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	02/27/2025

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** 47350 Based on observation, record review and interviews, the facility failed to ensure three (#13, #17 and #5) of four residents reviewed for accidents out of 24 sample residents remained free from accidents. Resident #13, who was identified with osteoporosis after a pathological (fracture caused by disease processes rather than trauma) right femur fracture (thigh bone above the knee) that required hospitalization and surgery on 6/22/24, sustained a non-displaced [NAME] fracture (an ankle injury that involves a fracture of the proximal fibula) on 1/12/25. The facility failed to ensure and document a root cause analysis and implement timely person-centered interventions after Resident #13 sustained a right femur fracture on 6/22/24. Additionally, the facility failed to schedule osteoporosis screening and treatment which was recommended after the resident had surgical repair to the fractured right femur. The facility failed to ensure and document a root cause analysis and implement timely person-centered interventions after Resident #13 sustained the right fibula fracture on 1/12/25. Additionally, Resident #17 was admitted to the facility on [DATE]. Upon admission the facility implemented fall interventions as the resident was determined to be a fall high risk. On 11/17/24 Resident #17 sustained an unwitnessed fall and sustained a concussion, a contusion (bruise) to the knee, a laceration of the forehead and cervical strain related to her fall. The facility updated the resident's fall care plan on 11/22/24 to include placing a floor mat at her bedside whenever she was in bed. However, observations revealed the facility did not consistently implement the fall mat while the resident was in bed (see observations below). On 1/11/25 Resident #17 sustained another unwitnessed fall when she attempted to self-transfer from her wheelchair to her bed. The fall care plan did not document any new interventions. The facility initiated 15-minute checks overnight for the resident on 1/16/25, however the facility did not update the resident's care plan to include the 15-minute checks. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/3/25 Resident #17 sustained another unwitnessed fall, the cause of which was not determined. Resident #17 sustained another unwitnessed fall on 2/4/25 when she attempted to self-transfer from her wheelchair to a sofa in the main living area. Upon evaluation, it was found Resident #17 sustained sacral insufficiency fractures (stress fracture). The facility failed to implement new person-centered fall interventions to prevent future falls. Also, the facility failed to complete a thorough root cause analysis to determine how Resident #5 obtained a skin tear. Findings include: I. Facility policy and procedure The Incidents/Accidents policy and procedure, revised September 2016, was provided by the nursing home administrator (NHA) on 2/27/25 at 3:11 p.m. It read in pertinent part, All incidents/accidents are to be documented. In the progress notes document the date time and location of the incident/accident; document any assistive devices in use; vital signs should be documented; document a full description of any injuries; any resident statement of the account of the incident; document only what was observed; indicate when the physician was notified and any orders; indicate when the legal representative was notified. II. Resident #13 A. Resident status Resident #13, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician orders (CPO), the diagnoses included Alzheimer's disease, type 2 diabetes mellitus (DM), displaced fracture of right lower femur and non-displaced [NAME] fracture of right fibula. The 1/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. She was dependent on staff for toileting, personal hygiene, required substantial/maximal assistance with bed mobility, transfers and required set up assistance with eating. The assessment did not document the diagnoses of osteoporosis (disease that weakens the bones). -However, review of Resident #13's electronic medical record (EMR) revealed the resident had a diagnosis of osteoporosis. B. Observations On 2/24/25 at 1:00 p.m. Resident #13 was sitting in her room in a wheelchair with her feet down and resting on the foot rests on her wheelchair. Her right leg was in a splint. Resident #13's call light was lying on the floor next to the resident's wheelchair. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

A foot board (a special padded board that attaches onto the wheelchair foot rests to keep feet from sliding off) was not on Resident #13's wheelchair.

On 2/24/25 at 2:00 p.m. Resident #13 was sitting in her room in a wheelchair with her feet down and resting on the foot rests on her wheelchair. Her right leg was in a splint. Resident #13's call light was lying on the floor next to the resident's wheelchair.

A foot board was not on Resident #13's wheelchair.

C. Resident #13's representative interview

Resident #13's representative was interviewed on 2/24/25 at 2:34 p.m. Resident #13's representative said she was told by a certified nurse aide (CNA), after Resident #13 returned from the hospital on 1/12/25, that she had transferred Resident #13 by herself and pivoted Resident #13 from the wheelchair to the bed. She said she had a care conference with the facility after the 1/12/25 fracture and told the facility because of Resident #13's fractures that two people needed to transfer her at all times for safety reasons. She said the facility told her that they would be using a hoyer lift with two people at all times.

D. Record review

1. Care plan

The activities of daily living (ADL) care plan, initiated 4/12/23, indicated Resident #13 had impaired physical mobility due to a right lower extremity fracture. Interventions included non-weight bearing on the right lower extremity (initiated 6/30/24 and revised 1/16/25) and required two people with the use of a hoyer lift (initiated 7/16/24 and revised 1/16/25).

The osteoporosis care plan, initiated 1/14/25, indicated Resident #13 had bone loss. Interventions included staff to observe for complaints of pain, completing labs per orders and reporting to the physician.

The fall/injury care plan, initiated 4/6/23, indicated Resident #13 was at risk for falls and injury. Interventions included assisting with transfers/ambulation as needed (initiated 4/6/23), completing fall risk assessment upon admission and quarterly (4/6/23), instructing and reinforcing safety awareness measures (4/6/23), keeping call light in reach (4/6/23), non skid socks/footwear (initiated 6/28/24 revised 6/28/24), encouraging bed to be in low position (initiated 6/28/24) and wheelchair with foot pedals and foot board at all times (initiated 1/15/25).

-However, observations revealed the resident did not have a foot board in place on her wheelchair (see observations above).

-A review of the comprehensive care plan revealed the osteoporosis care plan was not initiated until 1/14/25, the wheelchair foot boards was initiated on 1/15/25 and the use of the Hoyer lift with two people was re-initiated on 1/16/25, after Resident #13 experienced a second right lower extremity fracture.

2. Incident on 6/22/24

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The 6/22/24 nursing progress note, documented at 12:30 p.m., revealed Resident #13's right knee was swollen and she was unable to bend her knee. The nurse practitioner was notified. Vital signs were taken. The resident was administered Tylenol for pain in her right knee. The resident was sent out to the hospital for evaluation and treatment.

The 6/22/24 physical abuse investigation documented Resident #13 complained of pain in her right knee which was revealed to be a fracture above her knee. On 6/22/24, in the morning, Resident #13 was a stand pivot transfer by a CNA and had been up to the shower, up in her wheelchair for activities and laid down after lunch. Resident #13 denied anyone hurting her and there were no behavior changes. Staff were interviewed and did not witness any event that was a causative factor. Resident #13 was admitted to the hospital and required surgery to her right lower femur (thigh bone). The surgical report revealed specialized clips were used due to her brittle bones. The report of physical abuse was unsubstantiated.

-However, there was no identification of a root cause analysis being completed after the resident sustained a right lower femur fracture and there were no person-centered interventions implemented after the resident sustained the fracture.

The 6/22/24 hospital progress note documented Resident #13 had a displaced fracture of the right femur and was admitted for orthopedic consult and possible surgery.

The 6/24/25 hospital physical therapy (PT) note documented Resident #13 was up with two person assistance using a stand-pivot transfer on the left. Right lower extremity precautions were weight-bearing as tolerated for transfers.

The 6/25/24 hospital progress note documented Resident #13 had an open reduction internal fixation (ORIF) of the right femur (a surgical procedure to realign the bone and stabilize the fracture), done on 6/23/24. It recommended an outpatient osteoporosis screening and treatment.

-However, the facility failed to schedule the osteoporosis screening until March 2025, nine months after it was recommended (see facility follow up below).

-A review of the EMR failed to reveal an interdisciplinary team (IDT) risk management review note of the 6/22/24 incident and root cause analysis with any interventions that needed to be implemented to prevent any further fractures.

Review of the July 2024 CPO revealed the following physician's orders related to transferring the resident:

-Use a Hoyer lift for transfers, ordered 7/8/24 and discontinued 7/15/24.

-Weight bearing as tolerated for transfers only to the right lower extremity, ordered 7/15/24 and discontinued 7/17/24.

The 8/8/24 PT discharge summary notes documented Resident #13 was substantial/maximal assistance for transfers.

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Level of Harm - Actual harm

Residents Affected - Few

Review of the August 2024 CPO revealed a physician's order for the resident to be weight-bearing as tolerated, ordered on 8/16/24 and discontinued 1/12/25.

3. Incident on 1/12/25

The 1/12/25 nursing progress note documented Resident #13 was calling out in pain and had swelling and heat in her right knee and ankle. The physician was notified and an x-ray was requested of the knee and ankle. The resident was given ibuprofen for pain per physician's order.

The 1/12/25 nursing progress note documented the x-ray report identified a spiral fracture to the right lower extremity. Resident #13 was sent to the hospital emergency room for evaluation and treatment.

The 1/12/25 nursing progress note documented the resident returned to the facility with a cast.

The 1/12/25 physical abuse investigation documented Resident #13, before she got up in the morning, complained of pain to her right leg with swelling in her right knee and ankle. The right knee and ankle were warm to the touch. The physician was notified and an x-ray was obtained. The x-ray results indicated a spiral fracture to her right lower extremity. The resident was sent to the hospital for further evaluation and treatment. The resident had no recent history of falls or trauma. The activities director (AD) reported that on 1/11/25 the resident turned herself in her wheelchair which caused the affected leg to be twisted in front and outside the front of the wheel.

CNA #4 reported on 1/11/25 she changed Resident #13 before getting her up for dinner and she grimaced and complained of leg pain. She asked the nurse to assess her and the nurse gave her medication for pain. CNA #4 said she was then able to transfer Resident #13 to the wheelchair with a gait belt. The report of physical abuse was unsubstantiated.

-However, there was no summary of a root cause in the physical abuse investigation or identification and implementation of interventions to prevent future fractures.

Review of the January 2025 CPO revealed a physician's order to use a Hoyer lift for transfers, ordered 1/12/25.

The 1/15/25 quarterly care conference documented Resident #13's transfers were to be with a Hoyer lift with two people at all times.

-A comprehensive review of the resident's EMR failed to reveal an IDT risk management review note of the 1/12/25 incident and root cause analysis with interventions that needed to be implemented to help prevent any further fractures.

E. Staff interviews

Registered nurse (RN) #1 was interviewed on 2/26/25 at 10:00 a.m. RN #1 said Resident #13 was totally dependent on staff for transfers and required two person assist with the use of a Hoyer lift. She said prior to the most recent fracture, she was a one person extensive assistance with pivot transfers.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #2 was interviewed on 2/26/25 at 11:10 a.m. CNA #2 said Resident #13 was full weight-bearing before she fractured her femur bone in June 2024. She said after Resident #13 returned from the hospital in June 2024, Resident #13 required the use of a Hoyer lift until PT cleared her to be a two person transfer assist. She said Resident #13 needed a Hoyer lift after she experienced a fracture in her right leg in January 2025 for safety reasons. The director of rehabilitation (DOR) was interviewed on 2/26/25 at 11:20 a.m. The DOR said that prior to her fracture in June 2024, Resident #13 was full weight-bearing. The DOR said after Resident #13 returned from the hospital, she was maximum assistance of two people for transfers. He said an order for a Hoyer lift was in place from 7/8/24 to 7/17/24 and then she was cleared to be weight-bearing as tolerated on her right lower extremity with one to two person assistance. He said after her second fracture, she was required to be a Hoyer lift. He said he did education with nursing staff at that time on transfers, Hoyer lift use and how to manage her splint/cast. The director of nursing (DON) and the NHA were interviewed together on 2/26/25 at 11:55 a.m. The DON said prior to Resident #13's fracture in June 2024, there were no precautions in place and she was a one person pivot transfer. She said prior to the fracture in June 2024, staff were assisting Resident #13 in the morning and she was complaining of right knee swelling and pain after they put her back to bed. She said the staff noticed at that point that her right knee was swollen. She said during the investigation and staff interviews, they were unable to identify any events that happened before that may have contributed to the fracture. The DON said it was not identified until after Resident #13 had surgery in June 2024 that she had a significant osteoporosis. The DON said after Resident #13 returned from the hospital she was a two person Hoyer lift for transfers and worked with therapy to build up her strength and endurance. She said in August 2024 PT felt she could stand and pivot with her lower extremities. The DON said during the physical abuse investigation for the fracture in January 2025, staff indicated that on 1/11/25 Resident #13 was observed by staff members to be moving her wheelchair herself and had caught her right leg in front of the wheel on her wheelchair and may have twisted it. She said they reviewed camera footage and Resident #13 moved herself around in her wheelchair with poor safety awareness and would catch her leg against the door. She said Resident #13 did complain of some increased pain in the evening of 1/11/25 that was medicated with Tylenol. She said when staff tried to get Resident #13 up in the morning for breakfast Resident #13 was complaining of extreme right knee pain. The DON said staff then noticed her knee was red and swollen. She said the physician was notified and an x-ray was ordered. She said when the results of the x-ray came back positive for a fracture, Resident #13 was sent to the hospital for further evaluation and treatment. She said after she returned from the hospital, the intervention that was implemented for Resident #13 was to make her a two person Hoyer lift for safety reasons. The NHA said the facility had incident reports and physical abuse investigations which summarized their findings. She said the facility did not have a formal IDT root cause analysis which documented the findings with interventions in the resident's EMR. She said their process was informal and verbal. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #4 was interviewed on 2/27/25 at 1:15 p.m. CNA #4 said Resident #13 was a one pivot transfer prior to her fracture in January 2025. She said on 1/11/25 Resident #13 was up for breakfast and went to activities. She said she laid Resident #13 back down after activities. She said she tried to get Resident #13 up and she was tearful and complaining of right knee pain. She said she contacted the nurse to assess and Resident #13 was medicated with Tylenol. She said she was contacted by the facility later that Resident #13 had experienced a leg fracture. She said the facility watched the cameras for the day and they saw Resident #13 had reached down after she had twisted her leg. She said she was not aware of any other additional interventions to help prevent fractures. She said Resident #13 had foot pedals but she would take her feet off the pedals to self propel herself in the wheelchair. E. Facility follow up The facility fractures root cause analysis and timeline was provided by the NHA on 2/28/25 at 5:10 p.m. (after the survey). It documented the undated root cause of the 6/22/24 femur fracture was due to Resident #13's bone demineralization that was identified during surgery. The exact cause of the fracture was unknown. Interventions included transfers with a Hoyer lift and working with PT. On 7/15/24 she had an order by orthopedics that she could be weight-bearing as tolerated for transfers only. She was discharged from PT on 8/19/24 with a substantial maximal assistance of one person for transfers and remained wheelchair bound for mobility. The 1/12/25 fracture root cause analysis, undated, identified Resident #13's osteoporosis as a contributing factor. The resident was participating in activities and the facility suspected the resident twisted her leg when independently moving her wheelchair. Resident #13 was identified to lock her wheelchair and then tried to move forward and dragged her leg. After returning from the hospital to the facility, she was a Hoyer lift transfer, a footboard was to be in place and two people assisted for care. PT services were involved for strengthening of the upper extremity, ADLs and wheelchair positioning. The medical director letter, undated, documented a nondispaced spiral fracture of the right tibia and closed fracture of the proximal right fibula which were due to demineralization of the bone, severe peripheral vascular calcification and advancement of her comorbidities. A DEXA scan (a scan that measures bone density) was scheduled for March 2025. -However, osteoporosis screening and treatment was ordered nine months after osteoporosis was identified during an ORIF to the right femur and two months after Resident #13 sustained a second fracture to her right lower extremity. 50219 III. Resident #17 A. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included dementia, generalized muscle weakness, osteoarthritis, osteoporosis and a history of falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 2/13/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS assessment score of three out of 15. The resident was dependent on staff for most ADLs. B. Resident friend and representative interviews Resident #17's friend was interviewed on 2/26/25 at 1:30 p.m. The resident's friend said she felt Resident #17 was declining and wanted to sleep all the time. The resident's friend said Resident #17 had fallen several times at the facility, during which she had fractured her tailbone and had received seven stitches in her head. The resident's friend said the falls were serious. The resident's friend said there was someone sitting with Resident #17 for ten hours per day. The resident's representative was interviewed on 2/26/25 at 1:32 p.m. The resident's representative said Resident #17 had several falls within the months prior and sustained some injuries. The resident's representative said she thought some of Resident #17's falls had been the result of her trying to get out of bed without calling for help due to her dementia. She said she had asked the facility staff how they could prevent her falls, to which the facility said they were trying to monitor Resident #17 more closely. C. Resident observations On 2/25/25 at 1:11 p.m. Resident #17 was lying in her bed. The fall mat was folded up beside the one-on-one caregiver's chair. On 2/26/25 at 9:24 a.m. Resident #17 was lying in the fetal position in her bed. The fall mat was not in place and was folded up beside the one-on-one caregiver's chair. On 2/27/25 at 1:35 p.m. Resident #17 was lying in her bed. The fall mat was folded up beside the one-on-one caregiver's chair. D. Record review The fall care plan, initiated 10/7/24, revealed Resident #17 was at an increased risk of falls and/or serious injury related to falls due to a recent fall resulting in fractured vertebrae and antidepressant medication use. Pertinent interventions, initiated on 10/7/24, included encouraging Resident #17 to have the bed in lowest position, encouraging non-skid socks and footwear, keeping frequently used items within reach, assisting with transfers as needed and administering medications as ordered. An intervention for a floor mat at bedside while Resident #17 was in bed was initiated on 11/22/24. -However, Resident #17's care plan was not updated after her falls on 1/11/25, 2/3/25 and 2/4/25 (see below). A fall risk evaluation, dated 10/2/24, revealed Resident #17 was at a high risk for falling. A progress note, dated 11/8/24 at 2:33 p.m., revealed Resident #17 was discharged from skilled services with physical therapy. An order for an anti-rollback device for Resident #17's wheelchair was placed due to the resident transferring without asking for assistance because of her dementia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 11/11/24 at 10:46 a.m. revealed the facility received orders to place an anti-rollback device on Resident #17's wheelchair. -However, review of Resident #17's care plan did not reveal documentation regarding the implementation of anti-rollbacks for Resident #17. 1. Fall incident on 11/17/24 - unwitnessed A fall risk evaluation, dated 11/17/24 at 12:34 p.m., revealed Resident #17 was at a high risk for falling. A progress note, dated 11/17/24 at 4:43 a.m., revealed Resident #17 was found on the floor at 3:45 a.m. by a CNA. Resident #17 had blood on her gown and was bleeding from her head. Resident #17's vital signs and neurological examination were within normal limits. The nurse performing the assessment alerted Resident #17's provider and received orders to send the resident out for evaluation. Resident #17 was transferred to the emergency room at 4:05 a.m. The facility fall report, dated 11/17/24 at 4:28 a.m., revealed Resident #17 was found on the floor with her head underneath her bed. The resident's bed was in the lowest position. The report documented it appeared Resident #17 had been trying to get up and had repeatedly hit her head against the bars underneath the bed as evidenced by blood on them. Resident #17's bed was moved away from her to avoid further injuries. An abrasion was noted to the top of Resident #17's scalp. The report documented the predisposing environmental factors included the furniture and poor lighting. The report documented predisposing physiological factors included incontinence, weakness, and gait imbalance. -The report did not identify a root cause of Resident #17's fall or include what interventions were put into place. Hospital notes, dated 11/17/24 at 9:46 a.m., revealed Resident #17 presented to the emergency room after a sudden fall at the facility. Resident #17 sustained a concussion, contusion of the knee, laceration of the forehead, requiring stitches, and cervical strain related to her fall. A progress note, dated 11/17/24 at 10:10 a.m., revealed Resident #17 had returned to the facility. Resident #17 had swelling and bruising to both eyebrows, both eyelids and both knees. Resident #17 had seven stitches in place over the left side of her forehead. An administrative note, dated 11/18/24, revealed Resident #17 was found on the floor next to her bed during the night. The facility staff determined Resident #17 had increased confusion. A floor mat was added for a fall intervention. -However, observations during the survey revealed the floor mat was not consistently utilized. 2. Fall incident on 1/11/25 - unwitnessed A fall risk evaluation, dated 1/11/25 at 4:00 p.m., revealed Resident #17 was at a high risk for falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 1/11/25 at 4:00 p.m., revealed Resident #17 had an unwitnessed fall in her room after she self-transferred from her wheelchair to her bed. Resident #17 was assessed by the nurse and her vital signs and neurological assessment were within normal limits. Resident #17 denied any pain and her skin was intact without evidence of injury. Resident #17 was encouraged to use the call light to request assistance from the staff. The provider and Resident #17's representatives were contacted. The facility fall report, dated 1/11/25 at 4:00 p.m., revealed Resident #17 was found on the floor next to her bed. Resident #17 was sitting on top of a blanket which was on top of her floor mat. Resident #17 was sitting on her buttocks with her legs out in front of her. Resident #17 was wearing regular (not non-skid) socks and her shoes were across the room. Resident #17's wheelchair was within her reach. Resident #17 had attempted to self-transfer without calling for assistance. Resident #17 was encouraged to call for help if she wanted to get into bed. The report documented physiological factors included gait imbalance, impaired memory and weakness. The report documented predisposing situational factors included ambulating without assistance and improper footwear. An administrative note, dated 1/15/25, revealed Resident #17 was transferring herself without non-skid socks. Resident #17 was given non-skid socks and given education to wear the socks at all times to help with transferring herself. Resident #17 was educated on calling for assistance when attempting to transfer herself and having staff assist her with transfers. -However, review of the resident's care plan revealed non-skid socks were implemented on 10/7/24 and a new person-centered intervention was not implemented after the fall on 1/11/25. 3. Fall incident on 2/3/25 - unwitnessed A fall risk evaluation, dated 2/3/25 at 3:44 a.m., revealed Resident #17 was at a high risk for falling. A progress note, dated 2/3/25 at 2:50 a.m., revealed Resident #17 was found lying on the floor next to her bed. Resident #17 said she did not know how she got on the floor, but said she hit everything on her body very hard on the floor and that her buttocks hurt. Resident #17 was assessed by the nurse and her vital signs and neurological assessment were within normal limits. Resident #17 did not have any obvious signs of injury. Resident #17 was assisted back into bed and repositioned for comfort with her call light within reach. The facility fall report, dated 2/3/25 at 2:50 a.m., revealed Resident #17 was found out of bed lying on the floor. Resident #17 said she did not know what she was doing. Resident #17 said she hit the floor hard and that her buttocks hurt. The report documented predisposing physiological factors included gait imbalance and impaired memory. The report documented predisposing situational factors included ambulating without assistance and improper footwear. Resident #17 was out of bed without assistance and was not wearing any footwear. Resident #17's call light was within reach. A progress note, dated 2/3/25 at 12:30 p.m., revealed the facility received new orders for x-rays of Resident #17's lumbar spine, sacrum and both hips. Resident #17's representative was notified of these new orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Sharmar Village Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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

A progress note, dated 2/3/25 at 5:47 p.m., revealed Resident #17 was being monitored for a witnessed fall (however, the fall was unwitnessed). Resident #17 said she had pain in her sacral area. Resident #17 was receiving acetaminophen every six hours as needed and had a new order for tramadol as needed, but the tramadol was not available at that time. Resident #17 did not have much of an appetite due to her pain.

-The report did not identify a root cause of Resident #17's fall or include what person-centered interventions were implemented.

A progress note, dated 2/4/25 at 8:40 a.m., revealed Resident #17's x-ray results revealed she did not have any acute fractures.

4. Fall incident on 2/4/25 - unwitnessed

A progress note, dated 2/4/25 at 8:57 a.m., revealed Resident #17 was lying on the floor in the hallway after breakfast. Resident #17 said she fell out of her wheelchair. The nursing staff at were not able to determine if Resident #17 hit her head during the fall. Resident #17 was yelling out in pain when trying to move. Resident #17 was sent to the emergency room for evaluation.

A hospital note, dated 2/4/25 at 1:33 p.m., revealed Resident #17 presented to the emergency room after a fall at the facility. Resident #17 had pain in her buttocks and left leg and hit her head. The hospital note documented the facility staff reviewed camera footage after the incident and saw Resident #17 fall forward onto the ground from her wheelchair. Resident #17 was found to have bilateral sacral insufficiency fractures.

A progress note, dated 2/4/25 at 3:31 p.m., revealed Resident #17 returned to the facility. Resident #17 had a non-operable sacral insufficiency fracture and was ordered acetaminophen for her pain.

A progress note, dated 2/4/25 at 6:02 p.m., revealed Resident #17 had been found in the common area after breakfast that morning and tried to lie down or transfer herself to the couch. Resident #17 was found on the floor on her side. Resident #17 was wearing shoes and the anti-rollback device was on her wheelchair. Resident #17 was assessed for injury but was unable to move her limbs related to her pain. Resident #17's practitioner and representative were contacted and the resident was sent to the emergency room for evaluation.

An administrative note, dated 2/6/25, revealed Resident #17 was sitting in the common area waiting for breakfast. Resident #17 was uncomfortable and attempted to transfer herself to the couch. She was found on the floor in front of her wheelchair. Resident #17 had a fall the night prior. Resident #17 had fallen early in the morning for both falls. Resident #17 had a one-on-one companion at the time of the note while her pain management was addressed.

-Review of the resident's care plan did not identify a new person-centered intervention that was implemented following the fall and did not include the one-to-one companion.

A progress note, dated 2/12/25 at 1:40 p.m., revealed Resident #17 was moved to a new room.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

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	An interdisciplinary team progress note, dated 2/14/25 at 8:58 a.m., revealed Resident #17 had a recent fall. The team would continue to focus on pain management and positioning for Resident #17. Resident #17 was added to a one-on-one activity program. E. Staff interviews CNA #1 was interviewed on 2/26/25 at 2:43 p.m. CNA #1 said fall interventions were found in the resident's Kardex (staff directive tool). CNA #1 said the Kardex detailed if the resident needed a floor mat, how they needed to be transferred, and if they were a high fall risk. CNA #1 said Resident #17 wanted to