STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065320	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Littleton Care and Rehabilitation Center	5822 S Lowell WY Littleton, CO 80123

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 51710 Based on observations, record review and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group. Specifically, the facility failed to follow-up with concerns that were brought up by the group of residents during the resident council meetings regarding resident care and life in the facility. Findings include: I. Facility policy The Grievance Policy, dated 10/3/24, was provided by the social services consultant (SSC) on 10/3/24 at 11:47 a.m. It read in pertinent part, To address resident concerns without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. To make prompt efforts to resolve grievances the resident may have. The Grievance Official is responsible for overseeing the grievance process, receiving and tracking grievances; leading any necessary investigations by the facility. The Grievance Official or designee responds to the individual expressing the concern within three (3) working days of the initial concern to acknowledge receipt and describe steps taken toward resolution. The Grievance Official/Designee completes the Grievance Resolution Forms, takes appropriate corrective action in accordance with State law if the alleged violation of resident's right is confirmed by the facility or an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency within its area of responsibility. The Grievance Official or designee will contact all parties with the outcome. The grievance log is maintained by the Grievance Official and reviewed by the Quality Assessment & Assurance Committee and shall not become part of the medical record. Results of grievance will be maintained no less than 3 years from issuance of the grievance decision. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Observations On 10/2/24 at 9:55 a.m. the north and south hallways were observed to be cluttered with wheelchairs, oxygen concentrators, bedside commodes, empty boxes near the storage room and medication carts with computers. The floors of the hallways and the dining room had bits of trash and food on them. III. Resident Interviews Resident #6 was interviewed on 10/2/24 at 2:38 p.m. Resident #6 said the staff took a long time to answer the call lights in the evenings and at night. Resident #4 was interviewed on 10/2/24 at 2:59 p.m. Resident #4 said there were not enough staff to take care of everyone without having to wait a long time for call lights to be answered. She said the rooms were not cleaned daily. IV. Resident group interview The resident group interview was conducted on 10/3/24 at 9:30 a.m. The group consisted of seven residents (#5, #6, #7, #8, #9, #10 and #11) who were interviewable based on assessment and the facility. The residents all said they continued to have concerns with the facility's follow-up on grievances. The concerns were as follows: -The facility failed to act upon grievances; -The facility had a lot of turnover and therefore the grievances were not acted upon; -The facility did not listen to the resident council group in order to help resolve issues; -The residents did not hear back from staff in regards to any grievances filed; and, -The facility continued to have complaints regarding staffing issues, call lights not being answered, clutter in the hallways and cleanliness of the building. V. Resident council meeting minutes The resident council meeting minutes for July 2024, August 2024 and September 2024 were provided by the director of nursing (DON) on 10/2/24 at 10:37 a.m. The 7/22/24 resident council meeting minutes documented the following resident concerns: The old business section (from June 2024) documented resident concerns of trash not being emptied, the utilization of agency staff during night of care (NOC) and not enough towels or washcloths for residents. The status update documented by the interdisciplinary team (IDT) said they were trying to minimize using agency staff. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident concerns for the month of July 2024 included call light times were too long at night, there were too many wheelchairs and equipment in the hallways, and staff left wet towels in resident rooms and were not cleaning the toilet stools after use. -There was no documentation in the minutes which indicated how the facility planned to follow up on the resident concerns. The 8/19/24 resident council meeting minutes documented the following resident concerns: Hallways were cluttered with wheelchairs, commodes and supplies when the delivery trucks came and the residents did not have enough towels or wash cloths. -There was no documentation in the minutes which indicated how the facility planned to follow up on the resident concerns. The 9/23/24 resident council meeting minutes documented the following resident concerns: The old business section (from August 2024) documented resident concerns that hallways and shower rooms were cluttered, that all wheelchairs and bedside commodes be moved and that call lights were not being answered on time. -There was no documentation in the minutes which indicated how the facility had followed up on the resident concerns. VI. Staff interviews The activity director (AD) was interviewed on 10/3/24 at 10:37 a.m. The AD said resident council meetings were held once a month. She said all administrative team members were present and the residents and staff discussed resident concerns during the meetings. She said she was responsible for writing down meeting minutes. She said she provided the meeting minutes to the social services director (SSD), who was also the facility's grievance official. The AD said the SSD was responsible for filling out grievance forms based on the grievances voiced in the resident council meetings. The SSD was interviewed on 10/3/24 at 11:00 a.m. The SSD said she was the grievance official for the facility. She said she received the resident council meeting minutes from the AD. She said she filled out grievance forms based on the resident concerns brought up in the meetings. She said she would give the grievance forms to the appropriate department head to resolve the issue. The SSD said grievances were to be resolved within 48 hours of receiving the grievance form. She said she was supposed to follow up on grievances if the form was signed as resolved and a resolution was not actually obtained. After reviewing her grievance log, the SSD said she had two grievances filed from July 2024, however, she said they were not followed up on appropriately to ensure an actual resolution was obtained. She said she had no grievance forms filled out for the resident concerns brought up in the August 2024 and September 2024 resident council meetings.

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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	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** 51711 Based on record review and interviews, the facility failed to ensure two (#1 and #5) 11 residents out of 12 sample residents were kept free from abuse. Resident #1, who had limited mobility and required staff assistance with bed mobility and transfers due to a recent hip surgery, was admitted to the facility on [DATE]. On the night of 7/21/24, Resident #1 used her call light to request staff assistance with being repositioned in bed. The resident later used her call light to request staff assistance with going to the bathroom. Both times, when staff had not responded to the resident's call light in over one hour, the resident called her legal representative. Both times, the resident's representative called the facility and staff eventually answered Resident #1's call light. Early in the morning on 7/22/24, Resident #1 again called her representative. The resident was crying and scared and wanted to leave the facility. Resident #1 reported that registered nurse (RN) #1 had come into her room, got close to her face and yelled at her to stop using her call light. According to Resident #1, RN #1 told her if she did not stop using her call light, staff would not come to assist her. Resident #1's representative arrived at the facility after receiving the phone call and removed Resident #1 from the facility due to the resident crying hysterically, being scared and not wanting to remain in the facility. The resident's representative reported the incident to the local police department on 7/22/24. Certified nurse aide (CNA) #1, who witnessed the incident between RN #1 and Resident #1, wrote a statement on 7/22/24 which documented RN #1 had spoken sternly to the resident and told her to stop using her call light and nobody was going to answer the call light. The facility completed a grievance related to the allegation but failed to investigate the incident until 9/12/24, over one month later, when the facility was alerted by the state board of nursing that RN #1's nursing license was being investigated for an allegation of abuse. The facility failed to conduct a complete investigation of the incident or report the allegation to the State Agency on 9/12/24 and RN #1 continued to work at the facility. Additionally, on 10/3/24, during a group interview during the survey, Resident #5, who also required staff assistance, reported he waited for 45 minutes to answer his call light. When nobody came, Resident #5 began yelling for help. He said RN #1 came to the doorway of his room and yelled at him to shut up and quit using his call light. Resident #5 said he was angry at being treated that way by RN #1. Due to the facility's failures to ensure residents were kept free from abuse, Resident #1 and Resident #5 experienced psychosocial harm when RN #1 yelled at the residents for using their call lights and threatened that staff would not answer their call lights if they continued to use them. Findings include: I. Facility policy and procedure (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Abuse Investigation and Reporting policy, revised August 2024, was provided by the nursing home administrator (NHA) on 10/3/24 at 8:39 a.m. It read in pertinent part, It is the policy of this facility that reports of abuse, neglect, misappropriation of property and exploitation are promptly and thoroughly investigated. The investigation process will consist of at least the following: -A review of the completed complainant report; -An interview with the person(s) reporting the incident; -Interviews with any witnesses to the incident; -An interview with the resident, if possible; -A review of the resident's medical record; -An interview with staff members having contact with the resident during the period/shift of the alleged incident, if applicable; -Interviews with resident's roommate, family members, and visitors, if applicable; and, -A review of all circumstances surrounding the incident. Employees of this facility accused of resident abuse shall immediately be barred from any further contact with the residents of the facility, pending the outcome of further investigation, prosecution or disciplinary action against the employee. The summary of the investigation will be recorded and attached to the report. Should the investigation reveal that the abuse occurred, the administrator would report such findings to the State Licensing Agency, as necessary, health department within (24 hours) and police department within two (2) hours as necessary with the results of the completion of the investigation. The administrator or designee will complete a copy of the Resident Abuse Investigation Report Form within five (5) working days of the reported incident. II. Incident of verbal abuse on 7/22/24 between Resident #1 and RN #1 A. Facility investigation The facility's investigation of the incident was provided by the NHA on 10/2/24 at approximately 2:00 p.m. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A statement written by CNA #1 on 7/22/24 revealed resident #1 was admitted to the facility on the afternoon of 7/21/24. CNA #1 said the resident was using her call light throughout the day and night (on 7/21/24 into 7/22/24). CNA #1 said resident #1 requested assistance with the television, toileting assistance, retrieving food and repositioning in bed. CNA #1 reported RN #1 went into Resident #1's room and sternly told her she needed to stop taking advantage of her call light because the staff had had other residents to attend to. CNA #1's written statement further documented the resident's daughter arrived and removed Resident #1 from the facility. -Despite CNA #1's written statement of the incident, the facility completed a grievance for Resident #1's call light not being answered timely but failed to initiate an investigation for potential verbal abuse until 9/12/24 (see below). On 9/12/24, the facility was notified by the state board of nursing that RN #1 was being investigated for potential abuse. Upon receiving the notification from the state board of nursing, the facility spoke to CNA #1 and reviewed a written statement from RN #1 to the state board of nursing. A statement written by the NHA on 9/12/24 dated 9/12/24 documented his conversation via phone with Resident #1. The statement documented Resident #1 was asked if she recalled an incident with RN #1. The resident responded RN #1 had asked her to stop ringing the call light so frequently and had leaned over the bed and spoken loudly to her. Resident #1 reported she did not remember where or why she was at the facility because she had been on strong antibiotics and was having hip issues. Resident #1 said that she currently lived with her representative and had memory issues. According to the written statement, the NHA asked Resident #1 if she had planned to report RN#1 to the state or get her in trouble. Resident #1 indicated that was not her intention and she just wanted to get out of the facility. -The facility's investigation of the incident failed to include additional interviews with other staff members or residents and the incident was not reported to the State Agency (see interviews below). B. Resident #1 1. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged home with her representative on 7/22/24. According to the July 2024 computerized physician's orders (CPO), diagnoses included unilateral primary osteoarthritis, right total hip arthroplasty (hip replacement surgery), depression, unspecified and anxiety disorder. The 7/21/24 nursing admission assessment and functional performance assessment documented the resident was alert and oriented to person, place and time. The resident had limited range of motion of leg including hip and knee, used a walker for mobility and was unable to be evaluated for transfers due to a medical condition or safety concerns. She required substantial to maximum assistance for all other activities of daily living (ADL). The assessment indicated the resident did not have any behavior issues. C. Resident representative interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The resident's representative was interviewed on 10/2/24 at 4:27 p.m. The representative said Resident #1 was admitted to the facility for rehabilitation after a hip surgery. She said the resident arrived at the facility on the afternoon of 7/21/24. She said Resident #1 called her in a panic around 6:00 p.m. (on 7/21/24), because she needed to be repositioned in bed and staff was not answering her call light. The representative said Resident #1 called her again an hour later, still needing assistance.The representative said she called the facility to request assistance for Resident #1. The resident's representative said Resident #1 called her again at approximately 9:00 p.m. (on 7/21/24), when her call light was again not answered for over an hour and she needed to use the bathroom. The representative said she called the facility a second time to request help for Resident #1. The representative said, at 1:21 a.m. on 7/22/24, she received a hysterical phone call from Resident #1. She said the resident was crying and was scared and terrified. She said the resident wanted to call the police. She said Resident #1 told her that RN #1 got into her face, within two inches, and yelled at her to stop using the call light and that she was not allowed to use the call light. The representative said the resident reported RN #1 told her if she continued to use her call light, nobody was going to answer it. The resident's representative said she immediately went to the facility and found Resident #1 scared and terrified and she did not want to stay in the facility. She said because Resident #1 was scared and hysterically crying, she could not leave her at the facility and she took her out of the facility. She said a CNA helped carry the resident's belongings out of the facility and she told the CNA the reason she was taking Resident #1 out of the facility. The representative said the facility wanted her to sign an Against Medical Advice form (AMA), but she refused. The resident's representative said she did not receive any phone calls from the facility after the incident. She said she called the police on 7/22/24 to report the abuse. The representative said the police substantiated the allegation as abuse. D. Police interview The police officer who investigated the incident on 7/22/24 was interviewed on 10/3/24 at 9:56 a.m. The police officer said he was the investigator on the reported abuse of Resident #1. He said the resident had been threatened and yelled at by RN #1 to not use her call light. He said he had attempted to call RN #1 three times during his investigation of the incident and never received a call back. He said,through secondary interviews, he was able to substantiate the abuse and he reported RN #1 to the state board of nursing. E. Staff interviews The NHA and the director of nursing (DON) was interviewed on 10/2/24 at 3:32 p.m The NHA said he did not have a full investigation of abuse involving Resident #1. The DON said he recalled Resident #1 was at the facility for about eight hours and the resident's representative picked her up in the middle of the night. He said the resident's representative requested that CNA #1 help her get the resident into her car. He said while CNA #1 was helping transfer Resident #1 to the representative's car, CNA #1 requested that the representative sign a form to have the resident leave AMA but the representative refused to sign the AMA form. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON said CNA #1 informed him the representative was not happy with RN #1 and her response to Resident #1 using her call light. The DON said a grievance was filed due to the concerns of call light response time. He said a call light tracking was completed as part of the follow-up to the grievance filed. The NHA said he was not employed at the facility in July 2024. However, he said he had received notification from the state board of nursing in regards to RN #1's involvement in an abuse allegation. The NHA said he had not conducted a complete investigation which included other residents and staff or reported the abuse allegation to the State Agency. He said because the state board of nursing letter was on state letterhead, he thought the State Agency was aware of the incident. The NHA said, after receiving the letter, he contacted Resident #1 on 9/12/24 to get information related to the incident. He said the resident said she vaguely recalled the incident. The NHA said he attempted to contact Resident #1's representative twice on 9/12/24 with no response. The corporate consultant (CC) was interviewed on 10/3/24 at 8:49 a.m. The CC said the abuse policy was reviewed with both the NHA and the DON were educated on 10/2/24 (during the survey) regarding how to timely investigate abuse allegations. 51710 III. Incident of verbal abuse between Resident #5 and RN #1 A. Resident #5 1. Resident status Resident #5, age 82, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following unspecified cerebrovascular disease (stroke) affecting the left dominant side. The 8/28/24 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. He required up to two-person assistance with bed mobility, transfers and all ADLs. The assessment indicated the resident did not have any behaviors. B. Resident interview Resident #5 was interviewed on 10/3/24 at 9:30 a.m. Resident #5 said the other night (no date specified) he had his call light on in the evening and he waited for 45 minutes for someone to answer it. He said no one showed up or looked in the door which led to him screaming for help. He said RN #1 came to his room, stood in the doorway and started yelling at him from the door, telling him to shut up and quit calling on his call light. Resident #5 said he had not reported the incident to anyone at the facility. He said the treatment he received from RN #1 made him pissed off that he was treated in this manner. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA was informed of the abuse allegation on 10/3/24 at 10:20 a.m. C. Facility follow-up On 10/3/24 at 11:48 a.m., the NHA provided an update regarding Resident #5's abuse allegation. The NHA said the police were notified of the allegation, the interdisciplinary team (IDT) were conducting staff and resident interviews and RN #1 had been removed from the facility's schedule pending the facility's investigation of the allegation.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 51710 Based on observations, record reviews, and interviews, the facility failed to ensure staffing information was posted in a prominent place, readily accessible to residents and visitors. Specifically, the facility failed to: -Ensure nurse staffing data was posted on a consistent daily basis; -Ensure when nurse staffing data was posted, that it was posted in a prominent location, readily accessible to residents and visitors; and, -Ensure records of nurse staffing data were retained for 18 months. Findings include: I. Observations Observations in the facility on 10/2/24 at 9:55 a.m. revealed that the nurse staffing hours were not posted for the day. Observations in the facility on 10/3/24 at 10:03 a.m. revealed the nurse staffing hours were posted for 10/3/24, however, they were posted behind the main nurse's station and were not easily accessible to residents and visitors. II. Staff interviews The facility's scheduler was interviewed on 10/3/24 at 11:35 a.m. The scheduler said she was responsible for scheduling the nursing staff. She said she was responsible for posting the nurse staffing hours daily and that she was not sure why the nurse staffing hours information had not been posted on 10/2/24. The scheduler clarified the facility's director of nursing (DON) was responsible for posting nurse staffing hours and she was responsible for posting the schedule. The DON was interviewed on 10/3/24 at 1:15 p.m. He said during the week he would print the staffing information and post it, however, for the weekends, he said he would print the nursing staff data and the facility staff were responsible for hanging it. He said the information was not posted on 10/2/24 because he forgot to post it due to the arrival of the survey team. The DON said he did not keep the printed versions or the electronic copies of the nurse staff postings. He said he was not aware copies of the nurse staffing data needed to be retained for 18 months.