STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Morrison	150 Spring St Morrison, CO 80465

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** 43135 Based on observations, interviews and record review, the facility failed to ensure supervision, and monitor assistive devices and interventions to prevent accidents for three (#1, #8 and #9) of 10 residents reviewed for accidents out of 12 sample residents. Resident #1 was admitted to the facility for long term care on 9/13/23 with a diagnosis of dementia and repeated falls. The resident's care plan directed the staff to utilize a hoyer lift (mechanical lift) for transfers. On 2/25/25 Resident #1 was noticed to have an injury of unknown origin which was discovered to be a fractured ankle. The facility investigation revealed the staff had not been utilizing a hoyer lift to transfer Resident #1, which was indicated on the resident's plan of care and physician's orders. The facility failed to follow physician's orders and properly transfer Resident #1, which led to the resident sustaining a fracture of the left ankle. Resident #8 was admitted to the facility for long term care on 5/16/24 with a diagnosis of dementia. The resident's care plan identified the resident often sat on the floor next to her bed and would crawl on the floor. The care plan indicated a fall mat was to be placed next to the resident's bed at all times when she was in bed. On 3/21/25 certified nurse aide (CNA) #4 was providing care to Resident #8. CNA #4 did not place the fall mat on the ground when he left Resident #8's room. The resident fell out of bed and onto the floor which resulted in a right shoulder clavicle fracture, a fracture of the nasal bone, a large skin tear to the right elbow and superficial abrasions to both knees. The facility failed to ensure the identified person-centered interventions were consistently implemented for Resident #8, which led to the resident sustaining a fall with major injury. Resident #9 was admitted to the facility for long term care on 3/20/25 with a diagnosis of dementia and nicotine abuse. On 3/30/25 the facility implemented a wander guard due to the resident's increased wandering. On 4/6/25, another resident provided Resident #9 with a cigarette and deactivated the door alarm so Resident #9 could leave the facility without sounding the alarm. While Resident #9 was outside, he fell and sustained multiple closed fractures of the facial bone, a closed head injury, multiple abrasions and a closed fracture of one rib on the left side. The facility implemented a plan of correction after Resident #1 sustained a fracture of the left ankle and after Resident #8 sustained a clavicle fracture, nasal bone fracture, a large skin tear to the right elbow and superficial abrasions to both knees. However, the facility failed to implement an effective plan to address accident hazards. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Facility policy and procedure The Accident and Supervision policy, revised April 2025 was provided by the interim nursing home administrator (INHA) on 4/7/25 at 3:03 p.m. via email. It revealed in pertinent part, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: identifying hazard(s) and risk(s); evaluating and analyzing hazard(s) and risk(s); implementing interventions to reduce hazard(s) and risk(s); and monitoring for effectiveness and modifying interventions when necessary. Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident. Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he/she had caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Identification of hazards and risks - the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. Implementation of interventions - using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes communicating the interventions to all relevant staff, assigning responsibility, providing training as needed, documenting interventions, ensuring that the interventions are put into action and ensuring interventions are based on the results of the evaluation. II. Resident #1 A. Resident status Resident #1, age 84, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included unspecified dementia, anorexia, major depressive disorder, chronic obstructive pulmonary disease (COPD), chronic kidney disease, repeated falls and muscle weakness. The 2/17/25 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory problems and was severely impaired in decision making skills, per staff assessment. The resident was dependent on staff for eating, oral hygiene, toileting, bathing, personal hygiene and upper and lower body dressing. B. Incident investigation The facility investigation was provided on 4/7/25 at 12:00 p.m. by the director of nursing (DON). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The investigation documented that on 2/27/25 at approximately 7:15 a.m. a CNA went to assist Resident #1 to get out of bed and into her wheelchair. The CNA said, along with another CNA, they transferred the resident with two people. The CNAs put their arms into a locked position on either side of Resident #1 and lifted her into her wheelchair. The two CNAs did not use a hoyer lift, per physician's orders or the resident's plan of care. After they transferred the resident, one of the CNAs noticed Resident #1's ankle appeared abnormal. The CNAs notified the registered nurse (RN). Upon the RNs assessment it was determined to send Resident #1 to the hospital. C. Record review The activities of daily living (ADL) care plan, revised 10/31/24, revealed Resident #1 had a self-care performance deficit related to Alzheimer's dementia, fatigue and impaired balance. Pertinent interventions included the resident was dependent on two or more staff for all transfers using a hoyer lift and the staff were to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. D. Record review The 2/27/25 hospital record documented Resident #1 sustained a closed fracture of the lower end of her left tibia (shin bone). The note documented the resident had severe dementia. A splint was applied to the resident's leg as it was determined the resident was on hospice services and was not a surgical candidate. E. Plan of Correction The facility's plan of correction was provided by the DON on 4/7/25 at 12:00 p.m. It read in pertinent part, On 2/27/25 Resident #1 was sent to the emergency room and was diagnosed with a fracture of her left ankle. The DON and the INHA initiated an investigation. The facility conducted a full house audit to determine which residents required extensive and total assistance. The resident's care plans were reviewed. The facility determined all residents that required extensive/total assistance were at risk. The facility provided education to the nursing staff that included utilizing the residents' care plan. The facility implemented a flow sheet that was driven by the residents' plan of care. The flow sheet indicated the residents' transfer statuses and other personalized safety interventions. The DON or designee conducted random audits following the injury. F. Staff interviews CNA #1 and licensed practical nurse (LPN) #1 were interviewed together on 4/7/25 at 12:30 p.m. They said after Resident #1 sustained a broken ankle, all of the nursing staff were trained to use the hoyer lift for Resident #1's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transfers at all times. The assistant director of nursing (ADON) was interviewed on 4/7/25 at 1:55 p.m. The ADON said after Resident #1 sustained an ankle fracture, several staff members were interviewed in regards to how they transferred Resident #1 from her bed to her wheelchair and from her wheelchair to her bed. The ADON said all of the staff that were interviewed revealed no one used a hoyer lift to transfer the resident. The ADON said the staff said they transferred the resident with a two person assist. The ADON said that meant two staff members conducted the transfer, where there was a staff member on either side of the resident. She said the two staff members locked arms with the resident and transferred Resident #1. The ADON said the staff had not read the care plan or the physician's order that indicated the resident was to be transferred by a hoyer lift. The DON was interviewed on 4/7/25 at 12:00 p.m. The DON said she interviewed all of the nursing staff that provided care to Resident #1 after the resident sustained an ankle fracture. The DON said none of the staff were aware that Resident #1's ankle was swollen prior to 2/27/25. The DON said all of the staff said they transferred the resident with a two person assist and did not utilize the hoyer lift. The DON said after interviewing the nursing staff, she determined the resident sustained an ankle fracture due to the staff not following the care plan, which indicated to use a hoyer lift to transfer Resident #1. The DON said the problem was the facility staff's fault due to miscommunication with staff not utilizing the hoyer lift. The DON said no other injuries had occurred in the facility since 2/27/25 due to improper transfers. III. Resident #8 A. Resident status Resident #8, age 90, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included anxiety disorder, adult failure to thrive, cerebral infarction (stroke), vascular dementia, muscle weakness and insomnia. The 2/5/25 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of four out of 15. The resident was dependent on staff for eating, oral hygiene, toileting, bathing, personal hygiene and upper and lower body dressing. The resident was always incontinent of bowel and bladder. B. Incident investigation The incident investigation was provided on 4/8/25 at 11:11 a.m. by the DON. The investigation documented that on 3/31/25 at approximately 3:05 a.m. Resident #8, who resided on the secured unit, was found on the ground next to her bed by a CNA. The bed was in the lowest position. The CNA notified the LPN and the RN. Upon assessment, the resident was lying on her right side with a hematoma to the right side of her head. There was also blood noted on the ground around the resident. Resident #8 was complaining of head pain. The staff did not move the resident and called 911. Resident #8 was transported to the hospital emergency department. C. Record review (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall care plan, revised 5/6/24, revealed Resident #8 was at risk for falls, had impaired balance and mobility and poor safety awareness due to cognitive decline. The care plan indicated the resident wished to sit on her fall mat and would crawl on the floor. Pertinent interventions included placing a fall mat on the floor next to the bed when the resident was in bed. The 11/24/24 fall risk assessment revealed the resident was at a high risk for falls. The resident was at high risk due to intermittent confusion and a prior history of falls. The assessment documented the resident was legally blind or the resident's sight ability was unable to be determined. The 3/21/25 hospital record documented Resident #8 sustained a right shoulder clavicle fracture, a fracture of the nasal bone, a large skin tear to the right elbow and superficial abrasions to both knees. D. Facility plan of correction The facility's plan of correction was provided by the DON on 4/9/25 at 11:11 a.m.via email. It read in pertinent part: The plan of correction documented Resident #8 fell and the fall mat was not in place. Resident #8 was transferred to the hospital on 3/21/25 and was diagnosed with a minimally displaced fracture of the left clavicle, minimally displaced right sided nasal bone fracture. The resident's plan of care was reviewed. A new task was entered into the resident's electronic medical record (EMR) that indicated staff was to complete safety checks every two hours. The facility conducted a full house audit and determined that all residents that utilized a fall mat, had fall interventions in place or used an air mattress, had the potential to be affected. The INHA was interviewed on 4/9/25 at 2:00 p.m. The INHA said the DON educated the two CNAs that did not put Resident #8's fall mat on the floor next to the bed when the fall occurred. The INHA said that all nursing staff would be trained about fall mats in an upcoming staff education meeting. E. Staff interviews LPN #2 and CNA #2 were interviewed together on 4/8/25 at 1:15 p.m. They said when Resident #8 fell , the fall mat was not next to her bed. They said when Resident #8 was in bed, the fall mat was to be placed on the floor next to the bed in case Resident #8 fell out of bed. CNA #4 was interviewed on 4/8/25 at 3:26 p.m. via the phone. CNA #4 said he did not put the fall mat on the ground prior to Resident #8 falling out of bed. CNA #4 said he and another CNA went into Resident #8's room because the air mattress was not working properly. CNA #4 said he crawled on the ground and saw some wires that were unplugged. CNA #4 said he plugged the wires back in and the air mattress began to immediately work correctly. CNA #4 said the CNA that was with him left Resident #8's room to go help another resident. CNA #4 said he placed Resident #8's bed in the low position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #4 said he had worked with Resident #8 prior to the fall, and he knew she needed her floor mat next to her bed. CNA #4 said he was distracted, because he heard another resident call for help and forgot to put the fall mat on the floor next to her bed. CNA #4 said shortly after he left Resident #8's room, he heard a noise from Resident #8's room. CNA #4 said when he went back into the resident's room and he saw Resident #8 was on the floor without the fall mat in place. CNA #4 said he noticed Resident #8 was hurt, so he then called for the nurse and Resident #8 was sent to the hospital. CNA #4 said he did not put the floor mat back next to the bed and that was the reason Resident #8 had been injured. IV. Resident #9 A. Resident status Resident #9, age 75, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included COPD, alcohol and cannabis abuse, obstructive sleep apnea, unspecified dementia, epilepsy (seizure disorder), other specified forms of tremors, dependence on supplemental oxygen and cognitive communication deficits. The 3/24/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS of eight out of 15. He required partial to moderate assistance with oral hygiene, toileting and upper and lower body dressing. The MDS assessment indicated it was very important for him to go outside when the weather was warm. The assessment documented the resident did not wander and did not have a wander guard. B. Record review The smoking care plan, initiated 3/21/25 and revised 3/31/25, revealed the resident required supervision with smoking. Interventions included ensuring Resident #9's cigarettes were stored in a locked smoking storage container and providing staff assistance to get Resident #9's cigarettes. The 3/26/25 social service assessment revealed, since the last evaluation, Resident #8's behavior symptoms had increased. The resident displayed wandering tendencies. The resident made statements about wanting to leave the facility grounds. He expressed frustrations, anxiety and challenges with adjusting to placement. Non-pharmacological interventions were attempted. The 3/31/25 interdisciplinary team (IDT) progress note revealed the IDT and Resident #9's representative made a decision to place Resident #9 on the secured unit from 3/29/25 to 3/30/25. The 3/30/25 social service progress note revealed Resident #9 expressed that he wanted to move off of the secured unit and return back to live in the original room he was admitted into. Resident #9 said he had no desire to leave the property. Resident #9 agreed to trial a wander guard alarm. Resident #9 was moved into the original room and a wander guard was placed on him. The 3/31/25 physician's assessment revealed the resident received a wander guard alarm that was placed on his right ankle due to poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 4/6/25 incident progress note, documented at 11:58 a.m., revealed the resident went outside to smoke unsupervised. Resident #9 was brought back into the facility by a nurse and other residents. Resident #9's face and hands were noted to be covered in blood. Resident #9 was sent to the hospital. The 4/6/25 nursing progress note revealed Resident #9 was transferred back to the facility from the hospital at 6:00 p.m. via a stretcher. Resident #9 had multiple bruises and swelling to the face and skull. Resident #9 had multiple bruises and a skin tear to the arms and legs. Resident #9 was placed on one-to-one monitoring. The 4/6/25 hospital record documented the resident sustained multiple closed fractures of the facial bones, a closed head injury, multiple abrasions and a closed fracture of one rib on the left side. C. Staff interviews The INHA was interviewed on 4/9/25 at 2:00 p.m. The INHA said an investigation was underway for the fall that Resident #9 sustained on 4/6/25. The INHA said on 4/6/25 at approximately 7:30 a.m. Resident #9 went to the front lobby unescorted by staff members. The INHA said while he was in the lobby a resident gave him a cigarette and the same resident turned off the front door alarm to help Resident #9 go outside to smoke.He said Resident #9 went out the front door without setting off any alarms. The INHA said while Resident #9 was outside, he fell and sustained injuries. The INHA said the alarm code was immediately changed. The INHA said an electrician would come to the facility as soon as possible to ensure the doors and alarms were working properly. He said it was not certain yet how a resident knew the door alarm code, but it was possible the resident overheard staff members discussing the code and the resident remembered it. The INHA said Resident #9 would be on one-to-one monitoring until further notice. The DON was interviewed on 4/9/25 at 2:35 p.m. The DON said on 4/9/25 the facility had three residents with wander alarms and all three alarms worked correctly.