STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065393	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTH CARE OF AURORA	**1800 S POTOMAC ST AURORA, CO 80012**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents received adequate supervision to prevent accidents out of three sample residents reviewed. Specifically, the facility failed to ensure an assessment of Resident #1 was completed by a registered nurse (RN) following a fall. Findings include: I. Professional references According to the Colorado Department of Regulatory Agencies website, Board of Nursing: Laws, Rules and Policies https://dpo.colorado.gov/Nursing/Laws (retrieved 8/27/2020), The practical nursing student is taught to identify normal from abnormal in each of the body systems and to identify changes in the patient's condition, which are then reported to the RN or MD (medical doctor) for further or full assessment. II. Resident #1 A. Resident status Resident #1, age 95, was admitted on [DATE]. According to the September 2019 computerized physician orders [REDACTED]. The 9/16/19 minimum data set (MDS) assessment revealed the resident had short term and long term memory impairment and had severe impairment in making decisions regarding daily tasks of life. She required extensive assistance of two people with bed mobility, transfers and toileting. She required extensive assistance of one person with personal hygiene, eating and dressing. She was totally dependent with one person assistance for bathing. She was not steady and only able to stabilize with staff assistance for moving from a seated to a standing position. B. Record review The 9/18/19 nursing progress note revealed Resident #1 was being assisted by a certified nurse aide (CNA) in the shower room. While the resident was seated in the shower chair, the CNA dried off her legs. The resident leaned forward, fell on to the CNAs back and then onto the floor. The resident sustained [REDACTED]. It indicated the resident was assisted from the floor by the licensed practical nurse (LPN) and the CNA following an assessment of the resident. It did not indicate an RN was notified to complete an assessment of the resident immediately following the fall and prior to moving the resident off the floor. The 9/18/19 fall investigation revealed the resident fell forward, while sitting in a shower chair, onto a CNA and then onto the ground, while in the shower room. The resident sustained [REDACTED]. The physician and resident representative were notified at 10:30 a.m. A treatment was put into place to address the skin tear to the resident's left wrist. The fall investigation was completed by an LPN. It did not indicate an RN had conducted an assessment of the resident following the fall. C. Staff interviews RN#1 was interviewed on 8/25/2020 at 4:43 p.m. She said following a fall sustained by a resident, an RN should complete a head to toe assessment of the resident to determine if the resident sustained [REDACTED]. She said a LPN cannot perform an assessment because it is not within their scope of practice. She said an LPN could gather and report information but not assess a resident for injury. The director of nursing (DON) was interviewed on 8/25/2020 at 4:35 p.m. She said following a fall, an RN should complete a head to toe assessment of the resident to determine if the resident sustained [REDACTED]. She said she was unable to find documentation to indicate an RN assessment of the resident was completed the fall sustained by the resident on 9/18/19. She said the documentation indicated an LPN completed the assessment of the resident. She said the physician's assistant (PA) had come into the facility and assessed the resident following the fall. She confirmed the resident had fallen at 6:00 a.m. on 9/18/19 and the PA note indicated 10:59 a.m. She said she could not confirm what time the PA assessed the resident. She confirmed the evaluation of the resident was not immediately following the fall and after the resident had been moved from the ground and was back in her room.

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

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.