STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065256	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highline Post Acute	6060 E Iliff Ave Denver, CO 80222

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** 43950 Based on observations, record review and interviews, the facility failed to ensure one (#10) of three residents reviewed for falls out of 10 sample residents received adequate supervision and services to prevent an accident. Specifically, the facility failed to: -Ensure a root cause was identified for Resident #10's fall on 3/16/25; and, -Ensure Resident #10's care plan was reviewed for appropriate fall interventions after a fall. Findings include: I. Facility policy and procedure The Safety and Supervision of Residents policy and procedure, reviewed 4/4/25, was provided by the nursing home administrator (NHA) on 4/8/25 at 12:02 p.m. It read in pertinent part, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary care team (IDT) shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include the following: communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training, as necessary, ensuring that interventions are implemented and documenting interventions. Monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed and evaluating the effectiveness of new or revised interventions. (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	II. Resident #10 A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (DM), dementia, chronic obstructive pulmonary disease (COPD), unsteadiness on feet and chronic kidney disease. The 3/10/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. He required substantial/maximal assistance with showers/bathing. He required partial/moderate assistance with toileting hygiene, upper and lower body dressing, personal hygiene, putting on/off footwear, and walking 50 feet with two turns. He required supervision/touching assistance with bed mobility, toileting and sit to stand transfers, shower transfers and walking 10 feet. The resident used a manual wheelchair. The assessment revealed he exhibited no behavioral symptoms or rejection of care. B. Record review Review of Resident #10's fall care plan, revised 6/6/18, revealed the resident was at risk for falls related to COPD, dementia, DM type 2, chronic kidney disease, hyperlipidemia, nicotine dependence, GERD (gastroesophageal reflux disease), neuropathy, HTN (hypertension), depression, BPH (benign prostatic hyperplasia) and history of falls. Interventions included encouraging the resident to wear shorts/pants with appropriate length, ensuring the resident's call light was within reach and encouraging the resident to use it for assistance as needed, providing a prompt response to all requests for assistance, educating and encouraging the resident to call for assistance with picking up items from the floor, educating the resident/family/caregivers about safety reminders and what to do if a fall occurred, encouraging the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensuring the resident was wearing non-skid shoes, rearranging the resident's room as needed and ensuring the bedside phone was within reach, therapy screening for restorative nursing program and therapy to evaluate and treat as indicated. -Review of the fall interventions revealed there had been no revisions to the care plan since 6/1/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's secondary fall care plan, revised 7/25/24, revealed the resident had an unwitnessed fall and was at risk for recurring falls and unsteady gait related to cognitive impairment. Interventions, initiated 7/25/24, included medication regimen review as indicated, monitoring for complications related to the fall (change in neurological status, evidence of injury, loss of range of motion, pain) and notifying the physician promptly if observed, occupational therapy (OT) to screen for wheelchair management and smoking safety, keeping personal/frequently used items within reach, anticipating and meeting the resident's needs, educating/reminding the resident to call for assistance, encouraging activity as tolerated with rest periods between activities as needed, evaluation of medications for side effects that may increase fall risk, explaining all procedures and providing reassurance during mobility tasks to alleviate the fear of falling, keeping bed in low position with brakes locked, keeping the resident's call light within reach and initiating a restorative nursing program (initiated 9/19/23). -Review of the interventions revealed there had been no updates to the fall care plan since 7/25/24. -There was no documentation to indicate Resident #10's care plan was reviewed for the effectiveness of his fall interventions after his fall on 3/16/25. The 3/16/25 at 4:40 p.m. nurse's note revealed the certified nurse aide (CNA) called the nurse and said Resident #10 was on the ground in the main courtyard. The nurse went to the area and found the resident sitting down next to his wheelchair. Upon assessment, no apparent injuries were noted. The resident denied hitting his head, his pupils were equal, round, reactive to light and accommodation and his range of motion and vital signs were within normal limits. The resident was transferred to his wheelchair, with a maximum of two people safely. Neurological checks were initiated by the floor nurse. -The progress note did not identify a root cause for the resident's fall. The 3/17/25 at 11:32 a.m. physician's note revealed the reason for the physician's visit was follow up to a fall. Resident #10 was seen in his room, lying in bed comfortably and in no acute distress. The resident had a recent fall with no injuries. The physical examination did not show any trauma or bumps. Vital signs were stable. Resident #10 had a fall on 3/16/25 where he was found sitting next to his wheelchair in the courtyard. The note indicated staff were to continue follow-up with fall and neuroprotocol per facility. The 3/17/25 at 1:50 a.m. weekly nurse summary note revealed there had been no resident fall incident that week. -However there had been a fall the day before, on 3/16/25. -Review of the resident's progress notes revealed there was no further documentation of Resident #10's fall incident. -Review of Resident #10's EMR revealed there was no documentation to indicate a root cause for the resident's fall had been identified by the nurse on duty at the time of the fall or by the IDT. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Additionally, there was no documentation to indicate Resident #10's fall interventions had been reviewed for effectiveness or to determine if new fall interventions were needed. III. Staff interviews The director of nursing (DON) and the regional clinical resource (RCR) were interviewed together on 4/7/25 at 12:46 p.m. The DON said the facility's process after a fall depended upon if it was witnessed or not, but the nurse would be called and a RN would do an assessment before the resident would get up. The DON said if a resident hit their head or if it was unwitnessed, the nurses would do neurological assessments and notify physicians and residents' representatives. The DON said the facility would do an IDT meeting after the fall on the following business day to prevent a recurrence. The DON said IDT included herself, the director of rehabilitation (DOR), social services and the NHA. The DON said IDT would meet to discuss and determine the root cause of the fall. The DON and the RCR said they were not aware that Resident #10 had a fall on 3/16/25. They said they did not see an IDT note/assessment and said the fall had not been documented into their risk management system. The DON said the nurse on duty at the time of Resident #10's fall did not enter the fall into risk management and therefore the facility did not have an IDT meeting to determine the root cause because they were not aware of the fall. The DON said that Resident #10 had not been assessed for the root cause of his fall and the resident's care plan had not been reviewed to determine if new fall interventions were needed. The DON said the risk management entry was important so that it could trigger the next steps for fall review. The DON said it looked like it was an agency nurse that did not enter the information and she said she would call and educate the agency nurses and re-educate the staff nurses regarding the appropriate fall process. The DON said since Resident #10 had not had an IDT review of his 3/16/25 fall, she would talk with the resident, the physician and the nurse and find out the root cause of the fall and update the resident's care plan appropriately.