

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2025
NAME OF PROVIDER OR SUPPLIER  Irondale Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure one (#3) of eight residents reviewed for accidents received adequate supervision out of eight sample residents.</p> <p>Specifically, the facility failed to ensure Resident #3 was provided safe transportation. Resident #3 was wheelchair bound and dependent on staff for mobility and positioning. She had functional limitations in range of motion for her lower extremities due to below the knee amputations.</p> <p>Resident #3 was assisted into the van after an appointment on 1/22/25 by van driver #1. Resident #3 was not secured properly in the van. When the van accelerated, Resident #3's wheelchair tipped backward and she fell onto the floor with the wheelchair landing on top of her. When van driver #1 pulled over, she noticed the resident had blood in her mouth. Emergency services were called and the resident was transported to the hospital. The resident was diagnosed with fractures of the sixth and seventh cervical vertebra, first and second thoracic vertebra, epidural hemorrhage (brain bleed), multiple rib fractures and pain. Resident #3 required hospitalization in the intensive care unit (ICU).</p> <p>Findings include:</p> <p>Observations, record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/15/25 to 4/30/25, resulting in the deficiency being cited as past noncompliance with a correction date of 1/28/25.</p> <p>I. Situation of serious harm</p> <p>The facility's failure to ensure van driver #1 secured Resident #3's wheelchair in the facility's van when she was being transported to and from her appointment placed the resident at serious risk of harm, serious impairment or death. Resident #3 suffered multiple fractures, brain injury and pain.</p> <p>II. Facility plan of correction</p> <p>The corrective action plan the facility implemented in response to the accident on 1/22/25 involving Resident #3's was provided by the director of nursing (DON) on 4/16/25 at 10:35 a.m. The correction plan revealed the following:</p> <p>A. Immediate action</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #3 was sent to the hospital immediately following the incident on 1/22/25. Upon return to the facility, van driver #1 performed a demonstration and the facility verified the van driver's knowledge of the proper procedure for securing the wheelchair in the van on 1/22/25 (the date of incident). Van driver #1 was suspended from the facility on 1/22/25, pending an investigation. An inspection of the van and wheelchair restraints was completed on 1/23/25 by the maintenance supervisor (MS).</p> <p>B. Identification of others affected</p> <p>The facility determined the deficient practice had the potential to affect all residents who used wheelchairs in the facility. A review of other residents to determine if anti-tippers (a device used to prevent wheelchairs from tipping backwards) for their wheelchairs was needed was completed on 1/24/25.</p> <p>C. Systematic changes</p> <p>The facility provided documentation that all staff who could transport residents had completed wheelchair securement training by 1/29/25. The training included correct procedures for securing wheelchairs in transportation vehicles, the use of appropriate restraints and securing devices, how to inspect and ensure all safety equipment was functioning properly before transport and procedures to follow in case of an emergency or equipment malfunction. The activities director (AD) was included in the individuals having completed the training. The AD helped transport residents until a new van driver was hired on 3/24/25.</p> <p>III. Facility policy and procedure</p> <p>The Transporting a Resident, Facility Van policy, undated, was provided by the director of nursing (DON) on 4/16/25 at 11:05 a.m. It read in pertinent part, It is the policy of this facility to provide residents safe, non-emergency transportation to doctors appointments, activity outings, and any other trips the facility deems necessary. The van will be well-maintained and equipped with safety features. Each resident will be secured in a seat with a seatbelt or in their wheelchair, secured with wheelchair tie-downs.</p> <p>IV. Resident #3</p> <p>A. Resident status</p> <p>Resident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included (sustained during the van incident on 1/22/25) fractures of sixth and seventh cervical (neck) vertebrae, fracture of first and second thoracic (chest) vertebrae, multiple fractures of ribs and epidural hemorrhage (bleeding in the brain). Additional diagnoses included chronic obstructive pulmonary (lung) disease, bilateral (both sides) below the knee amputations, kidney disease, epilepsy (seizure disorder) and diabetes.</p> <p>The 2/4/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. Resident #3 utilized a wheelchair and was dependent on staff for repositioning, transferring, showering and toileting. She required substantial assistance for personal hygiene and dressing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>B. Resident #3 interviews and observations</p> <p>Resident #3 was interviewed on 4/15/25 at 10:00 a.m. Resident #3 had a neck brace in place. She was sitting in a wheelchair at the entrance to the facility and said she was waiting to go to an appointment and was hoping the neck brace would be removed at the appointment. She said she was required to continuously wear the neck brace for three months since she fell in the van. Resident #3 said she could not turn her head or see anything unless it was directly in front of her. Resident #3 said she was injured in January 2025 because the van driver did not secure her wheelchair in place as she was returning from an appointment. Resident #3 said the driver accelerated the vehicle and Resident #3's wheelchair flipped backward in the van. The resident said she fell onto the floor of the van and the wheelchair landed on top of her. Resident #3 said after the accident, the driver wanted to move her back into her wheelchair and was enlisting the assistance of passersby to assist with moving her. Resident #3 said she instructed the driver not to move her and to call emergency services.</p> <p>On 4/15/25 at 10:08 a.m. van driver #2 assisted Resident #3 into the facility's transportation van. Van driver #2 anchored Resident #3's wheelchair at four points to the floor of the vehicle and then added a lap seat belt and a shoulder strap. Van driver #2 also used his hand to push the wheelchair to ensure it did not move.</p> <p>Resident #3 was interviewed again on 4/16/25 at 3:30 p.m. Resident #3 did not have a neck brace on at that time. Resident #3 said the brace was removed at her appointment. Though the neck brace was not in place, Resident #3 turned her head to the side slowly and cautiously. Resident #3 said she had ridden with van driver #1 previously and van driver #1 had driven fast and erratically. Resident #3 said when she fell in the van, her head hit the door in the back of the van. She said she cried in pain when the accident happened. Resident #3 said she required neck to rib support (the neck brace extended down to the bottom of her chest) after her hospitalization.</p> <p>C. Record review</p> <p>1. Care plan</p> <p>Resident #3's activities of daily living (ADL) care plan, revised 1/29/25, revealed the following interventions:</p> <p>Resident #3 required a rigid cervical orthosis (collar which supported neck and spine and limited the movement of neck and head), a shower collar when bathing and cervical spine precautions including no bending, twisting or lifting greater than 10 pounds;</p> <p>Resident #3 required one to two staff participation for dressing, to use the toilet and reposition and turn in bed;</p> <p>Resident #3 required two staff to assist with transferring; and,</p> <p>Resident #3 should be encouraged to discuss feelings about self-care deficit.</p> <p>2. Progress notes</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A nurse progress note, dated 1/22/25 at 6:00 p.m., documented van driver #1 reported that Resident #3 had a fall in the van and was taken to the hospital for evaluation. The note documented the nurse would assess Resident #3 upon her return to the facility. The physician and the resident's representative were notified.</p> <p>A nurse progress note, dated 1/28/25 at 6:00 p.m., documented Resident #3 was readmitted from the hospital and transferred to bed via a stretcher. The note documented the resident had generalized pain which she rated at a 10 on a pain scale of 0-10 and also documented she was given Tramadol (pain medication) for pain. The note documented the resident required a rigid neck collar and bed wedges while in bed when Resident #3 was on her side.</p> <p>A social services progress note, dated 1/31/25 at 3:24 p.m., documented Resident #3 expressed sadness over her current physical limitations. The note documented the social services director (SSD) would look into pet visits and ordering a stand to enable Resident #3 to use her personal tablet computer in bed.</p> <p>3. Hospital report</p> <p>The hospital discharge summary record was provided by the nursing home administrator (NHA) on 4/16/25 at 1:40 p.m. The record documented Resident #3 was admitted to the hospital on [DATE] and discharged on 1/28/25. It documented the following diagnoses: fractures of sixth and seventh vertebra, first and second thoracic vertebra, epidural hemorrhage, multiple bilateral rib fractures and pain. The discharge instructions revealed Resident #3 required a rigid cervical collar at all times. Precautions included no bending, no twisting and no lifting greater than 10 pounds. The resident required additional medications at discharge which included a lidocaine patch (pain medication) for rib fracture pain and methocarbamol (pain medication) for muscle spasms.</p> <p>4. Facility investigation of Resident #3's fall on 1/22/25</p> <p>Resident #3's fall investigation was provided by the DON on 4/16/25 at 10:35 a.m. and included the following:</p> <p>The 1/22/25 incident report documented Resident #3 was returning to the facility in the transport van, when the resident fell from her wheelchair and landed on the floor in the van. Van driver #1 called 911 and emergency medical services (EMS) came to the van. EMS transported the resident to the hospital for evaluation. The incident report documented Resident #3 had no injuries.</p> <p>-However, Resident #3 sustained fractures of sixth and seventh vertebra, first and second thoracic vertebra, epidural hemorrhage, multiple bilateral (both sides) rib fractures and pain (see above).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Van driver #2 was interviewed on 4/15/25 at 10:12 a.m. Van driver #2 said when he transported residents, he anchored resident wheelchairs at the base of the four corners of the wheelchair to the floor of the van and then added a seatbelt and shoulder harness. Van driver #2 said he checked all wheelchairs to ensure they did not wiggle when he pushed on the wheelchair. Van driver #2 said residents had not reported any safety concerns with van transportation to him.</p> <p>Registered nurse (RN) #1 was interviewed on 4/15/25 at 1:15 p.m. RN #1 said van driver #1 called her after Resident #3 fell in the van and said she had called EMS. RN #1 said she told the DON about the resident's fall in the van. RN #1 said van driver #1 did not say anything to her about Resident #3's condition or what had happened.</p> <p>The DON and the clinical resource nurse (CRN) were interviewed together on 4/15/25 at 3:25 p.m. The DON said on 1/22/25, van driver #1 took Resident #3 to an appointment and when Resident #3 was returning from the appointment, Resident #3 fell in the van. The DON said van driver #1 called EMS, then notified the facility and waited for the resident to be taken to the hospital. The DON said the previous NHA conducted the investigation and did not find van driver #1 had done anything wrong and there were no mechanical issues with the van's seat belts or anchors. The DON said van driver #1 was initially suspended. She said van driver #1 was later terminated on 1/27/25, as she had not performed well in another role she had at the facility. The DON said she did not know if the NHA asked van driver #1 if she was certain Resident #3 was secured in the van. The DON said it would not be appropriate to move a resident who was involved in a fall until the resident was assessed, as it could harm the resident.</p> <p>The DON and the CRN both said they did not know how the wheelchair could have tipped over if the wheelchair was securely anchored to the floor of the van.</p> <p>The CRN said if the wheelchair was anchored properly, it should not tip backward. The CRN said the facility had not been able to determine how the incident happened.</p> <p>The DON said the facility was unable to interview Resident #3 until she returned from the hospital (on 1/28/25). The DON said there was not additional investigation after Resident #3 returned from the hospital and said van driver #1 did not secure the wheelchair.</p> <p>The DOR was interviewed on 4/15/25 at 4:10 p.m. The DOR said Resident #3 received physical therapy after the fall. The DOR said the resident received a new wheelchair, as she required a wheelchair that could recline after she returned from the hospital. The DOR said the wheelchair was delivered to Resident #3 with an anti-tip device on 2/4/25. The DOR said Resident #3's previous wheelchair did not have an anti-tip device.</p> <p>The AD was interviewed on 4/15/25 at 4:37 p.m. The AD said she was trained on securing wheelchairs and transporting residents in the facility's van. She said a five-point restraint was required (two anchors to the back of the wheelchair, two anchors in front of the wheelchair and a seat belt and shoulder strap). The AD said she would call 911 if a resident was injured and would pull over to be sure they were safe. The AD said she would not move a resident who fell.</p> <p>(continued on next page)</p>		

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