STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065367	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care and Rehabilitation Center, The	9221 Wadsworth Pkwy Westminster, CO 80021

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** 41032 Based on observations, record review, and interviews, the facility failed to ensure one (#1) of three residents reviewed for falls (#1) out of four sample residents received adequate supervision and assistance to prevent falls with injury. Resident #1 was admitted to the facility on [DATE] for rehabilitation therapy after undergoing surgical repair for a fractured right femur. The facility was aware upon the resident's admission for skilled nursing services that she had several falls in her prior living setting which resulted in the need for surgical repair after the resident fell and fractured her right femur. The facility also was aware that the resident needed to maintain non-weight-bearing status of her fractured leg. The resident was in the facility for two days when she fell on [DATE] at the bedside. Following this first fall, the resident fell an additional four times. The facility failed to prevent the resident from falling on 7/23/24, 7/25/24, 7/30/24, and 8/9/24. According to the director of nursing (DON), the interdisciplinary team (IDT) met after each fall. However, the IDT failed to assess the effectiveness of planned interventions and implement consistent and effective interventions to prevent the resident from repeated falls. The facility failed to consider interventions that had worked well and build upon the most effective interventions to provide consistent care and services to ensure the resident was safe and free from injuries related to accidental falls. The nurse's notes documented that the resident repeatedly tried to get up from her wheelchair and get out of bed. The resident's representative said she asked staff to involve the resident in meaningful activities to distract her from her continual attempts to get out of bed and to keep the resident out of her room. Facility staff provided these services on occasion, but the interventions were not consistently implemented. All the resident's falls occurred in her room from bed when the resident was not under the direct supervision of staff. Facility assessments and nurse's notes revealed that Resident #1 was impulsive, lacked safety awareness, and had a significant impairment in cognitive functioning. Yet, the resident's care plan included encouragement to use the call light, which staff reported the resident was unable to grasp the concept of using, and to wait for staff assistance. (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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(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	Finally, the facility failed to find out why the resident was trying to get out of bed and out of her wheelchair and to offer her sufficient interventions when she expressed a desire to get out of bed and walk. Rather, the record revealed staff tried to redirect the resident back into bed or back into her wheelchair, causing the resident increased agitation and anger. On 7/30/24, the resident experienced her fourth fall in the facility. Following the fall, the resident sustained a dislocated hip at the site of her recent right hip surgical repair. The resident returned to the operating room for a second surgery on the same hip (right) that she fractured a few weeks before. The resident returned to the facility on [DATE] after having her dislocated hip surgically repaired following the 7/30/24 fall in the facility. She was fitted with an immobilizer on her right leg to prevent excessive movement of the leg as it healed. However, the IDT failed to reassess the resident for post-surgical status to determine whether additional interventions needed to be implemented to keep the resident safe as she recovered from her surgery. The resident was in the facility for approximately 48 hours when she fell for the fifth time on 8/9/24 at approximately 11:15 p.m. The resident expressed pain and staff put her in bed as she was in isolation after testing positive for COVID-19. Sometime between (8/9/24) 11:30 p.m. and (8/10/24) 9:00 a.m., the nursing staff heard the resident calling out and when they checked on her, they found that she had removed the immobilizer and her right leg was in an abnormal placement. Staff failed to respond to the resident's change in condition in an appropriate and timely manner. Instead of calling the emergency medical services (EMS), the nursing staff called a mobile x-ray provider to come to the facility to perform an x-ray. At 9:07 a.m., when the technician refused to touch or move the resident, the nurse called the physician for advice on what to do. The staff's response to the resident's change of condition delayed the resident receiving timely assistance for her injury and left the resident in an awkward position, lying on the side of the bed in pain as she waited for a medical professional to respond. Resident #1 was transferred to the hospital again at approximately 9:40 a.m. for surgical repair of her right hip and did not return to the facility. The facility's failure to develop an effective response to the resident's known fall risk factors contributed to the resident re-injuring her repaired right femur (hip) twice. This in turn contributed to pain and two additional surgeries to repair the damage to the resident's right hip. Findings include: I. Facility policy and procedure The Falls and Fall Risk, Managing policy and procedure, revised March 2018, was provided by the nursing home administrator (NHA) on 10/9/24 at 10:38 a.m. It read in pertinent part: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to the MDS (minimum data set) assessment, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise when a resident is found on the floor, a fall is considered to have occurred. 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (hip padding or treatment of osteoporosis, as applicable) to try to minimize the serious consequences of falling. Monitoring Subsequent Falls and Fall Risk: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention causes that may not previously have been identified. II. Resident #1 A. Resident status - known fall risk factors - facility response 1. Known fall risk factors - diagnoses and assessments Resident #1, age over 65, was admitted on [DATE], readmitted on [DATE], and discharged on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included dementia, anxiety, depression, insomnia, lack of coordination, muscle weakness and arthritis, presence of right hip fracture, and artificial joint. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall risk assessment, dated 7/15/24, documented Resident #1 was disoriented to person, place, and time all of the time; had balance problems while standing and walking; decreased muscular coordination; and required the use of a manual wheelchair to get around. At the time of the assessment, the resident had prior falls in the last three months, took medications, and had predisposing diseases increasing her risk for future falls. The resident's fall risk score indicated that she was at risk of falling. A nurse's note, dated 7/16/24, revealed that Resident #1 was admitted to the facility on [DATE] with a diagnosis of right hip hemiarthroplasty (fracture repair) for a skilled therapy stay. The resident was alert and oriented to self only and was confused and forgetful. The resident had poor safety awareness and often attempted to get out of bed on her own. The resident was a fall risk and had three falls while living at a previous memory care unit before admitting to the hospital with a fractured hip. The resident required non-weight bearing on her right leg and used a mechanical lift assisted by two staff when transferring from surface to surface. Despite the need for assistance with transfers, the resident made attempts to get up on her own and needed reminders and encouragement to call staff for assistance. The 7/21/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident used a manual wheelchair for mobility and was unable to walk or put weight on her right leg. -The resident was dependent on staff to transfer surfaces, toilet, bathe, perform personal hygiene, and put on and take off clothing. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. -The resident had a fall in the month before admission with a fracture and had one fall in the facility at the time of the assessment. The resident was taking opioid, antipsychotic, antianxiety, and antidepressant medications. 2. Facility's response A review of the resident's care plan revealed a baseline care plan dated 7/16/24 that documented Resident #1 was a fall risk and was admitted to the facility to improve physical function. Interventions included physical and occupational therapy services. The resident's comprehensive care plan, initiated on 7/17/24, included a care focus for falls, incontinent care, and activity of daily living (ADL) deficits. The care plan revealed: -Resident #1 was at risk for ADL deficits related to a fractured right hip, dementia, need for two staff assistance with transfers, incontinence, and right-sided pain; risk for dislocation of the right repaired hip; and need for continuous cueing to ensure completion of self-care tasks. -Resident #1 was at risk for falling related to a history of falling and sustaining serious injury (fracture to the right hip) before admission to the facility. The resident required assistance with ADLs including mobility, repositioning, toileting, and transferring. The resident required monitoring and prompting due to cognitive impairment, poor safety awareness, and impulsivity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident #1 was independent with mobility when in her manual wheelchair but would try to stand without waiting for staff assistance. The interventions to address the resident's care needs included: assisting the resident with physical needs for repositioning, getting water to drink, constipation, pain, and other care needs, checking for incontinence, performing peri care as indicated three times a day, and providing one to one supervision and encouraging independent and group activities when the resident experienced episodes of anxiety starting 7/17/24. B. Falls after admission Record review revealed the resident was in the facility for two days when she fell for the first time at the bedside. Following the first fall, the resident fell an additional four times, on 7/23/24, 7/25/24, 7/30/24, and 8/9/24. The nurse's notes revealed the resident repeatedly tried to self-transfer from her wheelchair and bed, was confused, became angry when redirected, and was not able to learn or understand how to use the call light. 1. 7/19/24 to 7/23/24 - first fall A nurse's note dated 7/19/24 revealed the resident had a fall witnessed by the nurse as they approached the resident's room. The resident slid from her bed straight down to sit on her bottom (buttocks) on her floor mat. The resident did not hit her head and was at baseline mentation (cognition) when assessed. The resident had AROM (active range of motion) in all extremities and denied having pain. The resident was wearing a nightgown and no shoes at the time of the fall. The bed was in a low position and the fall mat remained in place. A nurse's note, dated 7/20/24, revealed that the resident was at baseline for fall charting related to the witnessed non-injury fall on 7/19/24. The resident was at baseline cognitively but had been exhibiting calling-out behaviors more frequently. Pain medications were administered for pain per the physician's orders. The IDT review note dated 7/22/24 revealed the IDT determined the resident's care plan was being followed at the time of the resident's fall on 7/19/24. The IDT recommended non-skid socks be implemented. 2. 7/23/24 - 7/24/24 - second fall - repeated attempts to get out of bed and wheelchair - failure of the facility to develop effective interventions to address this behavior A nurse's note, dated 7/23/24, documented that the certified nurse aide (CNA) on duty responded to Resident #1's call light at 1:39 a.m., and found the resident trying to get out of bed. The resident was transferred to her wheelchair and provided coffee per the resident's request. Another nurse's note, dated 7/23/24, revealed that while walking by Resident #1's room at approximately 5:45 a.m., the floor nurse heard Resident #1 call out for help when she could not get up off the floor. The resident was found kneeling on the fall mat with her right arm leaning against the bed. The bed was observed to be in the lowest position, the fall mat was in place and the call light was clipped next to the resident's pillow. When asked what happened the resident said she fell and could not get up. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident complained of pain in the right shoulder and was assessed to have weakness in the right leg (the leg with the hip fracture). The nurse and CNA assisted the resident to bed and applied an ice pack to the resident's right shoulder. The nurse educated the resident to use her call light if she needed assistance. The nurse left a voice message for the resident's physician and notified the director of nursing (DON). A clinical summary note, dated 7/23/24, revealed Resident #1 woke up at 1:00 a.m. (on 7/23/24) and was up in her wheelchair in the hall with nursing staff until 5:00 a.m. The resident was assisted back to bed at 5:00 a. m. and was found on the floor at the bedside at approximately 5:45 a.m. The resident would not go back to sleep after the fall and was assisted back into her wheelchair. Resident #1 complained of soreness in her right shoulder throughout the day after falling but was still able to move her arms and legs. The resident refused offers for pain medication. The summary continued that Resident #1 was restless throughout the day shift and continually attempted to get up out of her wheelchair; removed her oxygen; continually asked staff what she should be doing and at times became worked up and angry towards staff. Resident #1 needed constant redirection and reorientation and was only redirectable for short periods. The note also revealed that the resident was often confused and needed reorientation to the situation, place, and time. The call light was within reach but the resident was unable to learn the use of the call light to ask for assistance, requiring the initiation of frequent checks on the resident throughout the shift. A nurse's note, dated 7/24/24, revealed Resident #1 was up in her wheelchair throughout the day shift. Resident #1 slept some in her chair and made constant attempts to stand on her own from the wheelchair and needed constant reminders and encouragement to stay seated. The resident participated in some (recreational) activities and worked with the therapy providers. Despite the resident's call light being within reach, the note read Resident #1 was unable to learn or understand how to use the call light. It further read the resident has poor safety awareness and is compulsive, staff frequently provide reorientation and redirection. Frequent checks on the resident were provided throughout the shift. Another nurse's note, dated 7/24/24, documented Resident #1 was in bed asleep at 11:20 p.m., with her bed in the lowest position, fall mat in place, and call light within reach. The resident had been instructed to push the call button for assistance. See above; record review revealed repeated documentation of the resident's restlessness, confusion, and frequent attempts to stand on her own from her wheelchair and to get out of bed, prompting the initiation of frequent checks on 7/23/24 and 7/24/24; however, the record failed to reveal the facility identified the reasons why the resident continued to try to self-transfer and how this behavior could be effectively addressed. A review of the resident's care plan failed to include interventions to effectively address the behavior. While the nurse's notes revealed the resident was redirected and reoriented, this was only effective for short periods and, at times, increased the resident's agitation and anger. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The resident's representative (see interview below) said she had asked staff to involve the resident in meaningful activities to distract her from her continued attempts to get out of bed and to keep the resident out of her room. Facility staff provided these services on occasion, but the interventions were not provided consistently despite the care plan documenting an intervention for staff to provide one-to-one support and/or encourage group and or individual activities when the resident was presenting with symptoms of anxiety. The facility failed to ensure these interventions were consistently implemented. All the resident's falls occurred in her room from bed when the resident was not under the direct supervision of staff.

While the 7/23 and 7/24/24 nurse's notes documented the initiation of frequent checks throughout the shift, this was not added to the care plan. A review of the care plan revealed no revisions to the plan until after the resident's third fall on 7/25/24 (see below).

Finally, the review of the nurse's notes for 7/23/24 and 7/24/24 indicated staff continued to remind and encourage the resident to stay seated, to instruct the resident to use her call light for assistance, and to remind the resident to call for assistance, even though the resident was documented as confused and did not understand and was unable to learn the use of the call light.

3. 7/25/24 - 7/30/24 - third fall - repeated attempts to get out of bed and wheelchair - failure of the facility to develop effective interventions to address this behavior.

A nurse's note, dated 7/26/24, documented that on 7/25/24 at 9:45 p.m., Resident #1 was observed transferring herself from a low bed and fell on her hands and knees while doing so. It was not known why the resident was trying to get up.

A nurse's note, dated 7/27/24, documented that Resident #1 continued to display poor safety awareness related to numerous attempts to get herself out of bed despite her risk for falls, need for assistance, and physician's order to not put weight on her right leg and hip. The note read Resident #1 had been calling out for help and expressing a desire to get up and walk but nobody would help her.

Another nurse's note dated 7/27/24 documented that Resident #1 continued to have poor safety awareness and was not redirectable. It read that although fall charting was concluded, increased safety checks, monitoring, and observation of Resident #1 continued as the resident required an increased level of care and attention.

Record review revealed the resident's care plan was updated after the 7/25/24 fall. Interventions included frequent rounding to offer toileting assistance every 2 hours and non-skid socks. The following interventions did not include an initiation date: safety measures (keep the resident's room clear and well-lit, select clothing that was easily removed for toileting) - monitor for side effects of medication - move Resident #1's room to the front of the hallway - signs in the room to remind the resident to call for assistance - prompt and anticipate resident needs including for toileting - low bed positioning with a fall mat beside the bed.

However, the record failed to reveal the facility identified the reasons why the resident continued to try to self-transfer and how this behavior could be effectively addressed; the facility failed to develop and staff failed to offer the resident sufficient interventions when she expressed a desire to get out of bed and get out of her wheelchair.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	See above; the resident's fall care plan failed to include specific interventions, such as identifying meaningful activities and identifying the times when the resident was most at risk of self-transfer to minimize the resident's behavior. While the care plan read to round every two hours, there was no indication in the nurse's notes that this would be sufficient given the documentation in the nurse's notes of the resident's frequent attempts to get herself out of bed and out of the wheelchair. Staff recognized in the 7/27/24 nurse's note that the resident required an increased level of care and attention with increased safety checks, monitoring, and observation, but this, too, was not defined or noted on the resident's care plan. The resident's representative (see interview below) said she had asked staff to involve the resident in meaningful activities to distract her from her continual attempts to get out of bed and to keep the resident out of her room. Facility staff provided these services on occasion, but the representative's requests, including engagement in meaningful activities, were not consistently implemented. All the resident's falls occurred in her room from bed when the resident was not under the direct supervision of staff. Further, the record revealed no communication with the resident's representative/family about the resident's need for an increased level of care and attention and how her need could be met. The DON said in an interview on 10/7/24 at 2:22 p.m., that the resident would have benefited from one-to-one supervision. In a later interview on 10/11/24 at 12:00 p.m., as requested by facility leadership (NHA, DON, and corporate consultant), they said that one-to-one supervision would not have been helpful because the resident's behavior was unpredictable and she was noncompliant with redirection. However, there was no evidence in the record of attempts to provide one-to-one supervision and if so, of an interdisciplinary discussion on how to achieve it. 4. 7/30/24 - fourth fall with significant injury A nurse's note dated 7/30/24 revealed that Resident #1 had an unwitnessed fall at approximately 6:50 a.m. The resident was found on the floor at the bedside. An assessment was performed with the resident verbalizing pain in her right hip. The nursing supervisor was notified and the resident was transferred back to bed. A physical assessment was performed by the nurse supervisor and an x-ray was ordered. The x-ray indicated that the resident's right hip was dislocated. The record revealed the resident was hospitalized and returned to the operating room for a second surgery on the right hip that she had fractured earlier. 5. 8/7/24 - 8/10/24 - resident readmission - fifth fall 8/10/24 - failures in response a. Status on readmission - facility failure A nurse's note, dated 8/7/24, revealed Resident #1 was readmitted to the facility for a skilled rehabilitation stay with a diagnosis of open reduction to the right hip with tissue repair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Upon her return, record review and interview revealed the resident was tested for COVID-19; after testing positive, the resident was placed in isolation in her room. The record further revealed Resident #1 returned to the facility with an immobilizer on her right leg to prevent excessive movement of the leg as it healed. An interview with the DON on 10/7/24 at 2:22 p.m. revealed the resident would not leave the immobilizer alone and was observed picking at her wound dressing and the immobilizer. A nurse's note dated 8/8/24 revealed the resident continued to work with rehabilitation therapies, was restless at times, and continued attempting to self-transfer from bed (without calling for staff assistance). A nurse's note, dated 8/9/24, documented that Resident #1 continued to be agitated. Calling out to staff Help me, Come here. Her daughter visited for one hour the previous evening and the resident had decreased agitation for a few hours after the visit. Despite the resident's known behavior to self-transfer and her recent surgery, record review revealed the IDT failed to reassess the resident when she returned to the facility on [DATE] to determine whether additional interventions, such as one-to-one supervision, needed to be implemented to keep the resident safe from further injury while isolated in her room post-surgery. b. Fifth fall - facility failure A nurse's note revealed the resident was back in the facility for approximately 48 hours when she fell for the fifth time on 8/9/24 at approximately 11:15 p.m. Record review revealed the facility failed to appropriately and timely address the resident's fifth fall, delaying treatment by medical professionals for her injuries and pain. A nurse's note, dated 8/10/24, documented on 8/09/24 at 11:15 p.m., Resident #1 was observed during rounds by a CNA sitting on a fall mat in front of her bed with her feet in front of her. The circumstances of the fall were unknown. The resident was disoriented at baseline. Range of motion (ROM) in her right leg was restricted related to postoperative pain and the resident's ability to cooperate with the assessment. Able to transfer to bed with two staff assistants. Vital signs were within normal limits and the resident had no increase in baseline pain. The physician ordered an immediate x-ray. The note further read: -Resident #1 was calling out (in the early hours of the morning). When staff checked in on Resident #1 she was observed to have her feet off the bed. The nurse and CNA entered the room and attempted to assist the resident back into bed but immediately noticed that the resident's right hip and leg did not look appropriate to her body frame. The resident had removed her immobilizer from her right leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Upon assessment, the resident's right leg rotated inward as well as the right knee and foot with the right hip appearing to be sticking upwards and outwards. The resident's left leg was slightly bent at the knee but looked appropriate to her frame. The staff did not move the resident. A second nurse assessed the resident and agreed the placement of the resident's right leg was not correct. Staff called for a mobile x-ray provider to come to the facility to perform an x-ray. -The resident was left in the same position that she was found in while waiting for the mobile x-ray technician to arrive. Resident #1 told staff she was in pain. The x-ray technician arrived, looked at the resident and told the staff that he was not going to touch the resident out of concern for causing the resident further injury. -After the technician left, the resident was left in the same position with her right leg hanging off the side of the bed. Nursing staff placed a clean brief under the resident and the nurse called the physician's office (at approximately 9:07 a.m.) for guidance and was directed to call an ambulance to transport the resident to the emergency room for assessment and treatment. The ambulance arrived to transport the resident to the hospital at approximately 9:40 a.m. E. Resident representative interview On 10/8/24 at 1:26 p.m., the resident's representative was interviewed. The representative said she was highly concerned about the care Resident #1 received while in the facility. She felt a need after the resident had fallen three times (7/23/24, 7/25/24, and 7/30/24) to make frequent inquiries about the resident's care. The representative said that Resident #1 did not get safe care. She said she had asked staff to keep Resident #1 out of her room and involved in meaningful activities to try to distract her from her continual attempts to get out of bed and out of her manual wheelchair. The representative said Resident #1 seemed to be distracted and confused by group activities and maybe would have done better with one-to-one or smaller group activities where staff would be able to be more engaged with her. The representative said when the resident fell on [DATE], her right hip became dislocated as a result and the resident was sent to the hospital. The medical staff tried three times to get the resident's hip back into place but were unable to do so and the resident had to undergo a surgical procedure to restore hip placement. The resident was then readmitted to the facility on [DATE], and two days later, she fell again, damaging her hip and requiring another surgical procedure. F. Staff interviews The DON was interviewed on 10/7/24 at 2:22 p.m. The DON said Resident #1 was admitted in a very disoriented state. The family put signs up in her room to prompt the resident to call for staff assistance and not to get up to walk on her own. However, the resident's cognition was severely impaired and she was not able to understand the signs. The facility tried getting the resident to attend group activities and encouraged the resident to sit in public areas where staff could watch her but she resisted. The DON said the physician was making adjustments to the resident's medication to help the resident better manage her anxiety and insomnia and the resident was moved to a room closer to the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care and Rehabilitation Center, The	9221 Wadsworth Pkwy Westminster, CO 80021

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(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	The DON said when they admitted a resident with a high risk for falls or someone who fell frequently, they tried to not place too many limiting interventions on a resident all at once because they did not want to be too restrictive with the resident. The DON said, in hindsight, the resident really needed a constant one-to-one sitter but that was not something the facility was able to provide. The nursing home administrator (NHA) and the DON were interviewed on 10/8/24 at 12:16 p.m. The NHA said they were able to provide Resident #1 with one-to-one staffing on the overnight shift but they were not able to maintain that level of staff consistently. The DON said most of the time, Resident #1 did not listen to staff and was not redirectable. The DON said they tried to implement interventions slowly, starting with keeping the resident's bed in a low position and providing a bedside fall mat. After the resident's first fall on 7/17/24, they implemented and provided the resident with non-skid socks. Each fall was assessed by the IDT and they found that the care plan was being followed each time. The DON was not sure what other interventions could have been provided. Staff were trying to anticipate the resident's needs and make [TRUNCATED]