STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DENVER NORTH CARE CENTER	2201 N DOWNING ST DENVER, CO 80205

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the comprehensive care plans for one (#2) resident out of three sample residents were reviewed and revised by the interdisciplinary team. Specifically, the facility failed to: -Update comprehensive care plan with appropriate interventions for Resident #2 after the resident experienced a change of condition on 6/10/2020 and sustained a fall with a fracture on 9/14/2020. Cross-reference to F689, for Resident #2 (failure to develop and implement interventions timely to prevent a fall). Findings include: I. Resident #2 Resident #2, age 79, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 9/1/2020 minimum data set (MDS) assessment revealed resident was cognitively intact with a brief interview for mental status (BIMS) score 15 out of 15. The resident required extensive two person physical assistance for bed mobility, transfers, dressing, toileting and personal hygiene. She was always incontinent of the bowel and bladder. The fall section revealed the resident did not have a fall in the last six months. The behavior section indicated the resident did not resist the care, she did not have hallucinations, delusions or other types of behaviors. II. Record review A. Change of condition on 6/10/2020 and new [DIAGNOSES REDACTED]. The x-ray showed dislocation of the left hip. Resident was sent to the emergency room for evaluations. The discharge summary from the hospital on [DATE] revealed that Resident #2 was admitted to the emergency room due to pain and was diagnosed with [REDACTED]. Orthopedics attempted a closed reduction of the left hip which was unsuccessful. It was determined that dislocation was chronic. Resident #2 was not a good candidate for open reduction surgery and was discharged back to the nursing facility. B. Facility response to a change of condition on 6/10/2020 The resident was assessed for fall risk on 6/10/2020. -On the assessment it documented the resident was identified at a high risk for falls with a score of fifteen. Her fall risks were identified as having one to two falls in the last 90 days, she was wheelchair bound and required assistance with elimination, her gait and orthostatic blood pressure were not evaluated because resident was not able to stand up, she was daily taken three or more medications that can increase confusion or lethargy, and had three or more [DIAGNOSES REDACTED]. The physical therapy (PT) discharge summary dated 9/5/2020, revealed the resident was discharged from PT on 9/5/2020 as she achieved maximum potential. The comments read: patient with severe fear of falling and often unwilling to attempt transfers, refusing assistance or to attempt transfer from wheelchair, however able to perform sit to stand transfer in parallel bars and did perform squat pivot transfer with sliding board from bed. Nursing staff report that patient will intermittently allow transfers as willing, however patient is allowed to refuse cases and was educated on the benefits of transfer training practice for strength and mobility. Patient will benefit from a restorative nursing program to promote exposure to task and to reduce fear of movement. Restorative nursing program notes for Resident #2 were requested from director of nursing (DON) on 9/30/2020, no notes were provided by the time of survey exit or one business day after. C. Fall on 9/14/2020 The incident report on 9/14/2020 reads: (resident) calling out for help from the room. Upon entering the room (resident) found on the floor sitting up against the wall. (Resident) stated she fell out of the wheelchair on the floor. Immediate actions were listed as (Resident) stated she was reaching for something in front of her and fell . No injuries observed at the time of incident. (Resident) was oriented to person, place and situation. Predisposing environmental factors listed as clutter, crowding, and furniture. Predisposing physiological factors listed as boredom. Under predisposing other factors read: (Resident) was previously encouraged to go to bed at change of shift, but (resident) became upset and refused to let the care team put her to bed. This behavior was previously charted in a Foresight report by certified nurses aids (CNAs). The Foresight report by CNAs on 9/14/2020 demonstrated that the resident was approached at 12:27 a.m., when she refused to be changed or go to bed. No interventions were documented regarding what was done to keep the resident safe from falling. Next time the resident was approached at 1:35 a.m., she refused the care and refused to go to bed. Interventions were documented as positive reinforcement after which the resident appeared to be the same. There were no documented interventions regarding what was done to keep the resident safe from falling. At 4:49 a.m. was documented that the resident had a fall. The late entry progress note documented by the DON on 9/30/2020 (day of the survey exit), read that the resident was assessed by a registered nurse (RN) after the fall and was complaining of unresolved pain. The fall and pain were reported to the physician who ordered an x-ray. The nurses progress note on 9/14/2020 at 12:52 p.m. revealed that results of the x-ray showed right [MEDICAL CONDITION]. Physician was contacted and the resident was sent to the hospital for evaluation and treatment. D. Care plans The care plan for falls and activities of daily living (ADLs) was initiated on 5/24/2019, and revealed that resident was at risk for falls. Interventions such as to anticipate resident's needs, make sure the call light is within the reach, educate the resident about safety reminders, and physical therapy evaluation and treatment as needed were added to the care plan on the same day as it was initiated, 5/24/2019. -No new interventions were added to the care plan after 6/10/2020 after the resident was diagnosed with [REDACTED].#2 suffered a fractured right hip. -The intervention to offer the resident her repositioning pillow so she can lean over it was added on 9/30/2020 (the day of the survey exit). The care plan for behaviors, initiated on 5/24/2019 and revised on 9/30/2020 (the day of the survey exit) revealed the resident struggled with making safe choices in regards to care and declined care at times. Specifically, (Resident) will decline transfers to and from wheelchair, Gerichair, shower chair, commode. (Resident) screams at the staff when she does not want the care provided. Leave me alone. Help. Somebody help me. -The following interventions were added to resident's care on 9/27/2020: When (resident) declines care, yells, or refuses to speak; educate and encourage (resident) three times for any care that is needed. Approach (resident) every five minutes for three intervals, allow to decline care three times before other interventions are introduced. The third time (resident) is educated and encouraged to provide care, staff will intervene one of two ways: 1. Position (resident) safely and give her space by staff leaving her immediate area. 2. Staff will get a clinical member of an interdisciplinary team (IDT), nursing home administrator (NHA) or nursing supervisor to explain to the resident that staff will provide the care that is needed. The nursing supervisor will assist in providing care and talk to (resident) through the care while the staff provides care so (the resident) is informed of exactly what will occur. -There were no new interventions that were added on or after 6/10/2020 that were specific to the resident's new [DIAGNOSES REDACTED]. There were no new interventions that were added on or after 9/14/2020 that were specific to the resident's new [DIAGNOSES REDACTED]. III. Staff interviews LPN #2 was interviewed on 9/30/2020 at 3:30 p.m. She said when one of the residents sustained the fall, nursing responsibility was to assess the resident for injury, notify family, physician and follow any received orders from the physician. She said nurses were expected to fill out an incident report and put in place immediate interventions to keep the resident safe and prevent any additional falls. She said care plans were updated by MDS nurse and other managers, she said floor nurses were able to update care plans too. She said she did not work with Resident #2. LPN #3 was interviewed on 9/30/2020 at 3:45 p.m. She said it was nursing

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) responsibility to update immediate interventions to keep the resident safe. She said care plans also were updated by MDS coordinator and DON. The DON was interviewed on 9/30/2020 at 4:30 p.m. She said MDS coordinator was only responsible for creating the baseline care plan. After that, nurses were responsible for adding immediate interventions and she was responsible for adding additional interventions after they were discussed with IDT members. She said she did not have a chance to write down everything about what was attempted to keep Resident #2 free from falls. She said she believed nothing else could have been done to prevent the fall on 9/14/2020.