STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065259	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care Center	6005 S Holly St Littleton, CO 80121

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate an allegation for an injury or unknown origin for one (#1) of two residents out of 12 sample residents. Specifically, the facility failed to complete a thorough investigation to clarify conflicting facts after Resident #1 sustained an injury of unknown origin to her left lower leg (fractured tibia and fibula), which required hospitalization and surgical intervention. Findings include: I. Facility policy and procedure The Resident Mistreatment, Abuse and Neglect Prohibition policy, dated 2017, was provided by the director of nursing (DON) on 6/17/25 at 11:32 a.m. It read in pertinent part, All allegations of injuries of unknown origin are to be reported immediately and investigated by the administrator, risk manager or designee. Injury of unknown origin is an injury in which both of the following conditions are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury (its location is in an area that is not generally vulnerable to trauma) or the number of injuries observed at one particular point in time, or the incidence of injuries over time. Each facility will thoroughly investigate injuries of unknown origin in accordance with federal and state regulations. The electronic incident report and investigation system forms should be completed for all incidents of injuries of unknown origin. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 5/9/25. According to the May 2025 computerized physician orders (CPO), diagnoses included femur (upper leg) fracture, dementia and anxiety. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/8/25 minimum data sets (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. She required substantial assistance for lower body dressing and chair to bed transfers and was dependent for toileting and for transfers from sit to stand. B. Record review The hospital discharge summary documented Resident #1 was admitted to the hospital on [DATE] and discharged on 5/14/25. It documented Resident #1 was found in her wheelchair at the nursing facility complaining of lower left leg pain. The discharge summary further documented the resident was diagnosed with left leg tibia (front lower leg bone) and fibula (rear lower leg bone) fractures. The resident required surgical intervention to repair the fractures. III. Incident of injury of unknown origin on 5/8/25 The facility's investigation report, dated 5/14/25, revealed Resident #1 sustained an injury of unknown origin on the evening of 5/8/25 and there was no witness to what caused the resident's fractured lower left leg. The facility initiated an investigation on 5/9/25 after the sheriff's office arrived at the facility and informed the facility that they were investigating due to the injuries Resident #1 presented to the hospital with. The investigation documented the following series of events, which occurred from 5/8/25 to 5/9/25. The timeline of events (listed below) was generated by the facility based on staff interviews and video surveillance from the facility's hallway camera, which was positioned just outside Resident #1's room. The camera did not have a view inside of Resident #1's room. -Resident #1's room layout included a vestibule area just off the main hallway, adjoining two resident rooms and a separate bathroom with a shower. -On 6/18/25 and 6/19/25, during the survey, video footage was observed in the presence of the NHA and DON; however, the footage available did not have the time and date stamp available. The NHA provided clarification of the times during observation of the video. A. Timeline The facility established the following timeline of events based on the camera footage and staff interviews (see below). The facility's investigation timeline of the incident on 5/8/25, documenting the events occurring on the evening /night shift when Resident #1 was injured, was provided by the NHA on 6/16/25. The details of the timeline were reviewed at the same time that the video surveillance was viewed on both 6/18/25 and again on 6/19/25. The NHA clarified and explained the details of the timeline during review of the footage on 6/18/25 and 6/19/25. At 5:30 p.m. Resident #1 returned to her room from therapy to eat her dinner. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 6:00 p.m. the day shift nurse and certified nurse aide (CNA) told the facility investigator Resident #1 was observed sitting in her wheelchair eating dinner when they were leaving their shift. At 6:30 p.m. the evening/night shift nurse, licensed practical nurse (LPN) #4 said she performed first rounds and observed Resident #1 eating her meal. At 7:00 p.m. LPN #4 passed medications to the resident in the room adjacent/ adjoining to Resident #1's room and did not observe Resident #1 to be in any distress. At 7:08 p.m. CNA #7 was at the laundry cart outside of Resident #1 and Resident #12's rooms. At 7:11 p.m. CNA #7 entered the vestibule area to Resident #1's room; however, the camera was unable to see which resident's room she entered. At 7:12 p.m. CNA #7 was back in the hall at the laundry cart. At 7:14 p.m. CNA #7 went back into the vestibule. At 7:17 p.m. CNA #7 exited the resident vestibule and reentered at 7:19 p.m. From 7:20 p.m. to 7:23 p.m. LPN #4 was observed one room away at the medication cart. At 7:26 p.m. Resident #1's call light was on for nine minutes and 18 seconds. At 7:27 p.m. LPN #4 was outside Resident #1's room, checking on the resident and CNA #7. At 7:28 p.m. LPN #4 entered Resident #1's neighbor's room to pass medication and exited the room at 7:29 p.m. At 7:33 p.m. CNA #7 was observed exiting the vestibule of Resident #1's room and going back in at 7:34 p. m. then was observed looking out of the vestibule and going back into the vestibule. At 7:45 p.m. CNA #7 picked up meal trays from Resident #1's room and told Resident #1 she would assist her into bed once her food was digested. At 7:50 p.m. Resident #1's call light was on for three minutes and 28 seconds. At 7:50 p.m., CNA #7 was reported (by the NHA) to have observed Resident #1 sitting comfortably in her wheelchair and then proceeding on to assist Resident #12 from the adjacent adjoining room with a shower. At 7:59 p.m. CNA #7 exited the residents' doorway and entered the hall. At 8:00 p.m. CNA #7 went back into the vestibule of Resident #1 and Resident #12's rooms (no call light was observed turned on). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:02 p.m. CNA #7 said she heard Resident #1 yelling My foot! My foot! and she rushed out of the adjacent room to check on Resident #1. CNA #7 said she found Resident #1 in her wheelchair with a turned body trying to grab the bed frame to pull herself into the bed. CNA #7 said Resident #1 was twisted and yelling about her foot hurting. Resident #1's call light was activated at 8:03 p.m. CNA #7 said she called out for LPN #4 from Resident #1's doorway and LPN #4 ran to the room to assist. -However, during observations of the video during the survey, CNA #7 was observed on video entering the hallway from Resident #1's room and standing in the hallway for a few seconds and then walking down the hallway and returning to Resident #1's room, walking in the company of LPN #4. At 8:05 p.m. LPN #4 assessed Resident #1 and noticed swelling to Resident #1's left lower leg that was not present during her previous rounds (checking on the resident). LPN #4 was observed leaving Resident #1's room. LPN #4 said she left to call LPN #5 for assistance to assess Resident #1. At approximately 8:05 p.m. or 8:06 p.m. LPN #4 reentered Resident #1's room. At 8:10 p.m. LPN #4 exited Resident #1's room. At 8:14 p.m. LPN #5 entered Resident #1's room and recommended they have Resident #1's leg Xrayed. At 8:16 p.m. LPN #5 exited Resident #1's room. -It was not clear by staff interview and video surveillance during the survey what time and who assisted Resident #1 into bed because LPN #5 said in interview during the facility investigation (see below) that the resident was in bed when he arrived to the resident's room and the only other staff members in and out of the resident's room were CNA #7 and LPN #4, which contradicted CNA #7 and LPN #4's witness statements (see below). At 8:20 p.m. a nurse (not identified which nurse) called the on-call physician about Resident #1's change in condition. At 8:20 p.m. the unspecified nurse received orders for a STAT (urgent) Xray and 50 milligrams (mg) of Ultram (pain medication) for pain. At 8:25 p.m. LPN #5 provided Resident #1 with an ice pack and elevated her injured leg. At 9:15 p.m. Resident #1's pain was re-assessed by LPN #4, following the administration of the pain medication, and it was determined the medication was effective. At 9:45 p.m. the radiology technician arrived to take Xrays of Resident #1's leg. At 10:08 p.m. preliminary Xray results were received and facility staff called the on-call physician. The physician told staff to call the resident's guardian to see if they would like to send Resident #1 to the hospital for treatment, because the resident had previously signed an advanced directive for comfort care. At 10:28 p.m. the final results radiology results report confirmed Resident #1 had fractures in her left lower leg. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:25 p.m. the residents' guardian called back and said they wanted Resident #1 to be sent to the hospital, where her orthopedic physician would see her. At 10:35 p.m. LPN #4 called for non-emergent medical transport for Resident #1 to be taken to the hospital. At 12:30 a.m. the emergency medical services (EMS) transported Resident #1 to the hospital. B. Staff interviews conducted during the facility investigation of the 5/8/25 incident Staff interviews by the facility documented the following information: CNA #7 was interviewed on 5/9/25. CNA #7 said she arrived on shift at 6:00 p.m. and started rounds at 6:30 p.m. Resident #1 was eating dinner when she was checked on during rounds. Resident #1 did not need anything at the time, so she continued onward. CNA #7 said she checked on Resident #1 again at 7:30 p.m. Resident #1 was still eating and had no complaints. CNA #7 said she checked on Resident #1 at 8:05 p.m. and took her tray and told the resident she would come back in one hour after she had time to digest her meal. CNA #7 said she proceeded to assist Resident #12, the resident in the room adjacent/adjoining to Resident #1, to take a shower. The two resident rooms were connected by a vestibule connecting the two rooms and also a bathroom/shower room. -However, according to the timeline above and the NHA, CNA #7 checked on Resident #1 and proceeded to assist Resident #12 with a shower at 7:50 p.m., not 8:05 p.m. (see timeline above). CNA #7 said after approximately 15 minutes, she heard Resident #1 yelling my foot, my foot so she ran into Resident #1's room and found the resident holding the bed controller in her hand. CNA #7 said the resident was twisted to the left with her leg up under the wheelchair, reaching to the bed. CNA #7 said she yelled for LPN #4 to come and assess the resident. The nurse came with a second nurse. CNA #7 said they got two more CNAs to help transfer the resident back to bed. CNA #7 said the resident was transferred without putting pressure on her foot. Review of CNA #7's witness statement revealed a handwritten note that her witness statement was updated on 5/14/25 (six days after the incident occurred), upon reenactment of the incident. The addition to the statement, which was not signed by CNA #7, documented the position of Resident #1's leg and foot as being under the bed (instead of under the resident's wheelchair, as was originally documented by CNA #1 - see above). The updated statement indicated the resident's bed was in a low position at the same height as her wheelchair so that her lower leg (below the knee) aligned with the bed frame and it appeared Resident #1 lowered the bed on her leg. LPN #4 was interviewed on 5/9/25. LPN #4 said she took care of Resident #1 two times a week and the resident did not like to get into bed early. LPN #4 said she made rounds at 6:30 p.m. (on 5/8/25). She said at that time, Resident #1 was in her chair, eating dinner and watching television. Resident #1 was in no distress. LPN #4 said she next saw the resident around 7:30 p.m. when she administered medications to the resident in the adjacent room and Resident #1 was still in no distress. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #4 said around 8:45 p.m. CNA heard screaming from Resident #1's room. CNA #7 ran into her room and saw her attempting to get into bed. Resident #1 had the bed controller in her hand and was reaching for the bed. Resident #1's leg was caught up in the wheelchair, preventing her from falling on the floor. LPN #4 said she went down to assess the resident and saw a lump on her leg that was not there before. She said she got another nurse to look at the resident's leg and they decided to get her into bed to evaluate. LPN #4 said they got two more staff members and a gait belt to transfer Resident #1 without putting weight on her left leg. Once the resident was in bed, LPN #4 said she called the physician for Xrays, got the resident a pain pill and some ice and elevated her leg. LPN #4 said after the Xrays came back she called Resident #1's family, who said to send the resident to the hospital for assessment by her orthopedic physician. LPN #2 (on-call LPN) was interviewed on 5/9/25. LPN #2 said she had never received a report from staff that Resident #1 had tried to get in or out of bed on her own prior to this incident (on 5/8/25) but the resident used the call light a lot. LPN #2 said the resident sometimes used the call light every 10 to 15 minutes but her use of the call light was when she needed help. -LPN #2's interview did not document her knowledge of the events of 5/8/25 or her being on-call and responding to LPN #4's call to report Resident #1's injury. LPN #5 was interviewed on 5/14/25. LPN #5 said around 8:00 p.m. (on 5/8/25) that LPN #4 came to his unit to ask him for a second opinion about the injury to Resident #1's leg. He said he observed Resident #1's leg had a swollen bump on it and it hurt just when touched. He advised LPN #4 to get an Xray. He assisted LPN #4 to get the Xray while LPN #4 cared for Resident #1. C. Resident interviews conducted during the facility investigation of the 5/8/25 incident During the facility's investigation of the 5/8/25 incident involving Resident #1, several residents (including Resident #12, who was Resident #1's suitemate) were interviewed regarding their experience living in the facility. Questions asked of the residents were generic and closed-ended and some were not relevant to the investigation of the incident of Resident #1's serious injury of unknown origin. Questions asked included: -Do you feel safe here; -Do you have any care concerns; -Is your call light answered timely; -Do you get your meals and medications timely; -Are you happy here; -Do staff treat you with respect; and, -Do you get the care you asked for? (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility failed to ask the residents if they had any concerns with the care provided to them by CNA #7 and LPN #4. -Additionally, the facility failed to ask Resident #12, Resident #1's suitmate, who was cognitively intact, whether or not she witnessed or overheard any of the events involving Resident #1 on the evening of 5/8/25. D. Investigation conclusion The facility concluded that their investigation of the 5/8/25 incident of the injury unknown origin involving Resident #1 suggested that the resident attempted to self-transfer herself after learning how to use a slide board to transfer with therapy on that day (5/8/25), and had been previously working with slide board transfers with therapy since 4/16/25. The facility concluded the resident'sleg got caught up under her wheelchair and caused her injuries. -However, the facility's leadership said in interview during the survey (from 6/16/25 to 6/19/25) that based on additional review by leadership and a reenactment of the incident (conducted on 5/14/25, six days after the incident) with staff, they concluded that Resident #1'sinjuries were caused when the resident lowered the hospital bed down on her leg which resulted in the fractures to the fibula and tibia bones in her left leg. -Review of the facility's investigation failed to reveal how the facility came to their conclusion of the incident when the initial version of events reported by staff and observed during video surveillance review on 6/18/25 and 6/19/25 did not match the version of events reported and reenacted on 5/14/25. IV. Facility's investigation failures and discrepancies between staff reports and video footage on 5/8/25 Review of the timeline of events established by the facility for the 5/8/25 incident involving Resident #1, documentation of staff members witness statements and video footage from 5/8/25, revealed several discrepancies related to the investigation of the incident related to Resident #1's serious injury of unknown origin. The discrepancies and investigation failures were as follows: 1. The facility failed to clarify who assisted Resident #1 into bed after the injury was discovered. CNA #7 and LPN #4 both said they got two additional CNAs to assist them in getting Resident #1 into bed after she was found to be in distress. -However, review of the video footage revealed no other CNAs or staff members entered Resident #1's room prior to LPN #5 entering to assess Resident #1. LPN #5 said in an interview during the survey (on 6/18/25 at 5:45 p.m.) that Resident #1 was in bed when he arrived to examine her injured leg (see LPN #5's interview below). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. CNA #7 and LPN #4 both initially reported (during their interviews with the facility investigator on 5/9/25) that CNA #7 heard Resident #1 yelling and went into the resident's room to find the resident with her bed controller in her hand and reaching for the bed. Both staff members initially reported that Resident #1's leg was caught under her wheelchair and did not mention her leg being caught under the bedframe in their initial interviews. After a reenactment of the incident on 5/14/25 (six days after the incident occurred), the facility concluded that Resident #1's left leg was under the bed and the resident lowered the frame of the bed onto her own leg using the bed controller that was in her hand, which resulted in the fractures to the resident's leg. -However, the facility failed to clearly document who was involved in the reenactment of the incident on 5/14/25 or identify why the scenario changed from the resident's leg being found underneath the bed instead of the wheelchair, as was initially reported. 3. CNA #7's witness statement documented she was in and out of Resident #1 and Resident #12's suite area so frequently on 5/8/25 because she was assisting Resident #12 with a shower. -The facility failed to identify how much of the time that CNA #7 was seen on the video footage going in and out of the residents' suite area was spent assisting Resident #1 when she activated her call light versus how much time was spent assisting Resident #12. 4. The facility failed to ensure clear communication during the interviews with CNA #7 and LPN #4. The DON said in an interview during the survey (see below) that English was not the first language of either CNA #7 or LPN #4. Additionally, the DON said she may not have gotten the correct facts from CNA #7 and LPN #4 due to the language barrier and that she may have misunderstood the staff or they may have misunderstood her when they talked over the phone on 5/9/25 about the details of the prior evening (5/8/25) when Resident #1 was injured. V. Staff interviews LPN #5 was interviewed on 6/18/25 at 5:45 p.m. LPN #5 said he was working on the evening of 5/8/25 when Resident #1 sustained her fractures. LPN #5 said he was working on another unit when LPN #4 came and asked him to look at Resident #1 for a second opinion of her injuries. LPN #5 said when he arrived to Resident #1's room, she was already in bed with her left leg elevated below the knee. He said CNA #7 and LPN #4 told him they transferred Resident #1 back to bed. LPN #5 said the resident was guarded and did not want them to touch her leg. He said he recommended an Xray for the resident and said he did not have any information on how the resident was injured. The DON was interviewed on 6/19/25 at 3:30 p.m. The DON said she did not speak to CNA #7 or LPN #4 on the evening of Resident #1's injury to her leg (5/8/25). The DON said after being notified by the sheriff's office on 5/9/25, she called both CNA #7 and LPN #4 that day (5/9/25) for additional information She said she had separate conversations with each of them about the events leading up to Resident #1 being injured. The DON said English was not either CNA #7's or LPN #4's first language and she might have heard the staff members incorrectly with a couple of their responses during their initial interviews. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the services provided met professional standards of quality for one (#1) of seven residents out of 12 sample residents. Specifically, the facility failed to ensure Resident #1 was assessed by a registered nurse (RN) after a significant change of condition when she experienced a fracture of the left fibula and tibia (lower leg bones). Findings include: I. Professional reference According to Nurse Journal's Licensed Practical Nurses (LPN) Versus Registered Nurses (RN), (8/27/24), retrieved on 6/25/25 from https://nursejournal.org/resources/lpn-vs-rn-roles/, LPNs and RNs both monitor patients, administer medications, perform wound care, help patients with basic tasks like bathing and feeding, and often educate and support patients and their loved ones. However, there are differences in the education requirements and scope of practice between RNs and LPNs. LPNs perform vital work in collaboration with RNs, physicians and other healthcare professionals. LPNs work alongside or under the supervision of RNs to deliver care and support to patients. This role also requires gathering patient data, which other licensed healthcare providers later interpret. Unlike RNs, LPNs typically do not have state authorization to make health assessments, create nursing care plans or triage patients. Compared to LPNs, RNs generally operate independently. RNs use their specialized judgment, skills, and knowledge to provide direct patient care in various settings. Generally speaking, only RNs provide initial assessments. Therefore, an RN must perform all tasks that require close monitoring and frequent assessment, such as initiating blood products, the first round of antibiotics, and initial patient assessments. II. Facility policy and procedure The Notification of Change in Condition policy, dated 2016, was provided by the nursing home administrator (NHA) on 6/19/25 at 8:30 a.m. It read in pertinent part, When a resident is evaluated or assessed as having a change in condition, the charge nurse will follow through in documenting notification to family/legal representative/resident, the health care provider and other licensed nurses as indicated. A change in condition is a clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care Center	6005 S Holly St Littleton, CO 80121

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 5/9/25. According to the May 2025 computerized physician orders (CPO), diagnoses included femur (upper leg) fracture, dementia and anxiety. The 5/8/25 minimum data sets (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. She required substantial assistance for lower body dressing and chair to bed transfer and was dependent for toileting and for transfers from sit to stand. B. Record review The facility's incident report, dated 5/14/25, documented that on 5/8/25 at 8:02 p.m., certified nurse aide (CNA) #7, who was assigned and working on the unit, heard Resident #1 yelling out my foot, my foot. CNA #7 entered the room to find the resident trying to pull herself into bed. CNA #7 alerted LPN #4, who was working on the unit, to assess Resident #1. At 8:05 p.m., LPN #4 noticed new swelling to Resident #1's left lower leg, but she was not sure what was wrong with the resident. LPN #4 assisted CNA #7 to get Resident #1 into bed and then went to get LPN #5, who was also working in the facility, to look at Resident #1. -However, the time documented in the incident report regarding when LPN #4 noticed new swelling to Resident #1's left lower leg on 5/8/25 did not match the time documented in the 5/8/25 progress note in the resident's electronic medical record (EMR) (see progress note below). A review of Resident #1's EMR revealed the following progress notes: A nurse progress note, dated 5/8/25 at 10:54 p.m. and written by LPN #4, documented that at 7:40 p.m., Resident #1 was in distress, complained of left leg pain and the resident wanted to go to bed. LPN #4's note revealed Resident #1 had swelling below the left knee and pain with movement. The note revealed a STAT (urgent) Xray was performed, Tramadol pain medication was administered, the physician and family were notified and Resident #1 was transferred to the hospital. -The timing of the progress note contradicted the time documented on the facility's incident report (see incident report above). -Review of LPN #4's progress note revealed no documentation to indicate a comprehensive (head to toe) nursing assessment was completed by the RN on site, upon the discovery of a change in Resident #1's condition on 5/8/25 at 7:40 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing's (DON) late entry progress note, dated 5/16/25 at 11:38 a.m., (eight days after Resident #1's change of condition) documented that on 5/8/25 at 10:15 p.m. (almost two and a half hours after the resident's change of condition) LPN #2 (who was on-call and not in the facility) called the DON (who was also not in the facility) regarding Resident #1's condition change (fractured leg) on 5/8/25. The progress note revealed the DON advised LPN #2 to call the physician with Resident #1's Xray results for further treatment recommendations and to notify the resident's representative. -The DON's progress note indicated LPN #2 called her on 5/8/25 at 10:15 p.m., however, the facility did not receive results of Resident #1's Xrays until 11:28 p.m. (see radiology results report below). -The DON's progress note did not reveal communication with an RN, or that an RN assessment was completed at the time of the injury. The progress note did not reveal contain documentation to indicate that the DON instructed LPN #2 to notify the RN on duty to ensure an RN assessment was completed for Resident #1. -Additionally, there was no documentation in Resident #1's EMR to indicate LPN #2, LPN #4 or LPN #5 notified the RN on duty to conduct an assessment of Resident #1 after the resident's change of condition was identified. Review of the 5/8/25 radiology results report revealed an Xray of Resident #1's left tibia and fibula was obtained at the facility on 5/8/25 at 9:28 p.m. (one hour and 48 minutes after LPN #4's progress note (see above) indicated Resident #1 was in distress and had swelling below the left knee and pain with movement). The radiology results report further revealed Resident #1 had sustained fractures to both her left tibia and left fibula. The Xray results were not reported to the facility until 11:28 p.m. on 5/8/25 (two hours after the Xray was obtained and three hours and 48 minutes after LPN #4's progress note (see above) indicated Resident #1 was in distress and had swelling below the left knee and pain with movement). Review of the 5/9/25 emergency medical services (EMS) documentation revealed EMS arrived at the facility at 11:14 p.m. on 5/8/25 and found Resident #1 with severe left leg pain which began four hours prior. EMS transferred the resident to a stretcher and transported her from the facility at 12:07 a.m. on 5/9/25 (four hours and 27 minutes after LPN #4's progress note (see above) indicated Resident #1 was in distress and had swelling below the left knee and pain with movement). Further review of the 5/9/25 EMS documentation revealed that EMS arrived at the hospital at 12:35 a.m. on 5/9/25 and transferred care of Resident #1 over to the hospital staff at 12:42 a.m. Cross-reference F689 for failure to keep residents free from accidents/hazards. Cross-reference F610 for failure to timely and thoroughly investigate a significant injury of an unknown origin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff interviews LPN #5 was interviewed on 6/18/25 at 5:18 p.m. LPN #5 said that LPN #4 asked for his assistance to evaluate Resident #1's change of condition (on 5/8/25). LPN #5 said the resident was guarded and did not want anyone to touch her left leg. LPN #5 said Resident #1 could not say what had happened. LPN #5 said he called the resident's physician to request a physician's order for a STAT Xray and then went to the resident and applied an ice pack for the injury. LPN #5 said they monitored the laboratory portal for the Xray images and reported the results back to the on-call physician once the Xray results were received. LPN #5 said Resident #1 was then transferred to the hospital for further assessment and treatment. LPN #5 said he did not know how Resident #1 was injured; however, because the resident had not fallen out of her wheelchair to the floor, they did not call for the RN on duty to come to the unit to perform a post-fall assessment; an RN assessment was not completed. RN #1 was interviewed on 6/18/25 at 6:55 p.m. RN #1 said the process to follow if a resident experienced a condition change, including an injury, was for the LPN to call the RN on duty to assess the resident. LPN #2 was interviewed on 5/19/25 at approximately 3:30 p.m. LPN #2 said she was on-call the night of 5/8/25 when LPN #4 called her to report Resident #1 had sustained an injury to the lower left leg. LPN #4 said CNA #7 alerted her that the Resident #1 was complaining of pain and thought that she had an injury while trying to self-transfer. LPN #2 said LPN #4 told her that she was worried because after getting the resident back into bed, she noticed something sticking out of the resident's left lower leg and it did not look right. LPN #2 said once the Xray images came in over the laboratory portal, she called the DON to report the fractures. LPN #2 said the DON told her to call the physician for next step orders. LPN #2 said the on-call physician said since the resident had signed a do-not-resuscitate order with directives for comfort care, the family should make the decision for treatment type. LPN #2 said the resident's family gave directions for the facility to send Resident #1 to the hospital for further assessment and treatment. The DON was interviewed on 6/19/25 at 5:15 p.m. The DON said she was notified by the off-site on-call LPN unit manager (LPN #2) around 10:00 p.m. on 5/8/25, after LPN #2 was notified by the floor nurse on duty (LPN #4) that Resident #1 had sustained a left lower leg fracture confirmed by Xray results. The DON said she told LPN #2 to notify the resident's on-call physician and request further treatment orders. The DON said she did not lay eyes on Resident #1 and did not assess the resident's injuries on 5/8/25. The DON said she had not talked directly to LPN #4 who was in charge of the resident's care on the evening and night shift. The DON said the RN on duty at the facility on the night of 5/8/25 never observed the resident after the injury or prior to Resident #1's transfer to the hospital. The DON said she felt it was sufficient that she talked to the on-call LPN (LPN #2) over video chat and informed LPN #2 to call the floor nurse (LPN #4) back and give her directions to notify the on-call physician of Resident #1's Xray results.

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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** Based on record review and interviews, the facility failed to ensure one (#1) of five residents reviewed for accident hazards received adequate supervision out of 12 sample residents. Resident #1 was admitted to the facility on [DATE] with diagnoses of dementia with agitation, muscle weakness and reduced mobility related to left lower leg fractures sustained prior to admission to the facility. Resident #1 was dependent on two staff members providing maximum physical support/ assistance to complete positioning and transfer activities of daily living (ADL). Resident #1 had severe cognitive impairments, per staff interview, and was unable to understand the operation of the bed controls safely or appropriately (see staff interviews below). On [DATE], according to documentation, staff found Resident #1 with her bed controller in her hand and reaching toward her bed, potentially attempting to self transfer from her wheelchair to the bed. The resident was in distress and complaining of left lower leg pain. The resident was noted to have swelling to her left leg below the knee and pain with movement. A STAT (urgent) Xray was obtained, which identified the resident had two fractures in her left lower leg, specifically, the tibia and the fibula. Resident #1 was transferred to the hospital, where she underwent an intramedullary nailing (a surgical procedure used to stabilize and align fractured long bones by inserting a metal rod (nail) into the hollow medullary cavity of the bone) to repair the fractures. Following Resident #1's injury, while looking at possible causes of the resident's injury, the facility concluded that the likely cause of Resident #1's injury was due to her lack of ability to safely and properly operate the bed controls independently and unknowingly lowering the bedframe onto her legs, resulting in the fractures in her left lower leg. -However, the facility failed to thoroughly investigate the cause of Resident #1's injury. Cross reference F610 for failure to timely and thoroughly investigate a significant injury of an unknown origin. Staff interviews during the survey revealed Resident #1 was discovered on multiple occasions, prior to her injury on [DATE], using the bed controller in an unsafe manner and they worried about her being injured, leading them to provide more frequent checking on the position and location of the resident while she was in bed with the bed controller in hand (see staff interviews below). -However, the facility did not identify Resident #1's potential risk for injury related to her lack of ability to use the bed controls safely or identify effective interventions in order to prevent a potential injury to the resident. Specifically, the facility failed to ensure Resident #1, who was assessed to have poor safety awareness, impulsivity and severely impaired cognition, remained free from injury related to the resident's potential for self-transferring and the unsafe use of her bed controller. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Facility policy and procedure The Nursing admission at Risk Post Fall and Quarterly Evaluation policy, dated 2010, was provided by the director of nursing (DON) on [DATE] at 8:30 a.m. It revealed in pertinent part, The licensed nurse will evaluate residents for appropriateness of fall interventions per response obtained in effort to minimize the risk for resident's fall and or injury. The licensed nurse will ensure application of safety equipment interventions and notify other applicable staff of residents' risk for fall and related injury. The resident's care plan, Kardex and task assistance instructions are to be updated as indicated to reflect fall risk and interventions, as indicated. II. Bed manufacturer's manual The Invacare Long Term Care Bed User Manual, for bed model CS600, dated 2023, provided by the DON on [DATE] at 3:30 p.m. The manual documented in pertinent part, The bed is intended to be used as a mattress support system. The bed allows for articulation of the head and foot sections to provide different positions for the user. It is intended to be used at home and in long-term facilities. Warning: Danger -risk of death or injury. Conditions such as restlessness, mental deterioration, and dementia or seizure disorder, sleeping problems and incontinence can significantly impact the user's risk of entrapment. Monitor users with these conditions frequently. To avoid injury or damage from misuse or engraving, read and understand the instructions or label provided. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included femur (upper leg) fracture, dementia and anxiety. The [DATE] minimum data sets (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. The resident required substantial assistance from staff with dressing, sitting up and balancing unsupported. The resident needed two-person staff assistance to perform any surface-to-surface transfers and was dependent on staff assistance for toileting and for transfer from sitting to standing. The resident was unable to stand unsupported and did not walk. B. Observation (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:15 a.m., several Invacare long-term care beds model CS600 were observed in the company of the nursing home administrator (NHA). The beds had been removed from occupied residents' rooms and were no longer in use by residents in the facility. The bed control on each of the beds had several buttons to operate the head and foot of the bed, the height of the bed and the angle of the bed. The bed controllers had a red button labeled CPR (cardio pulmonary resuscitation), which lowered and flattened the bed to an appropriate position in order to facilitate CPR, when needed. Additionally, the beds had the capacity to lower within inches of the floor. The beds observed with the NHA included the bed that Resident #1 had used while she was present in the facility. The NHA demonstrated the facility's theory of what the interdisciplinary team (IDT) believed was the most likely scenario of how Resident #1 sustained the fractures in her left lower leg. The NHA said after the IDT investigated the events of the resident's fractures, the IDT determined that when certified nurse aide (CNA) #7, who responded to Resident #1 when she was yelling out in pain, discovered the resident was injured and almost falling out of her wheelchair, CNA #7 left Resident #1 to get licensed practical nurse (LPN) #4, who was the nurse for Resident #1's unit. The NHA said the IDT determined that while CNA #7 was out of the room, Resident #1 grabbed the bed controller, pulled herself towards the bed so her legs were under the bed frame and, due to her confusion, Resident #1 hit buttons on the bed controller and lowered the bedframe down on her knees causing her injuries (fractures). C. Record review The [DATE] physical therapy assessment documented Resident #1 was dependent on two staff members providing maximum physical support/ assistance to complete positioning and transfer ADLs. The resident had contractures in both ankles and was unable to sit upright, unsupported or stand and balance on her own. The resident was unable to walk any distance. Resident #1 had muscle atrophy (the decrease in size and strength of muscle tissue). Additionally, Resident #1 had moderately impaired decision making skills, decreased safety awareness and lacked the capacity to understand her condition and risk factors, with reduced skill for self-monitoring. Resident #1's dementia care plan, initiated [DATE], revealed Resident #1 refused care, was impulsive and had poor safety awareness. Interventions instructed staff to anticipate and meet the resident's needs. Resident #1's fall care plan, initiated [DATE], revealed Resident #1 was at risk for falls related to confusion, agitation and attempts to self-transfer from her chair. Interventions included screening the resident for fall risk and identifying fall risk factors, encouraging the resident to use her call light for assistance, as needed, providing physical therapy, occupational therapy and speech therapy to evaluate and treat, as ordered and as needed. -The care plan did not address the resident's risk of injury related to her bed controls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note, dated [DATE] at 10:54 p.m. and written by LPN #4, documented Resident #1's change of condition on [DATE] at 7:40 p.m. The note documented Resident #1 was in distress, complained of left leg pain and the resident wanted to go to bed. LPN #4's note revealed Resident #1 had swelling below the left knee and pain with movement. The note revealed a STAT Xray was performed, Tramadol pain medication was administered, the physician and family were notified and Resident #1 was transferred to the hospital. The hospital Discharge summary, dated [DATE], documented Resident #1 was admitted to the hospital on [DATE] after being found in her wheelchair complaining of left lower leg pain. In the emergency room, an Xray of the resident's left tibia and fibula revealed the bones were fractured. The resident was admitted to the trauma service unit and orthopedic surgery was consulted. Resident #1 underwent an intramedullary nailing surgery to repair the fractures. Review of the facility's incident report of Resident #1's injury documented that on [DATE], CNA #7 heard Resident #1 yelling my foot, my foot. CNA #7 checked on the resident. Resident #1 was found in her manual wheelchair, turned toward the bed and was trying to grab the bed frame to pull herself into the bed. CNA #7 left the resident in her room unattended while she walked down the hall get the floor nurse The incident report documented the nurse (LPN #4) noticed swelling to Resident #1's left lower leg that was not present in previous rounds. The incident report included staff interviews, which revealed Resident #1 was found with the bed controller in her hand. The report concluded that staff documentation and interviews suggested Resident #1 had been attempting to self-transfer back to her bed. IV. Staff interviews CNA #6 was interviewed on [DATE] at 6:00 p.m. CNA #6 said Resident #1 used her call light a lot and often did not know why she was calling. CNA #6 said Resident #1 was often impulsive and would use the bed controls without knowing what the purpose of the buttons were that she was pushing. CNA #6 said she had hidden the bed controller from the resident before. The medical director (MD) and the DON were interviewed together on [DATE] at 3:30 p.m. The MD said she reviewed Resident #1's medical record and discussed the incident with facility leadership and determined that the Invacare beds and their complex bed controllers should be removed from use with the residents who had impaired cognition. The MD said the IDT determined that the bed controllers had too many options and potentially caused a danger to residents with impaired cognition and impaired vision. The MD said the CPR red button posed an additional concern because it was assessed that the resident could misidentify the red button for a nurse call light (all of the newly purchased Invacare beds had controllers that had the red CPR button). She said if the resident continually pressed the CPR button, thinking it was the nurse call light button, it would cause the bed to lower to a low bed position and flatten The DON said Resident #1 had been working on safe transfers with the therapy department and had more recently not displayed signs and symptoms of impulsivity to get up on her own. The DON said the resident had a history of pressing her call light frequently and she said, based on the information she was told by the staff on duty the night of the incident ([DATE]), that Resident #1 had pressed the call light and was attempting to self-transfer when she injured herself. (continued on next page)

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