| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065188 | A. Building<br>B. Wing | 04/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Prestige Care Center of Morrison | 150 Spring St<br>Morrison, CO 80465 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>50690<br><br>Based on observations, interviews and record review, the facility failed to ensure nine (#7, #9, #6, #1, #12, #13, #14, #15 and #16) of nine residents out of 17 sample residents were provided prompt efforts by the facility to resolve any grievances.<br><br>Specifically, the facility failed to:<br><br>-Ensure concerns from the group regarding Resident #10 wandering into residents' room were followed up timely with a satisfactory resolution;<br><br>-Ensure Resident #7's personal concern regarding Resident #10 entering his room without permission was followed up timely with a resolution that was satisfactory to Resident #7; and,<br><br>-Ensure the resident council president was appointed based on the majority vote of the residents.<br><br>Findings include:<br><br>I. Failures regarding grievances<br><br>A. Facility Policy<br><br>The Resident and Family Grievances policy, updated July 2022, was received from the nursing home administrator (NHA) on 4/2/24 at 1:47 p.m. The policy read in pertinent part, Social services designee has been designated as the grievance official. The grievance official is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining confidentiality of all information associated with grievances; issuing written grievances decisions.<br><br>The grievance official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form.<br><br>All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the grievance official.<br><br>'Prompt efforts' include acknowledgement of complaint/grievances and actively working toward a resolution of that complaint grievance.<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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | B Resident group interview<br><br>The resident group interview was conducted on 4/2/24 at 10:00 a.m. The group consisted of<br><br>nine residents (#7, #9, #6, #1, #12, #13, #14, #15 and #16) who were identified as interviewable by the facility and assessment.<br><br>Resident #7, #9, #6, #1, #12, #13, #14, #15 and #16 said they all had concerns regarding Resident #10 frequently entering their rooms without their permission.<br><br>The residents said they had brought up the concerns regarding Resident #10 in resident council meetings, however, they did not feel the facility had done anything to address their concerns.<br><br>C. Resident #7 interview<br><br>Resident #7 was interviewed on 4/1/24 at 1:37 p.m. Resident #7 said he had complained to the director of nursing (DON) about his concerns with Resident #10 entering his room without his permission. He said Resident #10 entered his room over 10 times within the past month, usually at night, causing him sleep disturbances. He said he recently began to block his door at night so Resident #10 could not enter. He complained to the dementia program coordinator (DPC) about Resident #10 repeatedly entering his room, however, he said there had been no follow up or resolution from either the DON or the DPC. Resident #7 said he filled out several grievance forms, however, he said nothing was done. Resident #7 said there often were not any grievance forms available so he kept a pile of blank ones in his room.<br><br>D. Observations<br><br>On 4/1/24 at approximately 4:00 p.m., Resident #7's room was observed. There was no Velcro stop sign observed on the resident's doorway to prevent other residents from entering the room.<br><br>E. Record review<br><br>On 4/2/24 at 11:36 a.m. the facility's grievance log was reviewed with the SSD. The SSD was unable to locate any group or individual grievances regarding the residents' concerns related to Resident #10 entering their rooms without permission.<br><br>F. Staff interviews<br><br>The SSD, the NHA and the regional nurse consultant (RNC) were interviewed together on 4/2/24 at 11:36 a. m. The SSD said Resident #10 had behavioral outbursts and a history of entering rooms without authorization. She said several pertinent interventions had been put in place to try to prevent the resident from wandering into other residents' rooms.<br><br>The SSD said she was aware the residents from resident council, including Resident #7, had complaints about Resident #10 wandering in and out of their rooms. She said they were attempting to find a different facility for him and she had sent out several referrals to other facilities.<br><br>(continued on next page) |

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F 0565

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The SSD said anyone could write a grievance on behalf of the residents. She said when a grievance was written, the grievance form was sent to the appropriate department to follow up on the complaint and find a resolution that was satisfactory to the residents. She said when the grievance was completed, the residents were to be notified.

The SSD said she did not have any grievances from the resident council residents or Resident #7 in regards to Resident #10 wandering into their rooms.

The SSD said she was not aware she was the facility's grievance official.

The RNC said the facility had discussed placing Velcro stop signs on residents' doors to keep Resident #10 from wandering into other residents' rooms but had concerns the intervention might be a restraint so it had not been implemented. However, the RNC said the facility had placed an order for the stop signs on 4/1/24 (during the survey).

The NHA said she was newly employed at the facility in March 2024. She said the grievance process was to be initiated when a complaint was received. She said the concern forms could be filled out by the resident, resident representative or staff member. She said there was a 72 hour turnaround time for the responsible department to follow up on the grievance and come up with a satisfactory resolution.

The NHA said the resident should be informed of the resolution. She said at times the facility may need more than 72 hours to come up with a resolution, however, the resident was to be informed as the process progressed.

The NHA said the SSD was responsible to follow up to ensure the grievances were acted upon.

II. Failures with appointing resident council president

A. Facility policy

The Resident Council Meetings policy, reviewed July 2022, was received from the NHA on 4/2/24 at 1:47 p. m. The policy read in pertinent part, The resident council is a formal resident group with a president who is appointed by other residents. The president shall be a resident who is appointed by other residents by majority vote to serve for a term of at least one year.

B. Resident group interview

The resident group interview was conducted on 4/2/24 at 10:00 a.m. The group consisted of

nine residents (#7, #9, #6, #1, #12, #13, #14, #15 and #16) who were identified as interviewable by the facility and assessment.

The residents said they had voted for Resident #7 for their resident council president. However, they said the facility failed to follow the majority vote process and appointed Resident #6 as the resident council president instead.

C. Resident #6 interview

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #6 was interviewed on 4/1/24 at 3:15 p.m. Resident #6 said that she was recently told she was the resident council president. She said she was not aware what the responsibilities of the president were. She could not recall how she became the president.<br><br>D. Staff interviews<br><br>The SSD, the NHA and the RNC were interviewed together on 4/2/24 at 11:37 a.m. The RNC said the facility learned, after talking with Resident #7, that he had run for resident council president and the votes he received from the resident council group indicated he had won the election. The RNC said the facility policy was to have the residents vote in a president utilizing a majority vote. She said since the facility found out the current president (Resident #6) was appointed and had not been decided by a majority vote, new ballots were being passed out to ensure the appropriate process was followed.<br><br>The SSD said that the resident council president election results had not been announced. Residents had only been informed that Resident #6 was the president. However, the previous activity director had apparently appointed Resident #6 instead of following the majority vote process.<br><br>20287 |

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| 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** 50690<br><br>Based on record review and interviews, the facility failed to create an environment that protected residents from physical abuse for one (#5) of three residents out of 17 sample residents.<br><br>Specifically, the facility failed to ensure Resident #5 was protected from abuse by Resident #4.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Abuse Prohibition policy and procedure, reviewed December 2022, was provided by the regional nurse consultant (RNC) on 4/2/24 at 1:47 p.m.<br><br>It read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.<br><br>'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.<br><br>'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.<br><br>II. Incident of physical abuse between Resident #5 and #4<br><br>The 3/7/24 facility investigation documented certified nurse aide (CNA) #1 was taking lunch orders when a family member notified her Resident #4 and Resident #5 were fighting. When she looked over, she saw Resident #5 getting up from the floor. Resident #5 said Resident #4 punched him and pushed him down. Resident #5 had an open area on his hand. Resident #4 stood up and wanted to fight some more. Resident #5's statement after the incident on 3/7/24 said that he did not remember the event.<br><br>A statement dated 3/7/24 at 12:30 p.m. was obtained from a visiting family member. The family member said he did not hear the word exchange but he saw Resident #4 get up and go over to Resident #5 and hit him on his hand. The family member did not witness him fall.<br><br>A statement dated 3/7/24 at 12:30 p.m. was obtained from a visiting family member. The statement documented she did not notice what started the incident, however, she did see Resident #4 push Resident #5 with force, then cursing was exchanged between both residents.<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 facility substantiated the abuse.<br><br>III. Resident #4<br><br>A. Resident status<br><br>Resident #4, age 71, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included bipolar and type II diabetes.<br><br>The 1/25/24 minimum data assessment (MDS) showed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The MDS assessment documented the resident had no behaviors. He was independent with ambulation and activities of daily living.<br><br>B. Record review<br><br>Resident #4's behavior care plan, revised on 3/18/24, identified the resident was on a behavior contract due to a history of engaging in verbal and physical behaviors toward staff and other residents. Pertinent interventions were to assess the resident's living environment for potential triggers of verbal behaviors, such as noise levels, overcrowding or lack of privacy.<br><br>The 3/15/24 progress note documented the interdisciplinary team (IDT) met to discuss the incident from 3/7/24. The witnesses statements did reflect that they observed the resident reach out and grab Resident #5's left hand/forearm which resulted in three small skin tears, then pushed him to the ground. The residents were separated and 15-minute checks were initiated. Resident #4's statement reflected the resident did not know why he did it but he deserved it.<br><br>IV. Resident #5<br><br>A. Resident status<br><br>Resident #5, age 76, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included anxiety disorder, depression and dementia.<br><br>The1/19/24 MDS assessment showed the resident was cognitively intact with a BIMS score of 13 out of 15. The MDS assessment documented the resident did not have any behaviors. He was independent in activities of daily living.<br><br>B. Record review<br><br>Resident #5's behavior care plan, revised on 1/10/24, identified the displayed mood problems related to dementia, anxiety and depression. He had a history of agitation, pacing and hoarding. Pertinent interventions included re-directing and removing stimuli if agitated, and providing him with a homelike environment which included reducing sensory noise. He had a high risk of falls related to impaired mobility and was at risk for altered skin integrity to his fragile skin.<br><br>The 3/7/24 nursing note showed the following details of the wounds:<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 | 1) Left hand skin tear: 1 centimeter (cm) by 0.2 cm by less than 0.1 cm and 0.75 cm by 0.2 cm by 0.1 cm;<br><br>2) Left forearm skin tear: 0.2 cm by 0.2 cm by less than 0.1 cm; and,<br><br>3) Left forearm bruise: 1 cm by 1 cm.<br><br>The 3/8/24 skin check report showed Resident #5 did have new wounds as a result of the resident to resident altercation on 3/7/24, a bruise and a skin tear on his left forearm and a skin tear on the back of his left hand.<br><br>III. Staff interview<br><br>The social services director (SSD) was interviewed on 4/2/24 at 11:36 a.m. The SSD said in the report of the incident, Resident #5 was at his table in the dining room. Resident #4 came into the dining room, unprovoked, approached Resident #5 and yelled at him. He punched him, maybe hurting Resident #5's left hand, which caused him to fall to the ground.<br><br>The SSD said interventions after the incident included a voluntary room move for Resident #4. He initially agreed and all his belongings were moved. However, she said at the end of that night shift (3/7/24), he began to move his belongings back to his old room. The SSD did call Resident #4's representative and told him of the incident and attempted move. The SSD was told the resident's representative was considering moving him back home, however, that had not occurred yet. Resident #4 was placed on a behavior contract which included rules for the dining room. Both residents were to be seated on opposite sides of the room so they could not see each other. |