STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065077	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Englewood Post Acute and Rehabilitation	3575 S Washington St Englewood, CO 80113

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on interviews and record review, the facility failed to thoroughly investigate resident-to-resident allegations of physical abuse and staff-to-resident allegations of neglect of care to prevent further instances of abuse and residents from feeling neglected for two (#60 and #18) of four residents out of 40 sample residents. Specifically, the facility failed to: -Develop a care plan focus for Resident #18, who had a known history of aggressive behaviors towards others and a history of discharge from other facilities due to aggressive behavior; -Gather all pertinent unbiased observations to identify pertinent facts of the events that occurred before, during and immediately following the incident to determine necessary interventions to prevent further abuse. This could include but not limited to observations of the assailant's behavior; words; gestures; facial expression; demeanor; tone and volume of voice; proximity and assailant and victim during the incident; and other applicable details and responses of each resident; -Investigate the extent and medical implications of the assailant's alleged hallucinations to determine if they could occur in other settings including common areas of the facility if the resident fell asleep or experienced similar conditions that occurred during this reported incident on 9/24/24; and, -Complete thorough investigations of the alleged violation of resident-to-resident physical abuse between Resident #18 towards Resident #60 that included sufficient evidence to allow the nursing home administrator (NHA) to determine what actions were necessary to protect the victim, Resident #60, and others residents in the facility from potential abuse by Resident #18 when in common areas of the facility. Findings include: I. Facility policy and procedure (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse Prevention of and Prohibition Against Policy, revised October 2024, was provided by the NHA on 11/04/24 at 9:00 a.m. It read in pertinent part, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. All identified events are reported to the administrator immediately. A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the administrator or his/her designee; An interview will be conducted with staff members (on all shifts) who may have information regarding the alleged incident. Interviews will be conducted with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident. The investigation will include the following: -An interview with the person(s) reporting the incident; -An interview with the resident(s); -Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; and, -A review of the resident's medical record, including a review of all circumstances surrounding the incident. At the conclusion of the investigation, the facility will attempt to determine if abuse, neglect, misappropriation of resident property, or exploitation has occurred. The investigation, and the results of the investigation, will be documented. If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves another resident, the facility will continue to assess, monitor and intervene as necessary to maximize resident health and safety. At the conclusion of the investigation, the facility will take action, as necessary, in light of the information gathered, which may include but is not limited to: -If the allegation is substantiated, analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property, or exploitation occurred, and determining what changes are needed to prevent further occurrences; and, -Defining how care provision will be changed and/or improved to protect residents receiving services, if appropriate (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident to resident allegation of physical abuse towards Resident #60 by Resident #18 on 9/24/24 A. Facility investigation 1. Description of the incident The facility investigation, dated 9/25/24, revealed that nursing staff found Resident #18 standing over Resident #60 who was in bed. Resident #60 was holding on to Resident #18. The nurse separated the two residents. The responding nurse was not sure of what had occurred at the time of the intervention. A nursing note, in Resident #18's electronic medical record (EMR), dated 9/24/24 at 10:30 p.m. and written by the responding nurse, revealed that the nurse went to Resident #60 and Resident #18's room to answer the call light. Upon entering the room, the nurse observed Resident #60 sitting on the side of his bed holding on to the wrist of Resident #18. The nurse separated the two residents and took Resident #18 to the bathroom. -The nursing note failed to provide an assessment of Resident #18's cognitive status or assess his state of mind other than he was calm and cooperative as he was separated from Resident #60. There was no indication if the resident was assessed for consciousness or other altered state of mind as he was observed standing over Resident #60. 2. Witness statements Resident #60 was interviewed by staff just after the incident. Resident #60 said he woke up to find Resident #18 standing over him punching him in the left cheek with a closed fist. Resident #60 said he pushed Resident #18 off of him and held him by the wrist until the nurse was able to remove him. Resident #18 was interviewed by staff just after the incident. Resident #18 said he did not know what was going on and he did not have a problem with his roommate so he must have been hallucinating. A nursing note, dated 9/24/24 at 10:30 p.m., documented that Resident #18 was unable to tell the responding nurse what had occurred and that he did not know why he did that or what he did. Resident #18 said he did not mean it and apologized to Resident #60 several times then said I must have been hallucinating. The residents were moved to separate rooms pending an investigation. -There was no documentation in the investigative report indicating that the investigator asked the responding nurse for detailed information on the exact words of the residents involved or if she had any indication that Resident #18 might have been in an altered state or appeared to have been hallucinating at the time of discovery. There was no indication of which resident turned on the call light or why the call light was turned on in the first place. B. Resident #60 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #60, age 68, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included cognitive communication deficit, generalized muscle weakness and acute respiratory disease. The 10/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident did not display aggressive behaviors. The resident had a full range of motion (ROM) in the upper extremities (arms) and limited ROM in the lower extremities (legs). He used a manual wheelchair to get around the facility but was able to stand and transfer himself. 2. Resident interview Resident #60 was interviewed on 10/7/24 at 10:30 a.m. Resident #60 said his old roommate punched him and he was glad he had a new roommate. 3. Record review A progress note dated 9/25/24, documented that the interdisciplinary team (IDT) reviewed the resident-to-resident physical altercation that occurred on 9/24/24 and all details in the investigative report (see above). The IDT determined the room move to separate the living situation of the two residents was sufficient to prevent further incidents for Resident #60. -The progress note had no determination of the root cause of the incident and no recommendations for preventing future incidents. -There was no additional information in the resident's EMR from what was in the facility investigation (see above). C. Resident #18 (assailant) 1. Resident status Resident #18, age 67, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included anxiety, depression and cerebral infarction (stroke caused by brain tissue death). The 8/1/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. Resident #18 required partial to moderate assistance from staff for bathing, dressing, transfers and bed mobility. He used a wheelchair for mobility. The MDS assessment did not indicate Resident #18 had hallucinations, delusions or aggressive behavior. 2. Resident interview Resident #18 was interviewed on 11/5/24 at 3:00 p.m. Resident #18 said he did have an altercation with another resident a long time ago. Resident #18 said he hit the other guy, who was his roommate at the time of the altercation. Resident #18 said he was hallucinating at the time. He said he got along with everyone now and he had his own room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review -The comprehensive care plan, initiated 4/9/24, did not have a care focus to address Resident #18's history of aggressive behavior prior to the resident-to-resident alteration on 9/24/24. Following the resident to the resident altercation, Resident #18 was prescribed risperidone (an antipsychotic medication) on 9/25/24 for the diagnosis of aggression. A care plan was initiated for the antipsychotic medication and the incident (resident-to-resident altercation) on 9/26/24. -However, the care plan interventions for resident-to-resident altercations only provided interventions for the 72-hours post-incident and did not provide staff with interventions for the possibility of future resident-to-resident altercations. -There was no intervention for staff to monitor the resident for hallucinations as a precursor to aggressive acts towards their residents. The 9/10/24 psychiatric nurse practitioner follow-up note revealed Resident #18 had not been experiencing hallucinations but had a history of aggression and had been asked to leave previous long-term care facilities for his behavior. -However, there was no evidence in the resident's record that the facility addressed this assessment or that they care-planned the resident's history of aggression. According to the 9/24/24 nursing progress note, nursing staff found Resident #18 standing over the bed of Resident #60. The other resident said Resident #18 hit him on the left side of the face with a closed fist. Resident #18 was unable to tell staff what happened or why he would have hit the other resident. Resident #18 said he may have been hallucinating. The 9/26/24 physician's progress note documented Resident #18 had been hallucinating often, was combative with staff and was likely experiencing terminal agitation due to end-stage liver disease. -However, the nursing progress notes for September 2024 did not include any documentation about Resident #18 being combative with staff or hallucinating. D. Staff interviews The director of nursing (DON), the social services director (SSD), the social services consultant (SSC) and the NHA were interviewed together on 11/7/24 at 2:30 p.m. The NHA, the SSC and the DON said that they did not substantiate the allegation of abuse for the resident-to-resident altercation between Resident #18 and Resident #60 because neither of the residents were injured and neither were fearful. The DON said the IDT reviewed the incident and since Resident #18 said he was hallucinating, the IDT determined Resident #18's actions were not intentional. The DON said she had the staff assist Resident #18 to move to a different room on the second floor while Resident #60 stayed in his room and no longer had a roommate. She said both residents were happy with their new living arrangements. (continued on next page)

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