STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065345	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on observations, record review and interviews, the facility failed to ensure residents had the right to a dignified existence for one (#6) of three residents out of seven sample residents. Specifically, the facility failed to ensure Resident #6 experienced a dignified learning experience when certified nurse aide (CNA) #1 provided inappropriate redirection to the resident after the resident spilled a drink. Findings include: I. Resident #6 A. Resident status Resident #6, age 70, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included unspecified dementia, severe with mood disturbances and Parkinson's disease. The 4/17/25 minimum data set (MDS) assessment revealed the resident was unable to participate in the brief interview for mental status (BIMS) assessment. Per the staff assessment for mental status, the resident had short-term and long-term memory impairment and required substantial assistance with decisions regarding tasks of daily life. The MDS assessment revealed the resident did not display physical behaviors directed towards others. B. Resident observation On 4/29/25 at 12:55 p.m., during observation of the lunch meal service, Resident #6 got up from her dining room chair and walked to the food preparation counter located within the common area space on the unit. Resident #6 spilled a glass of clear liquid, either juice or water, that was on the counter. CNA #1 approached Resident #6 from behind. Without saying anything to the resident, CNA #1 placed both hands under the resident's armpits and physically redirected Resident #6 away from the area. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA #1 did not provide any verbal explanation, reassurance, or calming interaction to support the resident during this redirection. -CNA #1 did not implement the person-centered redirection strategies as outlined in the resident's care plan (see record review below). C. Record review Resident #6's communication care plan, revised 3/16/25, revealed the resident had impaired communication related to dementia and primarily spoke Vietnamese. Interventions included providing verbal redirection and allowing adequate time for the resident to respond, repeating statements as necessary, not rushing the resident to respond to verbal cues, facing the resident while speaking, reducing environmental noise and using simple and consistent words. Resident #6's behavior care plan, revised 4/21/25, revealed the resident had impaired cognitive functioning related to dementia, with non-aggressive behaviors, such as pacing, wandering and placing non-food objects in the mouth, as reported by family. Interventions included explaining all procedures before starting a care task, allowing the resident time to adjust to changes, intervening to protect the rights and safety of others, speaking to the resident in a calm manner, redirecting the resident to a safe alternate location as needed, and minimizing disruptive behavior and offering activities and tasks that diverted the resident's attention. Resident #6's cognition care plan, revised 4/21/25, revealed the resident had impaired cognitive functioning related to dementia and senile degeneration of the brain. Interventions included providing verbal and visual cues to support recall and orientation, reorienting the resident as appropriate and supervising tasks of daily life. -Review of the comprehensive care plan revealed that physical redirection was not included as an intervention approach. -Despite the development of the person-centered care plan interventions for Resident #6, CNA #1 failed to implement any of the interventions when the resident spilled water on the kitchen counter. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/30/25 at 8:47 a.m. LPN #1 said she observed CNA #1 attempt to stop Resident #6 after the resident spilled her drink by grabbing her under the arms and physically redirecting her. LPN #1 said CNA #1 should have provided the resident with verbal redirection instead. LPN #1 said she pulled CNA #1 aside afterward and told her to be more careful and advised CNA #1 that next time she should reach for the cup rather than the resident. LPN #1 explained that the facility expected staff to use verbal redirection or offer comforting objects such as a baby doll to effectively redirect residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/30/25 at 4:19 p.m. The DON said CNA #1 told her that Resident #6 was pouring water onto food and that she reacted by moving the resident's arm down to stop her. The DON said Resident #6 had a history of pouring hot liquids, such as soup, and staff were expected to respond quickly out of concern for her safety. The DON said the reaction of CNA #1 was not well thought through but was a reflex due to the resident's unpredictable behavior. The DON acknowledged that CNA #1's actions were inappropriate, but she said they were not intentional. The DON said staff received education on how to respond to potentially dangerous resident behavior while still acting appropriately as a caregiver. The DON said she planned to provide additional education to CNA #1 regarding appropriate redirection of residents.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received appropriate treatment and services to maintain personal hygiene for two (#7 and #3) of three residents reviewed for ADLs out of seven sample residents. Specifically, the facility failed to offer toileting or timely incontinence care for Resident #7 and Resident #3. Findings include: I. Facility policy and procedure The Urinary Management (UM) policy, dated December 2024, was provided by the nursing home administrator (NHA) on 4/30/25 at 7:03 p.m. It read in pertinent part, The facility will manage urinary incontinence as part of the person-centered resident care. Treatment for urinary incontinence depends on the type of incontinence, its causes, and the capabilities of the resident. A comprehensive assessment will be completed upon move-in, change of condition and annually to determine diagnosis or reason for incontinence. Residents will be monitored through the standard MDS/RAI (minimum data set /resident assessment instrument) process. If incontinence is identified and based on the type of incontinence, a care plan will be written for incontinent residents, utilizing the appropriate interventions to achieve or maintain as much as normal urinary function as possible. The interdisciplinary team (IDT) will determine if the resident is appropriate for a bladder re-training program or a toileting schedule following a review of the three-day data collection, assessment, and cognitive status of the resident. The care plan will be updated and communicated to the nursing associates if there are any suggested toileting plans for the resident based upon the information obtained from the data collection and assessment. A resident with or without a catheter receives the appropriate care and services to prevent infections to the greatest extent possible. II. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and dementia. The 4/14/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to participate in the brief interview for mental status (BIMS) assessment. Per the staff assessment for mental status, the resident was unable to make decisions regarding tasks of daily life.The resident was dependent on one staff member for assistance with eating, oral care, personal hygiene, toileting, bathing, dressing and transferring. B. Observations (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 4/30/25, beginning at 8:25 a.m. and ending at 12:30 p.m., the following was observed: At 8:25 a.m. Resident #7 was eating breakfast in the dining room, where she was assisted with eating and hydration. At 10:24 a.m. Resident #7 finished her breakfast and an unidentified staff member wheeled her from the dining room to the common area. -The unidentified staff member did not check the resident for incontinence or provide toileting assistance to the resident before placing the resident in the common area. At 11:46 a.m. the resident's hospice aide (HA) arrived and wheeled her from the common area to the spa room for a shower. -Per staff interview, Resident #7 was provided incontinent care at 7:45 a.m., four hours prior to the HA taking the resident for a shower (see certified nurse aide (CNA) #2's interview below). C. Record review Resident #7's bladder incontinence care plan, revised 2/16/24, revealed the resident had bladder incontinence and was at risk for falls, skin irritation, moisture-associated skin damage (MASD), urinary tract infections (UTI), social isolation, embarrassment, curtailment of fluids and reduced activity participation. Interventions included observing and reporting any potential causes of incontinence, such as bladder infection, constipation, loss of bladder tone, weakening of control muscles and decreased bladder capacity. Staff were directed to observe and document signs and symptoms of UTI, including pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, fever, chills, urinary frequency, foul-smelling urine, altered mental status or changes in behavior or eating patterns. Resident #7's activities of daily living (ADL) care plan, revised 2/9/23, revealed the resident had a self-care performance deficit related to muscle weakness from Alzheimer's disease with late onset. Interventions included assisting the resident with toileting throughout the day and always upon rising in the morning. Resident #7's skin care plan, revised 4/21/25, documented the resident was at risk for pressure ulcers related to bladder and bowel incontinence, fragile skin, limited mobility, and low body mass index (BMI). D. Staff interviews The HA was interviewed on 4/30/25 at 12:10 p.m. The HA said she worked for Resident #7's hospice services provider, not the facility, and came to the facility twice a week to provide the resident with showers. The HA said when she changed Resident #7's incontinence brief, the resident was soiled with urine and had a small red area near her tailbone that was not open. The HA said she applied barrier cream to the reddened area. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #2 was interviewed on 4/30/25 at 12:26 p.m. CNA #2 said she was aware of the expectation to provide incontinence care and change a resident's brief every two hours. She said she typically provided incontinence care for Resident #7 in the morning when the resident got up, after breakfast, after lunch and before dinner. CNA #2 said today (4/30/25) the resident got up sometime between 7:00 a.m. and 8:00 a.m. and she changed the resident's briefs around 7:45 a.m. She said she intended to change Resident #7 again after breakfast but decided not to because the HA was scheduled to arrive and provide care. CNA #2 said, based on her experience, the resident typically did not get very wet and usually did not require frequent changes. She said that during the 7:45 a.m. change, the resident's incontinence brief was damp with urine, but not heavily soiled, and there was no bowel movement. -Resident #7 was not offered or provided with incontinence care or toileting assistance for four hours (see observation above). The director of nursing (DON) was interviewed on 4/30/25 at 4:19 p.m. The DON said incontinence care was provided on an as-needed basis, with general expectations that day shift staff provide a resident's incontinence care or toileting assistance when getting a resident up out of bed, between breakfast and lunch and again between lunch and dinner. She said staff were expected to offer care assistance when checking on a resident. The DON said it was important for nursing staff to follow the facility's rigorous skin check process and monitor residents closely for skin concerns. The DON said Resident #7 could not tell staff when she needed to be changed and said that the presence of redness near the tailbone would require increased monitoring and potentially more frequent changes. 52094 III. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included Parkinsonism, neurogenic bladder and chronic pain. The 2/10/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required assistance with all of her ADLs and was on a urinary and bowel toileting program. She was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS assessment indicated the resident was dependent on staff assistance for toileting hygiene. B. Observations and interviews During a continuous observation on 4/30/25, beginning at 8:00 a.m. and ending at 11:30 a.m., the following was observed: At 8:00 a.m., Resident #3 was lying in her bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:30 a.m. CNA #4 brought breakfast to the resident. CNA #4 placed the meal on the over-the-bed table in front of Resident #3, uncovered the meal and left the resident without asking her if she needed any care assistance or incontinence care. Resident #3 started eating her meal as CNA #4 left the room. At 9:30 a.m. CNA #4 entered the resident's room a second time to retrieve the resident's meal tray. CNA #4 asked Resident #3 if she wanted to get up. Resident #3 said no. CNA #4 left the resident's room and did not check the resident's brief or ask her if she needed to be changed or toileted. CNA #4 was interviewed on 4/30/25 at 9:32 a.m. CNA #4 said that the morning shift CNA told her Resident #3 was last changed around 5:00 a.m. (on 4/30/25).CNA #4 said the day shift was running behind in providing care for residents and she had not had enough time to change Resident #3 yet because her morning was so busy with other tasks. She said she thought that Resident #3 would use her call light if she needed to be changed. CNA #4 said she was familiar enough with Resident #3 that she knew when she needed to be changed. CNA #4 said she usually changed the resident before breakfast and after lunch. At 10:40 a.m. CNA #4 and a hospice nurse entered Resident #3's room. Resident #3 was found to be soiled with urine and CNA #4 and the hospice nurse proceeded to change the resident's wet incontinence brief while she remained in bed. The soiled incontinence brief was wet and heavy and it made a thudding sound when it was thrown in the trash can. Resident #3 was interviewed on 4/30/25 at 2:00 p.m. Resident #3 said she was wet (soiled with urine) but she was not sure how long she had been wet. She said she needed the staff's assistance with getting cleaned up and changed. Resident #3 said she would press the call light when she needed to be changed. She did not mention having a whistle to call for staff assistance (see DON interview below). Resident #3 attempted to press her call light, but she did not have the strength to fully press and activate the call light. At 2:20 p.m. CNA #5 entered Resident #3`s room. Resident #3 asked for water and CNA #5 assisted her. The resident did not ask CNA #5 for assistance with incontinence care and CNA #5 did not ask the resident if she needed to be changed or toileted before exiting the resident's room. C. Resident's representative interview Resident #3's representative was interviewed on 4/29/25 at 2:45 p.m. Resident #3's representative said Resident #3 had some continence ability and was able to get up and sit on the toilet with assistance and a Hoyer lift. However, she said because the resident was dependent on staff to complete toileting tasks, she wore an incontinence brief in case she was unable to wait for staff assistance. The representative said a CNA told her it was easier on the staff if residents urinated into their briefs and then staff changed them in their beds. The representative did not remember which CNA had told her that. D. Record review (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Bowel and Bladder Elimination record from 4/29/25 to 4/30/25 was reviewed on 4/30/25 at 10:03 a.m. The record revealed that the last recorded toileting assistance was provided for Resident #3 on 4/30/25 at 5:03 a.m. for urinary incontinence. Review of Resident #3's progress notes between 3/25/25 and 4/30/25 revealed there was no documentation to indicate that Resident #3 refused incontinence care assistance from staff. E. Staff Interviews Licensed practical nurse (LPN) #2 was interviewed on 4/30/25 at 11:30 a.m. LPN #2 said it was the CNAs responsibility to check and change residents. She said CNAs recorded incontinence brief changes in the electronic medical record (EMR) for the nurses to reference. She said the CNAs gave verbal reports to each other at shift change so they would be aware of any resident needs. She said the CNAs knew the residents well enough to know when they needed to be changed, but she said staff should ask residents before and after meals if they needed to get cleaned up or get changed. LPN #2 said the general rule was for CNAs to check a resident every two to three hours and assist them with toileting or brief changes when needed. LPN #2 looked at Resident #3's Bowel and Bladder Elimination records and found said Resident #3 had last been changed at 5:03 a.m. that morning (4/30/25). The assistant director of nursing (ADON) was interviewed on 4/30/25 at approximately 3:00 p.m. The ADON said she had met with Resident #3 and asked her about the timing of her care this morning (4/30/25). She said Resident#3 told her she had not been changed before breakfast (see observation above). The DON was interviewed on 4/30/25 at 4:33 p.m. The DON said Resident #3 would call for staff assistance if she needed help. She said the resident was having difficulty with the call button so they had provided her with a whistle to call staff if she was unable to use the call light button. The DON said the resident had both the call button and the whistle because she sometimes forgot she had the whistle. The DON said a lot of residents in the facility had mixed incontinence and sometimes knew when they had to go to the bathroom and sometimes did not know they had to go and experienced incontinent episodes. She said Resident #3 did not always know when she had to go to the bathroom and was occasionally incontinent. The DON said for residents with mixed incontinence, the checking frequency could appropriately be every four hours because they sometimes were able to recognize they needed to be changed and could call for staff assistance. The DON said the CNAs knew the residents well enough to know how often to check on them for toileting or incontinence care. As a practice, she said the overnight staff should be toileting the residents between 9:00 p. m. and 6:00 a.m. and the day and evening shifts should check and change the residents before and after meals. -However, observations revealed staff did not offer toileting or incontinence care to Resident #3 for two hours and 40 minutes, even though she had not been toileted or provided incontinence care prior to breakfast (see observations above). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Additionally, record review and interviews revealed Resident #3 had not been changed or toileted from 5:03 a.m. until 10:40 a.m. (a period of five hours and seven minutes) when the hospice nurse and CNA #4 provided the resident with incontinence care (see record review and CNA #4's interview above).