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	08/26/2025

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 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 record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accidents out of 10 sample residents remained free from accidents.Resident #1 was admitted to the facility on [DATE] with diagnoses of history of falling, a fracture of the left ilium (upper part of the pelvis), atrial fibrillation (AFIB), hypertension (high blood pressure) and dementia. Resident #1 had severe cognitive impairments and required maximum assistance from staff. On 8/13/25 at approximately 4:30 p.m. Resident #1 was seated at the nurses' station where he sustained an unwitnessed fall. Resident #1 was assessed by a registered nurse (RN) and was assessed to have no injuries. After the fall, the staff assisted Resident #1 in his wheelchair back to the nurses' station. Certified nurse aide (CNA) #2 assisted Resident #1 to his room. CNA #2 and another CNA assisted him into his recliner. At this time the resident's representative walked into the room and observed Resident #1's right foot was turned inward at a 90 degree angle. Resident #1 was additionally screaming out in pain. The hospice nurse arrived at the facility around 9:00 p.m. and called emergency services (EMS). Resident #1 was sent to the hospital where he was diagnosed with a closed displaced comminuted fracture of the shaft of the right femur, sequela (broken into three or more pieces) and a right femoral diaphyseal fracture (a break in the shaft of the right thigh bone often caused by high-energy trauma). The facility conducted an investigation on 8/14/25. Video footage revealed that CNA #2 propelled Resident #1 without foot pedals. While CNA #2 was propelling Resident #1, the resident's right foot got stuck on the carpet under the wheelchair and CNA #2 continued to push him.Specifically, the facility failed to ensure CNA #2 propelled Resident #1 correctly in his wheelchair, which resulted in Resident #1 sustaining a fracture to his right femur. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 8/25/25 to 8/26/25, resulting in the deficiency being cited as past noncompliance with a correction date of 8/15/25.I. Incident on 8/13/25The facility investigation, dated 8/14/25, revealed Resident #1 sustained a fracture to his right thigh on 8/13/25. The investigation revealed while Resident #1 was being transported in his wheelchair by CNA #2, Resident #1 did not have the leg rests on his wheelchair. During video observation of the incident, video footage revealed while being assisted to his room in his wheelchair, the resident's foot was caught twice on the carpet, causing leg fractures. The fractures were not caused by a fall. The hospital records revealed Resident #1 had a closed displaced comminuted fracture of the shaft of the right femur, sequela.The investigation documented that on 8/14/25 the nursing home administrator (NHA) reviewed the video footage from 8/13/25. The video footage revealed CNA #2 was escorting Resident #1 from the nurse's cart back to his room. The video revealed CNA #2 was pushing Resident #1 in his wheelchair without the foot pedals in place. The video footage revealed that two different times, Resident #1's right leg went under the wheelchair as CNA #2 pushed his wheelchair. Each time Resident #1's leg went under the wheelchair, CNA #2 only momentarily backed the chair up to get his leg moved from where it was stuck on the carpet before the wheelchair was pushed again. Resident #1 grabbed his right thigh and his face was grimaced in pain. II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #1On 8/13/25 Resident #1 was sent to the hospital for an Xray based on a decision by the hospice nurse and Resident #1's power of attorney (POA). On 8/14/25 Resident #1 had surgical intervention for his fractured right leg. On 814/25 CNA #2, who propelled Resident #1 in his wheelchair, was suspended and later terminated. CNA #2 had no contact with any residents after the shift of 8/13/25 through 8/14/25. B. Identification of other residentsAn audit was initiated by the therapy department on 8/14/25 and was completed by 8/15/25. The audit identified if any residents had missing foot pedals and no concerns were identified.C. Systemic changesAn education was initiated by the director of nursing (DON) on 8/15/25 with the facility's CNAs regarding wheelchair mobility instructions. On 8/23/25 the same education was ongoing to other staff disciplines. The education was ongoing until (all) staff was trained. The DON/designee was to complete weekly observations of three residents who should have foot pedals available for use when in a wheelchair for 90 days. Identified concerns were to be addressed with staff.D. MonitoringThe DON/designee would report findings from the audits as well as any fractures related to mobility assistance to the quality assurance and performance improvement (QAPI) committee monthly for 90 days. The QAPI committee would identify any trends and take corrective action as needed.III. Facility policy and procedureThe Accidents and Incidents - Investigating and Reporting policy, revised 2017, was provided by the NHA on 8/26/25 at 12:53 p.m. via email. It revealed in pertinent part, All accidents or incidents