STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 51916

Based on observations, record review and interviews, the facility failed to ensure two (#6 and #9) of three residents reviewed for abuse out of 11 sample residents were kept free from abuse.

Specifically, the facility failed to protect Resident #6 and Resident #9 from physical and verbal abuse from Resident #7.

Findings include:

I. Facility policy and procedure

The Abuse policy, dated 5/3/23, was provided by the nursing home administrator (NHA) on 2/11/25 at 5:55 pm. It read in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including other residents. Residents have the right to be free from abuse.

Providing a safe environment for the resident is one of the most basic and essential duties of our facility. Identification of abuse shall be the responsibility of every employee.

Residents at risk for abusive situations are identified and appropriate care plans are developed.

If a resident experiences a behavior change resulting in aggression toward other residents, the community will implement interventions for protection of the alleged assailant and other residents. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse.

If abuse happens, separate the assailant from the victim, isolate the assailant to protect others, assess and treat the victim and notify the abuse coordinator.

II. Incident of physical abuse between Resident #9 and Resident #7 on 10/1/24

A. Facility investigation

(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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(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	The facility's investigation revealed there was a resident to resident altercation between Resident #7 and Resident #9 in the residents' shared room on 10/1/24. Resident #7 became upset when his roommate (Resident #9) called him crazy. Resident #7 punched Resident #9. Resident #9 punched Resident #7 back and they began to hit each other multiple times. Immediately, the residents were separated and Resident #7 was placed on one-to-one supervision with a staff member and a room change for Resident #7 was initiated. Resident #9 was assessed and found to have sustained an abrasion to his right arm and a headache from hitting his head on the door frame. Resident #9 was sent to the hospital for evaluation and further assessment to rule out a head injury. He was sent back to the facility from the hospital with negative results for a head injury. The local police department, the ombudsman, the residents` physicians and both residents` representatives were notified. B. Resident #7 (assailant) 1. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included personal history of traumatic brain injury (TBI), post-traumatic stress disorder unspecified, schizoaffective disorder bipolar type, unspecified intellectual disabilities, nicotine dependence and anxiety disorder. The 1/21/25 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 was able to ambulate independently and required supervised smoking assistance and minimal assistance with personal hygiene. The MDS assessment indicated the resident had hallucinations and delusions but did not exhibit physical or verbal symptoms. 2. Resident observations On 2/11/25 the following was observed: At 11:26 a.m. Resident #7 was sitting in the dining room rocking back and forth in his seat with his head in his hands being closely monitored by a staff member sitting beside him providing one-to-one supervision. At 11:35 a.m. Resident #7 let out a loud noise and stood up telling the staff member I can't be in here anymore and walked towards his room while being followed by the one-to-one supervision staff member. At 4:55 p.m. Resident #7 was pacing the hallway talking to himself and responding to internal stimuli (talking back to voices he was hearing in his head) and singing to himself. 3. Resident 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 #7 was interviewed on 2/11/25 at 4:57 p.m. Resident #7 was exhibiting paranoid behavior and was distracted by internal stimuli during questioning, but remained calm and pleasant. He said he made attempts to prevent altercations by being non-violent. He said staff were sometimes helpful in helping him control his urges. He said the interventions were sometimes helpful. Resident #7 said he was better now than when he had past altercations with other residents and said he tried to avoid the people who caused him problems. 4. Record review The behavior care plan, initiated 10/7/24 and revised 2/2/25, revealed Resident #7 had the potential to be physical toward other residents when he believed another resident had disrespected him and must defend himself. Pertinent interventions included one-on-one monitoring following an occurrence as needed (PRN), administering medications as ordered and documenting and monitoring side effects and effectiveness, reminding Resident #7 to seek out staff support to de-escalate the behavior, monitoring and documenting observed behaviors and attempted interventions PRN, monitoring, documenting and reporting PRN any signs or symptoms of the resident posing a danger to himself or others when Resident #7 became agitated, intervening before agitation escalated, guiding the resident away from the source of distress and engaging him calmly in conversation and if the resident responded aggressively, staff should calmly walk away and approach later. -The resident's behavior care plan was not initiated until 10/7/24, six days after the resident's altercation with Resident #9 (see investigation above). The psychotropic medication care plan, revised 10/3/24, revealed Resident #7 was prescribed antidepressant medication for trouble sleeping, an antihistamine and an anxiolytic medications for anxiety and antipsychotic medication for symptoms and behaviors associated with the diagnosis of schizoaffective disorder bipolar type. Pertinent interventions included monitoring, documenting and reporting changes in behavior, mood or cognition, hallucinations and delusions, monitoring and documenting side effects and efficacy of medications, administering medications as ordered and reviewing alternate therapies attempted and effectiveness. -The resident's psychotropic care plan was not updated with any new interventions after the resident's altercation with Resident #9 on 10/1/24. The auditory hallucinations and delusions care plan, initiated 12/31/24 and revised 2/2/25, revealed Resident #7 paced the halls most of the day, responded to internal stimuli and believed he was part African American and would say the N word as he believed he had a right to do so since it was socially acceptable for African Americans to say it to each other and staff had difficulty redirecting this delusion. Additional pertinent interventions included allowing Resident #7 to express how he felt and what he was talking about, offering psychiatric services and offering to take him out for a cigarette to assist in re-directing him. -The resident's auditory hallucinations and delusions care plan was not initiated until 12/31/24, almost three months after the resident's altercation with Resident #9 (see investigation above) and over a month after the resident's second altercation with Resident #6 (see investigation below). (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A progress note, dated 10/1/24 at 11:53 p.m., documented Resident #7 came out of his room and reported his roommate (Resident #9) was being mean to him and calling him names. Resident #9 then came out of the room and called Resident #7 crazy. Resident #7 told Resident #9 he was not crazy and started hitting Resident #9. The residents continued hitting each other and both residents fell to the floor. The residents were separated and assessed for injury and no injuries were noted.

A nurse progress note, dated 10/3/24 at 10:16 p.m., documented Resident #7 continued to be monitored post physical altercation with another resident. The resident continued to be on one-to-one monitoring.

-There was no further documentation related to the 10/1/24 incident with Resident #9 in Resident #7's electronic medical record (EMR).

C. Resident #9 (victim)

1. Resident status

Resident #9, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included schizophrenia, hypertension, cognitive communication deficit and major depressive disorder, recurrent severe, without psychotic features.

The 12/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The resident was independent for all activities of daily living (ADL).

The MDS assessment indicated the resident was taking antipsychotic and antidepressant medications.

The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.

2. Resident interview

Resident #9 was interviewed on 2/11/25 at 2:30 p.m. Resident #9 said he felt safe in the facility. He said he did not remember the altercation with Resident #7.

3. Record review

The behavior care plan, initiated 10/7/24, revealed Resident #9 had the potential to become verbally and physically aggressive toward other residents and staff members at the facility. He presented anger problems, history of harm to others and poor impulse control. Resident #9 had the potential to become physically aggressive toward other residents when he was physically or verbally instigated by others. Pertinent interventions included administering medications as ordered, monitoring and documenting for side effects and effectiveness, providing physical and verbal cues to alleviate anxiety, giving positive feedback, assisting the resident's verbalization of the source of agitation, assisting the resident to set goals for more pleasant behavior, encouraging the resident to seek out staff members when agitated, offering the resident choices about his care and activities, providing psychiatric consultation, intervening before agitation escalated and guiding Resident #9 away from source of distress and engaging the resident calmly in conversation and walking away if the response was aggressive.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 10/1/24 at 11:05 p.m, revealed a physical altercation occurred between Resident #9 and Resident #7 in the residents' room. The note documented Resident #7 became upset when his roommate (Resident #9) called him crazy and Resident #7 punched Resident #9. Resident #9 punched Resident #7 back and they began to hit each other multiple times. Immediately, the residents were separated and Resident #7 was placed on one-to-one supervision with a staff member and a room change was initiated for Resident #7. Resident #9 was assessed and found to have sustained an abrasion to his right arm and a headache from hitting his head on the door frame. Resident #9 was sent to the hospital for evaluation and assessment to rule out a head injury. He was sent back to the facility from the hospital with negative results for a head injury. Resident #9 felt safe in the facility and continued with his usual activities. He denied feeling fear. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 2/11/25 at 1:30 p.m. CNA #1 said she had not witnessed Resident #7 acting aggressively toward other residents but knew he was capable when triggered. She said he would talk to himself frequently. She said the tone of his voice could sound aggressive and other residents might mistakenly believe Resident #7 was talking to them offensively. CNA #1 was interviewed a second time on 2/11/25 at 4:45p.m. She said she would de-escalate Resident #7 by talking to him in a calm voice. She said she would redirect him by talking to him about a different topic or offer other distractions. She said Resident #7 was able to tell staff if he was being triggered. She said he would ask the CNAs to remove him from the situation before being triggered. She said staff were required to take mandatory online and in-person training on de-escalation of residents. She said her last in-person training was in October 2024. She said she would make behavior notes in residents' EMR which the nurses could see. She said new orders and intervention changes for residents would be sent to staff via text message from management. CNA #2 was interviewed on 2/11/25 at 12:30 p.m. CNA #2 said Resident #7 had frequent mood swings and could show physical and verbal aggression toward others. She said he paced and appeared to be agitated often. She said he often talked to the personalities inside his head. CNA #2 was interviewed a second time on 2/11/25 at 4:45p.m. She said she would approach him in a calm manner during an altercation and would offer choices, such as going outside or going to another area in the facility. She said she would redirect by taking Residen #7 out of the altercation. She said she received mandatory ongoing de-escalation training with computer based training. She said CNAs would chart behavior notes in the residents' EMRs and report the behaviors to the nurse. CNA #2 said interventions or new orders would be communicated from the admission office upon admission and via mass text to staff. III. Incident of physical and verbal abuse of Resident #6 by Resident #7 on 11/20/24 A. Facility investigation The facility's investigation revealed that on 11/20/24 at 5:00 p.m., Resident #7 and Resident #6 were sitting in the dining room. Resident #7 was responding to internal stimuli. Resident #6 thought he was talking to him so he stood holding up a fist. Resident #7 then stood up, held up his fist, said okay and pushed Resident #6 against the wall. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The immediate safety measures put into place to protect Resident #6 included separating the residents from one another, placing each resident on 15-minute checks for 72 hours and on a psychosocial follow up scheduled for one week following the incident. The investigation documented that the police, the residents' representatives, the ombudsman and the residents' physicians were notified. The investigation indicated that Resident #6 was assessed by the licensed practical nurse (LPN) on duty during the incident and he was found to have no pain or sign of injury. Resident #6 was interviewed during the investigation (date and time unknown). Resident #6 said Resident #7 was talking to no one about demons. When Resident #6 told Resident #7 to shut up, Resident #7 then told Resident #6 to shut up twice and asked Resident #6 if he wanted to fight. Resident #6 said Resident #7 got up and put two fists up so Resident #6 got up and put two fists up. Resident #6 said Resident #7 then pushed him and he tripped over his chair backwards and hit the wall. The investigation indicated that Resident #7 was interviewed by management during the investigation (date and time unknown). Resident #7 said Resident #6 said he (Resident #7) was talking to demons. Resident #7 said he told Resident #6 he was not talking to demons. Resident #7 said Resident #6 got up and put two fists up so Resident #7 got up and pushed him. Three resident witnesses of the occurrence were interviewed by management. Witness #1 said she looked up and saw Resident #7 push Resident #6. She said Resident #6 then fell against the wall. Witness #2 said Resident #7 stood up and then Resident #6 stood up. Witness #2 said both residents put two fists up and Resident #7 pushed Resident #6. Witness #3 said Resident #7 and Resident #6 had an argument and Resident #6 fell against the wall. Staff interviews conducted during the investigation revealed that no staff witnessed the occurrence. Record review revealed Resident #7 had a potential to be physical towards other residents when he felt he had been disrespected and had to defend himself. B. Resident #7 (assailant) 1. Record review Review of Resident #7's revealed there were no interventions updated on the resident's behavior, psychotropic medications or auditory hallucinations and delusions care plans following the resident to resident altercation with Resident #6 on 11/20/24 (see investigation above). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 11/20/24 at 6:19 p.m., documented that the nurse was at the nursing station when a concierge ran up saying a nurse was needed in the dining room because Resident #6 and Resident #7 were fighting. The nurse ran to the dining room as the concierge said it was over now. The nurse asked Resident #7 what happened. Resident #7 said he was defending himself because Resident #6 started yelling at him and stood up with his fist in the air, so Resident #7 stood up to defend himself and pushed Resident #6. Staff removed Resident #7 for safety and placed him on 15-minute checks until further notice. Resident #7 was assessed for injury and the nurse found no bruising or signs of injury. The nurse educated Resident #7 on controlling his emotions and physical impulsions and instructed him on walking away and deep breathing exercises. Resident #7 said he understood, although he was just trying to defend himself. He denied feeling fearful towards Resident #6. The nurse notified the manager on call, the physician and the residents' representative. The November 2024 progress notes revealed that one nursing progress note and two alert notes, all dated 11/21/24, were charted in the 72-hour period following the incident with Resident #6. The alert notes documented that the nurse would have the social worker talk with Resident #7. -There were no behavior monitoring notes regarding the incident documented on 11/22/24 or 11/23/24. The November 2024 treatment administration record (TAR) revealed staff failed to document Resident #7's targeted behaviors of anxiety and psychosis on 11/20/24. -However, according to the facility investigation of the incident with Resident #6 on 11/20/24, Resident #7 was exhibiting symptoms of psychosis as evidenced by him responding to internal stimuli (see investigation above). The interdisciplinary team (IDT) risk management review note, dated 11/29/24 at 6:35 a.m., documented that the abuse allegation for the 11/20/24 physical aggression incident was found to be unsubstantiated. -However, abuse occurred because Resident #7 willfully pushed Resident #6 (see investigation above). The behavior note, dated 1/27/25 at 5:57 p.m., revealed Resident #7 had an incident with his roommate following a psychotic episode of loudly responding to stimuli and yelling and using racial slurs. When the roommate responded, Resident #7 began to yell derogatory words louder and more directly. Staff intervened by moving Resident #7 to a new room not far from Resident #6's room. -However, Resident #7 had already had an abuse incident with Resident #6 on 11/20/24 (see investigation above). The behavior note, dated 2/10/25, documented that Resident #7 had an episode of loud yelling and talking to himself, was very restless and refused to talk with the nurse. -The note failed to indicate whether interventions were attempted or if the physician or the social worker were notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/20/24 frequent check form revealed close monitoring of Resident #7 every 15 minutes was conducted between the hours of 5:00 p.m. (prior to the incident) and 12:00 a.m. -The 11/21/24 frequent check form revealed staff failed to closely monitor the resident between the hours of 6:15 a.m. to 9:45 p.m. -The 11/22/24 frequent check form revealed staff failed to closely monitor the resident between the hours of 6:15 a.m to 12:00 a.m. -The facility was unable to provide a frequent check form for 11/23/24. -The facility failed to perform frequent checks on Resident #7 during the 72-hour alert monitoring timeframe following the resident's incident with Resident #6 on 11/20/24. D. Resident #6 (victim) 1. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included psychoactive substance abuse with psychoactive substance-induced psychotic disorder unspecified, antisocial personality disorder, drug-induced subacute dyskinesia (movement disorder that develops over days or weeks after taking certain drugs or medications) and schizophrenia unspecified. The 12/10/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He was independent and required minimal assistance with showers and hygiene. 2. Resident interview Resident #6 was interviewed on 2/11/25 at 1:04 p.m. Resident #6 said that during the incident on 11/20/24 with Resident #7, Resident #7 was running his mouth so he told him to shut up and Resident #7 started calling people names so they got in a fight and he (Resident #6) fell out of his chair. Resident #6 said he felt staff did not handle the situation well because Resident #7 still had the same behaviors. He said Resident #7 was a menace. He said sometimes Resident #7 saw him and apologized and told him he loved him, however, Resident #6 said Resident #7 was dangerous. Resident #6 said it was harder for him to avoid Resident #7 recently because Resident #7 had a fight with his roommate and he now lived upstairs closer to his (Resident #6) room. Resident #6 said he would feel safer if staff managed Resident #7's, and other problematic residents', behaviors better. 3. Record review The nursing progress note, dated 11/20/24 at 10:25 p.m., revealed that the nurse was alerted that a fight broke out in the dining room where she rushed to find Resident #6 sitting at the dining room table with no visible injuries. At that time, Resident #6 said Resident #7 was yelling at him so he had to defend himself. The nurse manager and the physician were notified and both residents were placed on 15-minute checks until further notice. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The November 2024 progress notes revealed one alert note, dated 11/21/24 at 9:15 a.m., was documented following the 11/20/24 incident. -The facility failed to ensure 72-hour follow-up monitoring was documented for Resident #6. E. Staff interviews LPN #1 was interviewed on 2/11/25 at 12:25 p.m. LPN #1 said Resident #7 had been talking to himself and pacing but had not been violent lately. She said if there was a resident-to-resident altercation, she would intervene by separating the residents for safety and notify the administrator, the supervisor and sometimes the police. LPN #1 said Resident #7's behaviors had not changed since he was admitted to the facility. She said when he first admitted to the facility he moved downstairs after an altercation with his roommate, then he was moved upstairs again after another altercation with another roommate. LPN #1 said the staff were offered crisis intervention training frequently in the form of meetings and in-services, but they were not mandatory. She said when management implemented new interventions for new behaviors, staff was notified via group messages. Registered nurse (RN) #1 was interviewed on 2/11/25 at 1:21 p.m. RN #1 said social services and management were highly involved in crisis intervention and prevention training. She said staff were provided mandatory online training that included informative videos on de-escalation and managing difficult resident behaviors. RN #1 said that new or unwanted resident behaviors were charted in the residents' EMR under the task documentation system for CNAs and in the residents' behavior progress notes for nurses. She said behaviors were also documented in a 24-hour nursing report. She said a mass text was sent out to nursing staff by management or social services for residents needing one-to-one supervision or frequent checks. She said behavior notes were mandatory for residents on 15-minute checks. LPN #2 was interviewed on 2/11/25 at 1:38 p.m. LPN #2 said that crisis intervention and prevention training was organized by the NHA. She said when Resident #7 had an altercation with his roommate, staff intervened by separating them, providing one-to-one supervision for him for 72 hours and placing the residents involved on frequent 15-minute checks for 72 hours. She said Resident #7 had had several resident to resident altercations and the same interventions were put into place. She said that Resident #7 was usually easily redirected and he liked snacks. She said he talked to himself and he paced a lot. LPN #2 said at one time, Resident #7 was attending a day program but had to stop going due to his behaviors and the facility was working on a new plan for him because he liked to socialize. The social services director (SSD) was interviewed on 2/11/25 at 3:42 p.m. The SSD said residents' behavior interventions were to be documented in care plans and progress notes and were updated based on whether staff had found new effective interventions or when there was an incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said interventions implemented for verbally and physically aggressive behaviors included redirecting and relocating the resident, ensuring safety and communicating with the resident to find the root of the problem. She said following Resident #7's incident with Resident #6, the police were notified but the facility did not send him out to the hospital as he was not a threat to himself or others at the time. The SSD said to keep other residents safe when Resident #7 experienced an episode of aggression, staff coordinated a room change and provided one-to-one supervision, frequent checks and medication review. She emphasized that he was usually very sweet, he just had mental anguish and got very upset at times. She said Resident #7's behaviors were not a daily concern and they were not unprovoked. The NHA was interviewed on 2/11/25 at 3:42 p.m. The NHA said staff huddles at nursing stations were implemented in 2024 and were intended to highlight residents' targeted behaviors and other pertinent incidents and changes in condition. She said a binder on huddle discussions was available at the nursing station for staff to review. The NHA said interventions for targeted behaviors were put into place by the director of nursing (DON) and the nurses and they were to be documented in the treatment administration record (TAR). The NHA said in the event of physical or verbal aggression, staff would move the resident to a new room, if deemed necessary, and conduct frequent 15-minute checks and one-to-one supervision would be implemented. The NHA said she was working on getting crisis prevention intervention (CPI) training for all staff. She said staff had monthly meetings, including how to manage verbally and physically aggressive behaviors, and said she felt staff were sufficiently trained on the subject. She said the training was also provided at the annual skilled nursing facility (SNF) competency training, as well as in verbal and written education materials. The NHA said staff was last trained on TBI behavior management around November 2024. She said Resident #7 had auditory hallucinations and responded to internal stimuli frequently. She said he would often go into the bathroom to yell, wander the halls and talk to himself. She said he would let staff know if he felt troubled by his mental state and needed to go to the hospital. She said a very effective de-escalation intervention was to take Resident #7 on walks or to smoke a cigarette. The NHA said Resident #7 often used derogatory language when responding to internal stimuli and this had been ongoing since he was first admitted to the facility. She said the care plan reflected his belief that he was half African American and felt he had the right to use the N word. The NHA said the intervention for Resident #7, after the incident with Resident #6, was to speak with staff regarding his concerns and place both residents on frequent checks. She said she was under the impression that Resident #6 was the assailant and Resident #7 was the victim in the incident. The NHA said, after the most recent incident involving Resident #7 on 1/27/25, Resident #7 was placed on one-to-one supervision with a staff member for 24 hours and relocated to a room upstairs. She said she did not acknowledge Resident #6 as the victim in the 11/20/24 occurrence. The NHA said she did not have any concerns about Resident #6 or Resident #7's safety, even though their rooms were now in closer proximity. (continued on next page)

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	065323	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	52094

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being for one (#1) of two residents reviewed out of 11 sample residents. Specifically, the facility failed to implement person centered interventions to address Resident #1's pattern of escalating behaviors. Findings include: I. Facility policy and procedure The Behavior Monitoring policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 2/11/25 at 4:23 p.m. It read in pertinent part, The purpose of behavior monitoring is to establish an accurate pattern of resident targeted behaviors as determined by the resident's history, evaluation, assessment. The goal is to determine appropriate behavior interventions such as counseling, behavior management plan including non-pharmacological interventions, and psychoactive medication management. When a resident displays targeted and/or inappropriate behavior, facility staff will implement behavioral interventions to assure the safety of the resident and/or other residents and staff/visitors. The behavior monitoring records of those residents under review will be discussed at the psychotropic drug committee for review and recommendations. IDT (interdisciplinary) members and/or designee will review behavior monitoring daily and as needed to follow up on any changes in behaviors. II. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), the diagnoses included traumatic brain injury, mood disorder and mild cognitive impairment. The 12/20/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) score of 15 out of 15. He required moderate to extensive assistance with dressing, bathing, transfers, and bed mobility. He used a wheelchair for ambulation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident had behaviors of physical and verbal aggression directed towards others. The MDS assessment indicated the resident did not experience hallucinations or delusions. The MDS assessment indicated the resident participated in the discharge assessment and there was no active discharge plan for the resident. B. Resident interview and observations Resident #1 was interviewed on 2/11/25 at 2:30 p.m. He said he did not recall any physical altercations between himself and other residents. Resident #1 said he struggled with anxiety and anger. Resident #1 said he had been in the facility for close to a year but did not feel the facility tried to understand his brain injury. He said the facility did not do anything to work with him regarding his brain injury or provide any type of rehabilitation for him to become more cognitively independent. Resident #1 said he would like to go to a facility that specialized in the care of brain injuries but no one at the facility has talked to him about helping locate a different facility. He said he had a difficult time with the other residents who suffer from mental illness and it was hard for him to handle being around them. He said he expressed this frustration with anger. C. Record review The social services care plan, revised 9/3/24, revealed the resident exhibited behaviors of cursing and yelling at staff and peers, name calling, and poor money management with the potential to be reduced with the implementation of a positive reinforcement/incentive program. The care plan documented therapy, social services, and activities would work with the resident on implementation of a reinforcement/incentive program utilizing cigarettes and lottery tickets to reward positive behavior. Interventions included providing consistent reinforcement and incentives to maintain motivation (initiated 6/27/24), regularly assessing progress towards goals and the effectiveness of reinforcement strategies (initiated 6/27/24), adapting reinforcement strategies to accommodate individual preferences and learning styles (initiated 6/27/24), being open to adjusting the resident's goals and incentives based on progress (initiated 6/27/24) and breaking down larger goals into smaller more manageable milestones (initiated 6/27/24). The psychosocial care plan, revised 10/6/24, revealed the resident exhibited behaviors of verbal and physical aggression towards others, displayed as the use of racial slurs, verbal aggression, spitting and striking out physically at others. The care plan indicated the residents identified triggers included: feeling the staff were not moving fast enough, believing others had wronged him and when he or his wheelchair were accidentally touched. Interventions included allowing the resident to verbalize his frustration (initiated 7/7/24), educating the resident on what is appropriate behavior (initiated 7/7/24), completing a medication review requested by the pharmacist and the medical director (initiated 9/6/24), reminding the resident to verbalize his dislike of being moved without his permission to avoid physical aggression (initiated 10/6/24), setting clear and strict boundaries (initiated 7/7/24) and weekly follow ups from the NHA/IDT team following an occurrence (initiated 9/6/24). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavior care plan, revised 2/5/25, revealed the resident had the potential to be verbally and physically aggression related to poor impulse control and a traumatic brain injury. The care plan indicated the resident would swing at other residents, use derogatory language and spit at the staff. Interventions included administering medications as ordered (initiated 6/27/24), analyzing key times, places, circumstances, triggers, and what de-escalated the resident's behavior and document this (initiated 6/27/24), assessing the resident's coping skills and support systems (initiated 6/27/24), assessing the resident's understanding of the situation (initiated 6/27/24), behavior monitoring (initiated 6/27/24), providing positive feedback for good behavior (initiated 6/27/24) and intervening before agitation escalates when the resident becomes agitated escalates (initiated 6/27/24). The discharge care plan, revised 6/27/24, revealed the resident would remain in the facility for long term care related to a history of a traumatic brain injury. Interventions included discussing the resident's current living arrangement and desire for discharge to the community with the power of attorney/family periodically or as needed (initiated 6/18/24). -The facility failed to update the care plan to include person centered interventions to address the residents escalated behavior after resident to resident altercations on 9/29/24, 10/14/24, 10/18/24, 11/2/24, 11/13/24 and 2/1/25 (see record review below). The February 2025 CPO revealed the following physician's orders: -Behavior monitoring for behaviors of hallucinations/expressing delusions, verbal/physical aggression, and hypersexualized comments, ordered on 8/16/24. A review of the monthly psychoactive pharmacological meeting notes from 9/15/24 to 1/27/25 did not reveal the resident's behaviors were reviewed or interventions were implemented to address the resident's aggressive behaviors. A review of the progress notes in resident's electronic medical record (EMR) from 9/29/24 to 2/10/25 revealed documented behaviors of verbal or physical aggression towards others occurred on 9/29/24, 10/1/24, 11/14/24, 11/17/24, 11/18/24, 11/19/24, 12/2/24, 12/23/24 and 1/26/25. -There were no descriptions of the non-pharmological interventions that had been tried to address the behaviors or if the interventions were effective in the resident's progress notes. The NHA provided the facility's investigations of the resident to resident altercations pertaining to Resident #1 on 2/11/25 at approximately 11:00 a.m. A review of the investigations revealed the following: The 9/29/24 incident revealed Resident #1 and Resident #11 were arguing. Resident #1 attempted to spit in Resident #11's face. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included providing education to Resident #11 to talk to staff if she was having problems with another resident. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/29/24 incident revealed Resident #2 tried to move Resident #1's wheelchair out of the walkway and Resident #1 hit him in the stomach. Resident #2 responded by hitting Resident #1 in the back. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included reminding Resident #1 to verbalize his dislike for being moved without his permission to avoid physical aggression. The 10/14/24 incident revealed Resident #1 believed Resident #4 was trying to cut in line to go into the social services office and Resident #1 attempted to hit Resident #4. When he was unable to hit him, Resident #1 kicked Resident #4's wheelchair. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included putting Resident #1 on frequent checks, reviewing his behaviors and medications in the monthly psychoactive pharmacological meeting and continuing to seek alternative placement for Resident #1 due to increasing behaviors. The 10/18/24 incident revealed Resident #3 accidentally cut in line in front of Resident #1. Resident #1 cursed at him and kicked him in the leg. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included putting Resident #1 on frequent checks, reviewing his behaviors and medications in the monthly psychoactive pharmacological meeting and to continue to seek alternative placement for Resident #1 due to increasing behaviors. -However, frequent checks and reviewing medications were existing implemented interventions. Upon record review, there was no evidence the facility made efforts to find alternative placement. The 11/2/24 incident revealed Resident #4 was passing Resident #1's wheelchair and Resident #1 became upset. Resident #1 began to hit Resident #4 in the arm and Resident #4 attempted to hit him in return. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included putting Resident #1 on frequent checks for 72 hours and for the psychoactive pharmacological team to review medications and behaviors during monthly meetings. -However, frequent checks and reviewing medications were existing implemented interventions. The 11/13/24 incident revealed Resident #1 hit Resident #5 in the face after cutting in front of Resident #5 in line and Resident #5 attempting to hit him. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included putting Resident #1 on 15 minute checks for 72 hours and for the psychoactive pharmacological team to review medications and behaviors during monthly meetings. However, frequent checks and reviewing medications were existing implemented interventions. The 2/1/25 incident revealed Resident #10 was trying to pass Resident #1 to exit the smoking area and accidentally hit his wheelchair with hers. Resident #1 hit Resident #10 in the left arm twice. Both residents were separated with no injuries reported. Interventions put into place to prevent a recurrence included putting both residents involved on 15-minute checks and escorting Resident #1 to and from the smoking area. -However, review of Resident #1's comprehensive care plan did not reveal the intervention of escorting Resident #1 to and from the smoking area (see care plan above). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #1's EMR did not reveal any psychological and psychiatric behavior health provider notes. -Review of the resident's medication administration records (MAR) and treatment administration records (TAR) from 9/1/24 to 2/10/25 did not reveal any behaviors had been documented. III. Additional resident interview Resident #10 was interviewed on 2/11/25 at 2:19 PM. Resident #10 said the incident between herself and Resident #1 happened so fast she did not even see it coming. She said it occurred outside of the facility in the designated smoking area. She said she had tried to go past Resident #1 to get back into the facility and he reached out and hit her in the arm. She said she now tried to avoid him and not go out to smoke when he was out there. She said she had not seen the staff do anything different with Resident #1 in regards to his escalating behaviors. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/11/25 at 12:25 p.m. LPN #1 said if there was an incident between two residents, she would separate them, call the NHA, the SSD, her supervisor and the police. She said when a resident had behaviors, she would chart in the behavior progress notes. LPN #1 said if the IDT team put new interventions in place to address a resident's behaviors, the staff were notified in the twice weekly huddles. LPN #1 said Resident #1 displayed behaviors such as arguing with other residents, yelling at others who walked past him and demanding the staff's attention. LPN #1 said the staff redirected the resident when he had these behaviors. Certified nurse aide (CNA) #2 was interviewed on 2/1/25 at 1:00 p.m. CNA #2 said Resident #1 had behaviors of demanding staff attention and becoming impatient with the staff. CNA #2 said these behaviors could trigger physical and verbal aggression from the resident. She said the interventions the CNAs tried were to speak to him in a calm voice or offer him a soda. CNA #2 was interviewed on 2/1/25 at 1:15 p.m. She said Resident #1 was inpatient and was physically aggressive. She said the interventions she tried with the resident were to speak in a calm voice, remove him from the situation or redirect him to an activity. Registered nurse (RN) #1 was interviewed on 2/11/25 at 1:21 p.m. She said Resident #1 expressed behaviors when he did not get his way, such as being told he had to wait for staff assistance. She said this would trigger him to become verbally and physically aggressive. She said the resident would apologize sometimes and acknowledge his behavior was inappropriate. She said the staff attempted to redirect Resident #1 and would try to resolve the concern he had. RN #1 said the CNAs charted behaviors in the CNA electronic charting system and the nurses charted behaviors in the progress notes. She said if the IDT team put a new intervention into place, the nurses were notified via text message. LPN #2 was interviewed on 2/11/25 at 1:38 p.m. She said Resident #1 had behaviors of attention seeking and using his call light frequently for staff attention. She said he was verbally and physically abusive towards the staff, so the staff had to provide care in pairs (two people providing care at all times). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, review of Resident #1's comprehensive care plan did not identify the intervention of cares in pairs. LPN #2 said the interventions for Resident #1's behavior included redirection. She said his behaviors were documented on the behavior tracking order in the TAR. She said when new interventions were implemented, the management team put an alert into the EMR to alert the nurses. RN #2 was interviewed on 2/11/25 at 2:46 p.m. She said Resident #1 had behaviors of lashing out at other residents and staff and becoming physically aggressive. She said Resident #1 was triggered when other residents or staff were in his personal space when he would prefer they not be. She said the non-pharmological interventions for his behaviors consisted of assisting him back and forth to the smoking area and providing care in pairs. However, review of Resident #1's comprehensive care plan did not identify the intervention of cares in pairs or escorting the resident back and forth to the smoking area. She said when the resident displayed behaviors, the nurse wrote a progress note, as well as documented the behavior on his behavior tracking order in the TAR. RN #2 said she was not sure why there was no documentation on the resident's behavior sheet on the TAR from 9/1/24 to 2/11/25. She said she had access to view the resident's care plans but she did not look at the care plan for target behaviors or non-pharmacological interventions. She said the nurses got their information regarding behaviors and interventions from the behavior tracking order and verbal instructions from the administration. RN #2 said the CNAs did not have access to view the resident's care plans. The social services director (SSD) and the NHA were interviewed together on 2/11/25 at 3:45 p.m. The SSD said she expected nursing staff to document the resident's behaviors in a progress note and to let social services know if there were behavior concerns. The SSD said the IDT team also conducted twice a week huddles at each nursing station to address any concerns the staff had with any of the departments. She said this meeting included discussing behavioral issues with residents. The SSD said there was a behavior tracking order on Resident #1's TAR. She said the behavior tracking order included the behaviors the nurses were to observe for and the non-pharmological interventions the nurses were to attempt. She said the nurses could either document behaviors on the TAR or in the progress notes. She said the CNA's documented behaviors on their task sheet in their own electronic system which was separate from the nurses. She said if there were specific interventions the SSD wanted the staff to try with the resident, she would tell the staff during a huddle or the IDT would send out a text message to the staff. She said all updated behaviors and interventions were included in the resident's care plan which the staff, including the CNAs, had access to review. The SSD said when a resident had a change in condition regarding behaviors or non-pharmological interventions, the staff provided feedback on interventions they had tried, or there was an occurrence involving a resident it would trigger an update to the resident's behavior tracking order and care plan. She said if a resident was having behaviors of physical or verbal aggression towards others some of the behavior interventions that would be tried would be redirection, changing the environment, determining the psychosocial trigger, frequent checks, and one-on-one supervision. The SSD said r Resident #1 displayed impulsive reactions when feeling strong emotions such as anger or frustration. She said the resident had a short temper and if another resident bumped into him or his wheelchair, he would respond immediately and could become verbally and physically aggressive. (continued on next page)

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F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The SSD said the IDT reviewed the resident in the psychoactive pharmacology monthly meeting. She said during the meeting, the residents' behaviors and occurrences were discussed as well as reviewing medication changes and behavior interventions for efficacy. The SSD said she was not aware these meetings were not documented. The SSD said some of the interventions tried with Resident #1 included monitoring him when he went back and forth to the smoking area and moving his room to a calmer and quieter area of the building without the disruptions of other residents coming and going from the smoking area. She said additional interventions included locating a facility specializing in traumatic brain injuries for Resident #1. The SSD said she had sent out several referrals but had not had facilities show interest due to the aggressive behaviors. She said her efforts to find him placement were documented in the progress notes as well as on paper documentation within her office.

She said when Resident #1 began displaying behaviors of verbal and physical aggression, the staff tried to redirect him from the environment and would try talking to him about his feelings. The SSD said Resident #1 could show insight into his behavior at times. She said the resident had told her he was not always the way he was currently, as far as his behaviors in relation to his traumatic brain injury. She said he currently saw the facility's psychological and psychiatric behavior health provider and that was documented in his progress notes.

-However, review of Resident #1's EMR did not reveal documentation that the resident was seen by the behavior

health provider (see record review above).

The NHA said the facility kept other residents safe from Resident #1's behaviors by monitoring Resident #1 to ensure he did not get too physically close to other residents, initiating room changes if necessary, reviewing his medications and behaviors in the psychoactive pharmacological meeting and discussing new interventions with the care staff in the huddles. She said the expectation of the nursing staff was to either document the resident behaviors on the behavior tracking order on the TAR or to make a progress note in the chart. The NHA said the progress note included the same information found on the behavior tracking order such as non-pharmological interventions the staff were to use and whether the interventions were effective or not. The NHA said she was unsure why the behavior progress notes did not include the intervention attempted to address Resident #1's behaviors or the effectiveness of the non-pharmalogical intervention.

The NHA said whenever the facility developed new interventions for Resident #1, the interventions were added to his care plan and the care plan was updated after every occurrence the resident was involved in.

-However, review of Resident #1's comprehensive care plan did not reveal new person centered interventions to address the resident's aggressive behaviors after the 10/14/24, 10/18/24, 11/2/24, 11/13/24 and 2/1/25 resident to resident altercations (see record review above).

The NHA said the behavior care plan was updated after the resident to resident altercations.

-However the updates made were to the focus behaviors and there had been no updates to the interventions since initiated on 6/27/24.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said she reviewed the resident to resident altercations involving Resident #1. She acknowledged the facility implemented the same interventions that were put into place to prevent a recurrence on several occasions and were not person centered. V. Facility follow up The NHA provided documentation of one psychological visit note for Resident #1 on 2/11/25 at approximately 4:45 p.m. The note was dated 9/18/24 and revealed the resident had been discharged from services on 9/11/24 due to verbally aggressive behaviors during the therapist. The NHA said the psychological provider said the facility could attempt to put him back on services, but from 9/11/24 to 2/11/25 (the time of the survey) the resident was not receiving psychological services. No additional psychiatric visit notes were provided. The NHA provided documentation on 2/11/25 at approximately 4:45 p.m. that indicated the SSD had sent out referrals to 22 other skilled nursing facilities on 9/7/24 with six denials and sixteen facilities not responded. There were no additional documented efforts to find alternative placement provided by the NHA or SSD. -However, review of Resident #1's EMR did not reveal any other evidence of efforts to find alternative placement or a specialized facility for Resident #1 was provided (see record review above).