| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065168 | A. Building<br>B. Wing | 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Falcon Heights Rehabilitation and Nursing LLC | 1795 Monterey Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536<br><br>Based on record review and interviews, the facility failed to ensure one (#2) of six residents investigated for abuse out of seven sample residents were kept free from physical abuse.<br><br>Specifically, the facility failed to protect Resident #2 from two physical abuse altercations by Resident #3.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Abuse policy, revised on 6/11/24, was provided by the nursing home administrator (NHA) on 1/30/25 at 2:42 p.m. The policy read in pertinent part,<br><br>Every resident has the right to be free from abuse. All occurrences of resident abuse shall be promptly reported to the abuse coordinator for investigation.<br><br>The facility will ensure that all residents are protected during and after abuse investigations by:<br><br>-Responding immediately to protect the alleged victim;<br><br>-Increasing supervision of the alleged victim and the other residents as indicated; and,<br><br>-Providing emotional support to the resident during and after the investigation.<br><br>Residents with aggressive or abusive behavior shall have their care plans include approaches to reduce or eliminate risk for abuse.<br><br>II. Incidents of physical abuse towards Resident #2 by Resident #3<br><br>A. Facility investigation of the altercation on 1/7/25<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 1/7/25 facility occurrence investigation was provided by the NHA on 1/30/25 at 1:15 p.m. The investigation documented that at 6:51 p.m., certified nurse aide (CNA) #1 heard Resident #3 yelling at Resident #2 to get away from her. The nurse responded immediately and discovered Resident #3 pushed Resident #2 to the floor. The nurse completed assessments on both residents, and no injuries were apparent. Resident #3 was redirected by staff and the residents were separated immediately. The family, the physician and the administration were notified of the occurrence. Resident #2 recalled that she fell , and the investigation documented that neither resident recalled the physical occurrence. Resident #3 was placed on frequent monitoring for behavioral changes and redirection. The facility investigation determined Resident #2 was pushed to the floor by Resident #3 but abuse between the residents was not substantiated.<br><br>-However, abuse occurred when Resident #3 pushed Resident #2 to the floor.<br><br>B. Facility investigation of the altercation on 1/14/25<br><br>The 1/14/25 facility abuse investigation was provided by the NHA on 1/30/25 at 1:15 p.m. The investigation documented the nurse witnessed Resident #3 approach Resident #2 with agitation and push Resident #2 in her face. The investigation documented that the nurse assessed the residents in the altercation and the residents had no apparent injuries. The investigation documented that the residents were separated and Resident #3 was placed on a permanent one-to-one staff observation for resident safety. On 1/14/25, Resident #3 was transported to the hospital for emergency evaluation and was prescribed a new antipsychotic medication, Olanzapine 5 milligrams (mg) twice daily for agitation/anxiety. The facility investigation determined Resident #2 was pushed in the face by Resident #3 but abuse between the residents was not substantiated.<br><br>-However, abuse occurred when Resident #3 pushed Resident #2 in the face.<br><br>II. Resident #3 - assailant<br><br>A. Resident status<br><br>Resident #3, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included Alzheimer's disease unspecified, dementia with behavioral disturbance, depression, anxiety and unspecified disorientation. Resident #3 resided in the memory care unit of the facility.<br><br>The 1/21/25 minimum data set (MDS) assessment documented Resident #3 had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The assessment documented the resident had inattention present continuously. The resident was prescribed antipsychotic and antianxiety medications.<br><br>Resident #3 had physical and verbal behavioral symptoms directed toward others for one to three days during the assessment period. Resident #3 put others at significant risk for physical injury for one to three days during the assessment period.<br><br>Resident #3 was independent with bed mobility, transfers, and ambulation.<br><br>B. Record review<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The dementia care plan, revised on 6/23/24, identified that Resident #3 had impaired cognitive function related to dementia and Resident #3 did not have good insight into the disease process. Interventions included administering medications as ordered, keeping the resident's routine consistent with a consistent caregiver, presenting one thought at a time and using the resident's preferred name.<br><br>The cognitive care plan, revised on 12/30/24, identified Resident #3 as having poor safety awareness and being physically aggressive. Interventions included ensuring the resident's safety, changing the resident's environment to promote safety for self and others and ensuring Resident #3 was not aggressive with people.<br><br>The physical aggression care plan, revised on 1/2/25, identified Resident #3 had the potential to be physically aggressive related to his diagnosis of dementia. Interventions included administering medications as ordered and analyzing and documenting behavior triggers.<br><br>-The care plan did not identify behavior triggers or effective behavior interventions for Resident #3.<br><br>The mood and behavior care plan, revised on 1/7/25, revealed Resident #3 had physically aggressive behaviors. Interventions included administering medications as ordered, interacting with the resident in an empathetic and supportive manner, monitoring and documenting each behavioral event and reviewing the resident in the psychotropic review committee to review the resident's medications.<br><br>The 1/8/25 physician's progress note documented Resident #3 had increased delirium and aggression toward staff in December 2024. On 1/8/25, the physician gave a new medication order for lorazepam 0.5 mg (antianxiety medication) twice daily, for dementia with agitation.<br><br>The 1/8/25 nurse progress note documented Resident #3 continued to have behaviors on 1/8/24. Resident #3 was yelling in the hallway and refusing to wear her prescribed oxygen.<br><br>The 1/9/25 nurse progress note documented Resident #3 was very angry and could not be redirected by staff. The nurse documented Resident #3 had a mood change without warning or trigger.<br><br>III. Resident #2 - victim<br><br>A. Resident status<br><br>Resident #2, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included dementia with behavioral disturbance, anxiety and depression.<br><br>The 11/6/24 MDS assessment revealed the resident had severely impaired cognition and never/rarely made decisions per staff assessment.<br><br>Resident #2 continuously had inattention and disorganized thinking for one to three days during the assessment period.<br><br>Resident #2 was independent with bed mobility, transfers, and ambulation.<br><br>B. Record review<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The behavior care plan, initiated on 8/10/23, identified Resident #2 had behaviors related to her diagnoses. Interventions included administering medications as ordered, monitoring for medication effectiveness and encouraging appropriate expression of feelings and monitoring behavior episodes to determine cause.<br><br>IV. Staff interviews<br><br>CNA #1 was interviewed on 2/3/25 at 1:15 p.m. CNA #1 said she was assigned one-to-one duties to provide care to Resident #3. She said Resident #3 sometimes yelled at staff and residents. She said since Resident #3 was on one-to-one supervision, Resident #3 had not had additional physical altercations. She said the resident appeared to be happy during the day and looked forward to speaking to her family on the telephone. CNA #1 said Resident #3 responded well to consistent caregiver routines.<br><br>Licensed practical nurse (LPN) #1 was interviewed on 2/3/25 at 1:33 p.m. LPN #1 said when residents were agitated or aggressive, the staff were trained to redirect the resident to prevent escalation of behavior. LPN #1 said it was important for staff to know what specific behavior triggers residents had so that individualized care could be provided. LPN #1 said resident care plans, task assignments and shift reports were all used to report to staff what was helpful for each resident. LPN #1 said Resident #3 was impulsive and the staff knew to watch her closely. She said Resident #3 could move quickly and was agitated when other residents were close to her. She said the staff tried to intervene promptly and redirect Resident #3. LPN #1 said Resident #3 had had no behaviors reported since she had new medications prescribed on 1/14/25.<br><br>The NHA was interviewed on 2/3/25 at 4:05 p.m. The NHA said Resident #3 had dementia with escalating behaviors since December 2024. The NHA said after the 1/7/25 altercation, the staff began to monitor and observe Resident #3 closely. She said on 1/23/25, the resident was evaluated by a behavior health provider who recommended increasing the resident's medications.<br><br>The NHA said staff provided dementia care during the day for Resident #3, including providing a consistent environment and caregivers and helping the resident use the telephone. The NHA said Resident #3 was recently transitioned to hospice care services and the hospice providers visited with the resident during the week. The NHA said Resident #2 had not been injured during the altercations. She said Resident #2 was monitored after the 1/7/25 fall and had no apparent injury. She said Resident #2 remained active, pleasant and social in the memory care unit. |