

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Hallmark Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3701 W Radcliff Ave Denver, CO 80236	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032</b></p> <p>Based on record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accident hazards out of three sample residents remained free from accident hazards.</p> <p>On 2/27/24, just before 2:00 p.m. certified nurse aide (CNA) #1 was providing care to Resident #1. The resident was rolled on her side during the care and the resident slid off the side of the bed, fell to the floor and sustained a left hip fracture. The resident was sent to the hospital for treatment and underwent surgical repair of the left hip fracture.</p> <p>Through a facility investigation, it was found that CNA #1 had not followed the resident individualized care plan accurately when she made the decision to provide care without a care partner to ensure proper technique for safety and appropriate bed mobility.</p> <p>The facility failed to ensure that Resident #1 received appropriate care per her comprehensive care plan for two staff members to assist with bed mobility and incontinent care which resulted in the resident falling out of bed and sustaining a hip fracture that required surgical intervention.</p> <p>Findings include:</p> <p>Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 11/14/24, resulting in the deficiency being cited as past noncompliance with a correction date of 2/28/24.</p> <p>I. Incident on 2/27/24</p> <p>CNA #1's failure to follow the resident's care plan to provide bed mobility with the assistance of two staff members led to the resident falling out of a high bed and sustaining a major injury (hip fracture).</p> <p>II. Facility plan of correction</p> <p>Interviews and record review during the onsite investigation on 11/14/24 revealed the facility investigated this singular event and implemented corrective actions to prevent the recurrence of the incident.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A. Immediate action to correct the deficient practice for Resident #1</p> <p>CNA #1 was suspended during the investigation and, upon her return on 3/1/24, CNA #1 was provided coaching and education on the facility's policy that the resident's care plan must be followed at all times. CNA #1 was educated on where to locate a resident's care plan, the care plan interventions and on the expectation to check each resident's care plan daily and before the start of care. Additionally, CNA #1 was educated that, per facility policy, the resident's care plan was to be followed as written and that any concerns about care were to be brought to the attention of the nurse on duty.</p> <p>Resident #1's care plan was revised with appropriate interventions for all care areas.</p> <p>All facility nurses and CNAs were educated on the facility's policy for following each resident's care plan, where to find the care plan and expectations for reporting concerns about care plan interventions. The education was completed on 2/27/24 and 2/28/24.</p> <p>B. Identification of other residents</p> <p>All residents (90) were assessed for ADL level of assistance and care needs and the information was compared to the existing care plan. All discrepancies and conflicting documentation were clarified or corrected to reflect each resident's assessed care assistance needs. This was completed on 2/28/24.</p> <p>C. Systematic changes</p> <p>The facility's quality assurance performance improvement committee developed a plan of improvement on 2/28/24. The plan included:</p> <p>A root cause analysis of the incident was conducted and it was determined that CNA #1 was not following facility policy for reviewing and following Resident #1's comprehensive care plan, which led directly to the resident falling off the bed while in the care of a facility staff member causing the resident a significant injury (see above).</p> <p>Staff education was completed with all nurses and CNAs on 2/28/24 and completed with new staff and staff upon their assigned work shift by 2/28/24.</p> <p>Following the provision of staff education, each staff member was required to show a return demonstration that they understood and were capable of accessing resident care plans. This was completed with every staff member by 4/30/24.</p> <p>Observations and interviews during the survey revealed staff were consistently following the care plan interventions of the residents included in the survey process on 11/14/24.</p> <p>An interview with the director of nursing (DON) confirmed the corrective actions, and therefore the facility's substantial compliance, by 2/28/24, at the time of the survey was conducted on 11/14/24.</p> <p>D. Monitoring</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DON/designee was tasked with ensuring each resident was assessed for appropriate care needs upon admission, quarterly, and with each change in condition and that the resident's care plan was updated accordingly. Needs for care plan revision out of sequence (when a change of condition occurred) were to be brought to the attention of the DON and other members of leadership and discussed with the interdisciplinary team ( IDT) and then documented in the resident's record.</p> <p>II. Facility policy and procedure</p> <p>The Fall Management policy and procedure, revised on 4/7/24, was provided by the DON on 11/14/24 at 3:01 p.m. It read in pertinent part, The facility will assess the resident upon admission/readmission, quarterly, with change of condition and will identify appropriate interventions to minimize the risk of injury-related falls.</p> <p>The resident environment remains as free of accident hazards as is possible. Each resident shall receive adequate supervision and assistance to prevent accidents.</p> <p>III. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was admitted on [DATE] and was discharged to the hospital on 11/1/24. According to the November 2024 computerized physician orders (CPO), diagnoses included a fracture to the left femur (hip), a history of stroke, muscle weakness and Alzheimer's disease.</p> <p>The 9/16/24 minimum data set (MDS) assessment revealed Resident #1 had short-term and long-term memory impairment, severely impaired daily decision-making skills and continuous symptoms of inattention, per staff assessment. The resident had difficulty focusing attention on tasks, was easily distractible and had difficulty keeping track of what she was told.</p> <p>The resident was dependent on two staff members to complete activities of daily living (ADL), including performing toileting hygiene, shower/bathing, and personal hygiene transferring and repositioning in bed.</p> <p>B. Record review</p> <p>Resident #1's comprehensive care plan documented the resident had an ADL performance deficit due to Alzheimer's disease, dementia, hemiplegia/hemiparesis (weakness) to the right side and a history of stroke. Interventions included providing assistance of two staff members to turn and reposition the resident (initiated 12/11/2020) and providing assistance of two staff members for incontinence care (initiated 12/11/2020).</p> <p>A progress note, dated 2/27/24 at 2:00 p.m., documented the nurse heard a loud noise and screaming for help from a CNA and Resident #1's roommate. The nurse went to the room to check on the resident. Resident #1 was found lying on the floor. CNA #1 said she was changing Resident #1 and she fell out of bed. CNA #1 said the resident landed on her right side.</p> <p>(continued on next page)</p>		

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