STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065256	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highline Post Acute	6060 E Iliff Ave Denver, CO 80222

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 - 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** 41032 Based on interviews and record review, the facility failed to protect and keep residents safe from physical abuse by a facility employee for one (#1) of three residents reviewed for alleged physical abuse by a facility employee of eight sample residents. On 8/18/24 Resident #1 was physically assaulted by a nonclinical employee of the facility. The facility failed to protect Resident #1 from being physically abused by a facility employee. The incident occurred in an outside smoking patio and was caught on the facility's video surveillance. The assault began following the initiation of an argument where the staff was asking the resident to pay him back and the resident and staff began to argue. As the argument continued the facility employee punched the resident in the head and face with so much force that the resident fell out of his manual wheelchair. Because the video surveillance had no audio capability; and Resident #1, the assailant and resident witnesses were reluctant to speak freely about the incident, it was unknown exactly what words were exchanged between the facility employee and Resident #1. The assault on Resident #1 by the facility employee caused Resident #1 significant bodily injury including two types of brain bleed, a subdural hematoma and a subarachnoid hemorrhage; fractures of the resident's nasal bones and facial contusions swelling and bruising of the head. The resident's injuries were so severe that he was admitted to the hospital's trauma intensive care unit (ICU) for treatment. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 9/3/24, resulting in the deficiency being cited as past noncompliance with a correction date of 8/20/24. I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 9/3/24 at 3:15 p.m. It read in part, 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. (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 - Actual harm Residents Affected - Few	The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: -Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: facility staff. Ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates. II. Incident of physical abuse A. Physical abuse investigation The facility investigation revealed Resident #1 was a victim of physical abuse by an employee of the facility. The investigation of the abuse began on 8/18/24 immediately following the abuse incident occurring on 8/18/24 at 8:21 a.m. The report documented the events of the incident (see below). The allegation was substantiated by video surveillance (no audio) and a resident witnessing the incident. Resident #1 was outside in the smoking area where he and housekeeper (HSK) #1 were observed on the facility's video surveillance having a conversation/arguing. Three other residents were in the smoking area. The investigation said the other residents were reluctant to say what happened. Only Resident #7 was able and willing to give a statement of what he observed. Resident #7 said he heard Resident #1 and HSK #1 arguing about money. HSK #1 was asking the resident when he was going to pay HSK #1 back; Resident #1 called HSK #1 a racial name and after that HSK #1 started punching Resident #1 over and over and did not stop. Resident #1 fell out of his wheelchair and HSK #1 then picked him up and put him back in his wheelchair. -The NHA and the director of nursing (DON) were interviewed on 9/3/24 at 11:10 a.m. The NHA said the video surveillance (visually) confirmed Resident #7's version of events. -The video surveillance had been turned over to the local police department for their investigation and was not available for review during the survey (9/3/24). Resident #1 did not report the abuse to staff initially; he called his family at approximately 9:00 a.m. to report the abuse to his representative and the resident's representative called the facility at 9:10 a.m. and reported the physical abuse incident to the nurse, licensed practical nurse (LPN) #1. After receiving verbal notification of the allegation, LPN #1 went to Resident #1's room to assess him for injuries and find out what happened. At first, the resident did not want to talk but told LPN #1 that HSK #1 hit him but he was not sure why. Resident #1 said HSK #1 had been a good guy and had never done anything like this before that morning. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Upon initial assessment, by LPN #1, Resident #1 was found to have bruising on his right eye, upper lip, right temple, a swollen nose, and a bump on his right eyebrow and right shoulder. LPN #1 encouraged Resident #1 to go to the hospital for an exam but he declined. LPN #1 notified the resident's physician and in-facility x-rays were ordered. The resident was given Tylenol and ice packs for the swelling. HSK #1 was interviewed on 8/18/24 just after the incident, by the on-duty nurse while on speakerphone with the DON. When asked, HSK #1 admitted to hitting Resident #1. LPN #1 asked HSK #1 to leave the premises immediately and was placed on suspension. HSK #1 handed over his keys and left without further incident at approximately 9:15 a.m. Resident #1's representative arrived at the facility and talked Resident #1 into going to the hospital for evaluation and treatment. Resident #1 was transferred to the hospital emergency roiagnom on [DATE] at 12:00 p.m. B. Record review The hospital transcript report dated 8/18/24 documented that the patient presented after he was assaulted by a staff member at his facility. The patient states that he was struck in the face. Denies other injuries. He reports left-sided facial pain and swelling, and abdominal pain. He has right-sided chest wall pain to palpation (touch) only. The hospital radiology report dated 8/18/24, revealed the resident had the following injuries: -Anterior parafalcine subdural hematomas (trapped blood that develops between the inner layers and the tough outer covering of the brain) measuring up to four millimeters (mm) at maximal diameter; -Small volume subarachnoid hemorrhage (brain bleed) along the paramedian right frontal sulci (frontal lobe of the brain); -Right nasal bone fractures, new from prior exam; and, -Left periorbital contusion (bruising/trauma around the eye). The resident was admitted to the trauma ICU for treatment of his injuries. III. Resident witness interview Resident #7 was interviewed on 9/3/24 at 4:15 p.m. Resident #7 said that he saw Resident #1 and HSK #1 arguing. He believed Resident #1 was punishing the HSK's buttons. HSK #1 then punched Resident #1. IV. Facility corrective actions A. Immediate action (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA provided a follow-up action plan, dated 8/18/24, and evidence of the corrective actions, the plan documented: Issue identified: The facility was notified of an allegation of abuse of a resident by staff on 8/18/24. Immediate action items: The resident's condition was assessment and provided treatment. -Immediate suspension/ removal from facility property of the staff assailant during the investigation. -The resident's family and physician were notified.The police, adult protective and the State oversight office were notified and an investigation was initiated. B. Interventions put into place Root cause analysis: The possible root cause was ineffective management of the resident's behaviors. Action items: -Staff education on resources for the employee assistance program; stress management and management of resident behavior; completed on 8/20/24. Other staff were to receive training by their next working shift or by 8/26/24 whichever was first. -Resident witnesses were interviewed, completed on 8/19/24. -A mental health provider was contracted to provide counseling services to the three resident witnesses of the incident, completed on 8/20/24. Identification of others: -Complete audit of all staff for a completed background check. Missing background checks were requested. Completed by 8/20/24. -All residents and resident representatives of residents who were not interviewable were interviewed to determine if any had a similar experience of being abused (emotionally or physically) by a staff; completed on 8/20/24. -Skin evaluations were completed on residents who were not interviewable to assess for any potential injuries of unknown origin, completed on 8/20/24. System Changes: -Abuse identification, prevention and reporting; how to recognize resident triggers; and how to address resident in the moment of distress training was provided to all staff; initiated on 8/19/24 and completed with all active staff by 8/20/24. Other staff to receive training by their next working shift or by 8/26/24 whichever was first. (continued on next page)

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