

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on record review and interviews, the facility failed to prevent two of six sample residents (#2 and #3) from sexual abuse by certified nurse aide (CNA) #1.</p> <p>Record review and interviews revealed Resident #2, cognitively impaired and physically dependent, was sexually abused by CNA #1 on 7/27/24. The CNA was suspended immediately and terminated on 8/13/24. Resident #3, cognitively intact but visually impaired, reported on 10/11/24, that she, too, was sexually abused by CNA #1 before his suspension.</p> <p>Findings include:</p> <p>Record reviews and interviews confirmed the facility corrected the deficient practice before the onsite investigation from 10/21/24 to 10/22/24. The deficiency was cited as past non-compliance with a correction date of 8/2/24.</p> <p>I. Situation of serious harm</p> <p>Record review and interviews revealed Resident #2, cognitively impaired and physically dependent, was sexually abused by CNA #1 on 7/27/24. The CNA was suspended immediately and terminated on 8/13/24. Resident #3, cognitively intact but visually impaired, reported on 10/11/24, that she, too, was sexually abused by CNA #1 before his suspension.</p> <p>I. Facility policy</p> <p>The Abuse and Neglect policy and procedure, dated 7/22/24, was provided by the nursing home administrator (NHA) at approximately 12:00 p.m. on 10/21/24. It read in pertinent part, The resident has the right to be free from abuse, misappropriation of resident's property and exploitation. Residents must not be subjected to abuse by anyone, including but not limited to, location, employees, other residents, consultants or volunteers, employees of other agencies serving the resident, family members, legal guardians or other individuals. If an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident property, the employee will take measures to protect the resident. The employee will then report the allegation to a supervisor.</p> <p>II. Sexual abuse of Resident #2</p> <p>(continued on next page)</p>

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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A. Resident status</p> <p>Resident #2, age over 65, was admitted to the facility on [DATE]. According to the October 2024 computerized physician orders (CPO), pertinent diagnoses included Huntington's disease (a progressive brain disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability), muscle weakness, encephalopathy (brain disease that alters brain function), anxiety and cognitive communication deficit (difficulty paying attention, remembering, responding, understanding, following direction).</p> <p>The 8/14/24 minimum data set assessment (MDS) revealed Resident #2 was severely cognitively impaired based on a staff assessment of her mental status. She was dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, bathing, eating, and locomotion on and off the unit.</p> <p>A review of Resident #2's care plan, revised 9/26/23, revealed the resident had impaired cognitive function and thought process related to Huntington's disease, as evidenced by impaired memory and decisions, impaired executive functioning, impulsivity, poor safety awareness, delayed processing and responses, trouble concentrating, and inattention. Interventions included the resident understood consistent, simple, direct sentences. Staff were to ask yes/no questions to determine the resident's needs, to present one idea, question, or command at a time, to allow time for Resident #2 to process and respond, and to validate the resident's message by repeating it aloud.</p> <p>Resident #2 was observed on 10/22/24 at 9:30 a.m. in her room lying on the floor mat covered with a blanket. Her eyes were open. She was asked if she ate breakfast and if she was comfortable. She did not respond to the questions.</p> <p>B. Record review and interviews revealed Resident #2, cognitively impaired and physically dependent, was sexually abused by certified nurse aide (CNA) #1 on 7/27/24.</p> <p>1. A nursing progress note in the resident's record, dated 7/27/24 at 6:14 p.m., documented that the police were notified of an incident concerning an elderly female resident. CNA#1 was found in a compromising position at Resident #2's bedside by CNA #2 when she entered the resident's room. CNA #2 immediately informed the onsite registered nurse (RN) of her observation. The RN called the on-call clinical nurse manager (CNM) who collaborated with the director of nursing (DON) and nursing home administrator (NHA) for directions to address the potential abuse. The onsite RN verified the resident's immediate safety and reported to the CNM that the resident was resting in bed.</p> <p>2. The NHA provided an investigation report and a timeline of the 7/27/24 incident involving Resident #2 and CNA #1 at 12:00 p.m. on 10/21/24.</p> <p>a. Report</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility investigation report which included interviews with CNA #1, CNA #2, CNA #3, certified nurse aide with medication aide authority (CNA-Med) #1, and all residents CNA #1 cared for, read CNA #2 walked into Resident #2's room to find CNA #1 for report and witnessed Resident #2 lying in her bed fully clothed with a blanket up to her chest and her body turned to the left side. There was a food tray behind CNA #1, out of reach. CNA #1 was positioned with his right knee on the resident's bed and his left leg on the floor. CNA #1 was facing the resident at the level of her face. When CNA #2 walked in, CNA #1 jumped off the bed, startled, shifted his pants, and pulled his shirt down. CNA #2 immediately walked away to find a nurse. CNA #3 was also looking for CNA #1. She walked into the room as CNA #1 was walking out of the room carrying a tray of food. CNA #3 said CNA #1 was more talkative and friendly.</p> <p>b. Timeline</p> <p>On 7/27/24:</p> <ul style="list-style-type: none"> -CNA #2 reported to RN #1 about what she witnessed with CNA #1 and Resident #2 at approximately 6:00 p. m. -RN #1 called the on-call clinical nurse manager (CNM) after getting CNA #2's report, to inform the CNM of a staff member reporting a possible abuse. -The CNM called the NHA and the director of nursing (DON) after the incident was reported to her on the phone. -The NHA, the DON, and the CNM spoke to CNA #1 on the phone together after the incident was reported, to get a description of the incident (see investigation interviews below). -CNA #1 was removed from the facility by security immediately and suspended from his job. -Resident #2 was assessed by RN #1 and licensed practical nurse (LPN) #1 at 6:18 p.m. There were no signs of injuries present. Resident #2 was interviewed by the CNM, RN #1, and LPN #1 (see investigation interviews below). -CNA #2, CNA #3, and CNA-Med) #1 were interviewed by the CNM, the DON, and the NHA by phone (see investigation interview below). -All other residents on CNA #1's assignment were interviewed by RN #1 and LPN #1 (see summary of recorded interviews below). <p>On 7/29/24:</p> <ul style="list-style-type: none"> -Ten residents on side one (1), where CNA #1 was working on 7/27/24, which included some residents on CNA #1's assignment and others in the hallways CNA #1 could have been helping out on, were interviewed by RN #1 and LPN #1. The 10 residents denied ever being abused by any staff members or having concerns about other residents being abused. -CNA #1 was brought into the facility and interviewed by the NHA, the DON, and the CNM (see investigation interviews below). <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/30/24:</p> <p>-The facility began education on neglect and abuse to the nursing care staff, including all direct care staff (see action plan and facility follow-up below).</p> <p>c. Investigation interviews</p> <p>i. RN #1, LPN #1, and the CNM interview on 7/27/24 with Resident #2</p> <p>Although, in an interview after the initial facility interview, Resident #2 responded no to all abuse questions, in her interview on the day of the incident, 7/27/24 (no exact time was recorded), the resident responded uh-huh (affirmative) when asked if she had been approached by CNA #1. She responded uh-huh (affirmative) when asked if CNA #1 had exposed his privates to her. She arched her back and emphatically said yes when asked if CNA #1 had put his penis on her face or in her mouth.</p> <p>ii. CNM, DON, and NHA interview on 7/27/24 with CNA #2, CNA #3, and CNA-Med #1</p> <p>CNA #2 and CNA #3 interviews were as documented in the investigation report above. CNA #2 walked into Resident #2's room to find CNA #1 for report and witnessed Resident #2 lying in her bed fully clothed with a blanket up to her chest and her body turned to the left side. There was a food tray behind CNA #1, out of reach. CNA #1 was positioned with his right knee on the resident's bed and his left leg on the floor. CNA #1 was facing the resident at the level of her face. When CNA #2 walked in, CNA #1 jumped off the bed, startled, shifted his pants, and pulled his shirt down.</p> <p>CNA #3 reported she also was looking for CNA #1. She walked into the room as CNA #1 was walking out of the room carrying a tray of food. CNA #3 said CNA #1 was more talkative and friendly.</p> <p>CNA-Med #1 reported that she entered the room while CNA #1 was feeding Resident #2. CNA-Med #1 reported when she entered the room, CNA #1 got up and moved the chair he was sitting on. She did not witness any inappropriate behaviors.</p> <p>iii. The NHA, DON, and CNM interview together with CNA #1 on the phone on 7/27/24.</p> <p>CNA #1 said he was feeding Resident #2 in bed with her head elevated. CNA #1 stated he was sitting in a chair beside Resident #2 with the food tray to the side of him. CNA #1 stated that CNA-Med #1 came in to give Resident #2 medication. CNA #1 said he stood up to move the chair out of the way for CNA-Med #1 to get closer to Resident #2. After CNA-Med #1 left the room, CNA #1 decided to stand up and put his left knee on the bed because he had a sore on the bottom of his left foot and it was hurting because of the pressure on it while sitting in the chair. CNA #1 denied putting his groin in Resident #2's face. CNA #1 denied exposing himself or putting his penis in or around Resident #2's face or mouth. CNA #1 stated he was startled when CNA #2 entered the room behind him and as he stood up on both feet, he readjusted his pants at the waist so the bottom of the pants was not around his feet/shoes due to being long.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>But see CNA #2's interview for the investigation report above. CNA #2 reported she walked into Resident #2's room to find CNA #1 for report and witnessed Resident #2 lying in her bed fully clothed with a blanket up to her chest and her body turned to the left side. There was a food tray behind CNA #1, out of reach. CNA #1 was positioned with his right knee on the resident's bed and his left leg on the floor. CNA #1 was facing the resident at the level of her face. When CNA #2 walked in, CNA #1 jumped off the bed, startled, shifted his pants, and pulled his shirt down.</p> <p>4. Action plan and facility follow-up to the incident of abuse on 7/27/24</p> <p>a. CNA #1</p> <p>See the facility timeline above. CNA #1 was suspended on 7/27/24 immediately after the incident was reported. An interview with the NHA at 4:00 p.m. on 10/22/24 (see below) revealed CNA #1 was terminated on 8/13/24 and reported to the appropriate governing agencies, and complaints were filed on his license.</p> <p>b. Facility staff</p> <p>A review of the facility investigation documents provided by the NHA at 12:00 p.m. on 10/21/24 revealed follow-up actions specific to training on abuse and neglect by the nurse educator (NE) and included interviews, assessments, education, and reporting. The training included for staff to take measures to protect the resident and then report the allegation to a supervisor, steps that had not been taken on 7/27/24, per the facility investigation report.</p> <p>The facility's investigation was completed on 8/2/24 and 75 percent (%) of the direct care staff training was completed by 8/2/24. The remaining staff training was completed by 8/15/24, as staff schedules allowed.</p> <p>C. Staff interviews</p> <p>1. CNA #4 was interviewed on 10/21/24 at 2:15 p.m. CNA #4 said she got education on abuse and neglect when she started working there and the facility's NE held an education session about abuse and neglect at the end of July 2024 where CNA #4 learned about the different kinds of abuse and how to report it. She said if she saw a resident being abused, she would make sure the resident was safe and then report it to a nurse, the DON, or social services. She said there is always a nurse on-call to call if she could not find the nurse working.</p> <p>2. RN #2 was interviewed on 10/21/24 at 2:50 p.m. RN #2 said she was educated about the types of abuse and who to report abuse to and how to report it at the end of July 2024. RN #2 said she would make sure the residents involved were safe before reporting the abuse.</p> <p>3. The NHA and the DON were interviewed together on 10/22/24 at 4:00 p.m.</p> <p>-The NHA said there was no indication that CNA #1 would have engaged in sexually abusive behavior. She said the human resource (HR) department ran his background checks before his hiring on 4/30/24 and he completed all his abuse and neglect education before beginning orientation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The NHA said they thought he was a lazy worker because he was frequently found in the restaurant part of the community and left work early. She said he always worked the 2:00 p.m to 10:00 p.m. shift and was always on the 500 hallway (on side 1).</p> <p>-The NHA said she instructed security to remove him from the building immediately following the incident on 7/27/24 and placed him on suspension. She said they ended up terminating him on 8/13/24.</p> <p>-The NHA said they conducted education for direct care staff, which included nurses and CNAs, on abuse and neglect beginning on 7/30/24. She said they got approximately 75% of the staff educated by 8/2/24, and the remaining staff were educated by 8/15/24, due to their schedules.</p> <p>4. The CNM and the DON were interviewed together on 10/22/24 at 10:07 a.m.</p> <p>-The CNM said she was called by RN #1 on 7/27/24 around 6:00 p.m. and was asked to talk with CNA #2. She said CNA #2 said she was coming on to her shift and looking for CNA #1 to get a report. She walked into Resident #1's room without knocking and saw CNA #1's right leg on the resident's bed and he was leaning over the resident's face. She said Resident #2's face was turned toward the left side, facing CNA #1's groin area. She said she saw him jump up and adjust his pants, grabbing them from the front and he pulled down his shirt. She said the resident's food tray was across the room on top of stacked up mats and out of reach for him to be feeding the resident, and the head of the resident's bed was flat. CNA #2 walked away to find a nurse after witnessing this, as she said it made her feel uncomfortable.</p> <p>-The CNM said she interviewed CNA #3 on 7/27/24 around 6:00 p.m. and she said she walked into Resident #2's room after CNA #2 left. She said she was looking for CNA #1 to get a report. She said she walked into Resident #1's room and saw the room tray was across the room, not next to the bed. She noticed the head of the bed was flat. CNA #3 said CNA #1 was acting more friendly and talkative.</p> <p>-The CNM said she interviewed CNA #1 with the DON and the NHA on 7/29/24 in person. The CNM said CNA #1 demonstrated how he was positioned on the bed with his left knee on the bed. The CNM said CNA #1 showed her, the DON and the NHA the sore on his left foot and said it was the size of a pinprick. The CNM said she asked CNA #1 why he pulled his pants up from the front and not the back and she said CNA #1 did not have an answer.</p> <p>5. The campus director (CD), the DON, and the NHA were interviewed together on 10/22/24 at 3:10 p.m. The CD said CNA #1 did not have to be exposed for abuse to occur.</p> <p>III. Sexual abuse of Resident #3</p> <p>A. Resident status</p> <p>Resident #3, age over 65, was admitted to the facility on [DATE]. According to the October 2024 CPO, pertinent diagnoses included type 2 diabetes, primary open-angle glaucoma, left eye severe stage (optic nerve damage resulting in vision loss), central retinal vein occlusion (eye condition affecting the retina and leading to vision loss), left eye with macular degeneration and need for assistance with personal care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The 7/17/24 MDS assessment revealed Resident #3 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial/maximal assistance from staff for bed mobility, transfers, dressing, toileting, personal hygiene, bathing, eating, and locomotion on and off the unit.</p> <p>B. Record review and interviews revealed Resident #3, cognitively intact but visually impaired, reported on 10/2/24, that she, too, was sexually abused by CNA #1 before his suspension.</p> <p>1. The NHA provided an investigation report and a timeline of the incident involving Resident #3 and CNA #1 at 12:00 p.m. on 10/21/24.</p> <p>1. Report</p> <p>The facility investigation report read the NHA was informed on 10/4/24 by the local police and adult protective services that CNA #1 talked to the police (during an interview with the police on 10/3/24) about a second incident involving him before his suspension on 7/27/24.</p> <p>2. Timeline</p> <p>On 10/4/24:</p> <p>-The local police department notified the NHA of CNA #1's statement (see above) and the facility determined that Resident #3 matched the description CNA #1 gave to the police.</p> <p>-The social services director (SSD) interviewed Resident #3 and the resident denied ever being abused at the facility. The SSD and social services assistant (SSA) #1 interviewed 50 total residents, all on the side of the unit where CNA #1 was assigned.</p> <p>-Facility-wide education was conducted on abuse and neglect.</p> <p>On 10/9/24:</p> <p>-The DON and SSA #1 interviewed Resident #3 and she denied ever being abused at the facility.</p> <p>-The HR department expanded the sample and interviewed all employees in the healthcare facility to ask if the staff had noticed any resident acting differently, if any dependent residents changed how they tolerated care, or if the behaviors of their coworkers ever made them feel uncomfortable. Staff denied this in the interviews.</p> <p>C. Interviews</p> <p>The NHA and DON were interviewed together on 10/21/24 at 4:00 p.m. The NHA said the police came back to the facility on [DATE] and told her CNA #1 had confessed to the police about sexual abuse with Resident #2. She said the police also told her CNA #1 made statements about other residents and gave identifying information. The NHA said because of this new information, they expanded their interview sample and initiated a facility-wide education on abuse and neglect on 10/4/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society -- Loveland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 S Garfield Ave Loveland, CO 80537	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The campus director (CD), the DON, and the NHA were interviewed together on 10/22/24 at 3:10 p.m. The CD said the police arrived at the building on 10/11/24 to interview Resident #3. The CD said the police told her staff were to stop conducting interviews with Resident #3. The CD reported she was told by the police that Resident #3, in an interview with the police on 10/11/24, said there was a male CNA who she did not like who worked at the facility. She said he put something in her hand. She said, What did you put in my hands and I could tell it was his penis. She said she never told anyone, not even her family until then. The NHA said that the CNM documented this statement from Resident #3 in a trauma assessment in her medical record on 10/11/24.</p> <p>The NHA said the facility identified the incident, investigated, reported to all agencies, and put in place a plan of correction that included healthcare staff education that was completed by 8/2/24.</p>		