STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065226	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McIntosh Care and Rehabilitation Center	1800 Stroh Pl Longmont, CO 80501

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to ensure resident rights were promoted and dignity was maintained for one (#1) of three residents out of five sample residents. Specifically, the facility failed to ensure Resident #1's care was provided in a dignified and respectful manner by certified nurse aide (CNA) #1. Findings include: I. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included epilepsy (seizure disorder), bipolar disorder (mental disorder that causes unusual shifts in behaviors), low back pain and muscle weakness. The 9/12/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on one staff member's assistance with toileting hygiene. She required substantial/maximal assistance for putting on/taking off footwear. She required partial/moderate assistance for bathing, upper/lower body dressing and personal hygiene. The MDS assessment indicated the resident did not have any behavioral symptoms or rejection of care during the review period. B. Resident interview (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was interviewed on 11/25/24 at 3:05 p.m. Resident #1 said that certified nurse aide (CNA) #1 was rough with her, for example, when turning her during her incontinence care she rolled her too quickly, made her do her activities of daily living (ADL) tasks in a hurry, and was impatient with her when she was unable to move as quickly as CNA #1 wanted her too. Resident #1 said she could not move as quickly as CNA #1 wanted her to because she was in a wheelchair and could not walk. Resident #1 felt that the way CNA #1 treated her was rude. Resident #1 said CNA #1 made her feel terrible, she could not stand it and it made her feel helpless. Resident #1 said CNA #1 was a sour apple and she wanted her banned from taking care of her and wanted her fired. Resident #1 said this happened a few weeks ago in October 2024 but she could not recall the exact day. Resident #1 said she could not recall whom she told about the incident but that CNA #1 has not worked with her since. C. Record review The behavior care plan, initiated on 10/29/24 revealed the resident had the potential for a mood/behavior problem related to her diagnosis of bipolar disorder. Interventions included anticipating and meeting the residents needs, approaching the resident in a calm manner, assisting the resident in developing more appropriate methods of coping and interacting, encouraging the resident to express feelings appropriately, explaining all procedures to the resident before starting and allowing her to adjust to changes, discussing the resident's behavior if reasonable, explaining/reinforcing why the resident's behavior was inappropriate and/or unacceptable, intervening as necessary to protect the rights and safety of others, approaching/speaking in a calm manner, diverting the resident's attention, removing the resident from the situation and taking her to an alternate location as needed observing the resident for side effects and adverse reactions of psychoactive medications and a program of activities that was of interest and accommodates the residents status. -The care plan was updated on 10/29/24 to include a potential for a mood/behavior problem related to bipolar diagnosis. The 10/30/24 nurse note revealed that administration met with Resident #1 that day (10/30/24) regarding the concern of the call lights and working with CNA #1. Resident #1 reported feeling safe and had no issues with any of the CNA's. The statement was completed with a nurse and human resources staff member. The 10/31/24 nurse note revealed the nurse and the MDS coordinator (MDSC) interviewed Resident #1 regarding her care at night and the call lights. Resident #1 was laying in bed, resting and reported she had no concerns and was okay with working with all of the CNAs. Resident #1 reported she felt safe and all needs were met regularly. The 11/3/24 psychosocial monitoring note revealed the resident was monitored for signs and symptoms of increased tearfulness, increase in isolation, or other changes every shift for three days. No increase in isolation or refusals of care that shift. D. Facility investigation The nursing home administrator (NHA) provided a facility investigation report regarding Resident #1's care on 11/25/24 at 4:37 p.m. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/31/24 facility investigation revealed the facility had a report of a conflict/concern between Resident #1 and CNA #1 the night prior (10/29/24). The unit manager (UM) #1 reported CNA #1 was moved to the front hall per the director of nursing's (DON) direction due to the concern between Resident #1 and CNA #1. UM #1 reported that CNA #1 had completed a pass off shift report and would be supervised until she exited the facility. The event description read that the compliance officer for the company called to notify the DON that there were two anonymous calls to the compliance line reporting neglect in the manner on part of CNA #1 refusing to answer specific residents'call lights. CNA #1 completed a pass off report for the oncoming shift with staff supervision, and exited the building. CNA #1 was suspended pending a full investigation by the facility. The report revealed the concern between Resident #1 and CNA #1 had not been witnessed. Resident #1 was assessed and interviewed the morning of 10/31/24. Resident #1 reported no issues, call lights were good and she was okay to work with CNA #1 and felt safe within the facility. Results of the interview with CNA #1 revealed she answered call lights appropriately and had not had issues with Resident #1 in the past. The facility interviewed other residents in the facility who reported no issues with CNA #1 and stated call lights were answered and they had no concerns or complaints. Nurses who were interviewed as part of the investigation reported CNA #1 could present as lazy, however, they had not seen any behaviors or neglect of residents by CNA #1, such as ignoring call lights, and they felt comfortable working with CNA #1. One nurse reported she preferred to work with CNA #1 as she was a hard worker and a team player. The facility found the allegation of neglect to be unsubstantiated. The facility actions included monitoring Resident #1's treatment regimen for any psychosocial changes or needs. Clinical staff was provided regarding the importance of answering call lights timely to ensure resident needs were met. Education was completed with the staff regarding kindness. CNA #1 received education on her approach and how she was perceived by other staff members and was allowed to return to work. II. Staff interviews CNA #2 was interviewed on 11/25/24 at 3:17 p.m. CNA #2 said that sometime in October 2024 Resident #1 had asked him how to report care concerns about something that had happened a few days before. CNA #2 said he told her he would contact the DON since it was after 9:00 p.m. CNA #2 said he called the DON and she said she had already spoken to the nurse on the back hall because Resident #1 had directly reported the concern to the nurse. CNA #2 said Resident #1 had told him she needed to report CNA #1, but she did not tell him the particulars of what happened. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 11/25/24 at 4:05 p.m. via telephone. CNA #1 said she knew about the situation (allegations) but she said she did not know why Resident #1 felt that way about her caring for her. CNA #1 said Resident #1 was not following any orders when she was trying to provide care for her. CNA #1 said Resident #1 had gotten into a mood all day (on the day of the concern), did not feel like doing anything and was incontinent that day because she was not moving. The DON was interviewed on 11/25/24 at 3:47p.m. The DON said on 10/29/24 she got a phone call from CNA #2 regarding Resident #1 being upset with CNA #1. The DON said it was her understanding that the resident was upset with CNA #1 for how she acted during the resident's incontinence care. The DON said she called and talked to CNA #1 and CNA #1 said it was more about her trying to get the resident to roll over with her incontinence care. The DON said she called UM#1 and told her to move CNA #1 to a different hall because Resident #1 was irritated at her. The next morning, 10/30/24, the NHA interviewed the resident and there were no concerns. The DON said the next day, on 10/31/24, she received a phone call from the facility's internal compliance hotline stating that a neglect allegation had been called in for Resident #1 related to Resident #1 not wanting to be changed. The DON said the trigger word of neglect had been used in the compliance line report, so she immediately reported to the State Agency, CNA #1 was suspended and she began an investigation. The DON said she began education with CNA #1 about her approach and the importance of answering call lights. The DON said CNA #1 had not worked with Resident #1 since that date. The NHA was interviewed on 11/25/24 at 4:48 p.m. The NHA said from what he was told, it had sounded like Resident #1 was not getting care from CNA #1 but when he spoke with Resident #1 on 10/30/24, it was a different story and she had no concerns. The NHA said when he asked Resident #1 if the staff had ever neglected her care, she said no, they did a good job. He said he also asked Resident #1 if she had trouble getting her call light answered in a timely manner and Resident #1 said sometimes but not lately. The NHA said he also asked the resident when the staff answered her call light, did they assist her with what she needed and Resident #1 answered yes. The NHA said the DON had told Resident #1 that CNA #1 would not be working with her anymore. III. Facility follow-up On 11/27/24 at 4:28 p.m. the DON provided the following information via email revealing she and the NHA had completed further investigation into Resident #1's concerns. The NHA interviewed Resident #1 on 11/25/24 at approximately 6:00 p.m. Resident #1 was asked about if she felt safe and if she had any issues with any CNA's at the facility. Resident #1 said she had an issue with CNA #1, who was rough and rude. Resident #1 reported the situation had happened awhile ago and said she knew that she would not be working with CNA #1 any longer and felt safe with CNA #1 in the building if she was not working with her. When asked, Resident #1 was unable to detail the time or what she meant by rough. Resident #1 did not appear distressed when discussing the incident, however psychosocial support and validation of her feelings was offered. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Education was provided to CNA #1 on 11/25/24. The education revealed when she was approaching residents and providing care, CNA #1 was to make sure that she talked through each step with the resident and offered residents help with each task that she was completing. If a resident refused care, she was to ensure she asked what she could do to help, what the resident needed and how CNA #1 and the resident could work together. CNA #1 was reminded it was important to make the residents feel comfortable in their home and ensure that staff were not being perceived as pushy or infringing on their rights.