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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065418 | A. Building<br>B. Wing | 05/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Forest Ridge | 16006 W US Hwy 24<br>Woodland Park, CO 80863 |

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) |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112<br><br>Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for two (#68 and #70) of five residents reviewed for falls out of 33 sample residents.<br><br>Specifically, for Resident #68 and #70, the facility failed to:<br><br>-Identify the root cause of falls and implement timely and effective interventions to prevent further falls; and,<br><br>-Update and revise the residents' care plans with new interventions after each fall.<br><br>Findings include:<br><br>I. Facility policy.<br><br>The Fall Clinical Protocol policy, revised March 208, was provided by the director of nursing (DON) on 5/16/24 at 1:44 p.m. It read in pertinent part,<br><br>Staff will begin to try to identify possible causes within 24 hours of the fall. The staff will continue to collect and evaluate information until either the cause of the fall is identified or it is determined that the cause cannot be found or is not correctable.<br><br>If underlying causes cannot be readily identified, staff will try various relevant interventions based on assessment until fall reduces or stops or until a reason is identified for its continuation.<br><br>II. Resident #68<br><br>A. Resident status<br><br>Resident #68, age [AGE] years old, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia with agitation, abdominal pain, vascular (blood vessels) disorder of the intestine and cystic disease (condition that causes fluid filled sacs) of the liver.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 2/13/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15. The resident required partial assistance with oral hygiene and dress. He required substantial assistance with showering and personal hygiene. He required supervision with toileting.<br><br>B. Record review<br><br>Resident #68's fall care plan, revised 1/4/24, revealed the resident was at risk for falls related to confusion and poor safety awareness. Interventions included ensuring the resident wore non-skid shoes when ambulating and anticipating the resident's needs.<br><br>The vision care plan, revised 8/16/23, revealed the resident had impaired visual functions in both eyes. Interventions included reminding the resident to wear glasses and ensuring glasses were clean and free from scratches.<br><br>A 4/13/24 fall nurse note revealed Resident #68 had an injury to the left side of his eye, brow and bridge of his nose.<br><br>-A 4/14/24 nurse note revealed there was bruising noted over the bridge of his nose, left eye upper and lower eyelids and lateral aspect of the left eye. There was black and blue bruising of his bilateral hands.<br><br>-An incident report was requested for the 4/13/24 fall but not provided.<br><br>A 4/25/24 interdisciplinary team (IDT) progress note revealed a fall meeting was held. The fall from 4/13/24 was reviewed. The new intervention was for physical therapy to do an evaluation.<br><br>-The intervention was not implemented until 12 days after the resident's 4/13/24 fall.<br><br>-The interdisciplinary team (IDT) did not identify the root cause of the fall.<br><br>-The new intervention for a physical therapy evaluation was not added to the Resident #68's fall care plan.<br><br>A 5/16/24 fall incident report was reviewed. The resident was found on the floor in the secure unit dining room. The report documented the resident tried to maneuver around another resident's wheelchair and his foot was caught in the other resident's wheelchair's back wheel. He tried to hold onto the wheelchair's handles but lost his balance and fell on his right side.<br><br>-The incident report did not identify any new fall interventions that were implemented at the time of the fall.<br><br>A 5/17/24 nurse note revealed the resident continued to walk around the unit. He looked down at the floor while walking instead of looking ahead.<br><br>A 5/19/24 nurse note revealed the resident walked around the unit with his head down at the floor or bent over to pick up items from the floor. Staff monitored the resident to give safety prompts as needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -There was no IDT note documented to indicate the fall had been reviewed by the IDT and new interventions were implemented.<br><br>-The fall care plan did not identify new interventions after the fall.<br><br>-The IDT did not identify the root cause of the fall.<br><br>The 5/22/24 fall risk assessment revealed that the resident fell before, did not use an assistive device, such as a wheelchair or walker to ambulate, had a weak gait and overestimated or forgot his limits. He scored a 65 which indicated he was a high risk to fall.<br><br>D. Staff interviews<br><br>Certified nurse aide (CNA) #6 was interviewed on 5/23/24 at 11:32 a.m. CNA #6 said she knew a resident was at a high fall risk if the resident used oxygen, if they were woozy or if the resident tried to stand without assistance when the resident required assistance. She said she kept an eye on residents to prevent a fall. She said she was familiar with Resident #68. She said he was a high fall risk. She said she kept an eye on the resident, encouraged the resident to sit down and kept food and water close to him to prevent him from falling.<br><br>Registered nurse (RN) #2 was interviewed on 5/23/24 at 11:40 a.m. RN #2 said she knew a resident was at a high fall risk based on their gait, diagnoses and observation of the resident. She said she made sure the area was clear of spills to prevent a fall. She said she was familiar with Resident #68. She said he was a high fall risk. She said she asked him to sit and walked with him to prevent him from falling.<br><br>The DON was interviewed on 5/23/24 at 10:13 a.m. The DON said staff knew a resident was a high fall risk based on a fall star placed on the door of residents who were a high fall risk. She said a nurse knew a resident was a fall risk based on the fall assessment. She said the nurses communicated to the staff verbally when a resident was a fall risk. She said if a resident fell , a RN completed an assessment and started a fall protocol that included neurological checks.<br><br>The DON said the nurse should look at what happened to cause the fall and add a fall intervention to prevent further falls. She said the IDT met weekly and added further interventions if appropriate. She said she was familiar with Resident #68. She said he was a high fall risk.<br><br>The DON said there was not a root cause analysis done for Resident #68's falls on 4/13/24 and 5/16/24. She said she was not aware Resident #68's eyesight was decreasing and his head was down frequently. She said if she knew she would include therapy and maintenance to develop interventions to prevent accidents and falls.<br><br>The DON said interventions were not reviewed and a new intervention was not added for Resident #68's fall on 5/16/24. She said the nurse who completed the nurse assessment should identify the initial root cause of the fall and an intervention.<br><br>V. Facility follow up<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/28/24 at 7:23 a.m. the minimum data set coordinator (MDSC) sent a performance improvement plan which indicated the facility had created an action plan to review falls and interventions in a timely manner and to decrease the number of falls. It revealed the steps included reviewing falls, reviewing interventions, staff considerations, staff education and staff awareness of high fall risk residents.<br><br>-The follow-up plan did not include dates when the action steps were completed.<br><br>31229<br><br>III. Resident #70<br><br>A. Resident status<br><br>Resident #70, age 81, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included malignant melanoma of skin, malignant neoplasm of prostate, malignant neoplasm of brain, nontraumatic intracerebral hemorrhage, and history of falling.<br><br>The 2/29/24 MDS assessment revealed the resident's cognition was severely impaired with a BIMS score of six out of 15. He had no behaviors. He required partial moderate assistance with toileting, dressing, personal hygiene and transfers.<br><br>B. Resident representative interview<br><br>Resident's #70's representative was interviewed on 5/20/24 at 3:45 p.m. The representative said the resident was falling frequently at home and in the facility. She said the resident still thought he was strong and tried to do things he used to, such as getting up and walking. She said he was not able to use the call light to call for assistance with transfers.<br><br>C. Record review<br><br>The fall care plan, initiated 3/7/24, revealed the resident had a history of falls due to poor balance, poor communication/comprehension and unsteady gait. Interventions included placing a fall mat by the resident's bed while he was in bed (initiated 4/1/24), placing a wedge cushion in the resident's wheelchair (initiated 4/8/24), placing a silent bed sensor (bed alarm) on the resident's bed (initiated 4/23/24), staff to provide frequent checks on the resident (initiated 4/23/23) and providing a lipped mattress on the bed (initiated 5/16/24).<br><br>-Despite the resident's history of frequent falls (see resident's diagnoses and resident representative interview above), the facility failed to initiate a fall care plan with interventions to prevent falls until 3/7/24, after Resident #70 sustained a fall on 3/6/24 (see below).<br><br>-The care plan failed to specify how often frequent checks should be conducted for Resident #70.<br><br>On 2/17/24, a nursing note revealed Resident #70 was admitted to the facility under hospice care. The note documented the resident was admitted to the facility following falls at home. The resident required extensive assistance of one staff member for transfers.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. Fall on 3/6/24<br><br>On 3/6/24 at 5:45 a.m. a nurse documented Resident #70 sustained an unwitnessed fall. The resident was noted to be on the floor at the side of his bed, face down. The resident had been displaying increased restlessness and/or confusion during the night. The resident's call light had been in reach, but the resident did not always use it to call for assistance from staff.<br><br>-The progress note failed to document a new intervention to prevent further falls.<br><br>-There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall.<br><br>2. Fall on 3/26/24<br><br>On 3/26/24, a nurse documented Resident #70 was sitting in one of the regular chairs, watching TV (television) in the lounge area. The resident's wheelchair was locked/parked close to the chair. The nurse heard a noise and found the resident lying on his back on the floor in front of the chair he had been sitting in and the resident's wheelchair had been unlocked. The resident was placed in bed with the bed in low position and the call light in reach. The door to the resident's room was left open so he could be monitored by the staff. The nurse encouraged the resident to call for assistance when needing to transfer. The resident continued to display his usual episodes of forgetfulness/confusion and made some comments to the nurse that he could stand on his own.<br><br>-The progress note failed to document a new intervention to prevent further falls.<br><br>-There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall.<br><br>-The resident's fall care plan was not updated until 4/1/24 (six days after the fall) when a floor mat was added as an intervention (see care plan above).<br><br>3. Fall on 4/4/24<br><br>On 4/4/24 at 10:30 p.m. a nurse documented Resident #70 was found sitting on the floor in front of his wheelchair in the hallway. Two staff members used a gait belt to stand the resident and get him in his wheelchair. The resident had been watching TV late in the TV room.<br><br>-The progress note failed to document a new intervention to prevent further falls.<br><br>-There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall.<br><br>-The resident's fall care plan was not updated until 4/8/24 (four days after the fall) when a wedge cushion was added to the resident's wheelchair as an intervention (see care plan above).<br><br>4. Fall on 4/14/24<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/14/24 at1:14 a.m. a nurse documented Resident #70 was found sitting on the floor with his feet towards the wall, holding on to the bed halo (bed rail). The resident was unable to state what occurred but mentioned his wife and trying to meet with someone. The resident was reoriented to time. He required a two) person assistance back to bed.<br><br>-The progress note failed to document a new intervention to prevent further falls.<br><br>-There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall.<br><br>-The resident's fall care plan was not updated until 4/23/24 (when the resident sustained another fall which was nine days after the 4/14/24 fall) when a bed alarm and frequent checks on the resident were added as interventions (see care plan above).<br><br>5. Fall on 4/23/24<br><br>On 4/23/24 at 7:11 a.m. a nurse documentedResident #70 had been in his wheelchair in the lounge area watching TV. The nurse was searching for him and found him on the floor beside his bed in his room. The resident had closed the door to his room. The floor mat was beside the bed and the resident had landed on the floor mat. The resident's call light was in reach, but the resident did not use it to call for staff assistance.<br><br>-The progress note failed to document a new intervention to prevent further falls.<br><br>-There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall.<br><br>6. Fall on 5/16/24<br><br>On 5/16/24 at 6:30 a.m. a nurse documented Resident #70 attempted to transfer himself out of bed and was found by CNA lying on the fall mat beside his bed.<br><br>The 5/16/24 IDT fall review note documented the hospice services provider was to provide a lipped mattress. No further interventions were documented.<br><br>D. Staff interviews<br><br>CNA #7 was interviewed on 5/22/24 at 10:45 a.m. CNA #7 said Resident #70 was falling frequently during evening or nighttime looking for his wife or trying to get out of bed. She said the resident's room was across the nurses' desk and the staff was keeping an eye on him through the open door.<br><br>RN #3 was interviewed on 5/22/24 at 10:55 a.m. RN #3 said most of Resident #70's falls happened at night. She said the resident was not able to understand or remember to use his call light. She said he did not have any of his falls on her shifts (during the day).<br><br>CNA #8 was interviewed on 5/23/24 at 1:18 p.m. CNA #8 said she checked on Resident #70 frequently and took him to the toilet. She said the resident did not fall on her shifts.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RN #4 was interviewed on 5/23/24 at 1:23 p.m. RN #4 said the resident had been falling usually in the late afternoon and at night. She said he had a short attention span. She said the resident would not participate in activities for longer than a couple of minutes before he started looking for his wife. RN #4 said when he was in the living room watching TV he would try to stand up and look for his wife. She said he did the same thing when he was in bed. She said as soon as he opened his eyes he would try to stand up and ask the staff about his wife. She said the best approach to prevent falls for the resident would be to have someone with the resident at all times. RN #4 said his wife lived very close to the facility and visited most of the weekdays in the afternoon.<br><br>The DON was interviewed on 5/23/24 at 3:00 p.m. The DON said falls were reviewed in the facility during morning stand-up meetings and approaches to prevent falls were discussed. She said the IDT was meeting to review falls weekly and there was a new fall intervention added after each fall for Resident #70.<br><br>-However, Resident #70's progress notes and care plan did not reflect that a new intervention was added timely after each of the resident's falls (see record review above). |