STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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 observations, record review and interviews, the facility failed to ensure one (#9) of three residents received treatment and care in accordance with professional standards of practice out of 12 sample residents. Specifically, the facility failed to: -Ensure the emergency crash cart containing essential resuscitation equipment and a backboard was utilized during a resuscitation attempt for Resident #9; -Ensure a timely call was placed to emergency medical services (EMS) for immediate assistance when Resident #9 experienced a life threatening change of condition; and, -Ensure a licensed nurse remained with Resident #9 until EMS arrived. Findings include: I. Professional reference According to the American Heart Association (AHA), (2020). Basic Life Support Provider Manual eBook, retrieved from https://ebooks.heart.org on [DATE] at 12:15 p.m, The two key components of cardiopulmonary resuscitation (CPR) are chest compressions and breaths. High quality CPR improves a victim's chances of survival. Immediate activation of the emergency response system, early high-quality CPR, and rapid defibrillation are essential. In the workplace, every employee should know how to activate the emergency response system in their setting. A high performance team, three emergency responders who are called to assist in cardiac arrest will perform multi-rescuer coordinated CPR: rescuer one performs chest compression, rescuer two gives breaths with a bag-mask device, rescuer three uses the automated external defibrillator (AED). Rescuer three also assumes the role of CPR coach. The coach helps team members perform high quality CPR and minimize pauses in chest compressions (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
	065222	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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	If the victim is not breathing normally or is only gasping and has no pulse, begin high quality CPR. Start cycles of CPR with 30 chest compressions followed by two breaths. Position the victim face up on a firm, flat surface, such as the floor or a backboard. This will help ensure that the chest compressions are as effective as possible. If the victim is on a soft surface, such as a mattress, the force from the chest compressions will simply push the victim's body into the soft surface. A firm surface allows compression of the chest and the heart to create adequate blood flow. For breaths to be effective, the victim's airway must be open. Two methods (for opening the airway): head tilt/chin lift and jaw thrust. Use a bag-mask device if available to provide positive pressure ventilation to victim who is either not breathing or not breathing normally. Because every second matters during a resuscitation attempt, it is important to define clear roles and responsibilities as soon as possible. II. Facility policy and procedure The Emergency Procedures, Cardiopulmonary Resuscitation (CPR) policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 1:42 p.m. It read in pertinent part, It is the policy of this facility to provide basic life support (BLS), including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel. Only staff members with current CPR certification for Healthcare Providers should perform the procedure. If unresponsive, not breathing (occasional gasps are not breathing) and no pulse, activate the EMS system. Page or yell loudly Code Blue to the area. Call 911. Position the resident face-up on a firm, flat surface. Start chest compressions. Open airway (tilt head back and lift the chin up), give two rescue breaths. May use a bag valve mask (BVM) or Ambu bag (a hand held device used to provide ventilation to someone who is not breathing) to give rescue breaths. Continue cycles of 30 chest compressions to two rescue breaths. III. Resident #9 A. Resident status Resident #9, age 82, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included respiratory failure, dementia, Parkinson's disease (disorder of the central nervous system that affects movement) and dysphagia (difficulty swallowing). The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He required partial assistance with eating, hygiene and dressing. He required substantial assistance with transferring. The MDS assessment indicated he had loss of liquids/foods from his mouth when eating, held food in his mouth/cheeks or had residual food in his mouth after meals and had complaints of difficulty swallowing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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	B. Observations The [NAME] hallway unit emergency crash cart was observed with the director of nursing (DON) on [DATE] at 9:40 a.m. A bag-mask device and airway supplies (including suction) were present on the cart. Two backboards were present next to the cart. -However, interviews during the survey revealed the supplies observed on the emergency crash cart on [DATE] were not utilized in the attempt to resuscitate Resident #9 on [DATE] (see interviews below). C. Record review A nursing progress note documented on [DATE] at 1:40 p.m. revealed Resident #9 had a change of condition which included nausea, vomiting, abnormal vital signs and shortness of breath. The nursing note revealed a report was provided to the primary care physician (PCP) at 1:50 p.m. The nursing note documented an emergency call was made to 911. -The progress note did not indicate what time 911 was called. -A review of the electronic medical record did not reveal any further documentation, details or timeline regarding the resuscitation/code of Resident #9. The Nurse Comprehensive Clinical Competency Review Skills Checklist was provided by the NHA on [DATE] at 9:49 a.m. The following items were included on the checklist: Ambu bag, this is used in an emergent situation. Attach 15 liters (of oxygen) per minute to the ambu bag. Suctioning and airway management. Oral suctioning, trach suctioning, and deep suctioning (RN only). The Emergency Crash Cart Daily Check Log was provided by the NHA on [DATE] at 11:35 a.m. Review of the daily check log revealed documentation indicating the following items were present on the [NAME] hallway crash cart on [DATE]: -Suction machine (and documentation that it worked properly); -Suction kit; -Ambu Bag (bag/mask device); -Rebreather mask; and, -Oxygen mask. -However, none of the supplies present on the emergency crash cart on [DATE] were utilized in the attempt to resuscitate Resident #9 (see interviews below). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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	IV. Staff interviews. Registered nurse (RN) #1 was interviewed on [DATE] at 2:01 p.m. RN #1 said she was Resident #9's nurse on [DATE]. She said after lunch on [DATE], Resident #9 called for assistance with positioning. RN #1 said she and certified nurses aide (CNA) #1 assisted the resident with positioning. She said Resident #9 asked for a drink of water which was thickened per the dietary department. RN #1 said all of the liquids on the resident's bedside table were thickened. RN #1 said Resident #9's condition deteriorated after he drank the liquids. She said he began having difficulty breathing and his color was blue. RN #1 said she yelled out for staff to call 911. She said CNA #2 came into the room and the staff checked Resident #9's vital signs (heart rate, respiratory rate, oxygen saturation and blood pressure). RN #1 said Resident #9's oxygen saturation (oxygen level in the blood) was less than 85% and it was difficult to obtain other vital signs. RN #1 said she went to the door of the room and asked if anyone had called 911. RN #1 said there was no response from other staff. RN #1 said she left the room to call 911 since there was no response from other staff. She said Resident #9's color was blue when she left the room. -RN #1 failed to delegate CNA #1 or CNA #2, who were in Resident #9's room with her, to go call 911 while she remained with the resident. RN #1 said while she was calling 911, CNA #2 had started chest compressions. RN #1 said she did not know when Resident #9 stopped breathing or when his pulse stopped. RN #1 said the director of rehabilitation (DOR) was doing chest compressions when she returned to the room. RN #1 said she had a current Basic Life Support (BLS) for Healthcare Providers certification. -CNA #2 was unavailable for an interview during the survey. CNA #1 was interviewed on [DATE] at 2:16 p.m. CNA #1 said CNA #2 completed chest compressions on Resident #9. She said Resident #9 was turned to his side when he began vomiting with chest compressions. She said she never saw the emergency crash cart in or near the room. CNA #1 said, during the resuscitation, she never saw staff use a bag-mask device for providing breathing assistance for Resident #9. CNA #1 said there was not a backboard underneath Resident #9 during compressions. She said someone came in the room with an AED between two to four minutes after RN #1 called for help. The DOR was interviewed on [DATE] at 2:57 p.m. The DOR said she when she was informed Resident #9 was coding she brought the AED to the room. The DOR said when she arrived to Resident #9's room, CNA #2 was providing chest compressions and the resident was vomiting. The DOR said she used the AED for two cycles and provided chest compressions between cycles. She said the staff in Resident #9's room at the time did not ask for the emergency crash cart. The DOR said RN #1 was out of the room calling 911 when she arrived with the AED. The DOR said she did not know if anyone had suctioned Resident #9. The DOR said she had a current BLS for Healthcare Providers certification. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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	Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 3:19 p.m. LPN #1 said she arrived to the resident's room shortly after the DOR arrived. She said there was not a backboard under Resident #9 when the facility staff was performing CPR on Resident #9. LPN #1 said she asked for a non-rebreather mask and she thought staff were bringing the emergency crash cart to the room when the paramedics arrived. LPN #1 said EMS immediately put Resident #9 on the floor when they arrived. She said the paramedics intubated (insertion of a tube into a person's airway to enable oxygen to get through) the resident and used the AED several more times to shock the resident's heart. LPN #1 said the facility staff were aware of Resident #9's code status (the type of emergency treatment a person would or would not receive if their heart or breathing were to stop) and desire to be a full code, which included CPR. The DON was interviewed on [DATE] at 9:00 a.m. The DON said there was not a root cause analysis or investigation done after the unexpected death of Resident #9 at the facility. The DON said she was not at the facility during the resuscitation attempt of Resident #9. She said she received a text from CNA #4 which revealed Resident #9 was coding. She said she called CNA #4 and was told resuscitation attempts were still ongoing by staff and EMS had not arrived at the facility yet. The DON said based, on her phone information, Resident #9 had coded at approximately 1:44 p.m., staff were still resuscitating the resident at 1:51 p.m and EMS had not arrived (at least seven minutes). She said she did not have a timeline of events during the code and staff should have documented the events as they occurred. The DON said residents should be placed on a hard surface during chest compressions. She said certified staff were expected to perform CPR based on the BLS for Healthcare Providers standards. The DON said there was a bag-mask device on the cart and staff should have asked for it. She said it would have been difficult to use, however, as several staff told her Resident #9 was vomiting much of the time during the code. The DON said all staff knew where the emergency crash cart was located and the DON had not been aware until the survey that the cart was not in the room prior to EMS arrival. The DON said CNA #2 told her she provided chest compressions but did not ventilate (use bag-mask device) or manage the airway of Resident #9. The DON said she provided a staff inservice in early [DATE] to review how to respond to a code. She said the education included the need for the nurse to stay in the room to lead the code and to delegate responsibilities to other staff, including delegation to an individual for the responsibility to call 911. She said she had not been tracking who had BLS for Healthcare Provider certification but would start tracking it. CNA #4 was interviewed on [DATE] at 10:36 a.m. CNA #4 said she sent a text message to the clinical team (nursing staff), which included the DON, when the code was in progress. CNA #4 said EMS was not yet in Resident #9's room when the DON called CNA #4. -Based upon the DON's and CNA #4's interviews, Resident #9 was coding for at least seven minutes prior to the arrival of the EMS team without using a backboard or having airway equipment in the room to be available for use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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 CPR Instructor (CPRI) was interviewed on [DATE] at 11:55 a.m. The CPRI said if a resident did not have a pulse and was not breathing, she would expect the staff to initiate chest compressions. The CPRI said if a bag-mask device and suction were available, she would expect them to be used if needed. She said students were taught to be prepared for and manage emesis (vomiting) during a code. The CPRI said if the resident was not actively throwing up, the staff should provide positive-pressure ventilation with a bag-mask device if the airway was clear. The primary care provider (PCP) was interviewed on [DATE] at 3:15 p.m. The PCP said if Resident #9 had no pulse, chest compressions were indicated. She said she would have expected the staff to take care of the airway and provide ventilations whenever possible. The PCP said ideally there should have been an ambu bag (bag-mask device) at the bedside during resuscitation for use if needed. The PCP said she would have expected the staff to use a backboard if there was one available as it could make chest compressions more effective. The PCP said she did not think the outcome would have been different due to Resident #9's medically fragile state. The DON was interviewed again on [DATE] at 8:38 a.m. The DON said she was told the team was considering using the emergency crash cart supplies when the paramedics arrived. She said she would have expected resuscitation equipment to be available in the room as soon as possible after a code had begun to be able to be used if the airway was able to be cleared. The DOR was interviewed again on [DATE] at 9:00 a.m. She said Resident #9 was vomiting most of the time while she was present. She said she did not see airway supplies or the emergency crash cart in the room. V. Facility follow-up An In-Service Training Report titled CPR and dated [DATE] (during the survey) was provided by the NHA on [DATE] at 1:42 p.m. The training was conducted by the DON and included the following: -The resident's nurse should remain at the bedside with the resident throughout the code, or until the resident is transferred to the hospital. The nurse should delegate the following activities: - 911 call -retrieval and set up of the crash cart (obtaining and setting up the resuscitation equipment needed) -documentation and timeline of events during the code. The DON planned to utilize mock codes (scenarios to simulate a real emergency code) to provide additional learning opportunities to the staff.