| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065272 | A. Building<br>B. Wing | 02/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sierra Post Acute | 1432 Depew St<br>Lakewood, CO 80214 |

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) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185<br><br>Based on record review and interviews, the facility failed to ensure one (#3) of three residents received adequate supervision to prevent accidents out of eight sample residents.<br><br>The facility failed to develop and implement a person-centered care plan upon Resident #3's admission to the facility that identified the resident's fall risk and put effective interventions into place to reduce falls and prevent injury.<br><br>Resident #3 fell on [DATE] (10 days after his admission to the facility) and sustained a T12 to L1 fracture, which required surgical intervention.<br><br>The facility failed to ensure Resident #3 was assessed by a qualified person, a registered nurse (RN), prior to Resident #3 being moved off the floor.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Fall Prevention Program policy and procedure, implemented March 2020, was provided by the nursing home administrator (NHA) on 2/26/25 at 12:08 p.m. It revealed in pertinent part, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.<br><br>A fall is an event in which an individual unintentionally comes to rest on the ground, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere.<br><br>Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. The nurse will refer to the facility's high risk or low/moderate risk protocols when determining interventions.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | High risk protocols: the resident will be placed on the facility's fall prevention program: indicate fall risk on care plan, place fall prevention indicator on the name plate to the resident's room and place fall prevention indicator on resident's wheelchair; implement interventions from Low/Moderate Risk Protocols, provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status or recent changes in functional status; provide additional interventions as directed by the resident's assessment, including but not limited to: assistive devices, increased frequency of rounds, sitter if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education and therapy services referral.<br><br>Low/Moderate risk protocols: implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: a clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed, call light and frequently used items are within reach, adequate lighting and wheelchair and assistive device are in good repair; implement routine rounding schedule; monitor for changes in resident's condition, gait, ability to rise/sit and balance; encourage residents to wear shoes or slippers with non-slip soles when ambulating; ensure eye glasses are clean and the resident wears them when ambulating; monitor vital signs in accordance with facility policy; and complete a fall risk assessment every 90 days and as indicated when the resident's condition changes.<br><br>When any resident experiences a fall, the facility will: assess the resident, complete a post fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions and obtain witness statements in the case of injury.<br><br>II. Resident #3<br><br>A. Resident status<br><br>Resident #3, age 81, was admitted on [DATE] and discharged to the hospital on 12/23/24. According to the December 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with agitation and a history of falling.<br><br>The 12/5/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. He was dependent on staff for toileting and transfers and substantial to maximal assistance with showering, dressing and bed mobility. It indicated he used a manual wheelchair and a walker for mobility.<br><br>B. Resident #3's representative interview<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | The resident's representative was interviewed on 2/25/25 at 4:49 p.m. The representative said Resident #3 fell out of bed on 12/23/24 at 4:00 a.m., but the facility did not contact her until 7:15 a.m. She said she asked why she was not contacted when the fall happened, but the facility staff did not have an answer. She said she was informed Resident #3 had rolled out of bed. She said Resident #3 was transported to the hospital later that night and MRI (diagnostic imaging) and CT (diagnostic imaging) scans were completed. She said the results showed Resident #3 had fractured his lower back. She said the physician at the hospital said when a resident fell out of bed without a mat, the injury could be significant.<br><br>The representative said while Resident #3 was at the facility, his bed was never low to the ground. She said she was 5 feet, 3 inches tall and the bed was consistently waist high. She said she went to visit him at the facility every day.<br><br>She said there was never a fall mat in place next to the bed.<br><br>She said she asked the facility to consider putting side rails on the bed because Resident #3 said he kept feeling like he was going to fall out of bed. She said the therapist said he would benefit from small side rails at the top of the bed, however the facility never installed them.<br><br>C. Record review<br><br>1. Resident's history<br><br>The 11/17/24 hospital progress notes documented Resident #3 presented at the hospital with a functional decline at home including multiple falls with the caregiver unable to keep the resident safe. It indicated the resident's responsible party said he had experienced multiple falls at home.<br><br>The 12/13/24 admission nursing summary progress note documented Resident #3 was admitted for hospitalization for COVID-19 and sepsis (infection of the blood). The resident required a wheelchair and a front wheeled walker for mobility.<br><br>The 12/13/24 admission evaluation/assessment documented Resident #3 was alert with short-term and long-term memory impairments and was oriented to self and place. The resident was non-ambulatory and required assistance with transfers, dressing, bathing, grooming/hygiene, toileting and bed mobility. There were no bed rails attached to the bed.<br><br>The 12/16/24 physician admission history and physical documented the resident was admitted following a urinary tract infection with sepsis, stage four chronic kidney disease, hypertension (high blood pressure) and paroxysmal atrial fibrillation (type of heart rhythm disorder characterized by short, irregular episodes of rapid heart rate that originate in the upper chambers of the heart. The physician documented the resident had functional impairments and cognitive deficits with potential high risk for frequent falls<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | The 12/13/24 fall risk assessment documented Resident #3 sustained three or more falls in the past 90 days, had moderately impaired vision, ambulated with problems and with devices, the resident displayed the following behaviors: easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varied over the course of the day; and had three of more circulatory/heart conditions. This assessment concluded the resident was considered a high risk for falls, scoring 32 out of 42.<br><br>The 12/13/24 rehabilitation screening form documented Resident #3 was a new admission with observable functional and cognitive deficits. The resident leaned to the right and was unable to hold up his bilateral lower extremities when seated. The resident reported back pain with transfers and required physical, occupational and speech therapy.<br><br>The 12/16/24 bed rail and entrapment assessment documented that bed rails were being considered for use for the left and right upper portion of the bed. The resident had significant difficulty engaging in bed mobility and required significant assistance. It indicated the bed rails would reduce back pain with self-repositioning and assist with bed mobility and transfers. The assessment recommended to install bedrails on Resident #3's bed, however the rails were never installed as indicated (see resident representative interview above and staff interviews below).<br><br>The activities of daily living (ADL) care plan, initiated on 12/14/24, documented Resident #3 was at risk for ADL/mobility decline and required assistance related to chronic disease progression, cognitive impairment and a recent hospitalization . Resident #3 required assistance of one staff member with bed mobility and assistance of two staff members with transfers.<br><br>The fall risk care plan, initiated on 12/14/24 and revised on 12/16/24, documented Resident #3 was at risk for falls with or without injury related to altered balance while standing and/or walking, altered mental status, hearing impairment, hypoglycemia (low blood sugar), unsteady gait, type 2 diabetes, pain, recent illness and protein caloric malnutrition.<br><br>The interventions, initiated on 12/14/24, included anticipating and meeting the resident's needs, educating and reminding the resident to call for assistance with all transfers; encouraging the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; keeping the call light within reach and obtaining a physical and occupational therapy consult as indicated.<br><br>-The facility failed to develop the comprehensive care plan to include person-centered interventions and address the residents' history of falls and recent ADL decline.<br><br>2. Fall incident on 12/23/24<br><br>The 12/23/24 nursing progress note, documented at 4:08 a.m. by licensed practical nurse (LPN) #1, revealed Resident #3 was alert and able to make his needs known. Resident #3 was found on the floor by the certified nurse aide (CNA). The note documented the resident said he said he tried to stop himself, but he could not and fell off the bed. He said the bed was too small.<br><br>LPN #1 documented Resident #3 did not hit his head (however, this could not be verified since the fall was unwitnessed), had no bruising, was able to move all extremities and denied pain. His neurological checks were within normal limits.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A review of Resident #3's electronic medical record (EMR) did not reveal documentation of Resident #3 being assessed by a RN prior to being moved off the floor (see staff interviews below), nor vital signs taken.<br><br>-At 2:33 p.m. Resident #3 experienced an episode of hypotension (low blood pressure) of 86/58 milliliters of mercury (mmHg). The nurse left a message for the physician.<br><br>-At 3:31 p.m. Resident #3 was still experiencing hypotension when the physician called back. The physician ordered the resident to be sent to the hospital.<br><br>The 12/23/24 hospital notes documented Resident #3 presented to the emergency room following a fall with a sustained vertebral fracture. The CT scan of the thoracic spine demonstrated an acute distraction fracture through the T12 to L1 intervertebral disc space with 1.5 centimeters (cm) diastases across the injury.<br><br>The 12/24/24 interdisciplinary team documented that on 12/23/24 at approximately 4:00 a.m., Resident #3 was found down on the floor at the side of the bed. The resident said he was trying to turn in bed and rolled out. The interventions included placing a fall mat at the side of the bed and providing the resident with a bariatric bed.<br><br>The 12/24/24 rehabilitation post-fall screen documented Resident #3 rolled out of bed when he attempted to turn and reposition himself. It indicated Resident #3 would benefit from a fall mat and a bariatric bed to reduce the risk of falls out of bed.<br><br>The 12/24/24 neurologist hospital progress notes documented Resident #3 presented with an unwitnessed fall and sustained an unstable fracture with hypotension. The resident was found to be possibly septic and imaging revealed a three column injury, a traumatic fracture with distraction/extension at the T12 to L1. The resident wished to proceed with surgical stabilization.<br><br>The 12/27/24 operative note documented the surgeon performed an open reduction and stabilization of the T12 and L1 vertebral body fracture. The surgeon documented in pertinent part, Resident #3 was an [AGE] year old male found to have a T12 to L1 fracture<br><br>III. Staff interviews<br><br>The director of nursing (DON) was interviewed on 2/26/25 at 10:48 a.m. The DON said Resident #3 sustained a fall on 12/23/24 at approximately 4:00 a.m. She said Resident #3 rolled out of the bed on his right side. She said the resident was not on a low bed at the time of the fall. She said she thought a fall mat was present, however, she was unable to find documentation that it was in place.<br><br>The DON said immediately following a fall and prior to a resident being moved from the ground, the resident must be assessed by a RN. She said the RN assessment was important in determining if an injury occurred. She said a LPN was unable to conduct an assessment because it was outside their scope of practice. She said Resident #3 was not assessed by a RN immediately following the fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | The DON said there was a RN in the facility at the time of Resident #3's fall, but the LPN chose not to get the RN to perform an assessment. She said, at approximately 8:00 a.m., when she arrived to the facility, she performed an assessment of Resident #3, however she said she did not document that assessment in the resident's EMR.<br><br>The DON said she was aware Resident #3 sustained a fracture to the back once he was evaluated at the hospital. She said Resident #3 had complained of back pain throughout his stay at the facility, however she did not know what it was attributed to.<br><br>The DON said Resident #3 fell at 4:00 a.m. and the resident's responsible party was not contacted until 8:04 a.m. She said she did not have a good reason as to why the facility waited four hours to contact the resident's family.<br><br>The DON confirmed an assessment was conducted to determine if bed rails were appropriate and safe for Resident #3, based on his responsible party's request. She said it was determined that partial upper side rails would be both safe and effective for Resident #3, however, she said they were never installed on the bed. She said Resident #3 was over six feet tall and they decided to order the resident a bigger bed before installing the partial side rails.<br><br>-However, the DON was unable to provide documentation to show the facility had ordered a bigger bed for Resident #3.<br><br>The DON said the fall interventions documented on the resident's comprehensive care plan were not person-centered. She said the facility was waiting on the therapy department to implement person-centered interventions. She acknowledged Resident #3 had been in the facility for 10 days at the time of the fall. She said the facility staff did not think to put the intervention of a low bed in place for Resident #3.<br><br>The primary care physician (PCP) was interviewed on 2/26/25 at 1:32 p.m. The PCP said Resident #3 was admitted with a history of frequent falls. He said Resident #3 was a little non-cooperative with care when he was first admitted , however after a couple of days, he was compliant with care. He said he did not feel the bed was unusually high, however, he said he would have liked to have seen the facility implement a fall mat.<br><br>The PCP said a distraction fracture typically was caused from a motor vehicle accident and was known as a seatbelt fracture. He said it was possible the fracture was caused from the fall if he rolled in a weird way out of the bed, but unlikely. However, he said he did not have any other explanation for how Resident #3 sustained an acute fracture of the T12 to L1 intervertebral disc space for Resident #3 other than the fall. |