| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065395 | A. BUILDING _____ B. WING _____ | 09/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| SUITES AT HOLLY CREEK CARE CENTER, THE | 5590 E PEAKVIEW AVE CENTENNIAL, CO 80121 |

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 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews and record review, the facility failed to ensure two (#1 and #2) of three out of three sample residents were kept free from abuse. The facility failures to ensure a system was in place prevent neglect to Resident #1. Resident #1 who was a known high fall risk, was not provided care and services needed according to her fall risk care plan. Resident #1 was care planned to have bed in the lowest position. The failure of staff to ensure the bed was in the lowest positioned contributed to neglect of Resident #1 who fell and sustained a left hip joint fracture and required hospitalization .<br>-Additionally, the facility failed to ensure Resident #2 received the necessary supervision and assistance while in the bathroom. The resident fell when left unattended in the bathroom and sustained multiple skin tears. Findings include: I. Professional references According to the Centers for Disease Control (CDC) website, Preventing Elder Abuse https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html (Retrieved 9/14/2020), Elder abuse is an intentional act or failure to act that causes or creates a risk of harm to an older adult. Common types of elder abuse include: physical abuse, sexual abuse, emotional or psychological abuse, neglect and financial abuse. Neglect is the failure to meet an older adult ' s basic needs. These needs include food, water, shelter, clothing, hygiene, and essential medical care. II. Facility policy and procedure The Resident Abuse Non-Tolerance policy and procedure, reviewed March 2020, was provided by the nursing home administrator (NHA) on 9/10/2020 at 11:38 a.m. It revealed, in pertinent part, Residents and clients must be free from abuse by anyone, including associates, other residents, consultants or volunteers, associates from outside agencies, family members or legal guardians, friends or other individuals. Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Examples of neglect include but are not limited to: failing to provide needed care such as not responding to a call light, failing to nourish, toilet, hydrate a resident, etc. The Fall Prevention and Management policy and procedure, revised August 2018, was provided by the NHA on 9/10/2020 at 11:38 a.m. It revealed, in pertinent part, The purpose of the fall prevention and management program is to identify residents/clients and areas at risk for falls, initiate interventions to prevent and respond to falls and thus reduce the risk of injury due to falls. A fall is a sudden, unintentional descent, with or without injury to the person, that results in the person coming to rest on the floor, on or against some other surface. III. Failure to ensure care and services were provided to prevent a severe injury following a fall for Resident #1 A. Resident #1 1. Resident status Resident #1, age 100, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/24/2020 minimum data set (MDS) assessment revealed the resident had short term and long term memory impairment and had severe impairment in making decisions regarding tasks of daily life. She required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident was under hospice care. It indicated the resident sustained [REDACTED]. 2. Record review The impaired cognition care plan, initiated 11/17/17, revealed the resident had impaired cognitive function and dementia and impaired thought processes. It indicated the resident required supervision and assistance with all decision making. The fall risk care plan, initiated on 11/17/17 and revised on 7/21/2020, revealed the resident was classified as a high risk for falls. The interventions included a safe environment with floors free from spills or clutter, adequate glare-free light, a working and reachable call light, the bed in the low position at night, handrails on the walls and personal items within reach. It indicated the intervention of a low bed had been in place since 11/17/17. The actual fall care plan, revised on 8/25/2020, revealed the resident sustained [REDACTED]. The intervention included to ensure the resident ' s bed was in the low position when she was lying down. It indicated care providers should be educated in the residents' need for the bed to be in the low position. The 8/24/2020 incident progress note revealed the resident was taken to the hospital following a fall. It revealed the resident appeared to be in pain at the time of the transport to the hospital and the bed was found in the highest position. The 8/26/2020 (noted late entry for 8/24/2020) nursing progress note revealed a certified nurse aide (CNA) entered the nursing station searching for help. The CNA and registered nurse (RN) entered the resident ' s room on 8/24/2020 at approximately 4:00 p.m. and found the resident lying on the floor. The resident was lying on her left side with her back against the wall, facing the rear of the bed. The 8/27/2020 (noted late entry for 8/24/2020) nursing progress note revealed the resident was found on the floor, lying on her left side. It indicated the resident had fallen out of the bed, which was observed to be in the highest position. The nurse said the resident was last attended to by the hospice agency CNA and could have left the bed in an unsafe position. The resident was observed to be groaning and guarding the left thigh. The paramedics arrived at the facility and transported the resident to the hospital. The 8/25/2020 social services progress note revealed the resident ' s family had contacted the facility to inform the resident had been transferred from the hospital to an in-patient hospice facility. The resident ' s family contacted the facility again on 8/28/2020 to notify the resident had passed away that morning. The 8/24/2020 hospital physician encounter notes revealed the resident was admitted to the hospital following a fall and sustained a displaced [MEDICAL CONDITION] acetabulum (socket of the hip bone) extending superior laterally. It indicated after discussion with the resident ' s family, the goals of the resident were comfort care and did not want any aggressive measures. The risk and harm of surgical management outweighed the benefits of surgical intervention. The physician transferred the resident to an in-patient hospice facility for aggressive palliative and symptomatic care. 3. Staff interviews The hospice case manager was interviewed on 8/31/2020 at 5:04 p.m. She said she was an active part of the resident ' s hospice care, which was provided at the facility. She said she visited the resident weekly. She said she was aware the resident ' s plan of care indicated the resident ' s bed should be in the low position due to the resident ' s fall risk status. She said on 8/24/2020, two hospice CNAs entered the facility to provide a bed bath to the resident at 1:34 p.m. She said the CNAs clocked out of the facility at 2:05 p.m. She said she interviewed both CNAs that provided care to Resident #1 on 8/24/2020. She said both CNAs were interviewed separately and provided the same recollection of events. She said CNA #2 and CNA #3 provided a bed bath to the resident. She said following the bed bath, CNA #2 said they placed the resident underneath the covers and put the resident ' s bed in the lowest position. CNA #2 said CNA #3 went into the resident ' s bathroom to wash her hands. While CNA #3 was washing her hands, CNA #2 said she sat down at the foot of the resident ' s bed. CNA #3 said after she was finished washing her hands, they informed the nurse they had completed the bed bath and left the facility. CNA #2 said if the bed had been in the highest position, then she would not have been able to sit on the end of the bed due to her height. The HCM said she did not believe CNA #2 and CNA #3 left the bed in the highest position. She said each CNA was interviewed separately and gave the same account of events during the day. CNA #1 was interviewed on 9/10/2020 at 10:54 p.m. He said he had worked at the facility for many years. He said he regularly provided care to Resident #1. He said Resident #1 was considered a high fall risk due to her cognitive impairment. He said when the resident was in the bed, the bed should be placed in the low position. He said the resident was able to roll side to side |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>on her own. He said the staff would always place the call light within reach before leaving the resident alone in the room, when she was in bed, even though the resident was unable to use the call light. He said she would not know how to use the bed controls to move the bed up and down. He said Resident #1 would not have been able to use the bed controls to move the bed to the highest position on her own without assistance. He said it was communicated to him, the facility did not know who left the bed in the highest position on 8/24/2020, when the resident fell out of bed. He said the staff assumed it was the hospice CNAs but was not certain. He said the resident was very kind and did not deserve to fall out of her bed in that manner. The NHA and the director of nursing (DON) were interviewed on 9/1/2020 at 12:26 p.m. The NHA said the facility conducted an investigation following the fall Resident #1 sustained on 8/24/2020. The DON said the resident was found on the floor on 8/24/2020 at approximately 4:00 p.m. She said the resident complained of pain on the left side and was transferred to the hospital. She said while the resident was at the hospital, it was determined she had sustained a fracture to the hip joint. She said it was her understanding, hospice CNAs had provided care to the resident and left the facility around 2:00 p.m. She said the resident was not found until 4:00 p.m. by the facility staff. The NHA said the facility was unable to determine what staff member left the resident ' s bed in the highest position. He said the facility staff said they did not leave it in the highest position and so did the hospice staff. He said the facility substantiated the neglect because the resident was not provided the care and services consistent with her plan of care which led to her fall and fracture. He said, because of conflicting interviews, the facility was unable to determine who left the bed in the highest position. The DON was interviewed on 9/10/2020 at 11:45 a.m. She said neglect occurred when a resident was not provided the care and services they required to avoid physical harm.<br><br>B. Resident #2 1. Resident status Resident #2, age 98, admitted on [DATE]. According to the September 2020 computerized physician's orders [REDACTED]. The 7/16/2020 minimum data set (MDS) assessment revealed Resident #2 had short term and long term memory impairment. Resident #2 utilized a wheelchair and had an unsteady gait. Resident #2 required total dependence on staff regarding activities of daily living including toileting. 2. Record review The care plan initiated 2/20/18 and last revised 2/3/2020 identified Resident #2 needed extensive assistance with most activities of daily living (ADLs). The Interventions used by staff documented Resident #2 needed extensive assistance with toileting and transfers. The care plan further revealed staff were to provide privacy but to remain in line of sight. Review of the nurse progress note dated 7/22/2020 documented Resident #2 had an unwitnessed fall when Resident #2 was sat on the toilet and left unattended. When Resident #2 fell , she sustained skin tears to forehead, right knee, right elbow and shearing on the buttocks. 3. Staff interview Licensed practical nurse (LPN #1) was interviewed on 9/10/2020 at 10:58 a.m. he said on the evening of 7/22/2020 Resident #2 had been seated on the toilet and fell . (Resident #2 had been left unattended and required assistance to be within reach). LPN #1 said Resident #2 had a sitter that worked with her in the evenings due to being a fall risk. LPN #1 stated the sitter was not known to make mistakes like this and should have asked for help. He stated Resident #2 had sustained multiple small skin tears. The director of nursing (DON) was interviewed on 9/10/2020 at 11:38 a.m. regarding the fall. She said it was a poor decision on the sitter's part. DON said the sitter should not have been assisting Resident #2 to the restroom. DON said the sitter was not a CNA and she should have gotten assistance from the facility staff. The DON confirmed that she, the sitter, had been educated before working with the Resident #2 and she received further education after the fall so this mistake would not occur again in the future. She said Resident #2 received multiple skin tears and was healing. The DON said new ways of training were being implemented with additional oversight being put in place to ensure resident safety. |