STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065355	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharmar Village Care Center, Inc	1209 W Abriendo Ave Pueblo, CO 81004

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** 31820 Based on observations, record review and interviews, the facility failed to ensure the residents environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for one (#1) of three residents reviewed for accidents/hazards. Resident #1 had a diagnosis of advanced Huntington's disease (inherited disease that causes degeneration of the nerve cells in the brain) and was identified as a fall risk. Interventions for Resident #1 included a low bed and a fall mat. Resident #1 needed the assistance of two staff for transfers. On the morning of [DATE], certified nurse aide (CNA) #1 was assisting Resident #1 to get ready for the day. CNA #1 had lifted the bed from a low position to a higher position and had removed the fall mat to prepare to transfer Resident #1. CNA #1 stepped away from Resident #1 with the bed in a high position and left the room to find assistance for the transfer. While CNA #1 was away from Resident #1, she fell out of bed and was found on the floor lying on her right arm with the right side of her face against the floor. Blood was visible around Resident #1's head. Resident #1 was sent out to the hospital and received sutures to her right temple and was noted to have a sacral fracture. Resident #1 passed away on [DATE]. According to the death certificate the cause of death was decomposition following a mechanical fall. Findings include: I. Resident status Resident #1, age 67, was admitted on [DATE], readmitted on [DATE] and passed away on [DATE]. According to the [DATE] computerized physician's order (CPO), diagnoses included Huntington's disease and abnormal involuntary movements. The [DATE] minimum data set (MDS) assessment documented the resident was severely cognitively impaired with a brief interview for mental status (BIMS) of zero out of 15. The assessment identified a diagnosis of a progressive neurological condition. Resident #1 was identified as receiving hospice care. II. Fall on [DATE] (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility investigation dated [DATE] at 7:53 a.m. described the incident as, The CNA was providing care to the resident. The CNA stepped out of the room to ask for assistance to transfer the resident. the resident rolled out of the bed sustaining injury. The resident plan of care included an air mattress with winged overlay for sensory perception. The conclusion to the investigation documented, The staff member did not have a history of this type of incident. Staff member was providing care services to the resident and left the room to get a second staff member to assist with the transfer- the resident had a recent medication change causing her to be more alert. This is an educational opportunity to press the call light when extra assistance is needed and not to step out of the room. The fall investigation and progress note, dated [DATE] at 8:00 a.m., noted CNA #1 notified the nurse that the resident had fallen out of bed. The nurse immediately entered the room finding the resident lying on her right arm with the right side of her face against the floor. Upon examination, the nurse and the charge registered nurse (RN) found Resident #1 had a large hematoma to the right temple area which was bleeding. Her entire head was examined but no other injury was noted due to the blood and her hair. Her vital signs and neurological assessment were completed immediately. The area was cleaned immediately and pressure was applied to her right temple until the ambulance arrived. Her family and medical doctor (MD) were notified by the assistant director of nursing (ADON). III. Record review The care plan, initiated [DATE] and revised [DATE], identified the resident required assistance with self-care deficits including dressing and impaired physical mobility secondary to Huntington's disease. Interventions included transfers with a Hoyer lift with two or more staff as she allowed. The anticoagulant care plan, initiated [DATE] and revised [DATE], identified a risk for bleeding related to the use of an antiplatelet. Interventions included to notify physician of any problems or concerns. The fall care plan, initiated on [DATE], identified the resident had an active history of falls related to weakness. Interventions included: -Assist with transfers/ambulation as needed. -Call light within reach when possible. Another fall care plan, initiated [DATE] and revised on [DATE], identified a history of falls. Interventions included: -Assist with transfers/ambulation as needed. -Keep call light in reach. -Notify physician of any changes in condition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident to have a soft helmet on at all times while in bed and hard helmet on while out of bed. -Helmet for safety related to unsteady gait/balance related to Huntington's disease. -Winged mattress for sensory perception. Fall intervention related to overestimating when transferring in and out of bed. -Encourage floor mat next to bedside when the resident is laying in bed. The care plan, initiated [DATE] and revised [DATE], identified limited physical mobility related to Hintington's disease. Interventions included the resident was totally dependent on staff for locomotion. The care plan, initiated [DATE] and revised [DATE], identified a communication related to impaired cognition. Interventions included to ensure/provide a safe environment, call light in reach, adequate low glare light, bed in lowest position and wheels locked and to avoid isolation. She was admitted to hospice care on [DATE] for Huntington's Disease. The provider follow-up note dated [DATE] included history of falls: continue with helmet when out of bed and fall mat at bedside for safety. The progress note dated, [DATE] at 8:05 a.m., identified the facility called and notified the hospice provider of the fall with a hematoma on the right side of the head with difficulty controlling the bleeding. An order to send the resident to the emergency room (ER) for evaluation. The progress note dated, [DATE] at 8:22 a.m., included a message was left with the resident's daughter. The facility explained the resident had a fall with a head laceration to the right temple with bleeding. The progress note dated, [DATE] at 2:16 p.m., included the report from the hospital that the resident received six sutures to the head laceration and would need to keep pressure bandage on for at least the next 24 hours. The resident was found to have a sacral fracture. The hospice provider was notified about the update. The provider progress note dated, [DATE] at 1:53 a.m., included Patient found resting comfortably in bed. She has head wrapped with pressure bandage due to a recent fall with head laceration. Was treated in emergency room and returned to the facility. Continues under hospice care. The provider follow-up note dated [DATE] included history of falls: continue with helmet when out of bed and fall mat at bedside for safety. The provider progress note, dated [DATE] at 4:15 a.m., included in part, appears comfortable. Patient with sutured area on forehead. The interdisciplinary team (IDT) fall risk note, dated [DATE] at 8:31 a.m., included Related to resident rolling out of bed on [DATE]. Soft helmet while in bed and hard helmet when out of bed for safety related to weakness of body movements from disease process of Huntington's disease. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The hospice note dated, [DATE] at 1:10 a.m., included the patient was in her bed in the low position. The note included discussion of status with risk of a brain bleed was possible. Interventions provided included fall precautions to include a low bed and call light in place. The hospice note, dated [DATE] (time unknown), included the nurse left the patient's room with the patient lying supine and helmet on, call light in reach, and fall mat in place on the floor next to the bed. The facility investigation, dated [DATE] at 11:30 p.m., described the incident, resident passed away peacefully with family at bedside under hospice care. The conclusion to the investigation documented, the resident passed away peacefully. Resident was without brain injury from fall 8 (eight) days prior. Facility concluded resident expired due to Huntington's disease process. The death certificate for Resident #1 identified the date of death as [DATE]. The cause of death was identified as decompensation following a mechanical fall, hypovolemia (low blood volume), and cephalohematoma (blood under the scalp from an injury). The death certificate was signed on [DATE]. IV. Interviews CNA #1 was interviewed on [DATE] at 1:05 p.m. CNA #1 said staff would check with their supervisor when they arrived to see which residents were fall risks and on fall precautions/interventions. He said if the resident had a fall mat they automatically knew there were fall interventions for the resident. He said every resident on fall precautions had a fall mat and repositioning pillows. He said if someone had a fall they were to notify the nurse immediately after making sure the resident was safe. He said if a resident required the assistance of two people, staff were to use the call light and wait for assistance and never to leave the resident unattended. He said if a resident had a fall after the nursing assessment they were to be monitored every 15 minutes. CNA #2 was interviewed on [DATE] at 1:10 p.m. CNA #2 said she would know who was a fall risk from the medical record on kiosks and the fall mats next to the bed. She said there were checklists that identified specific needs of the resident. She said the information in the kiosk had the resident specific fall interventions. She said if a resident were to fall she was to make sure the resident was safe and call for a nurse to assess. She said if she needed assistance from another staff member she was not to leave the resident alone but she was supposed to use the call light and wait for assistance. RN #1 was interviewed [DATE] on 1:15 p.m. RN #1 said the fall interventions for each resident were in the physician's orders. She said if a resident fell , the CNAs were to call her or any nurse and the nurse who completed the initial assessment would complete an assessment, fill out a fall risk assessment and notify the director of nursing (DON). She said if the injury was severe, she would send out the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on [DATE] at 1:35 p.m. The DON said the Resident #1 had fallen from the bed that was not in the low position and the fall mat was not in place when CNA #1 had stepped out to get assistance with the transfer. She said the resident had fallen and hit her head on the floor and sustained a laceration to the right temple. She said the facility sent her out to the ER and made notifications to the hospice provider, the family and the physician. She said the hospital reported to the facility the laceration needed six sutures and to keep the pressure dressing on for 24 hours. The DON said CNA #1 acknowledged she failed to follow facility protocol and left a resident identified as a fall risk unattended which resulted in the resident falling out of bed. She said the resident passed away eight days after her fall. She said after the fall, the facility provided education on assistance with transfers. She said the CNAs had access to the fall interventions on the Kardex (a tool utilized by staff for providing consistent care for residents) that could be accessed by the kiosk. The nursing home administrator (NHA) was interviewed on [DATE] at 2:45 p.m. The NHA said CNA #1 was terminated after the incident. The hospice executive director ([NAME]) was interviewed on [DATE] at 4:45 p.m. The [NAME] said hospice assessed the resident after notification of the fall and when the resident returned to the facility. She said the facility called hospice about the fall and bleeding and the ER transfer on [DATE]. She said the resident had trauma to the right temple which required six sutures. She said the coroner's death certificate identified the cause of death as decomposition following a mechanical fall.