STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peaks Care Center, The	1440 Coffman St Longmont, CO 80501

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents had adequate supervision and assistive devices to prevent accidents for one (#4) of six residents reviewed for accident hazards out of six sample residents. Specifically, the facility failed to ensure staff followed the appropriate transfer techniques when transferring residents, which resulted in Resident #4 sustaining rib fractures following a fall that occurred during an improper transfer with CNA #1.Resident #4, who had a history of falling, was admitted on [DATE] and readmitted on [DATE]. The resident had the ability to transfer to and from a bed to a chair (or wheelchair) with substantial/maximal assistance from staff (staff performed more than half of the effort by lifting or holding the resident's trunk or limbs and providing more than half the effort).On 7/11/25 Resident #4 was being assisted by certified nurse aide (CNA) #1 to transfer from her bed to her wheelchair. According to the facility's incident report, completed by licensed practical nurse (LPN) #1 on 7/11/25, CNA #1 reported that Resident #4 was sitting on the edge of her bed with her wheelchair beside the bed and CNA #1 was positioned behind the resident's wheelchair. The resident attempted to transfer, became weak and went down to the floor. CNA #1 reported she was unable to get around the wheelchair quick enough to prevent the resident from falling to the floor. Resident #4 was assessed by registered nurse (RN) #1 and was able to move all of her extremities and her vital signs were within normal limits. The resident sustained a hematoma (solid swelling of clotted blood within the tissues) to the left side of her forehead with bruising (localized area of discoloration on the skin caused by trauma or injury) to the left eye area.On 7/12/25 Resident #4 was transferred to the hospital for tachycardia (fast heartrate) with labored breathing utilizing urgent transportation. While at the hospital, a computerized tomography (CT) scan of Resident #4's head, cervical spine, and chest/abdomen/pelvis was completed due to the resident's fall on 7/11/25. The CT scan of the resident's chest revealed she sustained an acute, mildly displaced fracture of the left anterior third rib and a non-displaced fracture of the left anterior fourth rib from the fall.According to an interview with the nursing home administrator (NHA) during the survey, CNA #1 was given a verbal reprimand related to making sure the resident wore appropriate footwear before the transfer on 7/11/25 (see NHA interview below).-However, there was no documentation to indicate CNA #1 was provided with re-education on transferring residents following the incident with Resident #4 on 7/11/25 to ensure she was using the appropriate transferring technique when transferring residents with a gait belt.The facility's failure to ensure staff followed the facility's appropriate transfer technique when transferring residents resulted in Resident #4 sustaining rib fractures following a fall that occurred during an improper transfer with CNA #1.Findings include:I. Professional referenceAccording to Treas, L., [NAME], K. and [NAME], M. (2022) [NAME] Advantage for Basic Nursing (3rd ed.), pp. 1237-1238, Transferring a patient from bed to chair: stand toward the bed facing the patient. Brace your feet and knees against the patient's legs. Pay particular attention to any known weaknesses. Bend your hips and knees, and keeping your back straight, hold onto the transfer (gait) belt on both sides. Bracing provides stability.II. Facility policy and procedureThe Fall Prevention Program policy, dated 2024, was provided by the NHA on 10/27/25 at 12:02 p.m. The policy revealed each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall was described as an event in which an individual unintentionally came to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (such as a resident pushing another resident). The event might be witnessed, reported, or presumed when a resident was found on the floor or ground, and could occur anywhere.The facility utilized a standardized risk assessment for determining a resident's fall risk. The risk assessment categorized residents according to low, moderate, or high risk. For program identification purposes, the facility utilized high risk and low/moderate risk, using the scoring method designated on the risk assessment. The low/moderate risk protocols included implementing universal environmental interventions that decreased the risk of resident falling, including encouraging residents to wear shoes or slippers with non-slip soles when ambulating.Staff were also to monitor for changes in a resident's cognition, gait, ability to rise/sit, and balance.Each resident's risk factors and environmental hazards would be evaluated when developing the resident's comprehensive plan of care. Any interventions would be monitored for effectiveness and the resident's plan of care would be revised as needed.When any resident experienced a fall, the facility would assess the resident, complete a post-fall assessment, complete an incident report and notify the resident's physician and family. The facility