STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065430	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviva at Fitzsimons	13525 E 23rd Ave Aurora, CO 80045

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and interviews the facility failed to provide services for one (#3) of three residents out of seven sample residents according to professional standards of practice. Specifically, the facility failed to: -Ensure Resident #3 was consistently monitored when having a change in condition; -Follow the physician's orders; and, -Call the provider when Resident #3's blood pressure and heart rate dropped. Findings include: I. Facility policy and procedure The Change in Resident Condition policy, dated [DATE], was provided by the regional clinical resource (RCR) on [DATE] at 2:59 p.m. It read in pertinent part, A facility must immediately inform the resident; consult with the resident's provider; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychological status (deterioration in health in life threatening conditions). Immediate notification to the provider would include but not limited to: a fall resulting in significant injury, critical lab values, respiratory arrest, acute changes in respiratory status, acute changes in cardiac status, significant change in wound status, significant changes to vital signs, sudden cognitive changes, or any life threatening episode. Document in the resident's medical record the date and time of change of condition, who (physician/family member/responsible party) was notified regarding the condition change, information communicated, response and/or orders received, assessment of resident condition and ongoing monitoring of resident condition, care provided, document the time emergency personnel arrived and took over the care of the resident, if applicable and update the care plan as needed. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Verbal Orders policy, revised February 2014, was provided by the RCR on [DATE] at 2:59 p.m. It read in pertinent part, Verbal orders shall only be given in an emergency or when the attending physician is not immediately available to write or sign the order. Verbal orders will always be based on verbal exchange with the prescribing practitioner or on approved written protocols. Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf. A telephone order is a verbal order given over the telephone.The individual receiving the verbal order must write it on the physician's order sheet as a verbal order or a telephone order. The individual receiving the verbal order will read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed, record the ordering practitioner's last name and his or her credentials (MD, NP and PA) and record the date and time of the order. The Charting and Documentation policy, revised [DATE], was provided by the RCR on [DATE] at 11:36 a.m. It read in pertinent part: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record including objective observations, medications administered, treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details including, the date and time the procedure/treatment was provided, the name and title of the individual(s) who provided the care, the assessment data and/or any unusual findings obtained during the procedure/treatment, how the resident tolerated the procedure/treatment, whether the resident refused the procedure/treatment, notification of family, physician or other staff, if indicated and the signature and title of the individual documenting. II. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included acute and chronic respiratory failure with hypoxia (an absence of oxygen in the tissues to sustain bodily functions), dependence on oxygen, dependence on a ventilator (a machine that helps you breathe, encounter for attention to a tracheostomy, cerebral palsy, protein calorie malnutrition, chronic atrial fibrillation (irregular heart beat), type 2 diabetes, epilepsy (seizures) and bradycardia (slow heart rate). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status score (BIMS) of five out of 15. He was dependent on staff for all of his activities of daily living (ADLs). He received oxygen, suctioning, tracheostomy care and ventilator support. B. Record review On [DATE] at 1:18 a.m., Resident #3's heart rate was 91 beats per minute (bpm) and his blood pressure was ,d+[DATE] millimeters of mercury (mmHg). At 1:39 a.m. the resident's heart rate was 36 bpm and his blood pressure was ,d+[DATE] mmHg. At 3:49 a.m. the resident's heart rate was 34 bpm and his blood pressure was ,d+[DATE] mmHg. -A review of Resident #3's electronic medical record (EMR) did not reveal any additional documentation indicating the resident's heart rate and blood pressure was taken every 30 minutes per the nurse practitioner's (NP) orders. A NP note, dated [DATE] at 12:50 a.m. revealed, the nurse reported that Resident #3 complained of dizziness to the respiratory therapist (RT) and was found to have a heart rate in the 30's. A new order was given for a STAT (immediate) EKG (electrocardiogram), a CBC (complete blood count) in the morning, check the resident's blood pressure and heart rate every 30 minutes until the heart rate was stable above 50 and call back for any changes in condition. -Review of the resident's vital signs from [DATE] after the NP was notified indicated the resident's blood pressure continued to drop. Review of the resident's EMR did not reveal documentation that the NP was notified after the resident's blood pressure continued to decrease. A nursing progress note, dated [DATE] at 6:52 a.m., documented the RT reported Resident #3's heart rate was in the 30s. The resident was assessed and no distress was noted. Manual palpation of the resident's pulse was 33 to 36 BPM. The resident had a history of cardiac arrhythmias (irregular heartbeat) and was on amiodarone (blood pressure medication). The note documented the nurse called the on-call NP who reviewed the resident's chart and gave orders for a STAT CBC and STAT EKG to be done today ([DATE]). Resident #3 remained stable. At 5:37 a.m., the nurse administered the morning medications. The resident was asleep and responsive to tactile stimuli. The nurse returned to the room around 6:10 a.m. to change the resident's tube feeding. The resident was unresponsive and diaphoretic (sweating heavily). The day nurse was present in the room with the night nurse. The resident's blood sugar was checked and his blood sugar was 248. The nurse called the on-call NP and informed her that resident condition had deteriorated. A new order was received to call 911. The RT went to the resident's room and initiated CPR (cardiopulmonary resuscitation). Emergency medical services were called and they arrived around 6:25 a.m. and took over CPR. The resident's mother was called and informed that CPR was being performed and she said to keep her informed. -Review of the resident's EMR did not reveal any further documentation indicating the licensed nursing staff monitored the resident per NP orders. III. Staff interviews (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 10:52 a.m. LPN #1 said the nurses needed to follow the physician's orders as written to ensure care was provided as ordered. She said this ensured that the physician was in charge and the resident was getting care to promote their health. She said when the nurse received a telephone or verbal order they were supposed to read back the order to the provider to ensure they understood and wrote the order correctly. She said then the order was put into the medical record as a verbal order to show it was received over the phone and the provider did not write the order themself. LPN #2 was interviewed on [DATE] at 11:01 a.m. LPN #2 said it was important to follow the physician's orders to ensure the care was completed the way the physician wanted to get the best possible outcome. LPN #2 said when receiving an order over the phone, the nurse should repeat the order back to the provider to ensure they received the correct order. LPN #2 said the order was then put into the medical record as a verbal order to show it was received over the phone. The director of nursing (DON) was interviewed on [DATE] at 11:03 a.m. The DON said the nurse should always follow the physician's orders. She said the nurse should write down the verbal order and repeat it back to the provider for clarification. She said she had received a text message from the nurse, who was an agency nurse, on duty at the time of the incident and she said she was doing frequent vital sign checks. She said frequent checks did not have set parameters. She said when there was a change in Resident #3's blood pressure and heart rate, the NP should have been notified of his decline. The DON said there should have been documentation that the resident was monitored related to his change of condition.