STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065120	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clear Creek Care Center	7481 Knox Pl Westminster, CO 80030

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. (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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#10) of four residents reviewed for accidents out of seven sample residents.Resident #10 was admitted on [DATE] for long term care with a diagnosis of dementia. According to the care plan, Resident #10 was determined to be a high fall risk. On 8/30/25 Resident #10 sustained an unwitnessed fall. The facility updated the resident's care plan to indicate he needed a one-to-one caregiver. However, on 9/3/25 Resident #10 sustained an unwitnessed fall when he was found on the floor in his room with a laceration to his head. Resident #10 was transported to the hospital for further evaluation. Resident #10 sustained a three to four millimeter left tentorial subdural hematoma (brain bleed) and posterior left tenth and eleventh rib fractures. The facility failed to ensure the person-centered interventions were consistently in place. After the fall on 9/325, it was implemented that the one-to-one caregiver needed to be within an arms length of the resident. Observations revealed the facility failed to consistently implement the one-to-one fall interventions on the resident's care plan by leaving the resident unattended, where he rolled out of bed onto his knees. Specifically, the facility failed to ensure fall interventions were consistently implemented for Resident #10. Findings include:I. Facility policy and procedureThe Accident and Supervision policy, implemented 2/29/24, was provided by the nursing home administrator (NHA) on 10/20/25 at 3:50 p.m. It read in pertinent part,The purpose this fall management policy was to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury. A fall reduction program will be established and maintained, to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. Identifying risk factors, followed by timely and appropriate interventions, is the key to a successful program. Risk factors that were internal to the resident include the resident's physical health and functional status. External risk factors include medication side effects, the use of appliances, and environmental conditions Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. A baseline plan of care will be initiated for residents determined to be at risk.A. Resident statusResident #10, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), the diagnoses included dementia, repeated falls, muscle weakness, cognitive communication deficit and a history of falls prior to admission. The 9/5/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for a mental status (BIMS) score of two out of 15. He required touch assistance with bathing and substantial/maximal assistance with bed to chair transfers, toileting transfers and sit to stand. The MDS indicated Resident #10 had a recent fall at the facility. B. ObservationsDuring a continuous observation on 10/20/25, beginning at 11:30 p.m. and ending at 2:30 p.m., the following was observed:At 12:10 p.m. certified nurse aide (CNA) #1 was at the nurses' station and was overheard telling an unidentified staff member that she was assigned as the one-to-one caregiver for Resident #10.At 12:45 p.m. Resident #10 was lying in his bed on his back. He sat up and rolled over onto his knees on his floor mat and looked under his bed. There were no staff in his room at this time. There was not a pressure sensitive bed alarm in place. At 12:58 p.m. CNA #1 returned to Resident #10's room. At 1:02 p.m. CNA #1 assisted Resident #10 out of bed and assisted him down the hall in his wheelchair. At 1:10 p.m. CNA #1 returned to the unit while assisting Resident #10 in his wheelchair. CNA #1 positioned Resident #10 in the television room that was next to the nurses' station, with two unidentified residents to watch television. At 1:15 p.m. CNA #1 was sitting at the nurses' station documenting on the computer. CNA #1 was not facing the resident and her back was turned towards the resident, while she faced the computer. The resident was left in the television room and was not within an arms length of the one-to-one care giver. At 1:122 p.m. CNA #1 left the nurses station and returned to the TV room with Resident #10C. Resident #10's representatives interviewResident #10's representative was interviewed on 10/20/25 at 3:55 p.m. She said Resident #10 had a few falls shortly after admission, but had not had any recently. The representative said Resident #10 was provided a one-to-one caregiver for the last month. The representative said the resident had a fall and was sent to the hospital because he sustained a cut. She said after he returned, he was placed on a one-to-one caregiver.D. Record reviewResident #10's fall care plan, revised 9/15/24, revealed the resident was at a high fall risk due to dementia, history of frequent falls, new environment, weakness, gait imbalance, poor impulse control, decreased safety awareness and use of psychotropic medications. Interventions included one-to-one