

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Juniper Village - the Spearly Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2205 W 29th Ave Denver, CO 80211	

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 - Actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350</p> <p>Based on record review and interviews, the facility failed to ensure one (#2) of four residents reviewed for accidents out of seven sample residents remained free from accidents.</p> <p>Resident #2, who was non-weight bearing with a history of osteoporosis and was known to be at risk for pathological fractures (fractures caused by disease processes rather than trauma), sustained bilateral distal femoral fractures (thigh bone above the knee) during a transfer with a mechanical (Hoyer) lift into a wheelchair.</p> <p>During the facility's investigation, it was identified that the type of Hoyer sling being used was a split leg sling which required the sling straps to be placed under and crossed around the thighs while the resident was being lifted out of bed and being transferred to the wheelchair. It was identified that the placement of the straps caused pressure and external rotation on the resident's thighs while being lifted with the Hoyer lift and was consistent with the location of Resident #2's fractures.</p> <p>Due to the facility's failure to ensure Resident #2's lower extremities were handled without undue pressure and alignment was maintained during a hoyer transfer, Resident #2 sustained bilateral femoral fractures on 9/13/24 which resulted in hospitalization and an open reduction internal fixation (surgical repair) of the fractures.</p> <p>Findings include:</p> <p>Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 10/23/24, resulting in the deficiency being cited as past noncompliance with a correction date of 9/25/24.</p> <p>I. Incident on 9/13/24</p> <p>The facility failed to ensure Resident #2's lower extremities were handled appropriately, without undue pressure and in alignment of her lower extremities during a hoyer transfer into a wheelchair.</p> <p>Due to the facility's failure, Resident #2 sustained bilateral distal femoral fractures on 9/13/24 which resulted in hospitalization and surgery to repair the fractures.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review and interviews during the onsite investigation confirmed the deficient practice had been corrected and the facility was in substantial compliance at the time of the investigation on 10/23/24.</p> <p>II. Facility plan of correction</p> <p>A. Immediate action to correct the deficient practice for Resident #2</p> <p>The 9/13/24 facility incident report identified Resident #2 was being transferred from her bed to her wheelchair by a Hoyer lift. Resident #2 was being lowered into her wheelchair when a popping noise was heard and Resident #2 complained of pain in her lower extremities. Resident #2 was evaluated by nursing staff and given Tylenol and a lidocaine patch (topical pain patch). After lunch on 9/13/24, the resident continued to complain of pain and the physician was notified. An x-ray of her right knee was ordered. A fracture of the right femur was confirmed and the resident was transported to the hospital for further evaluation.</p> <p>On 9/16/24 (three days after the incident), the facility conducted an investigation of Resident #2's accident. The facility interviewed all staff on duty who were involved in care for the resident on the day of the accident (9/13/24).</p> <p>All interviewed staff said Resident #2 was being moved from her bed to her wheelchair using a Hoyer lift and as she was being lowered into the wheelchair a popping noise from the resident's lower extremities was heard. She was evaluated by the nurse and given Tylenol and a lidocaine patch. Resident #2 continued to complain of pain and the physician was notified and a right knee x-ray was ordered.</p> <p>The 9/16/24 investigation documented Hoyer lift safety education and repeat demonstration, last calibration and safety inspection were performed on 6/28/24.</p> <p>The 9/18/24 interdisciplinary (IDT) risk management note identified during Resident #2's Hoyer lift transfer from bed to wheelchair, the resident complained of increased pain in her right knee. No deviations in the transfer or care were identified. The note documented that upon Resident #2's return from the hospital to the facility, the use of a full body sling would be implemented during Hoyer transfers for the resident to prevent pressure on the lower extremities. Additionally, the facility would report the resident's transfer injury to the sling manufacturer.</p> <p>The 9/18/24 vendor mechanical lift calibration log identified the facility's mechanical lifts passed the safety inspection on that date.</p> <p>The 9/25/24 inservice documented Hoyer lift transfer competency with full body sling and geri chair.</p> <p>The September 2024 quality assurance and performance improvement (QAPI) report in response to Resident #2's accident while being transferred on 9/13/24 was provided by the nursing home administrator (NHA) on 10/23/24 at 4:12 p.m.</p> <p>The QAPI report identified Resident #2's bilateral femoral fractures during a hooyer lift transfer and the use of a full body sling as an intervention upon her transfer back to the facility. It discussed training for staff on Hoyer lift transfers and the use of full body slings.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The root cause analysis, undated, identified a review into staff education regarding Hoyer lifts and transfer training prior to incident and Hoyer and transfer training post incident. It identified Hoyer and mechanical lift calibration preventative maintenance before and after the incident. It identified an audit of damaged slings with none identified and to increase sling par level. It indicated a review of documentation of preexisting health conditions, medication and diagnosis list and physician documentation.</p> <p>B. Identification of other residents</p> <p>The facility completed an audit and identified other residents in the building who were at risk due to using the Hoyer lift for transfers. A total of four other residents were identified and assessed for appropriate Hoyer lift slings.</p> <p>C. Systemic changes</p> <p>Nursing leadership re-educated the nursing staff in regards to Hoyer lift safety and the use of full body slings in an effort to prevent further accidents with Hoyer lifts for facility residents on 9/16/24 and 9/25/24.</p> <p>D. Monitoring</p> <p>The IDT, the director of nursing (DON) and the assistant director of nursing (ADON) were responsible for identifying and ensuring all residents that required Hoyer lifts for transfers had the appropriate sling. They were additionally responsible for ensuring all nursing staff were provided the education and reeducation on the correct use of Hoyer lifts and full body slings.</p> <p>III. Professional reference</p> <p>According to the Food and Drug Administration (FDA) Patient Lifts Safety Guide (10/1/24), retrieved on 10/24/24 from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/patient-lifts,</p> <p>To increase patient safety, use the correct type and size of sling for your patient. Select sling and sling bar based on manufacturer recommendations for the following criteria: type of transfer task, patient's medical condition, patient's size and weight, pressure sensitivity, need for full back support, need for head support, need for padding, patient' preferred or medically appropriate position.</p> <p>IV. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included dementia, fractures of left and right femur and osteoporosis.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Licensed practical nurse (LPN) #1 was interviewed on 10/23/24 at 1:45 p.m. LPN #1 said Resident #2 usually complained of pain while being transferred but 9/13/24 was the first day she continued to express pain after she was transferred into her wheelchair. She said Resident #2 continued to complain of leg pain after they had taken her to the dining room. She said she was given Tylenol and a lidocaine patch. She said Resident #2 continued to complain of pain and the facility contacted the physician and obtained physician's orders for an x-ray of the resident's right leg. She said after the x-ray was done, it was confirmed that there was a fracture in the resident's right femur. LPN #1 said Resident #2 was transported to the hospital via ambulance for further evaluation. She said after the resident was transported to the hospital, the facility found out that Resident #2 had fractures in both femurs.</p> <p>The DON was interviewed on 10/23/24 at 1:45 p.m. The DON said nursing staff, along with restorative nursing staff, had a meeting the following morning (9/14/24) after they found out that Resident #2 had bilateral femur fractures after being transferred into a wheelchair with a Hoyer lift. He said the staff did a demonstration using a split leg sling for a Hoyer lift during the investigation. He said during the demonstration, the Hoyer lift transfer, they identified that the straps from the sling that crossed under the resident's thighs caused the thighs to externally rotate and, depending on placement, could rest under the thighs above the knee. He said Resident #2 had a history of osteoporosis, was non-weight bearing and was at a high risk for fractures. The DON said the facility contacted the mechanical lift company to report the incident and the company told them they were not aware of a similarly reported incident. He said one intervention that was identified during the root cause analysis was to use only a full body sling to help keep Resident #4's legs in alignment and prevent contortion or pressure on the legs once she returned from the hospital. He said the other intervention the IDT identified was to conduct nursing staff reeducation on the use of Hoyer lifts and on the correct placement of the mechanical lift slings. He said they had enough full body slings in the facility to give to the four residents identified in the audit as using Hoyer lifts for transfers.</p> <p>VI. Facility follow up</p> <p>On 10/24/24 at 2:27 p.m., after the survey exit, the NHA sent a follow up email. In the email, the NHA said the IDT team, the DON and the ADON were responsible for ensuring the interventions identified were completed. She said reeducation with CNAs about Hoyer lift and proper slings began on 9/13/24 and continued 9/16/24, once the facility was updated from the hospital regarding Resident #2's bilateral femoral fractures. She said, to date, all nursing staff had been educated on the Hoyer lifts and slings. She said all identified residents that required the Hoyer full body slings had been distributed to the identified residents and the facility had a sufficient par level of the full body slings. The NHA said the facility was in the process of ordering additional full body slings to have on hand if needed.</p> <p>-However, despite the NHA's email indicating staff education for the Hoyer lifts started on 9/13/24 and continued on 9/16/24, according to the inservice education documents provided by the facility during the survey, the dates of the staff education were 9/16/24 and 9/25/24 (see facility plan of correction above).</p>		