STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMS HAVEN CENTER	12080 BELLAIRE WAY THORNTON, CO 80241

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 -** 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 observations, record review and interviews, the facility failed to ensure effective fall interventions were in place to prevent resident falls for one (#1) of three residents reviewed for falls. Record review and interview revealed the facility failed to effectively and consistently develop and implement care plan interventions to ensure the resident was provided the assessed levels of supervision. Resident #1 had a history of [REDACTED].#1's initial admission on 2/12/2020, that she had a history of [REDACTED]. She needed extensive assistance with activities of daily living, had severe cognitive impairment and was taking two antidepressant medications, all factors that contribute to continued falls. However, the facility failed to identify and implement effective measures to anticipate and meet her needs to prevent further falls with injury. Documentation revealed the resident was confused and unsteady of her gait/balance and her care plan documented that she was at significant risk for future falls due to weakness, impulsivity, and unawareness of safety needs. The facility failed to reassess, develop and implement appropriate interventions to effectively prevent a fall where the resident sustained [REDACTED].#1 fell seven times while in care of the facility. The falls occurred when the resident tried to get up unassisted. The latest fall on 3/18/2020, assessed by the facility as unwitnessed (fall # eight), per resident's statement, resulted in a major injury requiring surgical intervention to repair damaged bone of the left femur. The hospital postsurgical report dated 3/19/2020, documented medical [DIAGNOSES REDACTED]. Findings include: I. Facility policies and procedures The Falls Management policy revised 2/18/2020, was provided by the director of nursing (DON) on 4/2/2020 at 3:00 p.m. The policy revealed all residents (patients) will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Residents experiencing a fall will receive appropriate care and investigation of the cause. The facility policy failed to address extensive measures for residents admitted with high risk for falls and include implementation of every 15 minutes checks or one on one close supervision for a specific time period after admission. II. Resident #1 A. Resident status Resident #1 age 56, was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The 3/2/2020 minimum data set (MDS) assessment revealed moderately impaired cognition with a brief interview for mental status (BIMS) score of eight out of 15. She had no hallucinations, delusions or rejection of care behavior. She required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. She was independent with eating. She had two or more falls with no injury since the admission. She received an antidepressant medication daily. The 3/30/20 MDS assessment revealed the resident was not able to complete a BIMS. The score was documented at 00. She required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene, and supervision with eating. She had two or more falls with no injury since her prior assessment. She received an antidepressant medication daily. The assessment did not appropriately code the resident's falls as the resident sustained [REDACTED]. B. Family interview The resident's daughter was interviewed on 4/7/2020 at 10:45 a.m. She said when her mother was admitted to the facility, staff were aware she was at high risk for falls. She said her mother lived with her for approximately a year and half. She said her mother was getting up a couple times at night to use the bathroom and also had a tendency to get up at night to close the bathroom door. She said on a few occasions she slid down from a couch to the floor. She said her mother was very unsteady in standing position and required assistance from another person. She said at the beginning of February (2020) her mother fell and broke her wrist. C. Record review The comprehensive care plan initiated on 2/13/2020, revealed the resident was at risk for falls due to cognitive loss, lack of safety awareness, history of falls and [MEDICAL CONDITION] medication use. Interventions included: - When resident is in bed, place all necessary personal items within reach (2/13/2020) - maintain a clutter free environment in the resident's room and consistent furniture arrangements (2/13/2020) - remind resident to use call light when attempting to ambulate or transfer (2/13/2020) - place call light within reach while in bed or close proximity to the bed (2/13/2020) - provide verbal cues for safety and sequencing when needed (2/13/2020) - staff will place floor mat next to bed at hours of rest (2/15/2020) - staff provided non-skid socks (2/17/2020) - staff to increase safety checks (2/21/2020) - staff brought patient out to nurses station (2/23/2020) - therapy evaluation and treatment (2/26/2020) - staff sat outside patient door to provide high supervision. Later staff brought her out to TV room to color (3/8/2020) - staff got patient up, assisted her in toileting needs and brought her out to common area (3/12/2020) - x-ray left hip related to pain complaints. Patient sent out to acute for evaluation and treatment (3/18/2020) The interventions were gradually added after each fall, however failed to address resident's toileting schedule and one on one close supervision. The computerized physician orders [REDACTED]. Both medications side effects included [MEDICAL CONDITION], dizziness and drowsiness. The care plan interventions failed to address side effects for both antidepressants pertinent to resident's fall risk. The 2/12/2020 nursing admission assessment revealed the resident was admitted for long term care after hospitalization . She had a history of [REDACTED]. She had no pain. She received an antidepressant medication. Pt (patient) is oriented to person. Resident balance during transitions and walking after observation is not steady, but able to stabilize with staff assistance .Resident speech is limited does not make long sentences .Pt. unable to locate significant landmarks without assistance, e.g., bathroom, dining room, patient room. Pt exhibits attempts to maintain daily routines and leisure interests are not consistent with their new environment routines. Musculoskeletal system reviewed Description/location of device/cast/splint: (Right) arm. Pt has right-sided upper extremity functional limitations. Pt. has right arm extremity weakness. Pt. has left leg extremity weakness. Pt. has right leg extremity weakness. Rehab services/ability reviewed with the following results: Could not determine if he or she is capable of increasing independence in at least some ADLs. Device(s) in use: Split Yes. The 2/12/20 nursing follow-up note documented in parts: admitted (age) female resident to (facility) with the following Dx (diagnoses) - [DIAGNOSES REDACTED], depression (Right) distal ulnar fracture. Resident alert, verbally responsive with limited words can not make long statements, denied pain or discomfort up on admission. Resident has split on right arm, wt (weight) bearing status is not clear yet. Resident is one or two person assist with transfer can go to the bathroom with two person assistance. Resident is incontinent of urine. Resident is vegetarian, can not eat beef, pork, and chicken, but can eat fish. Resident is full core. D. Falls -fall #1 On 2/15/2020 at 12:33 p.m., a nurse documented in Change in Condition Evaluation: Resident was observed sitting on floor close to bed assessed by RN (registered nurse), no injury, neuros checks started in WNL (within normal limitations). The 2/17/2020 interdisciplinary team note revealed: IDT review note for unwitnessed fall on 2/15/20. Staff observed patient on floor in her room. Patient unable to state what she was doing at time of fall. Denied pain and no s/s (signs and symptoms) of pain noted. No injury noted with RN assessment. Staff note patient had on her non-skid socks at time of fall. Patient is a new admit to facility on 2/12/20 and is likely still getting accustomed to the facility. Staff placed fall mat next to bed at hours of rest. All other fall interventions to remain in place. -fall #2 On 2/17/2020 at 4:40 p.m., a nurse

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) documented in Change in Condition Evaluation: un-witnessed fall no injury. The 2/18/2020 IDT note revealed: IDT review note for unwitnessed fall on 2/17/20. Staff noted patient on floor in her room next to her bed. Patient stated she was going to the bathroom and slid out of bed. Staff note patient was in bare feet. Staff provided her non-skid socks and assisted her into the bathroom for toileting assistance. Patient is a recent admit to facility. Staff assisted patient out to common area for closer observation. All other fall interventions to remain in place. -fall #3 On 2/21/2020 at 11:00 p.m., a nurse documented in Change in Condition Evaluation: Resident was getting out of bed to shut the door and she sat on the mat. The 2/24/2020 IDT note revealed: IDT review note for unwitnessed fall on 2/21/2020. Staff observed patient on floor in her room. Patient states she got up to shut her door to her room. Denied pain. No injury noted with RN assessment. Staff assisted patient up off of the floor. Staff will increase safety checks on patient as she continues to demonstrate poor safety awareness. Staff offered toileting assistance while in room post fall. All other fall interventions to remain in place. -fall #4 On 2/23/2020 at 9:18 p.m., a nurse documented in Change in Condition Evaluation: Unwitnessed fall with no injury. The 2/24/2020 IDT note revealed: IDT review note for unwitnessed fall on 2/23/2020. Staff observed patient on floor in her room. Patient unable to state what she was doing at time of incident. No s/s of pain noted by staff. RN assessment revealed no injury. Staff note patient had on her non-skid socks. Staff assisted patient up from fall and brought her out to nurses station for closer observation. Staff offered toileting assistance at that time as well. MD gave orders for therapy to eval and treat. Patient has early onset advanced dementia and demonstrates poor safety awareness. All other fall interventions to remain in place. -fall #5 On 2/26/2020 at 10:04 a.m., a nurse documented in Change in Condition Evaluation: Observed resident laying supine on floor in room next to floor mat. Unable to articulate what happened. RN (registered nurse) assessed resident. No injuries noted. Neuros without deficit. No s/s of discomfort. The 2/27/2020 IDT note revealed: IDT review note for unwitnessed fall on 2/26/2020. Staff observed patient on floor in her room next to mat on floor. Patient unable to state what happened. No s/s of pain noted by staff. No injury noted with RN assessment. Staff noted the patient had on non-skid socks at time of incident. Staff assisted patient up off of the floor. Staff offered toileting assistance. Staff brought patient out for breakfast. Therapy orders given by MD for eval and treat. All other fall interventions to remain in place. The therapy evaluation order was requested after Resident #1 suffered five falls in the facility. -fall #6 On 3/8/2020 at 11:00 p.m., a nurse documented in Change in Condition Evaluation: Resident was ambulating to the bathroom and sat on the floor. The 3/9/2020 IDT note revealed: IDT review note for unwitnessed fall on 3/8/2020. Staff noted patient on floor in her room. Patient states she was going to the bathroom. Denied pain. No injury noted with RN assessment. Staff noted patient was wearing her non-skid socks. Staff assisted patient up and offered toileting assistance. Staff assisted patient to TV room to color. When patient was ready to go to bed staff sat outside her door for closer observation. All other fall interventions to remain in place. -fall #7 On 3/12/2020 at 5:52 a.m., a nurse documented in Change in Condition Evaluation: Patient was found on the floor beside her bed. No injury noted. Assisted up and taken to the bathroom. The 3/13/2020 IDT note revealed: IDT review note for unwitnessed fall on 3/12/2020. Staff observed patient sitting on the floor in her room next to her bed. Fall mat was in place on floor next to her bed. Patient was sitting on the floor next to fall mat. Patient unable to state what she was doing to advanced dementia. No visible pain noted. No injury noted with RN assessment. Staff note patient was in her non-skid socks. Staff assisted patient to her bed. Staff offered toileting assistance. Staff got her up and brought her out to common area for closer observation. All other fall interventions to remain in place. The IDT failed to investigate the cause of each of the resident's falls (per the facility policy) and implement effective measures. There was no documentation whether or not Resident #1 was capable of using the call light or was her call light ever turned on? The IDT failed to address the medication regimen review to determine what meds and conditions placed her at greater risks, and plan accordingly to intervene. -left hip pain (fall #8 per IDT note) On 3/18/2020 at 4:03 a.m., a nurse documented in Change in Condition Evaluation: Resident complains of pain in left trochanter. A change in condition has been noted. The symptoms include: Pain uncontrolled. Res. complains of pain in left trochanter. Pain 7/10. Orders obtained include: X-ray of left trochanter. On 3/18/2020 a nurse documented: Called non emergent at 10:20 a.m. ambulance to transport resident to emergency department at (hospital). The 3/19/2020 IDT note revealed: IDT review note for unwitnessed fall on 3/18/2020. Staff observed patient on floor mat next to bed. Patient unable to state what she was doing at time of incident due to her advanced dementia. Patient complained of left hip pain by grabbing onto left hip. Provider ordered left hip x-ray which did show fracture. Provider gave order to send patient out to acute for eval and treat. Patient continues to demonstrate poor safety awareness. Staff provide frequent safety checks and offer toileting assistance frequently. All other fall interventions to remain in place. Further record review, including the facility investigation, revealed the resident was not found on the floor as the previous seven falls. The 3/2/2020 occupational therapy (OT) note revealed: Since admission to (facility) approximately three weeks ago, patient has experienced several falls. Throughout OT treatment, have practiced completing functional transfers. Amount of assistance required can be variable as patient has very significant [DIAGNOSES REDACTED] and her ability to functionally assist with transfers and follow instructions varies. Patient completed transfers with minimum assistance and moderate verbal/tactile cues for hand placement. Requires holding onto therapist ' s arms for support during transfer. CNA (certified nurse aide) staff reports that they feel most comfortable with completion of functional transfers without use of front wheeled walker. The hospital admission and treatment record dated 3/19/2020, revealed the resident was admitted with displaced left intertrochanteric fracture of left femur. She underwent a surgical intervention that included an open reduction internal fixation (ORIF) of left intertrochanteric proximal femur with hardware placement. The resident returned to the facility and was readmitted on [DATE]. D. Interviews Licensed practical nurse (LPN)#1 was interviewed on 4/2/2020 at 12:15 p.m. She said the resident had several falls in the facility prior to [MEDICAL CONDITION]. She said the resident was unable to ambulate independently and always required staff assistance with transfers. CNA#1 was interviewed on 4/2/2020 at 12:22 p.m. She said the resident was at high risk for falls and recently returned from a hospital. She said she was aware the resident was at risk for falls. She said the resident was always seated in her wheelchair and was able to take a few steps during transfers with staff assistance. She said the resident should not be left unattended and between meals was placed in her wheelchair in front of the TV in the common area so she could be observed by staff. She said she did not see any particular CNA was assigned for one on one supervision to Resident #1. RN#1 was interviewed on 4/2/2020 at 3:48 p.m. She said after admission to the facility, Resident #1 was frequently taken back to her room after meals and transferred to bed. She said after the falls the resident was placed in front of the TV in the living room so the staff could keep an eye on her. She said there was no one on one staff supervision with the resident. The director of nursing (DON) was interviewed on 4/2/2020 at 3:34 p.m. She said Resident #1's care plans were updated by the unit manager after each fall with additional intervention and CNA and nurses were responsible to make sure care planned interventions were carried out. The DON said despite the fact Resident #1 was not found on the floor, the IDT reviewed the hip pain as an unwitnessed fall due to the resident's statement of having a bad dream that made her feel like she was in a drunken state. The director of rehabilitation (DOR) was interviewed on 4/2/2020 at 3:57 p.m. She said the resident was not referred to physical or occupational therapy for evaluation despite the fact she was admitted with a wrist fracture after a fall at home and required extensive assistance with all activities of daily living because of an unknown medical insurance status. She said the resident was evaluated by an occupational therapist after sustaining five falls in the facility.