STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065243	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Junction Creek Health and Rehabilitation Center	2911 Junction St Durango, CO 81301

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 - Some	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** 50314 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accident hazards for four (#7, #27, #11 and #22) of five residents out of 45 sample residents. Specifically, the facility failed to: -Ensure neurological checks were completed appropriately for Resident #7 following an unwitnessed fall; -Ensure Resident #7's fall care plan was reviewed and new interventions were added following an unwitnessed fall; -Ensure Resident #27 was appropriately assessed for self-administration of a wart removal medication and eye drops; -Ensure a safety assessments was completed for Resident #27 to determine if she was safe to use a hot tea kettle with a heating element in her room; -Ensure a safety assessment was completed for Resident #11 to determine if he was safe to use a space heater in his room; and, -Ensure a safety assessment was completed for Resident #22 to determine if he was safe to use a coffee maker with a heating element in his room. Findings include: I. Resident #7 A. Facility policy The Fall Management policy was provided by the nursing home administrator (NHA) on 6/26/24 at 11:40 a. m. It documented in pertinent part, (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 - Some	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. Research has shown that a structured fall reduction program can substantially reduce the rate of falls and related injuries in nursing facilities. Identifying risk factors, followed by timely and appropriate interventions, is the key to a successful program. Each resident will be re-evaluated quarterly, annually and when a significant change occurs. Assess the environment and make appropriate changes, for example, bed in lowest position, placement of furniture, lighting, personal items within reach, non-slip footwear, night light, walker, wheelchair within reach if applicable. The call light and fluids should be within reach of the resident. If a resident experiences a fall with head injury, the fall is unwitnessed, or the resident self-reports a fall, neurological checks will be initiated. B. Resident status Resident #7, under the age of 65, was admitted on [DATE]. According to the June 2024 computerized physician order (CPO), diagnoses included unspecified diabetes, unspecified disorder of psychological development and muscle wasting with atrophy (gradual decline in function due to underuse or neglect). According to the 6/12/24 minimum data set (MDS) assessment, Resident #7 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required moderate assistance with bathing, supervision assistance with dressing, set-up assistance with personal hygiene, and was independent with all other cares. C. Observations On 6/24/24 at 10:52 a.m., Resident #7's room was observed. The bathroom call light cord was tightly wrapped around a bathroom grab bar next to the call light. The black connector attaching the call light cord to the wall appeared crooked and scratched. The call light cord did not function correctly (see interview below). D. Resident interview Resident #7 was interviewed on 6/24/24 at 10:52 a.m. Resident #7 said she had fallen in her bathroom earlier this month (June 2024), and could not call for help. Resident #7 said her call light cord did not work correctly. Resident #7 said she could activate her call light by taking her shoe off and hitting the black connector where the call light cord was affixed to the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 said she could not pull on her bathroom call light cord because it did not work that way. Resident #7 said her call light cord had been wrapped around the grab bar in the bathroom for more than a year. Resident #7 said after her fall she was told to call for help when she needed, but taking her shoe off to hit the call light also made her feel like she might fall in her attempt to call for help. E. Record review A progress notes dated 6/14/24 at 11:15 a.m. documented Resident #7 had an unwitnessed fall at 11:15 a.m. The progress note documented neurological assessments and vital signs were obtained beginning at 11:15 a.m. The progress note documented the resident's call light was activated when nursing staff entered the room. A progress notes dated 6/14/24 at 11:26 a.m. documented Resident #7 underestimated the distance to her chair and sat back on the floor, missing the chair while self-transferring off the toilet. The progress note documented the resident did not call for staff assistance. -However, the 11:15 a.m. progress note documented the resident's call light was activated when nursing staff entered the room (see progress note above). Resident #7's neurological record documentation, dated 6/14/24, was reviewed in the electronic medical record (EMR). The neurological record documented a full set of neurological assessments required a 72-hour period of time to complete appropriately. The neurological record documented the facility protocol was to document neurological checks every 30 minutes for four assessments, then every one hour for four assessments, then every four hours for six assessments and then every eight hours for the remainder of the 72-hour post-fall period. Resident #7's neurological record documented the resident received a neurological assessment on 6/14/24 at 11:15 a.m., 11:45 a.m., 12:15 p.m., 12:45 p.m. and 1:45 p.m. -However, the neurological assessment documented that at the time for the hourly 2:45 p.m. and 3:45 p.m. neurological assessments, the resident was out of the facility on a pass with the activities department. An activity progress notes dated 6/14/24 documented the activity staff took Resident #7 out for a shopping outing between 2:00 p.m. and 4:30 p.m. -The facility failed to complete neurological checks in accordance with facility protocol. -The facility failed to document neurological checks on 6/17/24. An interdisciplinary team (IDT) post-fall review, dated 6/19/23, was reviewed in the EMR. The post fall-review documented Resident #7 could demonstrate use of her bathroom call light. The post-fall review recommended the resident use a reacher or call for assistance to get objects from the floor, to ensure the resident was aware of safe wheelchair positioning and to provide the resident with education not to have a pillow in her wheelchair. The post-fall review documented a recommendation to revise Resident #7's care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The post fall review failed to identify Resident #7's call light cord could not be appropriately used. Review of Resident #7's care plan, revised 8/22/23, identified the resident as being a high risk for falls. Interventions included ensuring the resident's call light was within reach, encouraging the resident to use a reacher to pick up objects from the floor, ensuring Resident #7 was wearing appropriate footwear, providing education on appropriate wheelchair use, checking the resident's room for wet floors frequently and reviewing information on past falls to determine the root cause of the falls. -The facility failed to update Resident #7's care plan with new interventions following the resident's unwitnessed fall on 6/14/24. II. Staff interviews Registered nurse (RN) #1 was interviewed on 6/27/24 at 4:02 p.m. RN #1 said neurological assessments were a strict protocol and should be followed in accordance with the neurological record. RN #1 said she would never allow a resident who had experienced an unwitnessed fall to leave the facility until all 72-hours of post-fall neurological assessments had been completed. RN #1 said delayed brain bleeds or other important neurological changes could be missed if residents were not assessed appropriately after an unwitnessed fall. Licensed practical nurse (LPN) #1 was interviewed on 6/27/24 at 4:06 p.m. LPN #1 said residents with an unwitnessed fall should receive neurological assessments in accordance with the facility protocol printed on the neurological record. LPN #1 said if a resident was alert and oriented it would be acceptable to allow the resident to leave the facility on pass during the 72-hour post-fall assessment period because the resident could tell him whether or not they hit their head. The director of nursing (DON) was interviewed on 6/27/24 at 4:56 p.m. The DON said bathroom call light cords should not be wrapped up in a grab bar but should instead be readily available for a resident to use. The DON said neurological assessments should be completed in accordance with the facility protocol printed on the neurological record. The DON said nursing staff should not allow a resident who was within the 72-hour time frame following an unwitnessed fall to leave the facility without receiving their neurological assessments. The DON said it was important for nursing staff to assess residents who had an unwitnessed fall because staff did not know exactly what happened during the unwitnessed fall and the facility should remain cautious to ensure residents were kept safe. The DON said if nursing staff did not complete neurological assessments they could miss important neurological changes in the resident. 38185 III. Resident #27 A. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #27, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included nonrheumatic aortic valve disorders (inflammation of the heart's chambers and valves). The 4/16/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with activities of daily living (ADL). B. Resident observation and interview On 6/24/24 at 9:37 a.m. Resident #27's had a jar of Freeze Wart Removal sitting on the bedside table in her room. Resident #27 said she had a wart on her finger that bothered her. Resident #27's middle finger on her left hand was observed to have a wart-like lesion on the digit close to the fingernail. Resident #27 said she had tried to peel off the wart and it bled and bled and bled, so she started putting wart remover on it. During the interview, a box of Refresh Eye Drops and a hot water tea kettle with a heat source were observed on Resident #27's night stand. C. Record review The visual function care plan, initiated on 5/3/23 and revised on 8/14/23, documented Resident #27 had impaired visual function and required glasses. The interventions included providing the resident with glasses as required, ensuring the appropriate visual aids were available to support the resident's participation in activities and reminding the resident to wear her glasses. -A review of Resident #27's electronic medical record (EMR) did not reveal a physician's order for Refresh eye drops or wart remover. -Resident #27's EMR did not document an assessment to determine if the resident was able to self-administer eye drops or wart removal. Additionally, there was no assessment to determine the resident's safety level for the hot tea kettle kept in the resident's room. IV. Resident #11 A. Resident status Resident #11, age 74, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included a transverse fracture of the right humerus shaft (fracture of the upper arm). The 6/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required partial assistance with ADLs. B. Resident observation and interview (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/24/24 at 2:12 p.m. a space heater was observed in Resident #11's room. The space heater was turned on and operational. Resident #11 said he was often cold in his room. He said a family member brought him a space heater for his room. He said he used it almost every day. C. Record review -A review of Resident #11's EMR did not reveal documentation that an assessment had been completed to determine the resident's safety level to operate a space heater independently. V. Resident #22 A. Resident status Resident #22, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, the diagnoses included dementia, heart failure and hypertension (high blood pressure). The 5/3/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He was independent with ADLs. B. Resident observation and interview On 6/24/24 at 9:51 a.m. a coffee maker with a heating element was observed in Resident #22's room. Resident #22 said he used it almost every day to make himself coffee. C. Record review Resident #22's behavioral care plan, initiated 2/23/23 and revised 5/20/24, documented the resident had a behavioral problem related to a decline in health and a diagnosis of dementia. It documented that the resident had morning irritation, irritation when he needed to smoke or when having a bad day, verbal outbursts, making inappropriate vulgar statements, striking out at staff or making verbal threats. The interventions included providing the resident an opportunity for positive interactions and attention, explaining all procedures to the resident before starting and allowing the resident time to adjust to the changes, explaining why the resident's behavior is inappropriate, intervening as necessary to protect the rights and safety of others and providing a program of activities of interest. -A review of Resident #22's EMR did not reveal documentation that an assessment had been completed to determine the resident's safety level to operate a coffee pot alone and without supervision. VI. Staff interviews LPN #3 was interviewed on 6/27/24 at 2:50 p.m. LPN #3 said medications should not be left at the residents' bedside unless the resident had been assessed to be competent with administering their own medications. He said any medications in the residents' room should be kept in a secure location. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #3 said each resident should be assessed for self-administration of any medication, even over the counter medications. He said the self-administration assessment should be kept in the resident's EMR. LPN #3 said he was not aware Resident #27 had medications at the bedside. He said Resident #27's EMR did not have a physician's order for the resident to self-administer medications or a self-administration assessment completed. LPN #3 said a safety assessment should be completed for Resident #27's use of the tea kettle in her room. He said he was unable to locate a safety assessment for Resident #27. RN #2 was interviewed on 6/27/24 at 3:05 p.m. RN #2 said a safety assessment should be completed for Resident #22's use of the coffee pot in his room. She said she did not know anything about safety assessments or where to locate them. RN #2 said the facility's management team should know where the safety assessments were and she was not part of conducting any safety assessments. LPN #1 was interviewed on 6/27/24 at 3:15 p.m. LPN #1 said he was aware Resident #11 had a space heater in his room. He said he had seen the resident use it. LPN #1 said a safety assessment should have been completed for the resident's use of the space heater. He said he would not know where to find a safety assessment or who was responsible for completing the assessment. The DON was interviewed on 6/27/24 at 3:58 p.m. The DON said medications should not be left at the residents' bedside. She said for any resident to self-administer medications, an assessment should be completed along with obtaining a physician's order for self administration of medications. The DON said a safety assessment should be completed for any resident who wished to have a device with a heating element in their room. She said the nurse was responsible for completing the assessments. The DON said a safety assessment was not completed for Resident #27, Resident #22 or Resident #11 and a self-administration assessment was not completed for Resident #27.