STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065290	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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** Based on observations, record review and interviews, the facility failed to protect four (#12, #5, #9 and #15) of seven residents from abuse out of 12 sample residents.Resident #6 was admitted on [DATE] with a diagnosis of bipolar disorder (mental illness), depression, and dementia.Resident #12 was admitted on [DATE] with a diagnosis of dementia, other behavioral disturbance, anxiety disorder and depression.On [DATE], Resident #6 and Resident #12 were in the dining room when the residents began yelling at each other and hitting each other. On [DATE], Resident #6 grabbed Resident #12 on both of her arms. On [DATE], Resident #6 began yelling at Resident #12. Resident #6 then lunged at Resident #12 and pushed her to the ground, where she (Resident #6) attempted to hit Resident #12 in the face. As a result of the three incidents of physical and verbal abuse, Resident #12 began isolating herself and avoiding Resident #6. Resident #12 said she avoided Resident #6 when she could because Resident #6 was yelling at her, hitting her and pushing her. Resident #12 said she feared getting seriously injured. Observations revealed Resident #12 displayed anger and distress when talking about the encounter with Resident #6 and said she did not like talking about the incidents. Specifically, the facility failed to:-Prevent multiple abuse altercations between Resident #6 and Resident #12; and,-Protect Resident #5, Resident #9 and Resident #15 from physical abuse by Resident #4. Findings include: I. Facility policy and procedure The Abuse policy, dated February 2024, was provided by the corporate nurse consultant on [DATE] at 2:07 p. m. It read in pertinent 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 restraints not required to treat the resident's symptoms. “Providing a safe environment for the resident is one of the most basic and essential duties of our facility. This facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, friends, or other individuals. “Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Also, verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through use of technology. (continued on next page)

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	“Verbal abuse is defined as the use of oral, written, or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, regardless of their ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. “Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. “The following approaches and interventions are designated as part of the facility abuse prevention protocols: Education is provided at staff orientation and training programs that include topics such as abuse prevention, the elder justice act, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.” The Dementia-Clinical protocol, undated, was provided by the clinical nurse consultant on [DATE] at 2:07 p. m. It read in pertinent part, “As part of the initial assessment, the physician will help identify individuals who have been diagnosed as having dementia and those with otherwise impaired cognition. “The interdisciplinary team (IDT) will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes. “Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. Additionally, performance reviews will be conducted annually and in-service education will be based on the results of the reviews. “The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.” II. Incident of physical and verbal abuse by Resident #6 towards Resident #12 A. Facility investigation The facility investigation, dated [DATE], documented Resident #12 and Resident #6 were in the hallway after lunch and started to argue and hit each other. Staff immediately separated both residents. The investigation documented neither resident could explain why they were hitting each other. Resident #12 sustained mild swelling, redness and warmth to her left cheek from the altercation. She received Tylenol for pain and an ice pack for the swelling. The facility investigation documented Resident #6 had a history of being physically aggressive towards other residents with whom she had been friends with in the past. After the altercation, Resident #6 was not able to recall the argument or physical altercations and said that everything was fine. Resident #6 said she would be friends again with the other resident (Resident #12) that she attacked after an incident occurred. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The investigation documented Resident #12 was interviewed by registered nurse (RN) #4. Resident #12 said she went to the dining room and sat down. Then Resident #6 came over and accused Resident #12 of drinking her juice. Resident #12 said she did not drink Resident #6's juice. Resident #12 said Resident #6 started cursing at her. Resident #12 said she got angry and ended up cursing back at Resident #6. Resident #12 said she left the dining room, but Resident #6 followed her and continued to fight with her. The investigation documented Resident #6 was interviewed by RN #4. Resident #6 said when she went to the dining room, Resident #12 started cursing at her for no reason. Resident #6 said she fought with Resident #12, then Resident #12 left the dining room while she continued to curse at her. Resident #6 said she followed Resident #12 and fought with her. Later that day, Resident #6 said everything was fine. CNA #4 was interviewed as a witness to the incident on [DATE]. CNA #4 said she was passing room trays in the south unit. She saw Resident #6 and Resident #12 yelling and hitting each other. CNA #4 said she got in between them and yelled for help. CNA #4 said an unidentified RN came right away and helped her separate the residents. CNA #4 said she walked Resident #6 to her room and the unidentified RN took Resident #12 back to the north nurses' station. CNA #4 said the unidentified RN placed both residents on 15-minute checks and directed for them not to be in the same area. The facility investigation concluded Resident #6 was the aggressor and did have the intent to fight with Resident #12 because Resident #6 said she followed her out of the dining room on [DATE]. -However, abuse occurred due to Resident #6 and Resident #12 cursing at each other and hitting each other. III. Incident of physical abuse by Resident #6 towards Resident #12 on [DATE] A. Facility investigation The facility investigation, dated [DATE], documented Resident #12 was interviewed by the social services director (SSD). Resident #12 said she was asleep and was woken up by Resident #6 grabbing her arms and trying to pull her out of the bed. Resident #12 said she did nothing to retaliate and just yelled at Resident #6 to let her go and get out of her room. She said someone came and got Resident #6 out of the room. Resident #6 was interviewed by the SSD as part of the facility investigation. Resident #6 said they (Resident #6 and Resident #12) were coming in from outside and Resident #12 stepped on her foot. Resident #6 said she yelled at Resident #12 because it hurt, but Resident #12 did not care and they started yelling at each other. -However, Resident #6 was not able to explain how she ended up in Resident #12's room, grabbing at her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed as a witness to the incident on [DATE]. LPN #2 said she was in the south hall near the nursing cart and saw Resident #6 yelling, screaming and cursing at Resident #12, who was standing in the south hall. LPN #2 said Resident #6 told her that Resident #12 was putting clothes in bags in front of Resident #6's room. LPN #2 said she did not observe anything on the floor in front of Resident #6's room and nothing inside the room. LPN #2 said Resident #6 grabbed Resident #12 on both arms and tried to hit Resident #12's head. LPN #2 said she and the nurse practitioner (NP) separated the residents immediately. LPN #2 said she took Resident #6 to the other side of the building and notified Resident #12's nurse about the incident. -The facility investigation did not document that the incident of physical and verbal abuse was substantiated. IV. Incident of physical and verbal abuse on [DATE] by Resident #12 towards Resident #6 A. Facility investigation The facility investigation, dated [DATE], documented Resident #12 and Resident #6 were observed yelling at each other by the double doors that separated the north hallway and the north nurses' station. The nurse observed Resident #6 lunge at Resident #12. Resident #6 grabbed Resident #12's shoulders and pushed her to the ground and attempted to hit her in the face. The staff were able to separate the two residents before Resident #6 was able to physically hit Resident #12. Resident #6 said she was upset with Resident #12 because Resident #12 was stealing from her. Resident #12 was interviewed by the SSD as part of the facility investigation. Resident #12 said she was just walking down the hall and Resident #6 started yelling at her, and she yelled back too. Resident #12 said Resident #6 pushed her on the ground. Resident #12 said she felt safe when staff kept Resident #6 away from her. The facility investigation documented Resident #12 had a history of being friends with Resident #6 shortly after an altercation, as they both had cognitive deficits. Once the police came to interview the residents, they were holding hands, stating they loved each other and they were friends. The police told the residents to get along and not fight. Resident #6 was interviewed by the SSD as part of the facility investigation. Resident #6 said she was upset at her friend (Resident #12), who went into her room and stole all her money while she was mourning the loss of her husband. Resident #6 said she went to yell and confront Resident #12 because she stole all her money. RN #4 was interviewed as a witness to the incident on [DATE]. RN #4 said Resident #12 was walking towards the nurses' station and Resident #6 was walking towards Resident #12 at the north nurses' station. RN #4 said Resident #6 accused Resident #12 of stealing her money and keys. RN #4 said Resident #6 grabbed Resident #12's wrists and pushed her, which caused Resident #12 to fall. RN #4 said the staff separated the residents immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A staff nurse witness said she was working on the north cart when she heard yelling and saw Resident #6 come up to Resident #12 and push her hard down on the ground. The staff witness said she ran over to the fight, told them to stop and separated them. The staff witness said RN #4 came and took Resident #6 away. The staff witness said she assisted Resident #12 from the floor and conducted her assessment. -The facility investigation did not document that the incident of physical and verbal abuse was substantiated. The facility investigation concluded that Resident #6 was having delusional thinking and Resident #12 did not have keys or any of Resident #6's items. Resident #6's physician adjusted her medication after the altercation on [DATE] to help with the loss of her husband and her behaviors. A. Resident #6 (assailant) 1. Resident status Resident #6 was admitted on [DATE]. According to the [DATE] computerized physician's orders (CPO), diagnoses included bipolar disorder, depression and dementia. According to the [DATE] minimum data set (MDS) assessment the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment documented that the resident was oriented to herself and displayed aggressive and violent behavior towards others. The resident was able to walk independently and wandered almost daily. 2. Resident observations During a continuous observation on [DATE], beginning at 12:30 p.m. and ending at 1:05 p.m., Resident #6 was walking up and down the hallway by herself, unsupervised by staff. The resident was walking in areas of the hall where she was not in direct line of sight of the staff for extended periods of time. During a continuous observation on [DATE] from 10:30 a.m. to 10:59 a.m., Resident #6 was walking up and down the hallway by herself, unsupervised by staff. The resident was walking in areas of the hall where she was not in the direct line of staff. 3. Resident interviews Resident #6 was interviewed on [DATE] at 1:00 p.m. Resident #6, due to her impaired cognition, was unable to answer many of the questions and often provided contradictory details. She said she did not know how long she had been at the facility and had nothing to do but lie in bed. However, she then contradicted her previous statement and said the facility had lots of games, which she enjoyed. Resident #6 said she got along well with the staff and residents and did not have issues with anyone at the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #14, who was Resident #6's roommate, was interviewed on [DATE] at 1:01 p.m. Resident #14 said the staff was not taking very good care of Resident #6. She said Resident #6 was often pacing the halls of the facility without staff supervision and often appeared to be disheveled, unshowered and had an unpleasant body odor. 4. Record Review Resident #6's behavior care plan, initiated on [DATE], revealed the resident has potential to be physically aggressive related to dementia and bipolar disorder, and poor impulse control. She has a history of getting physically aggressive towards other residents. She has a history of being physically aggressive with one of the other residents, who was her friend. She can get physical but oftentimes does not remember all the details of the altercation or why she was making accusations. Interventions included documenting behaviors, administering medications as ordered and monitoring/documenting for side effects and effectiveness, providing physical and verbal cues to alleviate anxiety, giving positive feedback, assisting verbalization of the source of agitation, assisting in setting goals for more pleasant behavior, encouraging seeking out of staff members when agitated and when the resident became agitated, intervening before agitation escalated, guiding away from the source of distress, engaging the resident calmly in conversation and if the resident's response was aggressive, staff was to walk calmly away and approach later. Review of the resident's behavior log (from [DATE] to [DATE]) revealed the direct care staff had documented that Resident #6 had no identifiable aggressive or disruptive behaviors, including on [DATE] and [DATE], when Resident #6 was involved in altercations with Resident #12. B. Resident #12 (victim) 1. Resident status Resident #12, age [AGE], was admitted to the facility on [DATE]. According to the [DATE] CPO, diagnoses included dementia, other behavioral disturbance, anxiety disorder and depression. The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The assessment revealed Resident #12 was independent in all activities of daily living (ADL) and exhibited verbal behavioral symptoms directed toward others, such as screaming and cursing at others. 2. Resident observation On [DATE] at 1:50 p.m. Resident #12 was observed eating her lunch in her room. 3. Resident interview Resident #12 was interviewed on [DATE] at 9:25 a.m. Resident #12 said Resident #6 grabbed her left arm, twisted it and threw her on the floor for no reason. She said Resident #6 repeatedly punched her. Resident #12 said she sustained a sore arm that required staff to wrap it with an elastic bandage for a week. Resident #12 said Resident #6 pushed her against the wall, which caused back pain and soreness. Resident #12 said she had another incident with Resident #6 in the past. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #12 became emotional, waving her arms, saying no, shaking her head, while saying she did not want to be with Resident #6 while recounting the incidents involving her with Resident #6. Resident #12's voice trembled as she spoke and she was visibly shaking. Resident #12 repeatedly waved her hands and shook her head no when Resident #6's name was mentioned. Resident #12 was tense and spoke in a shaky tone. Resident #12 said she had to stay in her room more than usual out of fear that Resident #6 would hurt her again. Resident #12 said she avoided going to the dining room to keep from crossing paths with Resident #6 during meal time. She said she did not want to be in contact with Resident #6, even though Resident #6 tried to talk to her. Resident #12 said she was friends with Resident #6 before, but she did not trust her much and kept her distance from her after the altercations. 4. Record review Resident #12's trauma care plan, revised [DATE], documented Resident #12 had a history of trauma that resulted in difficulty connecting and trusting others. She had the potential to be verbally and physically aggressive related to dementia. She could get upset and start yelling and cursing at other residents. She tended to forget why she became physically aggressive after an incident had occurred. Pertinent interventions included analyzing key times of day, places, circumstances, triggers, and how to de-escalate behavior and document, assessing the resident's coping skills and support system, when the resident was agitated, intervening before the agitation escalated, guiding away from the source of distress, engaging calmly in conversation, and staff to walk calmly away and approach later if the response was still aggressive. The interventions further included providing physical and verbal cues to alleviate anxiety, giving positive feedback, assisting verbalization of sources of agitation and setting goals for more pleasant behavior and encouraging seeking out of staff members when agitated. The [DATE] nursing progress note documented RN #4 heard the sounds of a fight in the hallway and went to check on the disturbance. RN #4 found Resident #6 and Resident #12 were physically struggling and grabbing each other by the collar. Resident #6 was twisting Resident #12's left arm and RN #4 separated them. The provider ordered an Xray, icepack and as-needed (PRN) pain medication to be administered for Resident #12. The [DATE] nursing progress notes documented Resident #12 was involved in a physical altercation with Resident #6. Resident #12 said she was punched in the face by Resident #6. The nursing assessment noted mild and warm swelling and redness to Resident #12's left cheek as a result of the altercation. Nursing staff administered PRN Tylenol 650 milligrams (mg) and offered an ice compress to Resident #12. Resident #12 had been on the north side of the building for the entire shift, staying in her room and the north hallway. The resident ate in her room. -Review of Resident #12's electronic medical record (EMR) did not reveal documentation regarding the incidents of physical abuse with Resident #6 on [DATE] and [DATE]. C. Staff interviews (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on [DATE] at 3:34 p.m. CNA #1 said when a resident became aggressive, there was not much the staff could do besides disengage the resident if the behavior was directed at staff. She said the staff would try to separate the residents and move the residents to different rooms if the behavior was directed at another resident. CNA #1 said she heard of an incident last week (week of [DATE]) between Resident #12 and Resident #6. She said she was not sure how it had happened since the two residents were in completely different hallways. The director of nursing (DON) was interviewed on [DATE] at 11:15 a.m. The DON said it was hard to decide what to do about the conflicts between Resident #6 and Resident #12 because most of the time they would be very friendly with each other and even called each other sisters. She said after all the altercations, the interdisciplinary team (IDT) moved the two residents to different halls and tried to encourage them to stay away from each other, but that it was ineffective. She said the facility had nothing that they could do in addition to the interventions they had already been implementing. The SSD was interviewed on [DATE] at 5:00 p.m. The SSD said Resident #6 had no identified triggers before displaying aggressive behavior, but sometimes had delusional thinking. The SSD said that the IDT had informed Resident #6 on [DATE] that Resident #6's husband had died. The SSD said she had noticed Resident #6 had more aggressive behaviors after the news of her husband's passing. The SSD said she had offered Resident #6 other activities to distract her. She said the IDT recently reviewed Resident #6's medications and there were no plans to change Resident #6's medications at the time of the review. LPN #2 was interviewed on [DATE] at 2:56 p.m. LPN #2 said she was Resident #6's nurse on [DATE]. LPN #2 said both Resident #6 and Resident #12 were at the south nurses' station. She said Resident #12 was about three doors away from Resident #6. She said when Resident #6 saw Resident #12, she began yelling, accusing Resident #12 of touching her belongings in front of her room, which was not true. She said Resident #6 then attempted to touch Resident #12. LPN #2 said the NP and she intervened and separated them. She said both residents were escorted back to their rooms and placed on 15-minute checks. LPN #2 said no injuries were observed after the nursing assessment. LPN #2 said she reported the incident to the SSD and the nursing home administrator (NHA). LPN #2 said the SSD met with both residents and addressed the situation and that there were no further issues that day. RN #2 was interviewed on [DATE] at 12:25 p.m. RN #2 said if a resident's behavior became aggressive or violent, she would leave the room to allow the resident time to calm down for about 10 minutes and would report the incident to the NHA. RN #2 said before leaving the room, she would ensure the resident was safe and would ask what happened and what triggered the behavior. RN #2 said then the NHA would come to the floor and check on the resident and ask if they would like to talk about the incident. RN #2 said she would also ask the CNAs to check on the resident. RN #2 said she would ask for assistance if a resident became dangerous or posed a risk of self-harm when trying to de-escalate a situation. RN #2 said she could not recall all specific interventions for Resident #6 and Resident #12, as the approach would depend on the situation. RN #2 said if a resident became very aggressive, she would contact the police. RN #2 said in situations involving two residents, she would remove the calmer resident from the area. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	RN #2 said it had been a while since her last training on managing aggressive residents or de-escalation techniques and she could not recall the name of the program where she had the training. RN #2 said she could not remember when she last had dementia training. RN #2 said if a resident was suspicious or paranoid, she would speak with them calmly and try to orient them to reality, reassuring them that they were safe. She said she would assist them in locating their belongings by showing the inventory list completed at admission. RN #4 was interviewed on [DATE] at 3:04 p.m. RN #4 said on [DATE] she was speaking with Resident #6 in the conference room near Resident #12's room about the passing of her husband. RN #4 said Resident #6 appeared to be experiencing hallucinations and believed that Resident #12 had stolen her belongings. RN #4 said Resident #6 became agitated, saying she wanted to leave and was searching for her keys. RN #4 said Resident #6 repeatedly said that another woman had killed her husband and continued accusing Resident #12 of stealing her keys. RN #4 said, later in the day, Resident #6 was wandering in the building and crossed paths with Resident #12 in the hallway. She said Resident #6 grabbed Resident #12, shoved her and pushed her against the wall. RN #4 said this caused Resident #12 to sit down on the floor. RN #4 said she immediately intervened, separated them and escorted Resident #12 to her room while another staff member took Resident #6 to her room. RN #4 said both residents were placed on 15-minute checks and Resident #12 complained about shoulder pain. RN #4 said an Xray was performed, which was negative, and Resident #12 was administered Tylenol for pain relief. RN #4 said she reported the incident to the DON, the NHA and the police. The NHA and the SSD were interviewed together on [DATE] at 4:31 p.m. The NHA said if a resident's behavior became aggressive or violent, staff would separate residents and place them on 15-minute checks. She said the staff would notify the NHA and the SSD, who would call the resident's physician for medication review if necessary. The NHA said behavior notes were documented in the care plan and in progress notes. The NHA said leadership had recognized the facility had a need to provide increased training to staff on managing aggressive behavior and providing dementia-focused care. The NHA said prior to [DATE], the facility's training compliance was at 31 percent and was now at 50 percent. The NHA said the facility would continue working to ensure all staff received training. The NHA said she was not aware Resident #12 was fearful of Resident #6. She said the facility should have investigated and implemented interventions as appropriate to ensure she was not fearful. She said Resident #12 was observed eating lunch with Resident #6 today ([DATE]). The NHA said she spoke with the ombudsman regarding the situation between Resident #6 and Resident #12. The NHA said the ombudsman expressed a desire to uphold the residents' right to remain friends. The NHA said both residents verbalized that they were friends and considered each other like sisters and wished to remain together. The NHA said it would be detrimental to separate the residents and she did not know how to prevent resident-to-resident altercations between the two residents. V. Incident of physical abuse by Resident #4 towards Resident #5 on [DATE] A. Facility investigation (continued on next page)

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	065290	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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	The facility investigation, dated [DATE], documented that Resident #4 punched his roommate, Resident #5 in their room, after returning to the facility intoxicated from his community outing. Resident #5 alerted staff of the altercation. The local police department and emergency medical services were called to the facility. Resident #4 appeared to be intoxicated, per the incident report, and continued to demonstrate aggressive behaviors while staff attempted to de-escalate the situation. Resident #4 was taken to the hospital by emergency medical services. Staff relocated Resident #4 to a different room in the facility upon his return from the hospital. B. Resident #4 (assailant) 1. Resident status Resident #4, age less than 65, was admitted to the facility on [DATE] and discharged to jail on [DATE]. According to the [DATE] CPO, diagnosis included history of alcohol dependence, depression, and post-traumatic stress disorder (PTSD). The [DATE] MDS assessment documented the resident was cognitively intact with a BIMS score of 13 out of 15. The resident had verbal and physical aggression towards others. The resident was able to walk short distances and used a manual wheelchair to get around the community. 2. Resident interview Resident #4 was interviewed on [DATE] at 2:00 p.m. Resident #4 said he was on his way to the bar down the street. He said there was not much for him to do at the facility besides get drunk, high and gamble. He said that he could not do those activities on the facility grounds, but he could do them elsewhere. He said he usually came back to the facility drunk. He said that the facility discouraged him from drinking, but there were no real consequences. He said that he often felt like the other residents and staff were talking poorly of him, so he felt like he had to talk (expletive) to them. Resident #4 said that many people in the facility had bad attitudes and he often wanted to beat them up if they said disrespectful things to him. He said that his fights with residents were usually because other residents made false claims about his ethnic heritage. He said that made him very angry and that was why he would beat others up. Resident #4 said staff tried to keep residents apart from one another when they got into fights, but did not do anything to intervene when one resident was being disrespectful or threatening another resident. He said most of the time, the staff did not notice or ignored that behavior. 3. Record review The behavioral care plan, initiated on [DATE], documented Resident #4 occasionally returned to the facility from the community intoxicated. The care plan documented when the resident was intoxicated, he could become verbally and physically aggressive towards staff and residents. Pertinent interventions included while the resident appeared intoxicated, the staff were to provide the resident one-to-one observation. -However, the facility was unable to provide documentation that one-to-one observations were completed when Resident #4 was intoxicated on [DATE], [DATE] and [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	A review of the resident's behavioral tracking sheets, from [DATE] through [DATE], revealed that staff did not document any of the incidents of aggressive behavior towards others, as documented in the resident's record and in the incident investigation. C. Resident #5 (victim) 1. Resident status Resident #5, age less than 65, was admitted to the facility on [DATE] and was discharged in [DATE]. According to the [DATE] CPO, diagnoses included heart failure, diabetes and anemia. The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was not aggressive towards others. The assessment revealed Resident #9 needed substantial/ maximum assistance with ADLs involving mobility of his lower body (legs, hips and feet) and was independent with ADLs involving the uses of his upper body (hands, shoulders and arms). The resident used a manual wheelchair to get around independently. VI. Incident of verbal abuse by Resident #4 and Resident #11 towards Resident #9 on [DATE] A. Facility investigation The facility investigation, dated [DATE], documented