STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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** 51160 Based on interviews and record review, the facility failed to ensure three (#89, #59 and #67) of three residents out of 41 sample residents received adequate supervision to prevent accidents. Resident #89, who had a history of falls, was admitted to the facility on [DATE] after sustaining multiple pelvic fractures related to a fall sustained at home. The facility initiated a fall care plan on 11/15/23 which identified the resident was at risk for falls due to a gait imbalance (unsteady gait), poor cognition and a history of falls. The care plan documented generalized fall interventions which were not specific to the resident. The facility completed an initial fall risk assessment on 11/15/23 which was not consistent with the resident's care plan and inaccurately documented the resident had no history of falls, was independent and ambulated without problems using an assistive device. On 11/16/23, one day after the resident's admission to the facility, nursing documentation identified Resident #89 had poor safety awareness and did not use her call light for assistance. However, the facility failed to implement further person-centered fall interventions for the resident. Resident #89 sustained unwitnessed falls without injury on 12/16/23 and 2/4/24. The facility failed to implement new resident-specific fall interventions after either of the falls. On 7/17/24, Resident #89 sustained a third fall that resulted in the resident sustaining a sternal contusion (bruising of the flat bone in the center of the chest) and three left-sided rib fractures which required hospitalization in the intensive care unit. The facility implemented a fall intervention for a call, don't fall sign to be hung in the resident's room. However, per documentation, the resident had already been identified to not use her call light to call for assistance and the facility did not identify further interventions. On 8/5/24 Resident #89 sustained a fourth fall that resulted in a laceration to her forehead which required a transfer to the hospital for staples to the laceration. The hospital identified the resident had additionally sustained rib fractures to different ribs than her 7/17/24 rib fractures. An intervention for a checklist to anticipate the resident's needs was implemented. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	Following the fall on 8/5/24, Resident #89 experienced a decline in condition, however, the facility did not implement further fall interventions. On 8/22/24, Resident #89 sustained a fifth fall which resulted in the resident being transferred to the hospital where the resident was diagnosed with a left femur (thigh bone) fracture. The resident returned to the facility on hospice services and passed away at the facility on 8/23/24. Furthermore, Resident #59, who had a history of falls, sustained a fall on 1/27/24 without injury. The facility failed to identify new person-centered fall interventions for the resident. On 5/26/24 Resident #59 sustained a second fall which resulted in the resident being transferred to the hospital where she was diagnosed with a left pubic (lower pelvic bone) fracture. Despite the resident's fall with injury, the facility failed to implement additional fall interventions for the resident. Additionally, Resident #67, who was severely cognitively impaired, was admitted on [DATE]. The facility identified the resident as a fall risk and implemented generalized fall interventions which were not specific to the resident. On 10/12/24 Resident #67 sustained a fall which resulted in the resident being transferred to the hospital where she was diagnosed with a right wrist fracture. Due to the facility's failures to to ensure fall risk assessments were completed accurately and timely and person-centered fall interventions were implemented, Resident #89, Resident #59 and Resident #67 sustained falls which resulted in major injuries. Findings include: I. Facility policy and procedure The Fall Management policy and procedure, dated 4/7/22, was provided by the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It read in pertinent part, The facility will assess the resident upon admission, readmission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. During the admission and readmission process, a care plan will be developed and initiated by the admitting nurse on any residents assessed to be at risk for falls. The interdisciplinary team (IDT) will review any additional fall risk indicators and revise the resident's care plan as indicated. Accurate and thorough assessment of the patient is fundamental in determining indicators for potential falls. II. Resident #89 A. Resident status Resident #89, age greater than 65, was admitted on [DATE] and passed away at the facility on 8/23/24. According to the August 2024 computerized physician orders (CPO), diagnoses included generalized weakness, history of falling, difficulty in walking, localized edema, multiple fractures of the pelvis, multiple fractures of ribs (left side) and anemia. The 8/9/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. It revealed the resident was independent for sit to stand and toilet transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	The MDS assessment indicated the resident had sustained two falls resulting in major injuries. B. Record review The 11/15/23 admission fall risk assessment documented a fall risk score of 16 for the resident. The assessment documented Resident #89 had no falls, was independent and ambulated without problem with an assistive device. -However, the fall risk assessment was documented inaccurately and was not consistent with the resident's care plan. Resident #89 was admitted with multiple pelvic fractures related to a fall sustained at home, had a history of repeated falls, was observed with an unsteady gait with the use of an assistive device and was prescribed a diuretic medication which had the potential to contribute to falls (see care plan below). The fall care plan, initiated 11/15/23, documented Resident #89 was at risk for falls related to gait imbalance, poor cognition, and a history of falls with a goal that the resident would not sustain a serious injury requiring hospitalization related to falls. The interventions included assisting the resident with activities of daily living (ADL) as needed, placing the call light within the resident's reach, completing a fall risk assessment, and orienting Resident #89 to her room. The 11/16/23 nurse progress note documented Resident #89 had required frequent monitoring related to poor safety awareness and not using her call light prior to ambulating. Resident #89 had an unsteady gait even with the use of her front wheeled walker. Resident #89 did not utilize call light for assistance. -However, the facility failed to update the care plan and implement fall interventions after the above documented safety concerns. The 11/21/23 physician's admission progress note documented Resident #89 had generalized weakness, chronic debility that required assistance with self-care, fall precautions and required prompt pericare. The ADL care plan, initiated 11/29/23, documented Resident #89 had a self-care performance deficit related to generalized weakness. The interventions included encouraging the resident to participate in ADLs to the fullest extent possible, encouraging the resident to use the call light for assistance, praising all efforts at self-care and reporting any changes, potential for improvements, reasons for deficit, expected course or decline in function. The urinary incontinence care plan, initiated 11/29/23, documented Resident #89 had urinary incontinence. The pertinent interventions included assisting Resident #89 with toileting as needed and performing pericare as needed. 1. Fall incident on 12/16/23 The 12/16/23 progress note documented Resident #89 sustained an unwitnessed fall. Resident #89 was found seated on the floor under a tray table with her back against the nightstand after the resident was heard calling out for help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	The 12/18/23 fall risk assessment completed after the fall documented a fall risk score of 18 for the resident. The assessment indicated Resident #89 was independent and continent of bowel and bladder, had one to two relevant health conditions or risk factors and had only been taking one to two medications that increased her fall risk. -However, the fall risk assessment was documented inaccurately and was not consistent with the resident's care plan. Resident #89 had been care planned as being incontinent and prescribed a diuretic medication, had more than three relevant conditions (anemia, heart failure, edema, pelvic fractures, hearing impairment and depression) that could contribute to falls and was taking three or more relevant medications which had the potential to contribute to falls. -A review of Resident #89's fall care plan revealed the care plan was not updated with new person-centered fall interventions following the resident's fall on 12/16/23. 2. Fall incident on 2/4/24 The 2/4/24 nurse progress note documented Resident #89 was found on the bathroom floor after an unwitnessed fall. The resident reported hitting her head but denied losing consciousness. Resident #89 complained of left shoulder pain after the fall, which improved with the administration of acetaminophen (Tylenol). The 2/5/24 x-ray result was negative for a fracture to the resident's left shoulder. A review of the resident's electronic medical record (EMR) did not reveal a determination of the cause of the fall or a root cause analysis. The 2/5/24 fall risk assessment completed after the fall documented a fall risk score of 13 for the resident. The assessment indicated Resident #89 was independent, continent of bowel and bladder, had one to two relevant health conditions or risk factors that could contribute to falls and was taking one to two medications that increased the resident's fall risk. -However, the fall risk assessment was documented inaccurately and was not consistent with the resident's care plan. Resident #89 was incontinent, had more than three relevant conditions and medications that increased her fall risk and was taking three or more relevant medications which had the potential to contribute to falls. Based on the inaccurate assessment, Resident #89's fall risk score decreased indicating she was less of a fall risk, however, since she had been admitted , she had sustained two falls. A review of Resident #89's fall care plan revealed the care plan was not updated with new person-centered interventions following the resident's fall on 2/5/24. 3. Fall incident on 7/17/24 The 7/17/24 nurse progress note documented Resident #89 sustained an unwitnessed fall and reported hitting her head and back. Redness was noted to the left side of the scalp and the left lumbar area. Resident #89 was sent to the hospital for further studies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	-The progress note did not contain any further information regarding the fall including location and cause of the fall. The 7/17/24 computed tomography (CT) scan results from the hospital documented the resident sustained posterior left-sided fractures to ribs #4, #7 and #11. The resident's fall care plan was updated on 7/18/24 and identified Resident #89 sustained a fall with major injury. The updated intervention included placing a call don't fall sign in the resident's room. -However, per documentation, the resident had already been identified to not use her call light to call for assistance and the facility did not identify further fall interventions. The ADL care plan was revised on 7/18/24 and identified Resident #89 had sustained a recent fall with multiple rib fractures which caused a decrease in mobility. -There were no new interventions added to the care plan following the resident's fall on 7/17/24. The 7/19/24 fall risk assessment completed after the fall documented a fall risk score of 20 for the resident. The 7/20/24 nurse progress note documented Resident #89 had been non-compliant with safety throughout the night. Resident #89 had repeatedly walked to the bathroom without calling for help. Resident #89 had been educated by staff to call for assistance and had been apologetic, yet still continued to not call for assistance. Resident #89 required the floor to be decluttered multiple times by the nursing staff, however, Resident #89 had been observed frequently stepping on or over her oxygen tubing. -However, the facility failed to update the care plan and implement additional fall interventions after the above documented safety concerns. 4. Fall incident on 8/5/24 A review of the resident's EMR revealed documentation that Resident #89 sustained a fall and was transferred to the emergency department and returned on 8/6/24 with a laceration to the right forehead, which required staples and newly identified rib fractures. The resident's fall care plan was revised on 8/5/24 to include a new fall intervention of a checklist to anticipate the resident's needs. The 8/16/24 nursing progress note documented Resident #89 had a significant decline, which included confusion, lethargy and poor appetite. -However, the facility failed to update the care plan and implement additional fall interventions after Resident #89's significant decline was identified. 5. Fall incident on 8/22/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	The 8/22/24 nursing progress note documented the physician was notified of the x-ray result which indicated a left femur fracture. -The progress note did not indicate the resident had sustained a fall or the reason the x-ray was ordered in the first place. The fall care plan was updated on 8/23/24 (the day after the x-ray was obtained) and identified Resident #89 sustained a left femur fracture related to a fall. New fall interventions included anticipating and meeting the resident's needs, bed in lowest position at all times and educating resident/family/caregivers about safety reminders and what to do if a fall occurred. The 8/23/24 nurse progress note documented Resident #89 was assessed at 5:40 p.m. with an absence of breathing. Chest auscultation (listening with a stethoscope) revealed the absence of heart sounds and breathing which was confirmed with a second nurse at 5:45 p.m. C. Staff interviews The director of nursing (DON) was interviewed on 11/7/24 at 5:24 p.m. The DON said a fall risk assessment should be completed during the admission process along with a fall care plan listing the interventions related to the fall risk assessment. The DON said after a resident sustained a fall, the nurse should assess the resident for injury and neurological status and notify the physician, the family and the DON. The DON said the fall risk assessment, care plan, and documented interventions should be updated after a sustained fall. The DON said a root cause analysis should be completed the following day with the IDT. The DON said there should be a weekly reassessment to ensure that the updated fall interventions were effective. The DON said Resident #89 had sustained multiple falls throughout her time at the facility and she had three falls with confirmed major injuries. She said she was not the DON at the time the resident was in the facility, but based on a review of the resident's EMR, the facility did not implement person-centered interventions following each fall, nor did the facility identify the root cause of the falls. The DON said the root cause analyses that were completed for only three of Resident #89's falls repeated the circumstances of the fall but did not identify the cause. The DON said each fall risk assessment should be completed accurately with a comprehensive look at the resident to ensure the accurate fall risks were identified. She said Resident #89's fall risk score should not have decreased after she had sustained a fall with a major injury. The DON said fall prevention had been an area of improvement that the facility had identified during the survey process, after fall investigations had been requested. She said she had begun to implement care plan updates for residents throughout the facility. 50219 III. Resident #59 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	Resident #59, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 CPO, diagnoses included dementia, osteoporosis, glaucoma and history of falling. The 10/29/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of nine out of 15. The resident required partial to moderate assistance with most activities of daily living (ADL). The resident was independent for transfers. The resident was frequently incontinent of both bowel and bladder. The MDS assessment indicated the resident had not sustained any recent falls. B. Record review The fall care plan, initiated on 3/16/22, revealed Resident #59 was at risk for falls due to weakness, difficulty with gait, history of falls and poor safety awareness. Pertinent interventions included anticipating and meeting the resident's needs (initiated on 8/29/23), assisting with ADLs as needed (initiated on 3/16/22), having the call light within reach (initiated on 3/16/22), orienting the resident to her room (initiated on 3/16/22) and keeping items of personal importance within reach (initiated on 3/16/22). -The care plan did not reveal any new interventions added after Resident #59's falls on 1/27/24 or 5/26/24 (see risk management reports below). A risk management report, dated 1/27/24 at 3:05 p.m., revealed Resident #59 had an unwitnessed fall while trying to transfer herself to a chair. The report revealed Resident #59 did not have any apparent injuries and did not complain of any pain. Resident #59 said she was trying to get to her chair and slipped. Resident #59 was assessed by a member of the nursing staff, did not have any apparent injuries and her vitals and neurological assessments were both at baseline following the fall. -The report did not reveal any root cause analysis to identify the reason for the resident's fall. The report did not identify any new interventions added to prevent further falls for Resident #59. A risk management report, dated 5/26/24 at 1:50 a.m., revealed Resident #59 had an unwitnessed fall while trying to ambulate to the bathroom. The report revealed Resident #59 was heard crying for help by the nursing staff and found against the wall on her side. Resident #59 was trying to go to the bathroom and urinated on the floor which caused her to slip and fall. Resident #59 reported to the nursing staff that she had hit the back of her head on the wall and reported having pain in her left hip. Resident #59 was assessed and assisted onto her feet where it was noted she was unable to bear weight on her left leg. The nurse practitioner was contacted and Resident #59 was transported to the emergency department. -The report did not reveal any new interventions added to prevent further falls for Resident #59. A progress note dated 6/1/24 revealed Resident #59 had a left pubic (lower pelvic bone) fracture and was receiving physical therapy for strengthening and conditioning. C. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	CNA #6 was interviewed on 11/6/24 at 3:04 p.m. CNA #6 said Resident #59's last fall was a few months prior. CNA #6 said to prevent falls for Resident #59, she encouraged her to use her call light. CNA #6 said Resident #59 was very good about using her call light to ask for assistance after the fall when she sustained the fracture, however, she said as the resident had healed she had gotten more independent. CNA #6 said she tried to catch Resident #59 before she tried to get up on her own and made sure her room was cleared of any trip hazards. LPN #4 was interviewed on 11/7/24 at 10:42 a.m. LPN #4 said Resident #59's fall interventions included keeping her call light within reach, assisting with ADLs as needed, educating the resident and her family with safety reminders and notifying Resident #59's doctor if she had any signs of confusion. D. Additional information A fall performance improvement plan (PIP), initiated 5/15/24, was received from the NHA on 11/11/24 at 2:46 p.m. The PIP revealed a fall review was conducted by the facility administration team and system process gaps were noted. Pertinent interventions for this PIP included discussing recent falls and interventions in grand rounds and fall huddles were to be conducted after each fall with the facility administrators, direct care staff and the resident. The PIP revealed the facility would monitor for systemic changes by completing weekly risk management meetings to review current falls, unit managers would complete weekly fall audits and the DON would track and trend falls and review weekly audits. -However, Resident #59 sustained a fall with major injury on 5/26/24, after the PIP was put in place and no new fall interventions were implemented for the resident on the care plan. 47064 IV. Resident #67 A. Resident status Resident #67, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included, fracture of the right radius (broken bone in the lower arm), pulmonary embolism (blood clot in the lungs), respiratory failure with hypoxia (decreased ability to exchange oxygen), congestive heart failure (inability of the heart to push blood throughout the body) and chronic kidney disease (decrease kidney function). The 10/9/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. The resident required maximum staff assistance with toileting and transfers and moderate assistance for dressing, personal hygiene and eating. She used a walker and a wheelchair for mobility and was frequently incontinent of bowel and bladder but was not on a toileting program. The MDS assessment indicated the resident had a fall within the last month. B. Resident/family interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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	Resident #67 was interviewed with a family member present on 11/5/24 at 2:59 p.m. Resident #67 said she fell and hurt her hand and results from the x-ray done in the hospital revealed a broken bone in her arm. She said she got up in the middle of the night to use the bathroom and fell in the bathroom. She said her walker had sat against the wall of her room since the fall, even though her fracture had healed. Resident #67 said the staff would not let her use her walker after the fall. Resident #67's family member said she was told Resident #67 had gotten up early in the morning and fell in the hallway. The family member said since the fall, the facility only wanted her to use the wheelchair to get around even though she had been able to use the walker when she was admitted to the facility. C. Record review The 10/3/24 fall risk assessment, completed upon the resident's admission to the facility revealed Resident #67 was at risk for falls and had a history of falls within the 90 days prior to her admission. The assessment documented the resident required staff assistance for toileting and mobility but did not follow directions. The comprehensive care plan, initiated 10/4/24, identified Resident #67 was at risk for falls with a goal that the resident would not sustain a serious injury requiring hospitalization through the review date. Interventions included assisting the resident with activities of daily lying (ADL) as needed, keeping the call light within reach, completing fall risk assessments and orienting the resident to her room. -The care plan did not reveal any new fall interventions added after Resident #67's fall on 10/12/24 (see fall documentation below). A facility event progress note on 10/12/24 at 12:58 a.m. revealed the certified nurse aide (CNA) informed the nurse that Resident #67 was sitting on the floor in the bathroom with her back up against the wall. Resident #67 reported she went to the bathroom and accidentally fell on to the floor. Resident #67 reported pain to her right hand. The resident was educated on the use of her call light and verbalized understanding and her ability to use the call light. The note documented the resident was sent to the emergency department, per facility protocol, because she was on an anticoagulant (blood thinning medication) at the time of her fall. Hospital documentation for Resident #67, from 10/12/24 to 10/14/24, revealed the resident sustained a complex distal radial metaphyseal fracture (fracture of the wrist area) as seen in x-ray imaging. Resident #67 was placed into a splint and instructed to follow up with an orthopedic specialist in one week. A facility physician's note on 10/14/24 at 7:57 p.m. revealed Resident #67 was sent out to the hospital after a fall in the bathroom with pain to her right wrist. The note documented the hospital findings of a complex distal radial metaphyseal fracture and application of a splint. The note indicated orthopedic follow up would be arranged. The facility provided the incident report for Resident #67's 10/12/24 unwitnessed fall on 11/6/24 at 3:18 p.m. The documentation revealed the resident had no injuries at the time of fall on 10/12/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065370	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Littleton	1500 W Mineral Ave Littleton, CO 80120

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, Resident #67's hospital records indicated the resident sustained a radial fracture and the facility's nurse progress note dated 10/12/24 indicated the resident complained of pain in her right hand (see record review above). D. Staff interview The DON was interviewed on 11/7/24 at 5:42 p.m. The DON said there were no new fall interventions added to Resident #67's care plan after her fall on 10/12/24.