STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065146	A. Building B. Wing	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampden Hills Post Acute	14699 E Hampden Ave Aurora, CO 80014

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33298 Based on record review and interviews, the facility failed to ensure residents received treatment and care which met professional standards of practice, and was consistent with comprehensive assessments and comprehensive care plans, for two (#2 and #3) residents out of four sample residents. Specifically, the facility failed to fully assess Resident #2 to find the source of an infection which resulted in the resident being hospitalized on [DATE]; failed to assess the resident after reports of confusion, shortness of breath and distress on [DATE]; and failed to take timely action to treat the resident after rectal bleeding was discovered on [DATE]. The facility failed to timely assess pain and possible injury to Resident #3 after a fall out of bed on [DATE]. The resident suffered a fall out of bed on [DATE] and reported generalized pain. However, an x-ray was not completed until [DATE] (three days later) which revealed a distal femur fracture above the resident's knee. Cross-reference F689, fall/accident with injury. Findings include: I. Facility policy and procedure The Change of Condition policy, revised February 2021, was provided electronically by the assistant administrator (ANHA) on [DATE] at 5:30 p.m. It read, in pertinent part: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status. -Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the change of condition assessment form. -The nurse will record in the resident's medical record information relative to changes in the resident's medical and mental condition or status. -If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required. II. Resident #2 (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 0684 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #2, age 74, was admitted on [DATE] and passed away on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included atherosclerosis of autologous vein bypass, nonrheumatic aortic valve stenosis, diabetes mellitus due to underlying condition, chronic obstructive pulmonary disease (COPD), chronic pain syndrome, difficulty walking, cellulitis of left lower leg, repeated falls, peripheral vascular disease, and personal history of venous thrombosis and embolism. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. He required extensive assistance of one staff member with mobility and activities of daily living (ADLs). He reported occasional pain and shortness of breath at rest. He experienced falls, a major vascular surgery and had two venous ulcers and surgical wounds. B. Assessment of infection 1. Record review On [DATE] Resident #2 experienced four falls with no injury, he was assessed for injuries and neurological checks were completed. A nursing note at 10:18 p.m. revealed the resident was on monitoring for falls and reported pain and discomfort in his legs. Two skin assessments were documented on [DATE], at 5:15 a.m. and 9:46 a.m., with no skin issues noted for the resident at the time. Laboratory testing was ordered and completed for the resident on [DATE] and results received on [DATE] showed a critically high white blood cell count which indicated an infection. The results of the urinalysis showed no urinary tract infection and the chest x-ray revealed no signs of pneumonia. Repeat laboratory testing was ordered and completed on [DATE] and results received on [DATE] showed the resident's white blood cell count was still high, but not critically. The resident was started on antibiotic medication on [DATE]. Resident #2 experienced three more falls with no injury between [DATE] and [DATE] and assessments read the resident had no bumps or bruises and skin was warm and intact. The resident did not complain of pain or discomfort and his range of motion was within normal limits. On [DATE] the resident was ordered to receive intravenous fluids for weakness. A [DATE] change of condition assessment revealed the nurse was called to the resident's room to assess the color and temperature of his leg. The assessment revealed the resident's leg was warm to the touch and the resident reported pain when touched. The resident's leg was weeping fluid, and was cleansed with normal saline and wrapped. The resident's physician was called and gave orders to send the resident to the emergency department for further evaluation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Hospital records from [DATE] were reviewed and revealed the resident presented with altered mental status and left lower extremity pain, clinically consistent with cellulitis from venous stasis ulcers and concern for osteomyelitis due to dark toe. He was diagnosed with cellulitis of the left lower leg and diabetic ulcers of his second and third toes. Hospital records revealed family reported changes to the resident's baseline cognition for the past five days and the resident's leg was noted by family to be erythematous (abnormal redness), warm to the touch, and swollen the day before in the facility. The resident endorsed experiencing pain in the affected leg for a few days. His left lower leg distal to the knee was notable for diffuse erythema palpable warmth, and chronic appearing wounds. The left lower leg cellulitis and the ulcers of the second and third left toes were determined to be the cause of the resident's infection. 2. Provider interview The resident's medical provider was interviewed on [DATE] at 10:30 a.m . He stated the facility should have completed full skin assessments on the resident with each fall and should have completed an assessment of his legs when he complained on the evening of [DATE]. He stated it was unlikely that the resident developed leg and toe wounds overnight. He stated a full skin assessment should have been completed to try to determine the cause of the resident's infection which was indicated by the lab work completed on [DATE] and [DATE]. 3. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 12:27 p.m. She stated if a resident reported pain in an area, the area should be assessed and there should be documentation of the assessment of the area. She stated a full skin assessment should always include legs, feet and toes. LPN #2 was interviewed on [DATE] at 12:49 p.m. She stated resident pain and discomfort should be assessed and documented. She stated if a resident had signs of an infection, staff should try to determine the cause and a skin assessment would be included in the assessment. She stated a full skin assessment should include all skin, head to toes. The director of nursing (DON) was interviewed on [DATE] at 1:15 p.m. She stated the staff should have done a full skin assessment on the resident in an effort to determine the cause of infection. She stated a skin assessment should have been documented in the record. She stated through daily care and fall assessments, the cellulitis and toe eschar (dry, dead skin) should have been identified sooner. C. Assessment after reports of distress 1. Record review Resident #2 returned to the facility on [DATE] after a scheduled vascular bypass surgery. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A nursing note on [DATE] at 8:42 p.m. revealed the resident's son called the facility and reported he had just been speaking to the resident and he seemed distressed, out of breath and confused. The writing nurse documented she went to check on the resident who was lying in bed with his nasal cannula laying next to him and his legs slightly elevated. She asked the resident if he was in any distress, he stated he was on the phone with his son, though he felt he had lost track of what was going on. The nurse documented she helped him replace his nasal cannula and left the room to report to his son. -There was no documented assessment of the resident's condition or his vital signs at the time of the report that the resident was in distress. A nursing note on [DATE] at 12:32 a.m. revealed the resident was alert and oriented to person and place, though had been anxious and restless throughout the night, had reported he felt he had lost track of what was going on and his life was in shambles. Active listening was provided to the resident and he seemed to calm down. He was medicated with oxycodone 5 mg for a report of pain ,d+[DATE] (seven out of 10, severe pain). He had been incontinent of bowel and bladder and continued to remove his nasal cannula through the night. 2. Staff interviews LPN #3 was interviewed on [DATE] at 12:57 p.m. She stated she was taking care of the resident the night his son called. She stated she went to check on the resident and he did not seem to be in any distress. She stated he was confused but stated he was fine. She stated she did not remember if she had taken his vital signs when she went to check on him, though stated she did take them later on in the night. The DON was interviewed on [DATE] at 1:15 p.m. She stated a full assessment of the resident's condition should have been conducted and documented which would include a full set of vitals. She stated the nurse would be educated. D. Timely treatment for bleeding 1. Record review A nursing note on [DATE] at 1:15 p.m. revealed the resident was experiencing anal bleeding with bright red blood. No hemorrhoids were visible and the site of the bleeding was not visible from the outside. The resident was receiving lovenox (anticoagulant) 100 mg post surgery. The nurse called to inform the physician and left a voice message. A nursing note on [DATE] at 3:54 p.m. revealed the nurse attempted to call the resident's physician a second time with no answer. A nursing note on [DATE] at 4:51 p.m. revealed the physician called back and gave the nurse orders to hold the resident's lovenox that evening and would review the resident's orders to make changes if needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A nursing note on [DATE] at 11:25 p.m. revealed the resident was yelling for help at 7:30 p.m. and stating he could not breathe. His oxygen was increased which was ineffective. The nurse obtained a rebreather mask which was also ineffective. The nurse called 911 and started chest compressions and continued CPR (cardiopulmonary resuscitation) until EMTs (emergency medical technicians) arrived. The EMTs took over CPR, though this was unsuccessful and the resident was pronounced dead at 8:20 p.m. 2. Provider interview The resident's medical provider was interviewed on [DATE] at 10:30 a.m. He stated he remembered the situation with the resident's bleeding. He stated the resident's nurse called with a concern of anal/rectal bleeding and concern the resident's lovenox dose was too high. He stated if the resident was bleeding profusely, then 911 should have been called, though the nurse would have to be the judge of the seriousness of the bleeding. 3. Staff interviews Registered nurse (RN) #1 was interviewed on [DATE] at 12:18 p.m. He stated the resident had bright red blood in his brief and he called the doctor immediately after discovery. He stated it was enough blood for him to be concerned about the resident and his anticoagulant medication, but not enough where he felt he needed to call 911. He stated if he thought the resident was in immediate danger, he would have called the facility medical director, 911, and notified the director of nursing. The DON was interviewed on [DATE] at 1:15 p.m. She stated if a resident was in medical distress or having an emergency and the resident physician could not be reached, the nurse should call the medical director to obtain orders to treat or to send to the emergency room . She did not say the nurse should call 911. III. Resident #3 A. Resident status Resident #3, age 88, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included cerebral infarction, chronic respiratory failure, heart failure, primary osteoarthritis of left shoulder, unilateral osteoarthritis of right knee, morbid obesity, chronic pain, and chronic atrial fibrillation. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required extensive assistance of two staff members with bed mobility, transfers, and ADLs. B. Record review revealed treatment delays after the resident's [DATE] fall A nursing note dated [DATE] revealed the registered nurse was called to the resident's room to assess the resident after a fall out of bed. The resident was being changed by a certified nurse aide (CNA) and rolled off of the bed onto the floor. The resident was assessed to have small bruises on her left forearm and a scratch to her right buttock. She was able to move all of her extremities with no difficulty and did not complain of pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A physician assistant note dated [DATE] revealed the resident was prescribed oxycodone 5 mg for one time only for reports of right knee pain. The physician note continued the resident had a fall out of her bed the night before and was complaining of increased pain (full body) and was treated with aspercreme (topical analgesic) and an extra oxycodone tab. The physician saw the resident the day prior with a concern of increased abdominal girth and she had an abdominal and lung x-ray that showed colonic fecal residual but no concerning findings. The resident was on scheduled oxycodone but her pain is worse and will continue to monitor for one time extra oxycodone given that morning and the pain is 'whole body' and 'likely due to the fall.' A nursing note dated [DATE] at 10:00 a.m. revealed the resident received a one time dose of oxycodone due to pain from her fall from the previous night. The resident's skin was assessed for any injury and none were apparent, though the resident stated she was feeling overall general pain. A nursing note dated [DATE] at 2:03 p.m. revealed the CNA who was providing care to the resident the previous night was provided education related to how to properly roll a resident on an air mattress. (See MDS assessment above, the resident required two-person assistance for bed mobility.) A nursing note dated [DATE] at 9:30 p.m. revealed the resident continued on monitoring for the previous fall. She was assisted with scheduled pain medications, frequent repositioning and checking and changing. She refused to get up in her recliner and refused her shower. A nursing note dated [DATE] at 11:03 a.m. revealed a stat x-ray of the resident's right knee was ordered related to pain from her previous fall. The x-ray was taken at 8:15 p.m. on [DATE] and results were received on [DATE] at 7:30 a.m. and revealed osteopenia and an acute non-displaced distal femoral shaft fracture. The facility medical director gave orders to send the resident to the emergency department on [DATE] at 10:25 a.m. and the resident left at 11:15 a.m. The resident returned to the facility on [DATE] with a brace to her right knee as she was determined to not be a surgical candidate to repair the fracture. -The resident reported increased pain and an x-ray was not performed until three days after the fall incident. (Cross-reference F689 Accidents). C. Resident interview Resident #3 was interviewed on [DATE] at 12:09 p.m. She stated the CNAs who were assisting her during the brief change rolled her off of the bed by accident. She stated the nurse came to assess her and they got her back into bed but she did have a lot of pain from the fall. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 12:27 p.m. She stated if a resident was experiencing pain after a fall, the resident's physician should be called and an x-ray should be done to rule out injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on [DATE] at 12:46 p.m. He stated if a resident was two-person assist for bed mobility and changing CNAs should be on opposite sides of the bed to ensure proper body mechanics and to prevent the resident from falling out of bed. He stated Resident #3 was a two-person assist for bed mobility and turning, though he was not working the night the resident fell . LPN #2 was interviewed on [DATE] at 12:49 p.m. She stated when a resident falls, a registered nurse needed to be called to assess the resident for injury. She stated if the resident had pain, the nurse needed to identify where the pain was, assess the area and call the physician for additional orders. CNA #2 was interviewed on [DATE] at 12:55 p.m. She stated Resident #3 was a two-person assist for bed mobility and needed two people to turn her. She stated there should be one CNA on each side of the bed to ensure the resident did not fall. She stated the CNA staff had received training after the resident fell related to proper body mechanics and two assists for bed mobility. The director of nursing (DON) was interviewed on [DATE] at 12:47 p.m. She stated the resident's fall was investigated and revealed the resident was being changed by one staff member and the resident assisted in her bed mobility by holding the side of the bed and throwing her leg over her body which gave her momentum and she fell off the bed. She stated, at the time of her fall, she was determined to be a one-person assist for bed mobility, though was now a two-person assist due to this incident. -However, the resident required two staff assistance for bed mobility and transfer according to the [DATE] MDS assessment. She stated the resident did not complain of pain until two days after her fall and also had a history of arthritis in her knees. -However, the physician noted one day after the fall the resident was having increased right knee and full body pain.

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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** 33298 Based on record review and interviews, the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents for one (#3) out of four sample residents. Specifically, the facility failed to prevent a fall out of bed with injury for Resident #3 on 8/3/22. The resident was accidentally rolled out of bed by staff during a brief change on 8/3/22, the resident reported pain and an x-ray was performed on 8/6/22 where the resident was found to have a distal femur fracture. Findings include: I. Facility policy and procedure The Fall Prevention policy, updated 7/20/21, was provided electronically by the nursing home administrator (NHA) on 8/26/22 at 5:00 p.m. It read, in pertinent part: A fall can be defined as: when a resident is found on the floor; a resident slides to the floor unassisted; a resident rolls off the bed/chair onto the floor, including bedside mat; and a resident falls off any apparatus/equipment used for transfers. If a fall occurs, the following will be done: -The licensed nurse will complete a thorough assessment of the resident to evaluate for injury. -The licensed nurse will notify the physician and the family/responsible party. -Treatment will be initiated per physician orders. -An incident report will be completed. II. Resident #3 A. Resident status Resident #3, age 88, was admitted on [DATE]. According to the August 2022 computerized physician orders (CPO), the diagnoses included cerebral infarction, chronic respiratory failure, heart failure, primary osteoarthritis of left shoulder, unilateral osteoarthritis of right knee, morbid obesity, chronic pain, and chronic atrial fibrillation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 6/28/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required extensive assistance of two staff members with bed mobility, transfers, and ADLs. B. Record review An activities of daily living (ADL) care plan, initiated on 2/11/22 and updated on 6/29/22, read: Resident has an ADL self-care performance deficit . with pertinent interventions including: Resident requires extensive assistance by two staff physical assist to turn and reposition in bed and as necessary, which was initiated on 2/11/22 and revised on 8/25/22. A toilet use intervention initiated 2/11/22 read: The resident requires extensive assistance of two staff. A fall care plan, initiated on 2/11/22 and updated on 3/14/22, read: Resident is at risk for falls r/t (related to) Hx (history) of falling, Muscle spasm, Neuropathy and restless leg syndrome, Vitamin D deficiency, acute and chronic respiratory failure with hypoxia, morbid obesity with alveolar hypoventilation. A nursing note dated 8/3/22 revealed the registered nurse was called to the resident's room to assess the resident after a fall out of bed. The resident was being changed by a certified nurse aide (CNA) and rolled off of the bed onto the floor. The resident was assessed to have small bruises on her left forearm and a scratch to her right buttock. She was able to move all of her extremities with no difficulty and did not complain of pain. A physician assistant note dated 8/4/22 revealed the resident was prescribed oxycodone 5 mg for one time only for reports of right knee pain. The physician note continued the resident had a fall out of her bed the night before and was complaining of increased pain (full body) and was treated with aspercreme (topical analgesic) and an extra oxycodone tab. The physician saw the resident the day prior with a concern of increased abdominal girth and she had an abdominal and lung x-ray that showed colonic fecal residual but no concerning findings. The resident was on scheduled oxycodone but her pain is worse and will continue to monitor for one time extra oxycodone given that morning and the pain is 'whole body' and 'likely due to the fall.' A nursing note dated 8/4/22 at 10:00 a.m. revealed the resident received a one time dose of oxycodone due to pain from her fall from the previous night. The resident's skin was assessed for any injuries and none were apparent, though the resident stated she was feeling overall general pain. A nursing note dated 8/4/22 at 2:03 p.m. revealed the CNA who was providing care to the resident the previous night was provided education related to how to properly roll a resident on an air mattress. A nursing note dated 8/5/22 at 9:30 p.m. revealed the resident continued on monitoring for the previous fall. She was assisted with scheduled pain medications, frequent repositioning and checking and changing. She refused to get up in her recliner and refused her shower. A nursing note dated 8/6/22 at 11:03 a.m. revealed a stat (immediate) x-ray of the resident's right knee was ordered related to pain from her previous fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The x-ray was taken at 8:15 p.m. on 8/6/22 and results were received on 8/7/22 at 7:30 a.m. and revealed osteopenia and an acute non-displaced distal femoral shaft fracture. The facility medical director gave orders to send the resident to the emergency department on 8/7/22 at 10:25 a.m. and the resident left at 11:15 a.m. The resident returned to the facility on [DATE] with a brace to her right knee as she was determined to not be a surgical candidate to repair the fracture. -The resident reported increased pain and an x-ray was not performed until three days after the fall incident. (Cross-reference F684 Quality of Care). III. Resident interview Resident #3 was interviewed on 8/23/22 at 12:09 p.m. She stated the CNAs who were assisting her during the brief change rolled her off of the bed by accident. She stated the nurse came to assess her and they got her back into bed but she did have a lot of pain from the fall. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/25/22 at 12:27 p.m. She stated if a resident was experiencing pain after a fall, the resident's physician should be called and an x-ray should be done to rule out injury. Certified nurse aide (CNA) #1 was interviewed on 8/25/22 at 12:46 p.m. He stated if a resident needed two-person assist for bed mobility and changing, CNAs should be on opposite sides of the bed to ensure proper body mechanics and to prevent the resident from falling out of bed. He stated Resident #3 was a two-person assist for bed mobility and turning, though he was not working the night the resident fell . LPN #2 was interviewed on 8/25/22 at 12:49 p.m. She stated when a resident falls, a registered nurse needed to be called to assess the resident for injury. She stated if the resident had pain, the nurse needed to identify where the pain was, assess the area and call the physician for additional orders. CNA #2 was interviewed on 8/25/22 at 12:55 p.m. She stated Resident #3 was a two-person assist for bed mobility and needed two people to turn her. She stated there should be one CNA on each side of the bed to ensure the resident did not fall. She stated the CNA staff had received training after the resident fell related to proper body mechanics and two-person assists for bed mobility. The director of nursing (DON) was interviewed on 8/26/22 at 12:47 p.m. She stated the resident's fall was investigated and revealed the resident was being changed by one staff member and the resident assisted in her bed mobility by holding the side of the bed and throwing her leg over her body, which gave her momentum and she fell off the bed. She stated, at the time of her fall, she was determined to be a one-person assist for bed mobility, though was now a two-person assist due to this incident. She stated the resident did not complain of pain until two days after her fall and also had a history of arthritis in her knees. (continued on next page)

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Hampden Hills Post Acute	14699 E Hampden Ave Aurora, CO 80014

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	-However, assessments and staff interviews revealed the resident required two-person assistance for bed mobility before and after her fall with injury. In addition, she complained of pain one day after her fall as noted by the physician.