STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065235	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Health Care Center	900 S 12th St Rocky Ford, CO 81067

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 observations, record review and interviews, the facility failed to ensure two (#4 and #6) of four residents reviewed for abuse out of seven sample residents were kept free from abuse. Specifically, the facility failed to: -Protect Resident #4 from physical abuse by Resident #5; and, -Protect Resident #6 from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse and Neglect policy, undated, was provided by the director of nursing (DON) on 3/4/25 at 11:14 a.m. It read in pertinent part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The physician and staff will help identify risk factors for abuse within the facility. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. II. Incident of physical abuse towards Resident #4 by Resident #5 on 2/8/25 A. Facility investigation The investigation documented the following: On 2/8/25 it was alleged that Resident #5 hit Resident #4 in the head while walking past her in the hall. The incident was witnessed by Resident #7. Both residents were placed on 15-minute checks. The facility substantiated the abuse. A. Resident #5 (assailant) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident status Resident #5, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnosis included schizophrenia, unspecified dementia with behavioral disturbances and wandering. The 1/16/25 minimum data set (MDS) assessment revealed, per staff assessment, the resident was rarely or never understood. He had short and long-term memory problems. His cognitive skills for daily living were moderately impaired. He had inattention and disorganized thinking which fluctuated. He required moderate assistance with bathing. He was independent with positioning, transfers and walking. He received an antipsychotic (medication to treat psychosis) and an antidepressant. 2. Record review Resident #5's comprehensive behavioral care plan, initiated 10/3/22, documented the resident had behaviors related to schizophrenia and dementia. He had verbal aggression, physical aggression, obsessive pattern walking and had had resident-to-resident aggression. Pertinent interventions included administering medications as ordered, redirecting the resident to a calm environment, responding to the resident calmly, distracting and redirecting the resident, using consistent direction to calm changes gradually, having a quiet area to walk and checking on the residents location and ensuring safety every 15 minutes. A nursing progress note, dated 2/8/25 at 7:33 p.m., documented at approximately 4:00 p.m. the nurse was informed of the incident. Resident #4 reported Resident #5 made contact with her right eye. Both residents were separated and no injury was noted to Resident #5. A nursing progress note, dated 2/9/25 at 11:28 a.m., documented it was reported to the mental health physician that Resident #5's pacing was more than usual and was irritable with the staff. Frequent checks were initiated on the resident. C. Resident #4 (victim) 1. Resident status Resident #4, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnosis included bipolar disorder (mental illness), abnormalities of gait and mobility, weakness, unsteadiness on her feet, lack of coordination, difficulty in walking and delusional disorders. The 2/27/25 MDS assessment revealed, per staff assessment, her skills for daily decision making were moderately impaired. She had no behaviors and did not reject care. She used a wheelchair and required maximal assistance with toileting hygiene, bathing and lower body dressing. She required moderate assistance with personal hygiene, sit to stand and transfers. 2. Resident #4's interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 was interviewed on 3/4/25 at 11:16 p.m. Resident #4 said Resident #5 was mean and had attacked other women in the facility as well. She said Resident #5 punched her for no reason causing pain, redness and swelling to her right eye. She said the staff applied ice to her right eye/forehead and the following days she was left with bruising to her forehead. 3. Record review Resident #4's social behavioral care plan, initiated 11/30/22, documented the resident expressed inappropriate social behaviors verbally/physically towards staff and other residents. She had the potential to be physically aggressive related to anger, depression, poor impulse control, refusing psychotropic medications, throwing dishes and breaking them while in a manic phase. Pertinent interventions included administering medications as ordered, notifying the psychiatrist if the resident was refusing medications, if resident was in a safe location and away from others while being verbally or physically aggressive let her decompress before reengaging with her or trying to redirect her to a different location, notifying the resident's family and physician of increased behavioral concerns, observing the resident during smoke breaks for potential triggers from other residents when she was manic and observing the resident often for self safety and the safety of others. Resident #4's behavioral care plan, initiated 2/8/25, documented the resident had a behavioral problem related to bipolar disorder and delusional disorder. Resident #4 had severe episodes of manic and depressive phases. She could become verbally aggressive/argumentative and had been physically aggressive. She had made inappropriate comments about other residents putting her at risk for harm. Pertinent interventions included acknowledging the resident's delusional beliefs and not arguing with the resident, administering medications as ordered, notifying the physician of refusals, anticipating and meeting the resident's needs, attempting/encouraging aromatherapy to de-escalate when manic and crisis intervention and advocacy as needed, encouraging/assisting the resident away from other residents as allowed when in a manic phase and monitoring behavior episodes and attempting to determine the underlying cause. A nursing progress note, dated 2/8/25 at 7:46 p.m., documented at approximately 4:00 p.m. the nurse was informed of the incident. Resident #4 reported Resident #5 made contact with her right eye. Both residents were kept separated. Resident #4 was assessed and noted to have a discolored reddish area above her right eye. The resident accepted ice wrapped in a towel. A nursing progress note, dated 2/9/25 at 10:36 p.m., documented Resident #4's neurological checks were being monitored and the site above her right eyebrow remained discolored yellow and green. D. Additional resident interviews Resident #7 was interviewed on 3/4/25 at 11:18 a.m. Resident #7 said she was walking down the hallway and witnessed Resident #5 hit Resident #4 in the face. E. Staff interviews (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #2 was interviewed on 3/4/25 at 11:20 a.m. CNA #2 said Resident #5 wandered at times and paced. She said he liked his personal space and usually stayed to himself. She said she had heard he had aggressive behaviors with his peers, but had never witnessed those behaviors herself. Licensed practical nurse (LPN) #1 was interviewed on 3/4/25 at 11:25 a.m. LPN #1 said Resident #5 usually kept to himself. She said when he rejected care or said no, the staff knew to reapproach at a later time to avoid aggressive behaviors. She said she assumed Resident #4 was sitting in her wheelchair in the hallway where Resident #5 was pacing at the time of the incident. She said Resident #4 was very friendly and probably said hi to him, and Resident #5 may not have understood. LPN #1 said Resident #4 yelled my eye, my eye he got me in the eye. She said she placed ice wrapped in a towel on her right eye which was red. She said bruising developed the following days. The social services assistant (SSA) was interviewed on 3/4/25 at 2:25 p.m. The SSA said he had only been in his position for three weeks. He said he had not had any interactions with Resident #5 and was still in his training process. He said he had not heard of Resident #5 having any behaviors. He said he was still trying to learn who the residents were. He said he was in the process of familiarizing himself with the resident care plans and it was a work in progress. The DON was interviewed on 3/4/25 at 2:36 p.m. The DON said Resident #5 liked to pace back and forth and could have verbal outbursts and physical aggression but never actually hit a resident. She said the last incident involved physical contact with Resident #4. She said the staff would redirect him when he escalated. She said they had even tried a sensory program with therapy to identify a root cause for his behaviors. III. Incident of physical abuse between Resident #6 and Resident #2 on 2/16/25 A. Facility investigation The investigation documented the following: On 2/16/25 it was alleged that Resident #6 pushed Resident #2. However, after review of the facility cameras, it was determined that Resident #2 pushed Resident #6. Resident #6 said Resident #2 hit and pushed her. Resident #2 was placed on line of sight monitoring. The facility unsubstantiated the abuse allegation. -However, abuse occurred when Resident #2 pushed Resident #6. A. Resident #2 (assailant) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia with behavioral disturbances, Alzheimer's disease, bipolar disorder, insomnia due to mental disorder, vascular dementia, restlessness and agitation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/12/24 MDS assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. She required moderate assistance with bathing. She required set-up assistance with oral hygiene, upper/lower body dressing, personal hygiene, putting on/off footwear, sitting to stand, toilet transfers and walking. She received an antipsychotic medication and an antidepressant medication. 2. Record review Resident #2's mood/behavior care plan, initiated on 4/17/23, documented she had mood/behavior problems related to bipolar disorder, vascular dementia, Alzheimer's disease, insomnia, restlessness, agitation and making false accusations about other residents. She had resident-to-resident altercations which she initiated and was the aggressor. Pertinent interventions included administering medications as ordered, anticipating and meeting the residents needs, providing behavioral health consults, ensuring the resident was in line of sight when out of her room, providing frequent checks for the resident's safety, redirecting the resident and providing one-to-one care when needed. A nursing progress note, dated 2/16/25 at 9:28 p.m,. documented the staff reported a resident-to-resident altercation between Resident #2 and Resident #6 took place in the hallway. The residents were separated, interviewed and assessed for injury. No injuries were observed on either resident. Labs were ordered for Resident #6. A risk review note, dated 2/18/25 at 10:01 a.m., documented Resident #2 reported to staff that Resident #6 made contact with her on the previous shift. The incident was not observed by staff at the time of the report. Upon further investigation it was noted that in fact the initial alleged victim (Resident #2) was the aggressor. C. Resident #6 (victim) 1. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included major depressive disorder, unspecified dementia, anxiety disorder, muscle weakness, vascular dementia and collapsed vertebra (back). The 2/6/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of seven out of 15. She had hallucinations and delusions. She required maximal assistance with toileting hygiene and bathing. She was independent with positioning, transfers and walking. She received an antipsychotic medication. 2. Resident interview Resident #6 was interviewed on 3/4/25 at 11:03 a.m. Resident #6 said Resident #2 pushed her and she fell . She said she did not know why. She said it hurt, but she did not get injured. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's behavior care plan, initiated 4/17/23, documented she had mood/behavior problems related to vascular dementia, anxiety, major depressive disorder and could become aggressive with other residents. Resident #6 had become physically agitated with other residents. Pertinent interventions included administering medications as ordered, anticipating and meeting the residents needs, providing a psychiatric consult, assisting the resident to develop more appropriate methods of coping and interacting, providing frequent checks for the safety of others and keeping the resident in line of sight when she was out of her room. A nursing progress note dated 2/16/25 at 10:22 p.m. documented the alleged victim (Resident #2) claimed Resident #6 made contact with her. The altercation was not witnessed and the residents were separated and taken to separate rooms for assessments. There were no injuries observed. A risk review note, dated 2/18/25 at 10:02 a.m., documented Resident #2 reported to staff that Resident #6 made contact with her on the previous shift. The incident was not observed by staff at the time of the report. Upon further investigation it was noted that in fact the inital alleged victim (Resident #2) was the aggressor. 4. Staff interviews CNA #1 was interviewed on 3/4/25 at 11:08 a.m. CNA #1 said Resident #2 could get grumpy at times. He said he was not working the day of the altercation and had never seen Resident #2 become aggressive. LPN #1 was interviewed on 3/4/25 at 11:11 a.m. LPN #1 said Resident #2 liked to straighten and organize things. She said Resident #2 preferred to stay in her room. She said she was not working the day of the altercation. She said Resident #2 was not usually aggressive but could get frustrated. The SSA was interviewed on 3/4/25 at 2:25 p.m. The SSA said he was not aware of any aggressive behaviors from Resident #2. He said she usually just walked from her room to the dining room. He said he was not aware of the altercation. The DON was interviewed on 3/4/25 at 2:36 p.m. The DON said the previous nursing home administrator (NHA) conducted the investigation. The DON said Resident #2 would report false allegations and liked to fidget with things throughout the day even if the items were not hers. She said Resident #2 reported she fell , but when the NHA reviewed the cameras, Resident #2 pushed Resident #6, but she did not fall. She said she was not working the day of the altercation.