STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065233	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Nursing Center	3701 W Radcliff Ave Denver, CO 80236

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** Based on record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accident hazards out of three sample residents remained free from accident hazards. On 2/27/24, just before 2:00 p.m. certified nurse aide (CNA) #1 was providing care to Resident #1. The resident was rolled on her side during the care and the resident slid off the side of the bed, fell to the floor and sustained a left hip fracture. The resident was sent to the hospital for treatment and underwent surgical repair of the left hip fracture. Through a facility investigation, it was found that CNA #1 had not followed the resident individualized care plan accurately when she made the decision to provide care without a care partner to ensure proper technique for safety and appropriate bed mobility. The facility failed to ensure that Resident #1 received appropriate care per her comprehensive care plan for two staff members to assist with bed mobility and incontinent care which resulted in the resident falling out of bed and sustaining a hip fracture that required surgical intervention. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 11/14/24, resulting in the deficiency being cited as past noncompliance with a correction date of 2/28/24. I. Incident on 2/27/24 CNA #1's failure to follow the resident' s care plan to provide bed mobility with the assistance of two staff members led to the resident falling out of a high bed and sustaining a major injury (hip fracture). II. Facility plan of correction Interviews and record review during the onsite investigation on 11/14/24 revealed the facility investigated this singular event and implemented corrective actions to prevent the recurrence of the incident. A. Immediate action to correct the deficient practice for Resident #1 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 was suspended during the investigation and, upon her return on 3/1/24, CNA #1 was provided coaching and education on the facility' s policy that the resident' s care plan must be followed at all times. CNA #1 was educated on where to locate a resident' s care plan, the care plan interventions and on the expectation to check each resident' s care plan daily and before the start of care. Additionally, CNA #1 was educated that, per facility policy, the resident' s care plan was to be followed as written and that any concerns about care were to be brought to the attention of the nurse on duty. Resident #1' s care plan was revised with appropriate interventions for all care areas. All facility nurses and CNAs were educated on the facility' s policy for following each resident' s care plan, where to find the care plan and expectations for reporting concerns about care plan interventions. The education was completed on 2/27/24 and 2/28/24. B. Identification of other residents All residents (90) were assessed for ADL level of assistance and care needs and the information was compared to the existing care plan. All discrepancies and conflicting documentation were clarified or corrected to reflect each resident's assessed care assistance needs. This was completed on 2/28/24. C. Systematic changes The facility' s quality assurance performance improvement committee developed a plan of improvement on 2/28/24. The plan included: A root cause analysis of the incident was conducted and it was determined that CNA #1 was not following facility policy for reviewing and following Resident #1' s comprehensive care plan, which led directly to the resident falling off the bed while in the care of a facility staff member causing the resident a significant injury (see above). Staff education was completed with all nurses and CNAs on 2/28/24 and completed with new staff and staff upon their assigned work shift by 2/28/24. Following the provision of staff education, each staff member was required to show a return demonstration that they understood and were capable of accessing resident care plans. This was completed with every staff member by 4/30/24. Observations and interviews during the survey revealed staff were consistently following the care plan interventions of the residents included in the survey process on 11/14/24. An interview with the director of nursing (DON) confirmed the corrective actions, and therefore the facility's substantial compliance, by 2/28/24, at the time of the survey was conducted on 11/14/24. D. Monitoring (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON/designee was tasked with ensuring each resident was assessed for appropriate care needs upon admission, quarterly, and with each change in condition and that the resident' s care plan was updated accordingly. Needs for care plan revision out of sequence (when a change of condition occurred) were to be brought to the attention of the DON and other members of leadership and discussed with the interdisciplinary team (IDT) and then documented in the resident' s record. II. Facility policy and procedure The Fall Management policy and procedure, revised on 4/7/24, was provided by the DON on 11/14/24 at 3:01 p.m. It read in pertinent part, The facility will assess the resident upon admission/readmission, quarterly, with change of condition and will identify appropriate interventions to minimize the risk of injury-related falls. The resident environment remains as free of accident hazards as is possible. Each resident shall receive adequate supervision and assistance to prevent accidents. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and was discharged to the hospital on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included a fracture to the left femur (hip), a history of stroke, muscle weakness and Alzheimer' s disease. The 9/16/24 minimum data set (MDS) assessment revealed Resident #1 had short-term and long-term memory impairment, severely impaired daily decision-making skills and continuous symptoms of inattention, per staff assessment. The resident had difficulty focusing attention on tasks, was easily distractible and had difficulty keeping track of what she was told. The resident was dependent on two staff members to complete activities of daily living (ADL), including performing toileting hygiene, shower/bathing, and personal hygiene transferring and repositioning in bed. B. Record review Resident #1' s comprehensive care plan documented the resident had an ADL performance deficit due to Alzheimer's disease, dementia, hemiplegia/hemiparesis (weakness) to the right side and a history of stroke. Interventions included providing assistance of two staff members to turn and reposition the resident (initiated 12/11/2020) and providing assistance of two staff members for incontinence care (initiated 12/11/2020). A progress note, dated 2/27/24 at 2:00 p.m., documented the nurse heard a loud noise and screaming for help from a CNA and Resident #1' s roommate. The nurse went to the room to check on the resident. Resident #1 was found lying on the floor. CNA #1 said she was changing Resident #1 and she fell out of bed. CNA #1 said the resident landed on her right side. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #1 was assessed and found to have a hematoma (raised area due to swelling) on her forehead, a laceration on her nose, bruising to her chin, a skin tear to her left lower leg shin area, and a skin tear to her left elbow. The resident had rapid respirations, a very high blood pressure and was complaining of pain to her left hip and forehead. Emergency medical services (EMS) was called and the resident was taken to the hospital for assessment and medical treatment. C. Incident investigation The facility fall investigation report, dated 2/27/24, revealed Resident #1 fell out of bed on 2/27/24 at approximately 2:00 p.m. while being assisted by only one CNA (CNA #1). As a part of the investigation, the facility conducted a root cause analysis of the incident and determined CNA #1 was not following the resident' s care plan. When interviewed, CNA #1 was unaware of the resident's care assistance needs, including that the resident was to receive ADL assistance performed by two staff members for proper support and safety. CNA #1' s interview statement documented that she entered Resident #1' s room to assist her with toileting hygiene. CNA #1 said she started to provide care for Resident #1 by wiping her genitalia in the front and then turning the resident on her right side to wipe and cleanse her buttocks. After wiping the resident' s buttocks, the resident slid off the side of the bed to the floor. CNA #1 said the resident did not roll forward but slid off the bed while maintaining a side-lying position landing on her side. CNA #1 told the investigator that she had cared for Resident #1 for the past four years and she thought she was following the resident' s care plan and following interventions for the resident' s current level of care. CNA #1 admitted that she had not reviewed the resident' s care plan recently and believed Resident #1' s care could be provided by one staff member without assistance. -However, the resident' s care plan interventions indicated intervention for the need for two staff members to provide bed mobility assistance had been in place since 12/11/2020. A nurse practitioner exam note, dated 3/11/24 at 11:19 a.m., revealed the resident had been in the hospital since 2/27/24 receiving medical treatment after she fell out of bed during ADL care while in the facility. The note revealed Resident #1 returned that day (3/11/24) after being hospitalized for surgical repair to the left hip after falling out of bed while staff provided care. The note documented that the resident also had ecchymosis (bruising from broken blood vessels to the skin or mucous membranes) on the face resulting from trauma and a hematoma in the middle of the forehead. The resident was able to move all four extremities with decreased movement to both lower legs. A progress note dated, 3/12/24 at 2:03 p.m., revealed the resident moaned in pain when repositioned and was prescribed Tylenol three times a day for the pain. III. Staff interviews (continued on next page)

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