STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center The	1440 Coffman St Longmont, CO 80501

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 - Minimal harm or potential for 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** 19262 Based on record review and interviews, the facility failed to provide adequate supervision and assistance to prevent falls, and failed to assess, implement and monitor interventions consistent with resident needs for two (#3 and #9) of three residents reviewed for falls out of seven sample residents. Specifically, the facility failed to have a registered nurse (RN), nurse practitioner or physician assess the residents after unwitnessed falls, prior to the removal of the residents from off the floor. Findings include: I. Facility policy The Falls and Fall Risk Managing policy, revised January 2024, was provided by the nursing home administrator (NHA) on 8/20/24 at 8:31 a.m. The policy revealed on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks/causes to try to prevent the resident from falling and to try to minimize complications from falling. According to the minimum data set, (MDS) a fall was defined as an unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force; such as a resident pushed by another resident. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, would be considered a fall. A fall without injury was still considered a fall. Unless there was evidence suggesting otherwise, when a resident was found on the floor, a fall was considered to have occurred. The staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identified several possible interventions, the staff might choose to prioritize interventions, such as trying one or a few at a time, rather than many at once. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Examples of initial approaches might include exercise and balance training, rearrangement of room furniture, improving footwear, and/or changing the lighting. If falling recurred despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remained relevant. If the underlying causes could not be readily identified or corrected, staff would try various interventions, based on an assessment of the nature or category of falling, until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable. The Fall policy, not dated, was provided by the NHA on 8/20/24 at 11:18 a.m. The policy revealed a post fall physical head to toe assessment should be conducted by a licensed nurse. If spinal cord injury was suspected, staff were to ensure the resident's neck/head were stabilized, the resident should remain as still as possible, and staff would call emergency services (911). A licensed nurse and the interdisciplinary team (IDT) would evaluate the chain of events or circumstances preceding the fall. This would include: the time of day of the fall; the time of the last meal; what the resident was doing; whether the resident was standing, walking, reaching, or transferring from one position to another; whether the resident was among other persons or alone; whether the resident was trying to get to the toilet; whether any environmental risk factors were involved (such as a slippery floor, poor lighting, furniture or objects in the way); whether there is a pattern of falls for this resident; recent changes to medication and last administration of medication (narcotic, cardiac, psychotropic); the resident's location; the type of footwear; and the location of any assistive devices and call lights. The nursing staff would initiate the neurological evaluation flowsheet if a fall was unwitnessed or if the resident hit their head, or had a change in their mental status. A licensed nurse must initiate the first set of neurological vital signs and evaluation. A licensed nurse must fill out the entire time span of monitoring on the neurological evaluation flowsheet. A licensed nurse must follow the frequency outlined at the top of the neurological evaluation flowsheet. All areas on the neurological evaluation flowsheet must be filled out and completed. Any abnormal vital signs or evaluation findings must be notified to the resident's physician. II. Resident #3 A. Resident status Resident #3, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physicians orders (CPO), diagnoses included history of falling, abnormalities of gait/mobility, anxiety, heart failure, restless legs syndrome and wedge compression fracture of thoracic seven and eight vertebra. The 6/18/24 minimum data set (MDS) assessment identified the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out 15. The resident had no impairments in either the upper or lower extremities. The resident was independent in her ability to roll to her left and right side. The resident required supervision or touch assistance in her ability to walk at least 150 feet in a corridor or similar space, after she had stood upright. B. Resident interview (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was interviewed on 8/20/24 at 10:10 a.m. Resident #3 said for two of her falls, the mattress on her bed slid as she turned over in bed. She said she was asleep and then she woke up on the floor with the mattress on top of her. She said for both of the falls out of bed, she had to go to the hospital. She said she had a lot of all over body pain from each of the falls. She said she hit her head both times and had some bleeding but did not break anything. She said she still had some pain in her back. She said she did have sufficient pain medications. C. Record review The care plan for a history of falls, medication use, new environment and unsteady balance/gait was initiated on 2/26/24. The interventions included to provide the resident with a clutter free environment that was free from spills, provide the resident with adequate lighting and place personal items within reach. Staff were to ensure the call light was within reach and encourage the resident to use the call light. Nursing staff were to provide the resident with assistive devices as needed and refer the resident for therapy services as needed (initiated on 2/26/24). Nursing staff were to remind the resident to use the call light for safety which (initiated on 2/26/24). Nursing staff verbally educated the resident on the use of the call light, to ask for assistance as needed, and to use the proper footwear (initiated on 3/4/24). Nursing staff were verbally educated to anticipate the resident's needs and the visual cues for the use of the call light (initiated on 3/4/24). Staff were to provide the resident with non-slip socks and place the resident's walker within reach (initiated on 3/16/24). The resident was verbally educated to wait to undress at the toilet and not prior to going to the toilet (initiated on 3/16/24). Nursing staff were to provide visual cues for the resident to call for help as needed and staff were to anticipate the resident's needs (initiated on 3/18/24). Physical therapy and occupational therapy was approved and a cognitive evaluation to be performed by therapy (initiated on 3/18/24). The maintenance staff were to check the bed/mattress for proper fit (initiated on 3/23/24). The resident was currently working with physical therapy and occupational therapy (initiated on 3/23/24). Therapy services were to evaluate if a lipped mattress was appropriate for the resident (initiated on 3/29/24). The fall risk tool, dated 3/3/24 at 1:43 p.m., revealed the resident had a score of seven, or a moderate risk for falling. D. Fall 3/16/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident report dated 3/16/24 at 8:45 p.m., revealed a certified nurse aide (CNA) reported to the nurse that during walking rounds the resident was found on the floor. Upon entering the room, the resident was found sitting upright and said she fell trying to get her shorts off to go to the bathroom. The resident was not wearing any footwear nor using her walker for assistance. The resident had been educated prior to the fall related to being a high fall risk and not wearing any kind of footwear. The resident said that she just forgot. A head to toe assessment was completed. The resident said she hit her head and there were no concerns observed during the assessment of her head. The resident's range of motion and vital signs were at her baseline (normal). There were no observed cognitive changes and the resident returned to bed with two staff members assistance. All appropriate parties were notified of the fall. The resident was provided with non-skid socks and her walker was placed within reach. Resident #3 was able to make all needs known and the call light was placed within reach. She reiterated she slipped trying to take her shorts off to go to the bathroom. The resident was oriented to person, place, time and situation. The interdisciplinary team (IDT) interventions were to provide the resident with non-slip socks and have her walker placed within reach. The resident was verbally instructed to wait to undress when at the toilet not prior to going to the toilet. -Resident #3's clinical record revealed the resident was not assessed by a registered nurse (RN), nurse practitioner (NP) or physician before the resident was assisted from off the floor, after the fall on 3/16/24. The pain assessment tool, dated 3/16/24 at 9:53 p.m., revealed the resident had a pain rating of 3 out of 10. The nurse note dated, 3/16/24 at 9:57 p.m. and written by a licensed practical nurse (LPN), revealed the resident was found sitting on the floor. Neurological assessments were initiated according to facility protocol. All appropriate parties were notified. E. Fall 3/18/24 The incident report, dated 3/18/24 at 6:30 a.m., revealed a CNA informed the nurse that the resident was lying on the floor outside of her room, near her door. The resident's feet were towards the door and her head was facing near the Sunlight hallway. The resident was lying on her back. The resident's mattress was off the frame of the bed. The resident sustained bruising to the left knee and bruising to the right shoulder/arm. The resident had a laceration to the right side of her head with obvious bleeding. The resident said she fell to the floor while getting out of bed to use the restroom. She said the mattress landed on top of her body and she crawled to the hallway to scream for help. A full set of vital signs were taken and the staff assisted the resident back to bed. The resident and staff were verbally educated on the importance of call light use. The staff were also verbally educated on the importance of assisting the resident to and from her bathroom. Nursing staff called emergency services and the resident was sent to the emergency department (ED) for an evaluation. All contacts were notified. The resident was oriented to person, place, time and situation. The IDT interventions were to provide visual cues for the resident to call for help when needed, staff to anticipate the resident's needs, physical/occupational therapies had been approved, and a cognitive evaluation would be completed by therapy. -Resident #3's clinical record revealed the resident was not assessed by a RN, NP or a physician before the resident was assisted from off the floor, after the fall on 3/18/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pain assessment tool dated 3/18/24 at 6:30 a.m., revealed the resident had a pain rating of 2 out of 10. The hospital documentation revealed the resident arrived at the emergency department (ED) on 3/18/24 at 7:01 a.m. The resident presented with a primary complaint of a fall. The resident was in her bed, fell off the side of the bed and the mattress fell on top of the resident. The resident said she felt the mattress was unstable and when she laid too far to the side, the mattress started to slide off the bed. The resident hit the back of her head either on furniture or on the floor. The resident denied any loss of consciousness and reported pain to the right posterior head and neck. The resident also had right shoulder pain. The computed tomography (CT) images of the head and cervical spine did not reveal any acute injuries. A right shoulder x-ray was obtained and no obvious fractures or any dislocation was observed. The nurse note, dated 3/18/24 at 10:03 a.m. and written by a LPN, revealed the resident was on follow-up for a fall with no injuries. The resident was observed on the floor in the morning and was sent to the ED for evaluation. The resident had a gash to the right side of her head with a bruise to her left knee. The nurse note, dated 3/18/24 at 11:00 a.m. and written by a LPN, revealed the resident had returned to the facility from the ED. All performed tests ruled out any abnormalities. The CT was negative. The resident received pain medication as requested for a headache with effectiveness. The resident was educated on the importance of using the call light and staff would continue to monitor. The fall risk tool, dated 3/18/24 at 11:04 a.m., revealed a score of 11, or a moderate risk for falling. F. Fall 3/23/24 The hospital ED progress note, dated 3/23/24 at 1:22 p.m., revealed the resident had fallen out of bed. The resident was reported to have been sitting on the edge of her bed while placing her socks on her feet. She slid off the bed onto her right buttock and she denied any head trauma. The resident said she was unable to stand unassisted and a large amount of bruising was observed to the right buttock. Pelvic and right hip x-rays did not reveal any acute bony abnormalities or other acute pathologies. The incident report, dated 3/23/24 at 2:29 p.m., revealed the nurse was called to the resident's room by a CNA, related to the resident lying on the floor. Upon entrance to the room, the resident was lying on her back by the side of the bed. The resident was assessed and it was determined the resident should be sent to the ED for evaluation. Management, the physician and the family were notified. The resident said she was trying to put her socks on and fell out of bed. The resident had an injury to her right buttock. The resident was helped by paramedics and staff to be placed on the stretcher and taken to the hospital ED. The IDT interventions were for maintenance to check the resident's bed/mattress for a proper fit. The resident was currently working with physical and occupational therapies. The pain assessment tool, dated 3/23/24 at 2:29 p.m., revealed a score of 3 out of 10. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse note, dated 3/23/24 at 2:43 p.m. and written by a LPN, revealed the resident was found on the floor by the side of the bed. The resident was lying flat on her back and her bottom, when the nurse arrived. The resident was assessed by two nurses, her hips looked dislocated and she was in pain. Emergency services were called. When the paramedics arrived, the resident received an injection of pain medication. The resident was taken to the hospital. Management, the physician and the family were notified. The ED was called and a report was provided. The fall risk tool dated, 3/23/24 at 2:49 p.m., revealed a score of nine, or a moderate risk for falling. -Resident #3's clinical record revealed the resident was not assessed by a RN, NP or physician before the resident was assisted from off the floor, for the fall on 3/23/24. III. Resident #9 A. Resident status Resident #9, age 82,was admitted on [DATE]. According to the August 2024 CPO, diagnoses included stage 3 chronic kidney disease, anxiety, asthma, chronic diastolic congestive heart failure and chronic obstructive pulmonary disease. The 6/8/24 MDS assessment identified the resident had moderate cognitive impairment with a BIMS score of 10 out 15. The resident had no impairments in her upper or lower extremities. B. Resident interview Resident #9 was interviewed on 8/20/24 at 12:11 p.m. She said the fall on 5/1/24 was her fault because the facility wanted her to stay in her bed and she did not. She said her right knee and foot were the cause of her fall. She said she did hit her head and her back still hurt at times. C. Record review The care plan for being at risk for falls related to medication use, a new environment, weakness, unsteady balance/gait and the use of a Hoyer lift was initiated on 12/15/23. The interventions included to keep her environment free from clutter, free from spills, provide adequate lighting and to ensure her personal items were within reach. Staff were to encourage the resident to keep her bed in the lowest position. The facility would request hospice to provide a bolster sheet to be applied to her air mattress. Staff were to ensure the call light was within reach and encourage the resident to use the call light. Staff were to ensure the resident used the appropriate footwear when ambulating. Staff were to review the documentation on past falls and attempt to determine the cause of the falls. Staff would apply the bolster sheet and ensure it fit the bed properly related to the resident leaning to the right (initiated on 5/1/24). Staff would modify the resident furniture placement to ensure snacks were within reach (initiated on 5/1/24). Staff were to offer the resident snacks when in the room (initiated on 5/1/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall risk tool, dated 1/25/24 at 2:28 p.m., revealed a score of 11, or a moderate risk for falling. D. Fall 5/1/24 The incident report, dated 5/1/24 at 5:30 a.m., revealed the writer heard a shout for help. The resident had slid out of bed onto the floor. The resident was still upright when found. The resident received a scrape to the right side of her head that was approximately three inches in length. The resident was unaware of the injury and did not know how it had occurred. The resident said she was reaching for a snack that was out of reach. The resident was assessed head to toe and no other injuries were observed from the fall. The resident's range of motion was within normal limits. The resident was returned to bed with three staff assistance and the use of a gait belt. The resident denied any pain (0 out of 10) related to the fall. All parties were notified. The resident was resting quietly in her bed with her eyes closed and no physical indications of pain or acute distress were observed. The resident's bed was placed in the lowest position. The resident was oriented to person and place. The resident's room had been previously rearranged by her granddaughter's preference for more room between the dresser and the bed. The IDT interventions were to ensure a bolster sheet was properly fitted to the bed related to the resident had a tendency to lean to the right. The resident's furniture was modified to ensure snacks were within reach. Staff were to offer snacks when they were in the room. A nurse note, dated 5/1/24 at 5:30 a.m. and written by a LPN, revealed the resident had an unwitnessed fall from the bed that resulted in a small laceration to the right scalp area. All appropriate parties were notified. The fall risk tool, dated 5/1/24 at 11:15 a.m., revealed a score of 16, or a high risk for falling. IV. Staff interviews LPN #2 was interviewed on 8/20/24 at 1:06 p.m. LPN #2 said a RN, NP or a physician should complete an assessment of the resident, prior to moving the resident from off the floor. She said during this assessment, they would be looking for fractures, head injuries, bleeding, abnormalities in range of motion and the resident's consciousness. She said when a resident fell , during the next day's morning meeting, the fall would be discussed. She said Resident #3's mattress had slid off the frame and dycem (a non-slip material used to help stabilize objects, hold objects firmly in place, or to provide a better grip) was placed on the bed. She said the resident removed the dycem and threw it in the trash can. She said clips were placed on the bed to keep it from moving. LPN #3 was interviewed on 8/20/24 at 1:30 p.m. LPN #3 said a resident should be assessed by a RN, NP or a physician before they were moved off the floor. She said an RN would do an assessment because the LPN could not do the assessment prior to moving the resident off the floor. She said staff would be assessing the resident for any head injuries, bleeding, fractures, skin tears, bruises, lacerations, cognitive deficit, range of motion concerns and pupil size. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 8/20/24 at 1:50 p.m. LPN #1 said a RN, NP or a physician should assess a resident after an unwitnessed fall, prior to moving them from off the floor. She said during the assessment, they would be looking for any signs of a concussion, fractures, bleeding, range of motion problems, if the resident was alert/oriented and any possible head injuries. She said they were also looking for any changes in the resident's baseline (normality). The NHA and the director of nursing (DON) were interviewed on 8/20/24 at 3:20 p.m. The NHA said, for Resident #9, there were no RN, NP or physician assessments for the resident, prior to moving the resident from off the floor, for the unwitnessed fall in her room on 5/1/24. The DON said that a RN, NP or physician should perform an assessment for all unwitnessed falls, prior to moving the resident from off the floor. She said a fall was a resident unintentionally moving from one plane (position in space relative to the ground) to another plane. The DON said the assessment should include range of motion, skin assessment, vital signs and neurological assessments. She said the outcomes from a lack of an assessment could be any type of injury to the resident, fractures, orthostatic hypertension, low blood pressure, bleeding, skin tears, cognitive changes, altered mental status and aberrant range of motion. The NHA and the DON were interviewed together a second time on 8/20/24 at 4:20 p.m. The NHA said Resident #3 reported the two falls from the bed were due to the mattress issues. The resident's bed was locked and in the lowest position at the time of the two falls. The NHA said after the two falls from the bed, a new mattress was placed on her bed and anchor clips were placed on the bed to prevent it from sliding. The NHA said after the second fall from the bed, a dycem mat was placed under the mattress. He said the resident removed the dycem and placed it in the trash can. The NHA and the DON both said there were no RN, NP or physician assessments for Resident #3, prior to moving the resident from off the floor, for the unwitnessed falls on 3/16/24, 3/18/24 and 3/23/24.