STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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 - 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** 40960 Based on record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accidents out of five sample residents remained free from accidents. Resident #1, who was identified as a high fall risk, sustained a fall on 9/6/24 which resulted in a hip fracture that required hospitalization . The hip fracture was not identified until 9/12/24 due to the nurse failing to report the fall. Due to the facility's failure to assess, report and identify the injury, the resident was not treated for her fractured hip for six days. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 11/20/24, resulting in the deficiency being cited as past noncompliance with a correction date of 9/12/24. I. Incident on 9/12/24 The nursing home administrator (NHA) and the director of nursing (DON) started an investigation of Resident #1's change of condition and her bruising on 9/12/24. The NHA and the DON reviewed camera footage for Friday 9/6/24. The video footage revealed Resident #1 was in the doorway to her room when she stood up from her wheelchair and sat back down. Resident #1 backed her wheelchair into her room and then her feet came out into the doorway. The video footage also revealed certified nurse aide (CNA) #3, who was an agency staff member, and facility licensed practical nurse (LPN) #2 were present. The DON interviewed CNA #3 who verified the resident did have a fall. -The fall was not reported until 9/12/24 (see below). II. Facility corrective action A. Immediate action to correct the deficient practice for Resident #1 (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A thorough investigation of the incident was conducted on 9/12/24. The facility reviewed the camera footage which revealed Resident #1 sustained a fall on 9/6/24, in her doorway. CNA #3 and LPN #2 were identified in the video and interviewed. LPN #2 denied knowing anything about Resident #1's fall and was terminated. CNA #3 verified Resident #1 sustained a fall on 9/6/24. All of the nursing staff were educated by the assistant director of nursing (ADON) on 9/12/24 related to the facility fall policy, reporting a fall and documenting a fall. The facility continued to hold Quality Assurance and Performance Improvement (QAPI) meetings monthly to address concerns. B. Interventions put into place The facility reviewed their current fall policy on 9/12/24 to ensure appropriate procedures were in place to prevent falls/potential harm and reporting a fall. Their policy met all the criteria required and all staff were re-educated on the fall policy and procedure (on 9/12/24). The incident involving Resident #1 on 9/6/24 was in violation of the policy and procedure, so all staff that were present at the time of the investigation were provided further education on the following day (9/13/24). The DON would ensure all newly hired staff would receive education on the fall policy. The education given included the following information: Identifying neglect, reporting a fall, registered nurse (RN) assessment for injuries, neurological checks if there was a head injury or the fall was unwitnessed, and documenting the fall. The facility would review falls and discuss them in the monthly Quality Assurance and Performance Improvement (QAPI) meeting for three months. III. Facility policy and procedure The Fall Monitoring and Management policy, revised October 2021, was provided by the NHA on 11/20/24 at 3:00 p.m. It read in pertinent part, A fall is any unplanned sudden change of position. It is the policy of the facility that residents are assessed and evaluated to identify risks for injuries due to falls, residents receive necessary treatment and monitoring after a fall and interventions are implemented to minimize risks for injury due to falls. For an individual who has fallen, the following interventions should include, but are not limited to: -Obtain vital signs; -Assess for head injury/change in level of consciousness; -Assess for change in normal range of motion/weight bearing; -Initiate neurological assessment on residents who have hit their head or had an unwitnessed fall (even if the resident stated they did not hit their head, because they may have hit their head and may not have recollection that they hit their head); -Assess for pain; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Precipitating factors, details on how fall occurred; -Provide first aid (including intervention for pain if pain was identified); -Notify physician for further orders; -Notify responsible party; -Document details under risk management in the computerized record; -Document neurological assessments on the neurological assessment form.; -Monitor/document daily for 72 hours; and, -Notify the physician if signs/symptoms of complications and update the plan of care. IV. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 computerized physicians orders (CPO), diagnoses included displaced intertrochanteric fracture of the left femur (thigh bone), age-related osteoporosis, unspecified osteoarthritis, unspecified protein-calorie malnutrition, vitamin D deficiency, muscle wasting and atrophy (organ and tissue wasting), unspecified abnormalities of gait and mobility, unspecified lack of coordination, muscle weakness, difficulty in walking and unspecified dementia. The 9/6/24 minimum data set (MDS) assessment revealed the resident had severe impairment for daily decision making per the staff assessment for mental status. She had delusions and wandered. She required supervision/oversight for safety with transfers. She used a wheelchair for locomotion. B. Record review A 8/11/24 fall assessment revealed Resident #1 was a high risk for falls. The fall care plan, revised 9/17/24, revealed the resident was at risk for falls related to confusion secondary to dementia, gait/balance problems, osteoarthritis and osteoporosis. Interventions included anticipating and meeting the residents needs, placing the call light within the residents reach, placing the bed in lowest position, educating the resident/family/caregiver about safety reminders and what to do if a fall occurred, following facility protocol, keeping needed items within reach, maintaining a clear pathway and ensuring non-skid strips were placed at the bedside to provide traction during transfers. A change in condition note, dated 9/8/24 at 5:41 p.m., revealed Resident #1 had a functional decline, altered mental status and a decrease in food/liquids intake. The physician and responsible party were notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 9/8/24 at 6:04 p.m., revealed the resident continued to have increased lethargy (feeling drowsy or not alert), weakness, low intake, inability to self-transfer and ambulate. Fluids and meal intake were encouraged. A nursing progress note, dated 9/8/24 at 6:48 p.m., revealed a RN assessed the resident and found bruising to the upper part of her spine the size of a nickel. The resident was lethargic and weak during the assessment. The physician and responsible party were notified of the findings. A nursing progress note, dated 9/9/24 at 6:27 p.m., revealed the resident continued to be monitored due to lethargy, poor meal and fluid intake and mobility changes. A nursing progress note, dated 9/9/24 at 6:39 p.m., revealed the resident was noted to have bruising to her back on the right and left side. It was dark purple in color. Due to the resident's current state, she was unable to express pain or discomfort and unable to answer questions appropriately. A nursing progress note, dated 9/11/24 at 4:54 a.m., revealed the resident had dark bruising to her vaginal area. A nursing progress note, dated 9/11/24 at 2:29 p.m., revealed an x-ray for the left hip, leg and knee was ordered due to the identified bruising and swelling. A physician's progress note, dated 9/11/24 at 3:40 p.m., revealed the physician spoke with the DON and the facility staff related to Resident #1's bruising of unknown origin. The skin exam was limited due to the resident's resistance. There were some areas of ecchymosis (bruising) to her mid upper thoracic back. The lower extremity exam was remarkable for the left upper thigh with ecchymosis and bruising to the lower left thigh and in her vaginal area. The exam was concerning for a left hip fracture. A change in condition note, dated 9/11/24 at 8:15 p.m., revealed the resident had a change of condition related to trauma. The physician and family were notified. A nursing progress note, dated 9/11/24 at 10:00 p.m., revealed new orders were received to send the resident to the emergency room secondary to increased swelling and bruising to the left hip and knee. An x-ray of the left hip and knee were pending. The DON was aware of the transfer and the family was notified via a phone message. A nursing progress note, dated 9/12/24 at 1:55 p.m., revealed the resident sustained a fall on 9/6/24 that was not reported until 9/12/24. An x-ray revealed a left hip fracture. The physician and family were notified of the results. A fall committee note, dated 9/19/24 at 9:53 a.m., revealed Resident #1 sustained a fall in her doorway. The resident's injuries included latent bruising and after several assessments by the nursing staff and the medical director, a left hip fracture was suspected and an x-ray was ordered. The x-ray confirmed a left hip fracture and the resident was sent to the emergency room . Prior to the fall, the resident was sitting in her wheelchair in the hallway. She stood up and fell . Therapy evaluated the resident upon her return from the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A daily skilled note, dated 10/16/24 at 3:20 a.m., revealed the resident had limited range of motion (ROM) to her left hip and thigh due to the left hip fracture. V. Staff interviews CNA #1 was interviewed on 11/20/24 at 2:49 p.m. CNA #1 said if a resident had a fall she would immediately get the nurse to assess the resident before moving them. She said the nurse was responsible for reporting a fall to the DON. She said after Resident #1's fall, all nursing staff received education on reporting a fall, documenting a fall and assessing the resident after a fall. CNA #2 was interviewed on 11/20/24 at 2:54 p.m. CNA #2 said if a resident had a fall, a staff member would stay with the resident while another staff member reported it to the nurse. The nurse would assess the resident for any injuries. She said if a nurse was not available, the staff would report the fall to the assistant director of nursing (ADON) or the DON to complete an assessment before moving the resident. She said the nurse was responsible for completing a fall report and notifying the DON. She said after Resident #1's fall all staff was educated on the fall policy procedure. RN #1 was interviewed on 11/20/24 at 3:09 p.m. RN #1 said if a resident had an unwitnessed fall, the CNA would notify the nurse. She said the RN would assess the resident for any injuries. She said neurological checks were started as soon as possible. She said the nurse was responsible for reporting the fall to the DON, the physician and the responsible party. LPN #1 was interviewed on 11/20/24 at 3:11 p.m. LPN #1 said if a resident had a fall she would call an RN to assess the resident for any injuries. She said she would then call the physician and the responsible party. She said if the resident hit their head or had an unwitnessed fall, she would immediately start neurological checks. She said the nurse was responsible for reporting the fall to the ADON, the DON and the NHA. She said she started working at the facility three weeks prior and received the fall policy training, as well as education on reporting, assessing and documenting a fall. The DON was interviewed on 11/20/24 at 3:44 p.m. The DON said on Saturday, 9/7/24, she received a phone call from the RN working who reported Resident #1 was not acting like herself and not eating. She said a change of condition assessment was completed and the physician was notified. She said the following day, Sunday (9/8/24), she received a phone call from the nurse stating Resident #1 had bruises on her back. She told the nurse to document the bruising so the facility could figure out where the bruising came from. She said on Monday, 9/9/24, the staff were still trying to figure out where the resident's bruising came from. She said she interviewed Resident #1, utilizing a translator, and asked the resident if she had a fall. She said the resident said no and wanted to be left alone. She said on Tuesday, 9/10/24, she attempted to assess Resident #1 again and she refused. The DON said on Wednesday, 9/11/24, the medical director was in the facility and she asked him to look at her. She said Resident #1 agreed to the assessment and the medical director found bruising from her hip to her knee. She said the medical director said she needed to order an x-ray because it looked like a fracture. She said the x-ray confirmed a left hip fracture and Resident #1 was transferred to the hospital. She said the following day, Thursday, 9/12/24, she and the NHA reviewed the video footage prior to the resident's change of condition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON said the review of the camera footage revealed Resident #1 had a fall in her doorway on 9/6/24. She said CNA #3 and LPN #2 were present when the fall occurred. She said CNA #3 and LPN #2 walked directly into the resident's room and exited approximately three minutes later. She said she interviewed LPN #2 who denied the resident fell . She said LPN #2 was terminated. She said she then interviewed CNA #3 who verified the resident did have a fall. The DON said CNA #3 reported that LPN #2 picked Resident #1 up and placed her in her wheelchair after the fall. She said LPN #2 gave a report to the oncoming nurse and left the facility. She said CNA #3 said the resident should not have been moved until a RN assessed for injuries. The DON said the ADON immediately provided education to the staff on what abuse looked like and the facility policy and procedure for falls.