STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Post Acute, The	3131 S Federal Blvd Denver, CO 80236

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** 40960 Based on record review and staff interviews, the facility failed to ensure one (#1) of three residents reviewed for abuse were kept free from abuse out of five sample residents. Specifically, the facility failed to protect Resident #1 from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation policy and procedure, revised April 2024, was provided by the director of nursing (DON) on 7/11/24 at 12:39 p.m. The policy read in pertinent part, The nursing home administrator (NHA) is responsible for the overall coordination and implementation of the facility's policies and procedures against abuse, neglect, exploitation and misappropriation of resident's property. Policies are in place that prohibit and prevent resident abuse, neglect, exploitation and misappropriation of resident's property, establish processes to investigate such allegations, implement staff training and coordinate with the quality assurance and performance improvement (QAPI) committee. Policies address the following as part of abuse, neglect, exploitation and misappropriation prevention: Employee screening, staff training, prevention, identification of violations, investigative processes, protection of residents during investigations and reporting of and response to investigations. II. Facility investigation of the 2/4/24 incident between Resident #2 and Resident #1 The 2/4/24 altercation investigation revealed Resident #2 began getting upset when Resident #1 was looking at him while they were smoking. Resident #2 ran up to Resident #1 and hit him multiple times in the head. Resident #2 was immediately placed on one to one supervision with a staff member. Resident #2 said Resident #1 was talking crap so I hit him and he tried to fight me back. (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	Resident #1 stated Resident #2 had just hit him and he yelled at him to stop. He said he hit his head. III. Resident #2 (assailant) A. Resident status Resident #2, age greater than 65, was admitted on [DATE] and discharged on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included moderate vascular dementia with mood disturbances, alcohol abuse, depression and insomnia. The 3/7/24 minimum data set (MDS) assessment revealed the resident had short term memory problems and his cognitive skills for daily decision making was moderately impaired. He had physical behaviors directed towards others on one to three days during the assessment lookback period and verbal behaviors directed towards others on one to three days. He was independent with all of his activities of daily living (ADL) and received an antipsychotic medication. B. Record review The behavior care plan, initiated 12/18/23 and revised 3/12/24, revealed Resident #2 had the potential to be physically aggressive related to a history of harm to others. Interventions included administering medication as ordered, providing physical and verbal cues to alleviate anxiety, giving positive feedback, assisting verbalization of the source of agitation, assisting the resident to set goals for more pleasant behavior, encouraging the resident to seek out a staff member when agitated, referring the resident to behavioral health services and placing the resident on one to one supervision with staff indefinitely. The 2/4/24 nurse progress note, written at 12:49 p.m., revealed the nurse heard screaming down the hallway and, upon assessment, Resident #2 was observed near the smoking area entrance and stated, Resident #1 was talking crap so I hit him and he tried to fight me back. Resident #1 denied hitting Resident #2. The police and emergency medical services were notified. -Further review of Resident #2's progress notes revealed he had been involved in four verbal altercations and four physical altercations with other residents during his four month stay at the facility. IV. Resident #1 (victim) A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included cerebral infarction (stroke), dementia, traumatic brain injury, generalized anxiety disorder, major depressive disorder and muscle weakness. The 6/19/24 MDS assessment revealed, the resident was unable to complete a brief interview for mental status (BIMS). He had short and long-term memory problems. His cognitive skills for daily living decision-making was moderately impaired. He had no behaviors and did not reject care. He was independent with his ADLs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review The behavior care plan, initiated 11/2/21 and revised 6/26/24, revealed Resident #1 had behavior challenges related to a history of a traumatic head injury and could become aggressive with staff. Interventions included referring the resident to behavioral health services, caregivers to provide opportunities for positive interaction and attention, encouraging the resident to express feelings appropriately and providing a program of activities that were of interest to the resident. The 2/4/24 nurse progress note. written at 12:33 p.m., revealed the nurse heard screaming down the hallway and, upon assessment, Resident #1 was seen holding his head while using profane language towards Resident #2. Resident #1 stated That dumb guy hit me in the head. Both parties were separated and Resident #1 was assessed and denied pain. Resident #1 was unable to recall what led up to the incident. The police and emergency services were notified. A 2/4/24 nurse progress note, written at 5:36 p.m., revealed Resident #1 was hit by Resident #2 in the face several times and would not stop until he was told multiple times to go to his room. V. Staff interviews The medical director (MD) was interviewed on 7/9/24 at 2:04 p.m. The MD said Resident #2 had behaviors that were explosive. He said Resident #2 could be calm and then just act out. He said his behaviors were unpredictable. He said the facility put scheduled smoking times in place, which helped with structure. Registered nurse (RN) #1 was interviewed on 7/9/24 at 4:48 p.m. RN #1 said Resident #2 was placed on one to one supervision with a staff member indefinitely related to his aggressive behaviors. She said Resident #1 liked to sing while walking down the hallway and in the dining room. She said at times other residents would yell at him to shut up. The DON was interviewed on 7/9/24 at 5:29 p.m. The DON said Resident #2 was easily agitated. She said he did not have triggers that could be identified and would just snap. She said he was placed on one to one supervision with a staff member on 1/13/24. However, she said Resident #2's one to one staff member was discontinued when he was not showing any behaviors or aggression towards others. The DON said Resident #2 was again placed on one to one supervision with a staff member indefinitely following his altercation with Resident #1 on 2/4/24. The NHA was interviewed on 7/9/24 at 5:45 p.m. The NHA said Resident #2 had a history of aggression towards others prior to his admission to the facility. He said Resident #2 would go from a calm mood with no issues to extreme aggression towards others. He said Resident #2 was placed on one to one supervision with a staff member until the interdisciplinary team (IDT) felt he was no longer a risk to others. The NHA said, following his altercation with Resident #1, Resident #2 was placed on one to one supervision indefinitely. He said Resident #2 had no identified triggers, which made it difficult to anticipate his aggressive behaviors. The NHA said, following an attack on his one to one certified nurse aide (CNA), Resident #2 was discharged from the facility on 3/7/24 to a facility who was able to provide increased psychiatric services for the resident.