

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Springs Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W Van Buren St Colorado Springs, CO 80907	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185</p> <p>Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for one (#1) of three residents reviewed for abuse out of three sample residents.</p> <p>Specifically, the facility failed to report an allegation of sexual abuse to the State Agency made by Resident #1.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy and procedure, revised April 2021, was provided by the operations manager (OM) on 4/8/24 at 3:30 p.m. It revealed in pertinent part, Investigate and report any allegations within timeframes required by federal requirements.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age 82, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included displaced fracture of the demur, major depressive disorder and anxiety.</p> <p>The 3/9/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She required partial to moderate assistance with toileting, upper and lower body dressing and set up assistance for personal hygiene.</p> <p>The assessment indicated the resident had clear speech and was able to express her ideas and wants.</p> <p>B. Record review</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 12/26/23 physician's progress note documented Resident #1 was discussed during the interdisciplinary team (IDT) meeting on 12/18/23. During IDT, the staff indicated the resident had made an accusation that a male staff member had inappropriately touched her.</p> <p>The physician, along with another staff member, interviewed the resident. She was asked about the incident alluded to above, and she described it with a fair amount of detail. She did not appear fearful of this writer, and was cooperative and pleasant throughout the interview.</p> <p>-The facility was unable to provide documentation that the facility had reported the allegation of abuse to the State Agency (see staff interviews below).</p> <p>Cross-reference F610 for the facility's failure to investigate an alleged violation.</p> <p>III. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 4/8/24 at 2:11 p.m. The DON said she was at the facility on 12/16/23 when Resident #1 made an allegation of sexual abuse against certified nurse aide (CNA) #1. Resident #1 said he touched her inappropriately when he was changing her brief. The DON said she notified the nursing home administrator (NHA) immediately.</p> <p>The DON said she did not participate in an investigation of the abuse allegation. She said the former NHA was responsible for conducting all abuse investigations, including reporting the allegations to the State Agency.</p> <p>The OM was interviewed on 4/8/24 at 2:35 p.m. The OM said the former NHA was responsible for conducting abuse allegation investigations at the time the allegation was made by Resident #1. He said the former NHA no longer worked at the facility.</p> <p>The OM said he was not able to find any documentation that the allegation of abuse made by Resident #1 was reported to the State Agency. He said all allegations of abuse should be reported to the State Agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185</p> <p>Based on record review and interviews, the facility failed to investigate an allegation of abuse involving one (#1) of three residents reviewed for abuse out of three sample residents.</p> <p>Specifically, the facility failed to conduct an investigation when Resident #1 reported an allegation of abuse against certified nurse aide (CNA) #1.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy and procedure, revised April 2021, was provided by the operations manager (OM) on 4/8/24 at 3:30 p.m. It revealed, in pertinent part,</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>Investigate and report any allegations within timeframes required by federal requirements.</p> <p>Protect residents from further harm during investigations.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age 82, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included displaced fracture of the femur, major depressive disorder and anxiety.</p> <p>The 3/9/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status score of 12 out of 15. She required partial to moderate assistance with toileting, upper and lower body dressing and set up assistance for personal hygiene.</p> <p>The assessment indicated the resident had clear speech and was able to express her ideas and wants.</p> <p>The assessment indicated the resident did not exhibit depression or behaviors during the assessment period.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Record review</p> <p>The 12/26/23 physician's progress note documented Resident #1 was discussed during the interdisciplinary team (IDT) meeting on 12/18/23. During IDT, the staff indicated that the resident had made an accusation that a male staff member had inappropriately touched her.</p> <p>The physician, along with another staff member, interviewed the resident. She was asked about the incident alluded to above, and she described it with a fair amount of detail. She did not appear fearful of this writer, and was cooperative and pleasant throughout the interview.</p> <p>-A review of the resident's medical record did not reveal any further documentation of Resident #1's allegation of abuse against CNA #1.</p> <p>The clock in and clock out details for CNA #1 documented on 12/16/23, CNA #1 clocked in when he arrived at work at 5:55 a.m. He clocked out at 8:54 a.m. He then clocked back into the facility at 2:23 p.m. and clocked out for the day at 6:44 p.m.</p> <p>-The facility was unable to provide documentation that the facility had conducted an investigation regarding the allegation of sexual abuse (see staff interviews below).</p> <p>III. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 4/8/24 at 2:11 p.m. The DON said she was at the facility on 12/16/23 when Resident #1 made an allegation of abuse against CNA #1. She said he touched her inappropriately when he was changing her brief. The DON said she notified the nursing home administrator (NHA) immediately and then suspended CNA #1.</p> <p>The DON said she did not participate in an investigation of the abuse allegation. She said the former NHA was responsible for conducting all abuse investigations, including reporting the allegation to the State Agency (cross-reference F609 for reporting of an abuse allegation).</p> <p>The DON said the NHA had notified her later in the afternoon on 12/16/23 that CNA #1 could return to work. She said she called CNA #1 and he returned to work.</p> <p>The DON said the NHA never informed her of the outcome of the investigation. She said she did not follow up with the NHA.</p> <p>The OM was interviewed on 4/8/24 at 2:35 p.m. He said the former NHA was responsible for conducting abuse allegation investigations at the time the allegation was made by Resident #1. He said the former NHA no longer worked at the facility.</p> <p>The OM said he was not able to find any documentation that an investigation was conducted for the abuse allegation made by Resident #1. He said the former NHA had taken a flash drive with her, upon her dismissal, that held a lot of facility information, including QAPI (quality assurance and performance improvement) meeting notes.</p> <p>The OM said the DON should have followed up with the NHA as to the outcome of the abuse investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed again on 4/8/24 at 3:30 p.m. The DON said she was new to her position as a DON and was new to the facility during the time of the abuse allegation made by Resident #1. She said she trusted her former NHA and trusted that she had conducted an abuse investigation. She said she should have followed up with the former NHA.</p>