Ensure Resident #45's cardiac specialist was notified when the facility chose not to implement the specialist's recommended physician's orders; and, -Inform Resident #45 about medications ordered by a specialist that were not implemented by the facility. Findings include: I. Resident #45 status Resident #45, age 68, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included heart disease, cirrhosis of the liver, right leg amputation above the knee and peripheral vascular disease (reduced blood flow to limbs). The 12/23/23 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. He required substantial assistance with hygiene, mobility and transfer. II. Facility policies The Medication and Treatment Orders: Guiding Principles policy, undated, was provided by the nursing home administrator (NHA) on 2/26/24 at 10:20 a.m. It read in pertinent part, Physicians shall write medication orders that reflect known benefits and risks of medications in the facility's population. Medication orders will be accurate, timely, appropriate, and legible. The Physician Services Policy, revised February 2021, was provided by the director of nursing (DON) on 2/29/24 at 8:05 a.m. It read in pertinent part, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The attending physician will determine the relevance of any recommended interventions from other disciplines. The physician is not obligated to accept these recommendations if he or she has clinically valid reasons for not doing so. -The policy did not address any required communication with residents, nursing staff, or specialists from another discipline if the recommended interventions were not accepted by the attending physician. II. Resident interview Resident #45 was interviewed on 2/26/24 at 3:47 p.m. He said he had a heart and vascular clinic appointment on 2/26/24 and learned he had not received medications ordered by the specialist two months ago. He said he had been to the emergency roiagnom on several occasions to drain excess fluid from his abdomen (paracentesis) and he was told by the heart and vascular specialist this might not have been necessary if he had taken the medication which was prescribed in December 2023. He said the head nurse told him there had been a communication problem and this was the reason he did not start the medications. III. Record review The MD Office Visit Communication form for the heart and vascular clinic visit, dated 12/27/23, was provided by the DON on 2/28/23 at 9:00 a.m. The new orders and signature section contained the following physician's orders from the heart and vascular physician assistant: -Begin 25 milligrams (mg) Toprol XL (medication which can be used to treat heart failure) daily; and, -Begin 12.5 mg Spironolactone (a diuretic medication used to treat heart failure) daily. Hold if systolic blood pressure is less than 90. -The orders were signed by registered nurse on (RN) #1 on with the word noted next to the signature and dated 12/27/23. -However, the orders were not entered into Resident #45's electronic medical record (EMR) A comprehensive review of Resident #45's physician orders revealed Spironolactone 12.5 mg one time a day was ordered on 1/4/24, however it was discontinued on 1/18/24. The MD Office Visit Communication form for the heart and vascular clinic visit on 2/26/24 was provided by the DON on 2/28/23 at 9:00 a.m. The notes from the physician section were signed by the heart and vascular physician (HVP) and contained the following documentation in pertinent part: Recent paracentesis for heart failure. Not sure why guideline directed medical therapy (GDMT) medications have been stopped. Need to escalate GDMT as tolerated. This will likely help with minimizing the need for paracentesis. The 2/26/24 visit new orders and signature section contained the following physician's orders from the HVP: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start Spironolactone 25 mg PO (by mouth) daily. Start Toprol XL 12.5 mg PO daily. After visit hospital summaries revealed Resident #45 had undergone paracentesis procedures on 12/29/23, 1/25/24 and 2/23/24 -Resident #45 began receiving Spironolactone and Toprol XL as ordered on 2/27/24 (during the survey), almost two months after the heart and vascular physician had originally ordered the medications. IV. Staff interviews The DON was interviewed on 2/27/24 at 3:11 p.m. The DON said Resident #45 told her there were medications he was not receiving as ordered. She said an MD Office Visit Communication form was returned with the resident to the facility on [DATE]. She said the nurse who received the heart and vascular specialist orders signed off both medications, however, she said the orders were not entered by the nurse in the resident's EMR. The DON said she considered the instructions from the specialist to be actual orders. She said the facility needed to work on its process for communication of new orders. The DON said she reviewed the orders with the nurse practitioner (NP) on 12/27/23 and the NP decided not to start the Spironolactone and Toprol XL medications until after the resident's paracentesis scheduled for 12/29/23. The DON said she did not communicate with the heart and vascular specialist regarding the NP's decision to wait to start the medications and she did not know if the NP consulted with him regarding non-implementation of the orders. The DON said she did not know why the Toprol XL was never started or why the Spironolactone medication was ordered from 1/4/24 to 1/18/24 and then discontinued. The DON said the NP preferred Lasix medication over Spironolactone. She said the provider group for the facility changed on 2/25/24. The DON was interviewed a second time on 2/27/23 at 3:52 p.m. The DON said RN #1 should not have noted the orders written by the heart and vascular specialist on 12/27/24 as they had not been entered in the EMR or initiated for administration. The facility's physician's assistant (PA) was interviewed on 2/27/24 at 4:00 p.m. The PA said the facility received a new form on 2/26/24 from the heart and vascular specialist with the same medications which were ordered on 12/27/23. The PA said she would document in her note if she did not agree with the specialist's treatment plan. She said she was happy the facility was starting Spironolactone as the new medication could decrease Resident #45's frequency of paracentesis. The NP was interviewed on 2/28/24 at 11:24 a.m. The NP said she did not start the Spironolactone and Toprol XL as ordered on 12/27/23 by the heart and vascular specialist because of the resident's trend of low blood pressures. She said she did not know if the heart and vascular specialist was aware the medication was not started. The pharmacist consultant (PC) was interviewed on 2/28/24 at 11:34 am. She said the resident did not have orders for Spironolactone prior to 1/4/24. She said the pharmacy did not have orders for both Spironolactone and Toprol XL until 2/26/24. She said Spironolactone could help with reduction of fluid in the abdomen. She said Toprol XL would not be as helpful for fluid reduction, but would be indicated for the resident's heart condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's physician (PH) was interviewed on 2/28/24 at 12:48 p.m. The PH said Resident #45 had advanced heart disease and cirrhosis of the liver. She said if she disagreed with the specialist, her process was to reach out to the specialist directly. (This physician began working at the facility on 2/25/24). She said Resident #45 was medically fragile with a lot of chronic disease. She said it was important to communicate why medication should not be started. She said any order in the facility had to be signed by a provider at the facility. The PH said the communication sheet from the specialist was a recommendation and when the facility provider cosigned, it became an order. RN #1 was interviewed on 2/28/24 at 3:53 p.m. RN #1 said she signed the order at the bottom of the MD Office Visit Communication form and she said it meant she had seen the orders. She said she did not enter the orders into the electronic record as the NP wanted to wait to start the medications. She said she did not document this in Resident #45's record. The heart and vascular physician (HVP) was interviewed on 2/28/24 at 4:41 p.m. The HVP said the facility did not communicate with him when Toprol XL was not started or about the delayed start and then discontinuation of Spironolactone. He said two months of treatment was lost. He said he would expect the facility to call if there was concern regarding Resident #45's blood pressure being too low with the addition of Spironolactone and Toprol XL, as the parameters for low blood pressure was different for a population who were not as sick as Resident #45. The HVP said he hoped the facility provider would have communicated immediately with him if they were not going to follow his recommendations. The DON was interviewed again on 2/29/24 at 10:11 a.m. The DON said she asked the NP if she wanted to talk with the heart and vascular specialist (ordering physician) and the NP declined. She said there was a lack of collaboration between the primary care provider and the heart and vascular specialist. She said she would expect the nurse to document in the record if orders were not implemented. She said the facility process needed to be improved to provide better communication. Licensed practical nurse (LPN) #5 was interviewed on 2/29/24 at 1:33 p.m. LPN #5 said she would discuss with the DON if orders were not implemented by the facility physician. She said she would document in the resident's chart if the physician did not implement a specialist's orders. LPN #2 was interviewed on 2/29/24 at 1:47 p.m. LPN #2 said she discussed with the unit manager if there were order changes. She said she signed noted at the bottom of the orders, which means the orders have been completed and entered into the record. She said she would not sign the form if the orders were not implemented. She said she would check with the unit coordinator to see if she needed to document in the record if orders were not implemented. The NHA was interviewed on 2/29/24 at 2:07 p.m. The NHA said he expected the resident to be notified by nursing staff if the ordered medications were not implemented by the facility provider. He said he would expect the facility provider to discuss this with the resident. LPN #1 and the DON were interviewed together on 2/29/24 at 3:00 p.m. Both LPN #1 and the DON said RN #1 should have notified the resident if he was not going to start taking medications prescribed by the specialist. V. Facility follow-up (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/24 at 3:55 p.m., the DON provided the following documentation: Quality Assurance Orders Action Plan: Identified areas for improvement: -Physician Services Collaboration related to new orders. -When a new order is received from an alternate physician other than the attending physician collaboration is to occur between the two providers and nursing. -Communicate these changes with resident and/or family. Plan: -Education with new in-house providers related to collaboration with outside physicians. -Education with nurse's related to new orders received from outside providers. Nurses will also be educated on documenting follow up related to new order from outside providers. -MD communication forms will be reviewed and audited by DON and clinical coordinator. -The facility did not implement the action plan until the concern for orders not being implemented was brought to their attention during the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored and labeled in one of five medication carts and one of three medication storage rooms. Specifically, the facility failed to ensure: -Medications were labeled with the date opened; and, -Expired and discontinued medications were removed from the medication cart and storage room in a timely manner. Findings include: I. Facility policy and procedure The Storage of Drugs and Biologicals Policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:32 a.m. The policy read in pertinent part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. II. Professional references According to the manufacturer [NAME] Lilly and Company, Humalog U-100 Insulin (February 2024), retrieved on [DATE] from https://www.humalog.com/u100, Opened Humalog vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin. III. Observations and interviews On [DATE] at 7:35 a.m., the Red Cloud unit medication cart was observed with licensed practical nurse (LPN) #3. The following items were found: -A used Albuterol HFA inhaler was not labeled with the date it was opened; -A used QVAR Redihaler inhaler was not labeled with the date it was opened; and, -A used Humalog U-100 insulin Kwik Pen with a date opened label of [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Humalog insulin pen should have been discarded on [DATE], 28 days after opening. LPN #3 said the inhalers should be discarded because they were not labeled with the date they were opened. She said the insulin should have been discarded, however, she was not certain of the date it should have been discarded. On [DATE] at 9:31 a.m., the Frontier unit medication storage room was observed with registered nurse (RN) #2. The following item was found: Five vials of Hepatitis B Vaccine Recombinant Engerix B with an expiration date of [DATE]. RN #2 said the vaccines were expired and should be discarded. IV. Director of nursing (DON) interview The DON was interviewed on [DATE] at 11:06 a.m. The DON said nursing staff should label inhalers when opened. She said the insulin expired by [DATE]. The DON said she thought the insulin had been discontinued and should have been removed from the cart on the same day it was discontinued. She said expired vaccines should be discarded immediately upon expiration.