STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065179	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hildebrand Care Center	1401 Phay Ave Canon City, CO 81212

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 - Minimal harm or potential for 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 observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for two (#10 and #39) of five residents reviewed for accidents out of 51 sample residents.Specifically, the facility failed to ensure Resident #10 and #39 were transferred appropriately and according to their plan of care.Findings include: I. Facility policy and procedure The Safe Lifting and Movement of Residents policy, revised July 2017, was received from the director of nursing (DON) on 9/24/25. It read in pertinent part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include the following: -Resident's preferences for assistance; -Resident's mobility (degree of dependency); -Resident's size; -Weight-bearing ability; -Cognitive status; Whether the resident is usually cooperative with staff; and, -The resident's goals for rehabilitation, including restoring or maintaining functional abilities. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. Safe lifting and movement of residents is part of an overall facility employee health and safety. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident # 10 A. Resident status Resident #10, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, hypertension and muscle weakness. The 8/5/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The resident required substantial assistance with activities of daily living (ADL). B. Observations On 9/24/25 at 9:10 a.m. there was a sign observed hanging on the wall in Resident #10's room. The sign indicated Resident #10 was a two-person transfer using the transfer pole. The sign indicated staff were to use a safety gait belt during the resident's transfers. C. Resident interview Resident #10 was interviewed on 9/24/25 at 9:10 a.m. Resident # 10 said approximately a month prior (August 2025) she was sitting in her lounge chair. She said that the certified nurse aide (CNA) transferred her from the chair without a gait belt. She said she was transferred incorrectly as the CNA transferred her alone. She said when the CNA transferred her, she twisted and hurt her knee. She said she went to the hospital for an Xray which did not reveal an injury. She said she had to take pain medications to help with the discomfort in her knee. Resident #10 said it was a new agency staff CNA who did not know what she was doing. The resident said since the incident, there were extra gait belts in her dresser drawer and there was a sign on the wall to describe how she was to be transferred. D. Record review Review of Resident #10's fall care plan, revised 7/29/25, identified the resident had a potential for falls/injury related to cognitive deficit, decreased mobility, poor safety awareness and weakness. Pertinent interventions included assisting the resident with a transfer pole (at bed and recliner) and using a gait belt with transfers. The physician's order, dated 7/31/25, revealed the resident was a two-person assistance with a pivot disc (mobility device that rotates to assist with twisting/turning) for transfers. The nurse progress note, dated 8/9/25, documented Resident #10 stated she was not feeling well. She reported increased left knee pain. Voltaren gel (topical ointment used to treat pain) was applied to her left knee A new physician's order, dated 8/11/25, revealed the resident was a two-person assistance for transfers and indicated staff were not to use the pivot disc. The facility investigation, dated 8/11/25, revealed that on 8/8/25 Resident #10 was transferred (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:30 a.m. The report revealed that on 9/4/25 Resident #39 was transferred with one-person assistance with a gait belt by CNA #2, when the resident's transfer status and physician's order indicated the resident was a two-person assistance transfer with a gait belt. The investigation documented a second staff person was present in the room during the transfer, however, CNA #2 did not wait for assistance. Resident #39 was assessed by registered nurse (RN) #1 and no injuries were noted. CNA #2 was interviewed by the facility on 9/4/25 and stated that she transferred Resident #39 by herself using a gait belt. She said she did not follow the proper procedure of using two-person assistance. Resident #39 was interviewed by the facility on 9/5/25 and said she did not recall the incident and stated everyone took good care of her. She recalled no issues with her transfers. The conclusion of the facility's investigation revealed CNA #2 displayed a lack of professionalism and did not follow facility transfer procedures. The nursing progress note, dated 9/5/25 at 1:51 p.m., documented Resident #39's representative was called and notified that Resident #39 had been transferred by one-person staff assistance instead of two-person staff assistance by an agency CNA. The representative was notified the resident had no injuries. C. Staff interviews CNA #3 was interviewed on 9/25/25 at 3:24 p.m. CNA #3 said Resident #39 was a two-person assistance transfer with a gait belt. CNA #3 said Resident #39 had a sign posted in her room that instructed staff that she was a two-person assistance transfer with a gait belt. CNA #3 said if she was the only person in the room of a resident who required two people for transfers, she would pull the call light until another staff member came in to assist her with the resident transfer.RN #2 was interviewed on 9/25/25 at 4:51 p.m. RN #2 said Resident #39 was a two-person assistance for all transfers. RN #2 said one person should not try to assist the resident. RN #2 said two-person assistance was for Resident #39's safety and the safety of staff. RN #2 said agency staff had a binder that they had to review when working. RN #2 said the binder included residents who were a two-person assistance for transfers. RN #2 said if CNAs were not familiar with a resident, all they had to do was just ask another staff member. RN #2 said the incident of the one-person transfer for Resident #39 could have been prevented. The DON and the assistant director of nursing (ADON) were interviewed together on 9/25/25 at 5:23 p.m. The ADON said Resident #39 was a two-person assistance transfer with a gait belt. The ADON said an agency CNA was assigned to provide care for Resident #39 on 9/4/25 The ADON said Resident #39 was getting back into bed after breakfast and the second CNA who was in the room to assist with the transfer went to shut the door. She said while the second CNA was shutting the door, the agency CNA lifted Resident #39 using the gait belt and moved her to the bed by herself. The ADON said the agency CNA knew Resident #39 was a two-person assistance for transfers. The ADON said the agency CNA did not indicate why she decided to do the transfer by herself. The ADON said the agency CNA was pulled into her office for questioning and then was sent home and had not been allowed to return to the facility. The ADON said Resident #39 did not fall or sustain any injuries on 9/4/25. The ADON said she did (continued on next page)

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