STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065168	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Heights Rehabilitation and Nursing LLC	1795 Monterey Rd Colorado Springs, CO 80910

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for one (#5) of five residents reviewed for abuse out of 13 sample residents. Specifically, the facility failed to report an allegation of abuse involving Resident #5 to the State Agency. Findings include: I. Facility policy and procedure The Abuse policy, revised 6/11/24, was provided by the nursing home administrator (NHA) on 9/23/24 at 3:30 p.m. It read in pertinent part, Every resident has the right to be free from all forms of abuse: verbal, sexual, physical, mental, neglect, corporal punishment and involuntary seclusion. All occurrences of resident abuse, suspected abuse, neglect and injuries of unknown source shall be promptly reported to the facility abuse coordinator for investigation. Staff are encouraged to talk with supervisors, department heads, social services or the administrator about residents or situations they find difficult to manage, stressful or frustrating to mitigate the risk of conflict between staff and residents. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately, but no later than 2 (two) hours, after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides jurisdiction in long term care facilities and office of long term care ombudsman) in accordance with State law through established procedures. II. Resident #5 A. Resident status (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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NAME OF PROVIDER OR SUPPLIER: Falcon Heights Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 1795 Monterey Rd Colorado Springs, CO 80910	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5, age greater than 65, was admitted on [DATE] and discharged to the hospital on 9/10/24. According to the September 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease with late onset, chronic kidney disease, severe vascular dementia, and type 2 diabetes mellitus. The 8/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. He required partial to moderate assistance with toileting hygiene and dressing and set-up assistance with eating, oral hygiene and personal hygiene. The assessment indicated the resident had hallucinations, delusions, and verbal behaviors directed at others such as threatening, screaming, and cursing at others. B. Record review A review of Resident #5's electronic medical record (EMR) revealed the following nurse progress notes: On 9/9/24 at 5:19 p.m. Resident #5 struck another resident as she walked by in the dining room. The action was unprovoked. The other resident was not injured, but expressed frustration. The incident was reported by a certified nurse aide (CNA). On 9/10/24 at 9:37 a.m. Resident #5 was witnessed by a nurse and CNA to have shoved, with all his strength, another female resident who was sitting in her wheelchair into a group of residents, particularly another male resident with a front wheeled walker. Resident #5 also grabbed the arm of another female resident in an abrupt manner. On 9/10/24 at 11:18 a.m. Resident #5 grabbed another female resident and attempted to yank the resident by the arm to make her stand. -The facility was unable to provide documentation that the facility had reported the incidents of potential abuse to the State Agency. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 9/24/24 at 2:30 p.m. CNA #1 said she was educated on types of abuse and abuse reporting. CNA #1 said if she observed a resident being abused she would report the abuse immediately to the director of nursing (DON) or the assistant director of nursing (ADON). She said would also report suspected abuse to the NHA. Registered nurse (RN) #1 was interviewed on 9/24/24 at 3:00 p.m. RN #1 said if a resident forcefully grabbed another resident's arm and tried to aggressively pull the other resident she would report the incident as abuse. RN #1 said she would tell the NHA or DON. She said she would call the NHA if the NHA was not in the building. The NHA was interviewed on 9/24/24 at 3:30 p.m. The NHA said the documented incidents of alleged abuse involving Resident #5 were not reported, but the facility would report and investigate the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed again on 9/24/24 at 7:00 p.m. and said she would report the alleged abuse involving Resident #5. IV. Facility follow up The facility reported the allegations of abuse (see above) to the State Agency on 9/24/24, after the completion of the survey.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to ensure one (#5) of two residents and/or their responsible person and the ombudsman were provided a written discharge notice to include a physician's discharge order out of 13 sample residents. Specifically, for Resident #5, the facility failed to meet all requirements for a facility-initiated/involuntary discharge, including: -Ensure the Nursing Home Notice of Involuntary Transfer or Discharge included a physician's signature; -Ensure a physician's discharge order, to include the reason for the discharge, was obtained; -Ensure a copy of the discharge paperwork and a copy of the resident's pertinent medical information was provided to the hospital; -Ensure a transfer form (e-interact) for transfer to the hospital was completed; and, -Ensure a discharge summary and a copy of all discharge paperwork was retained in the resident's electronic medical record (EMR). Findings include: I. Facility policy and procedure The Discharging/Transferring the Resident policy and procedure, revised December 2016, was provided by the nursing home administrator (NHA) on 9/24/24 at 11:48 a.m. It read in pertinent part, Preparation: -The nurse on duty or designee shall obtain an appropriate order for discharge from the medical director; -If the resident is being discharged to the community or another facility, staff shall ensure that a discharge summary with a recapitulation of stay is completed and reviewed with the resident and/or resident representative, including teaching and discharge instructions, and that the discharge summary is provided to the provider at the next level of care; and, -If the resident is being discharged to a hospital, ensure that a discharge/transfer form, medication list, current history and physical, POLST (physician's order for life sustaining treatment) and bed hold notice are reviewed with the resident and/or resident representative prior to discharge to the extent reasonable and practical. A copy of these forms shall be sent with the resident to the hospital. The nurse on duty at the time of discharge shall complete a telephone report with the receiving facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discharging the resident to the hospital: -The nurse on duty shall document the discharge in the resident's medical record; and, -A copy of all discharge paperwork shall be retained in the resident's medical record. II. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE] and discharged to the hospital on 9/10/24. According to the September 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, chronic kidney disease, severe vascular dementia and type 2 diabetes mellitus. The 8/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. He required partial to moderate assistance with toileting hygiene and dressing and set-up assistance with eating, oral hygiene and personal hygiene. The assessment indicated the resident had hallucinations, delusions and verbal behaviors directed at others such as threatening, screaming and cursing at others. The resident resided on the secured unit. B. Record review -Review of the September 2024 CPO revealed there was no facility initiated physician's discharge order. Review of the 9/10/24 Nursing Home Notice of Involuntary Transfer or Discharge revealed Resident #5 was discharged /transferred to the hospital because the safety of individuals in the facility was endangered and the health of individuals in the facility would otherwise be endangered. The Nursing Home Notice of Involuntary Transfer or Discharge documented the following, in pertinent part: A doctor must agree if the nursing home checks this box. The doctor must also sign the second page. Or the nursing home must attach the doctor's written order. This could be your doctor - or the doctor at the nursing home. Or it could be a nurse practitioner or physician assistant who works for one of these doctors. -However, the discharge notice did not contain a physician's/provider's signature, nor was there an attached written physician's order. A 9/10/24 nurse progress note revealed the police had arrived to speak with Resident #5 about his aggressive behaviors. The ambulance was enroute as the resident would be going to the hospital. The family and attending medical doctor (MD) had been updated to the change and increased behaviors. The nurse had all the paperwork and was awaiting the ambulance. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second 9/10/24 nurse progress note revealed the ambulance had arrived and was taking Resident #5 to the hospital. The nurse would call and update his wife and the attending MD had been updated. The 9/11/24 post discharge interdisciplinary team (IDT) progress note revealed increased resident agitation and behavior resulting in multiple resident-to-resident altercations and each time the resident was sent to the emergency room (ER) he was cleared to come back to the facility. The resident was scheduled for one on one supervision and continued to behave aggressively which led to the final result of immediate discharge from the facility. The resident had three falls on 9/8/24 without injury but was very delusional, talking to an imaginary wife who was under the bed and he resisted using his assistive device. On 9/24/24 at 2:38 p.m. the following documentation for Resident #5 was requested from the NHA: -Physician discharge orders for the facility initiated discharge; -Copies of the discharge paperwork and paperwork provided to the hospital; -Discharge summary; and, -Transfer form (e-interact) for transfer to the hospital. -On 9/24/24 at 4:25 p.m. the NHA said the facility did not have any of the requested documents in the resident's EMR. C. Staff interview The NHA was interviewed on 9/24/24 at 4:50 p.m. The NHA said the facility did not have any physician discharge orders for Resident #5's involuntary facility-initiated discharge on 9/10/24. The NHA said there should have been a physician's order. The NHA said the facility should have had a copy of the discharge paperwork in the EMR and should have had a transfer to hospital form (e-interact) for the transfer.