STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065380	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Community Living Center at Fitzsimons	1919 Quentin St Aurora, CO 80045

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** 48114 Based on observations, record review and interviews, the facility failed to promote and maintain the resident's dignity for one (#65) of one resident reviewed for dignity and respect out of 45 sample residents. Specifically, the facility failed to ensure call light was in reach for Resident #65's use with limited range of motion. Findings include: I. Resident #65 A. Resident status Resident #65, age greater 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and neurocognitive disorder with lewy bodies (a brain disorder that can lead to problems with thinking, movement, behavior and mood). The 10/15/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. He required substantial/maximal assistance with oral hygiene, toileting, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. B. Observations and resident interview Resident #65 was interviewed on 11/18/24 at 3:06 p.m. Resident #65's call light which was a blue flat call light was placed on the tray table. Resident #65 said he was not able to reach his call light. He said his call light was always placed where he could not reach it. Resident #65 attempted to reach for the call light and could not reach it. On 11/20/24 at 2:35 p.m. Resident #65's call light was placed on the tray table which was an arm length away from the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65 was interviewed again on 11/21/24 at 11:25 a.m. Resident #65 said when he needed help he would roll over to his left side and hit the call light button on the wall. He said he would also yell for help. Resident #65 said he has had to wait an hour sometimes before staff would come by to help him. Resident #65 said when he was not able to push his call light made him feel lonely and angry. C. Record review The care plan for activities of daily living (ADL's), revised 10/25/24, documented Resident #65 required total assistance with his ADL's due to diagnoses of Parkinson's disease, history of cerebrovascular accident (stroke) and lewy bodies dementia. Interventions included providing total assistance with bed mobility and a hoyer lift (mechanical lift) and two persons for transfers. D. Staff interviews Registered nurse (RN) #2 was interviewed on 11/21/24 at 11:40 a.m. RN #2 said the call light would be placed according to the resident's mobility. She said she made sure the residents had the call light placed in their hand or clipped it to their clothing. She said she checked in on the residents frequently or every two hours. RN #2 said all the staff were responsible for making sure the call lights were placed where residents could reach them. She said there were different call lights for everyone. She said the residents had the red push button call light or the blue flat call light. She said the staff made accommodations to meet the resident's needs with the different call lights that were available. RN #2 said Resident #65 had limited range of motion and Parkinson's disease. RN #2 said Resident #65 was alert and oriented and able to make his needs known. RN #2 said Resident #65 was not able to reach for things and his call light should be placed on his chest. She said if Resident #65 was not able to reach his call light that he would call out for help. She said Resident #65 should not be rolling over to his left side to push the call light on the wall, because the call light should have been within the resident's reach. Certified nurse aide (CNA) #1 was interviewed on 11/21/24 at 12:00 p.m. CNA #1 said call lights should be within reach of the residents at all times. She said all staff were responsible for making sure call lights were in reach for all residents. CNA #2 said Resident #65 was able to use his right hand. She said Resident #65 was able to reach his tray table with his right hand. She said Resident #65 preferred to have his call light on the tray table so that was where she placed it. She said Resident #65 did not like things to be put on his stomach. She said she was not aware of Resident #65 rolling over to his left side to hit the call light on the wall. She said Resident #65 did not call out for help very often. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assistant director of nursing (ADON) was interviewed on 11/21/24 at 4:28 p.m. The ADON said there was not a specific place to place the call light. She said call lights should be within the reach of the residents. She said every resident was different and some residents preferred to have their call light on their tray table, attached to their pillow or bedside table. She said residents with limited range of motion should have their call light within reach, attached to their blanket or by their hand. She said all of the staff who were caring for the resident were responsible for making sure call light was within reach. The ADON said Resident #65 had left sided weakness. She said all of his items should be placed on his right side. She said if the call light was placed on Resident #65's right side that he would be able to reach it. She said Resident #65's call light should be attached to his bedside table as he could extend his right arm to reach it. She said the call light could also be attached to the edge of the mattress or hooked on the right side of his bed. She said Resident #65 could reach for the call light if placed on the tray table. She said she did not think the call light was out of reach for Resident #65. She said Resident #65 rolling to his left side to hit the call light on the wall was not an appropriate way to use the call light, because the call light should have been within the resident's reach.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47350 Based on observations, record review and interviews, the facility failed to ensure four (#127, #60, #45 and #92) of five residents reviewed for abuse out of 45 sample residents were kept free from abuse. Specifically, the facility failed to: -Prevent resident to resident physical abuse between Resident #127 and Resident #60, who had a known history of physically aggressive behaviors towards other residents and staff who he perceived to be in his personal space and had documented recent physically aggressive behaviors with staff; -Have timely effective interventions to protect Resident #127, who had a history of physical aggression and wandering into other residents' rooms and invading their personal space; and, -Prevent resident-to-resident sexual abuse of Resident #45 by Resident #92 on 5/29/24 and 9/16/24. Findings include: I. Facility policy and procedure The Abuse policy and procedure, revised 2/21/23, was provided by the nursing home administrator (NHA) on 11/21/24 at 1:22 p.m. It revealed in pertinent part, Physical abuse includes, but is not limited to hitting, slapping, punching, biting and kicking. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: aggressive and/or catastrophic reaction of residents; wandering or elopement type behaviors; resistance to care; outbursts or yelling out; and, difficulty in adjusting to new routines or staff. Residents at risk for abusive situations are identified and appropriate care plans are developed. II. Facility investigation of abuse between Resident #60 and Resident #127 on 11/17/24. The 11/17/24 abuse investigation documented an unwitnessed resident-to-resident physical altercation between Resident #60 and Resident #127. The staff observed the two residents on the floor fighting in the television room with one another after lunch. The staff separated the two residents and Resident #127 said that Resident #60 had hit Resident #127 on the head with his shoes and Resident #127 hit Resident #60 back. Resident #127 sustained skin tears to his forehead and left hand. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation indicated the residents were separated and placed on 15-minute checks. It indicated the on duty nurse did a skin assessment and provided first aid to Resident #127 for his skin tears on his face and left hand. The facility substantiated the allegation of physical abuse at the conclusion of the internal investigation. III. Resident #60 A. Resident status Resident #60, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease (degenerative disease that causes involuntary movements), dementia with Lewy bodies and post traumatic stress disorder (PTSD). The 8/22/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required substantial/maximal assistance with toileting, partial/moderate assistance with personal hygiene, set up assistance with eating and was independent with bed mobility and transfers. The assessment did not indicate the resident exhibited physical behaviors towards others. B. Record review The trauma informed (PTSD) care plan, initiated 11/21/19 and revised 8/23/24, indicated Resident #60 had dementia with behavioral disturbances and had a history of physical altercations with peers and had been moved to three different units. It indicated he was at increased risk for physical altercations related to his increasingly poor impulse control and frustration tolerance. It indicated a trigger was someone invading his space or room. Interventions included administering antipsychotic medication, monitoring for behaviors, notifying the physician for increasing behaviors, monitoring the resident with other peers and intervening if interaction becomes aggressive, avoiding placing with a roommate. The physical aggression care plan, initiated 9/22/22 and revised 11/17/24, indicated that Resident #60 had the potential of being physically aggressive towards the staff and other residents. It indicated on 1/25/23 he had a physical altercation with another resident when Resident #60 found the other resident in his bed, on 7/22/23 Resident #60 went into another resident's room had a physical altercation when he thought the other resident was in his house and on 4/22/24 Resident #60 raised his fist and threatened another resident. Interventions included analyzing and documenting what triggers and deescalates behaviors (initiated 9/22/22), providing physical and verbal cues to alleviate anxiety, goals for more pleasant behavior (initiated 9/22/22), monitoring and reporting the resident causing danger to self and others (initiated 9/22/22), redirecting the resident to stay near nurse station and show his room if needed (initiated 11/17/24), reminding the resident to ask for assistance to get peers out of his room, call light with sign to call for assistance when unwanted visitors found in his room, velcro stop sign across his door (initiated 9/22/22), providing a poster with his name redirecting to his room (initiated 7/24/23). Behavior monitoring of 15-minute checks for 72 hours initiated on 1/26/23, 7/24/23 and 11/17/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of Resident #60's comprehensive care plan did not reveal personalized interventions until 7/24/23, after the second documented physical altercation. The facility daily behavior monitoring, from 10/23/24 to 11/20/24, documented Resident #60 had physically aggressive behaviors including yelling/screaming, kicking/hitting, pushing/grabbing, pinching/scratching, biting on 10/31/24, 11/1/24 and 11/17/24. -However, a review of Resident #60's electronic medical record (EMR) did not reveal if the facility's routine daily behavior monitoring was for physically aggressive behaviors directed at staff or other residents. The 10/16/24 nursing progress notes documented Resident #60 hit a staff member and yelled that he needed a court order before receiving any care. He then hit other staff members and refused care from all staff members. The 10/31/24 nursing progress notes documented Resident #60 was resisting care to take off his wet underwear and was hitting, kicking and biting at staff members. The 11/17/24 nursing progress notes documented Resident #60 had an altercation with another resident and hit him on the face. He was to be monitored every 15-minutes for 72 hours. The house supervisor, the physician and the family were notified. IV. Resident #127 A. Resident status Resident #127, age 78, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included type 2 diabetes mellitus and PTSD. The 9/30/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of seven out of 15. He required partial/moderate assistance with personal hygiene and was independent with eating, toileting, bed mobility and transfers. The assessment did not indicate the resident exhibited physical behaviors towards others. B. Resident observation and interview On 11/18/24 at 12:01 p.m. Resident #127 was observed with a cut on his left forehead that was covered with steristrips (wound closure strips) and a cut with a bruise on his left hand that was covered with steristrips. Resident #127 was interviewed on 11/18/24 at 3:41 p.m. Resident #127 said on the previous evening a large man reached out and grabbed his hand and hit him in the face. He said the incident made him a little bit afraid and he would defend himself if he had to. He said the police were there to investigate the incident the previous evening. He said he did not remember all the details and did not remember who hit him. C. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The wandering care plan, initiated 9/26/24 and revised 10/18/24, indicated Resident #127 wandered in and out of other residents' rooms and significantly intruded on the privacy of others. Interventions included offering pleasant diversion, identifying patterns of wandering and providing structured activities. The physical aggression care plan, initiated 10/22/24 and revised 11/12/24, indicated Resident #127 was at risk for physical aggression due to threatening posture, raising his fists, kicking and pushing staff. Interventions included analyzing circumstances, triggers and what deescalated behavior, observing behaviors with family, providing physical and verbal cues to alleviate anxiety, assisting to set goals for more pleasant behavior, giving choices about care and activities and monitoring for any signs of the resident posing danger to self and others. -A review of Resident #127's comprehensive care plan did not reveal personalized interventions to prevent further abuse from aggression by other residents. The 11/17/24 nursing progress note documented the staff found resident #127 on the floor fighting with another resident. Resident #127 told staff the other resident hit him on the head with his shoes and he hit him back. Resident #127 had a skin tear to the forehead and one on the left hand. The physician, the director of nursing (DON), the police and the NHA were notified. The 11/17/24 nursing progress note documented Resident #127 was on monitoring for a physical altercation with another resident. Steristrips were applied to the left forehead and left hand. V. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 11/21/24 at 9:20 a.m. CNA #6 said Resident #60 and Resident #127 usually got along but on 11/17/24 they were on the ground fighting after lunch. She said Resident #127 was a recent transfer onto the unit due to his wandering. She said Resident #60 did not like anyone in his personal space or his room. She said the staff also kept a big stop sign across Resident #60's room to deter Resident #127 and other residents from going into his room. She said said the stop sign across the door did not stop Resident #127 or other residents from entering the room. She said Resident #127 liked morning activities to keep him busy and he liked conversation with other residents. She said currently both residents were on every 15-minute checks to monitor. Licensed practical nurse (LPN) #1 was interviewed on 11/21/24 at 12:45 p.m. LPN #1 said Resident #60 and Resident #127 were both fighters and Resident #60 could be aggressive. She said both residents were difficult to redirect. She said Resident #60 had other resident-to-resident physical altercations in the past, but she was not sure when or with whom. She said the stop sign across Resident #60's door did not stop Resident #127 or other residents from entering the room. LPN #1 said the only way to keep residents out of rooms was to redirect them away from those rooms. She said both residents were on frequent 15-minute checks for behavior monitoring. She said both residents had been interacting without further aggression since the incident. She said Resident #127 remembered he was in a fight but he did not remember with whom. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 11/21/24 at 5:03 p.m. The NHA said the physical altercation between Resident #60 and Resident #127 happened on 11/17/24. She said it was an unwitnessed altercation and staff was unsure of who initiated the altercation. She said Resident #60 did not remember any details. She said he did have a history of being physically and verbally aggressive with staff and often refused care. She said she was not aware of him becoming physically aggressive with another resident and if he was it was more than a year ago. She said she was not aware Resident #60 did not like other residents in his personal space or room and was not aware that one of the interventions was a stop sign across his door. She said Resident #60 also had a personal history of being a boxer. The NHA said Resident #127 was a recent transfer onto the unit from another facility. She said Resident #127 was upset with being in a new environment and he was unable to smoke. She said those were the only instances of agitation that she was aware of for the resident. She said he was getting better as he was adjusting to his new environment. The NHA said the social worker and the unit manager (UM) were back and were currently still investigating the incident. She said once the investigation was completed and a root cause of the altercation was identified, additional interventions would be put into place. She said proactively, in any resident-to-resident physical altercation, initial interventions would be to separate the residents involved and place them on frequent every 15-minute behavior monitoring to ensure the safety of the residents. 51710 VI. Incidents of sexual abuse between Resident #45 and Resident #92 A. Incident on 5/29/24 The facility's abuse investigation, dated 5/29/24, documented the allegation occurred on 5/29/24 at approximately 2:00 a.m. It documented Resident #92 entered Resident #45's room while she was sleeping and began touching her genital area. It documented that the alleged incident lasted approximately five minutes, and Resident #45 did not consent or want the interaction. The investigation documented the social services director (SSD), the unit manager (UM) and the social services assistant (SSA) interviewed Resident #45 on 5/29/24 at 2:15 p.m. It documented that Resident #92 went into Resident #45's room and woke her up by touching her vaginal area. It documented Resident #45 asked Resident #92 what are you doing? and Resident #92 proceeded to touch her. It documented that Resident #45 said the incident lasted approximately five minutes and that she did not consent to the interaction or want it. Resident #45 was offered to go to the hospital for further evaluation and she agreed. The investigation documented the SSA and the deputy director (DD) interviewed Resident #92 on 5/30/24 at 11:15 a.m. It documented Resident #92 said he went into Resident #45's room, reached down there and then she woke up. Resident #92 said he touched Resident #45 for a couple of minutes and could not hear Resident #45 talk because he was not wearing his hearing aids. Resident #92 said Resident #45 did not move her hands or attempt to move his arm during the incident. He said Resident #45 normally liked when he touched her and that he had not acted differently than he had with her before. He also said he would not stop there again. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation included a statement, dated 5/31/24, from certified nurse aide (CNA) #8. CNA #8 said she had not witnessed anything different or concerning about Resident #45 and Resident #92. She said she heard registered nurse (RN) #3 ask Resident #92 why he was sneaking out of that room in the night. The investigation included a progress note, date unspecified, in which RN #3 documented she saw Resident #92 coming out of Resident #45's room and that he got a little nervous when he saw RN #3. RN #3 documented Resident #92 kept hushing her and later asked if she was going to inform Resident #45's roommate of what RN #3 saw. RN #3 documented she would report the incident to the day shift staff for them to notify the social services department. The investigation documented that the police, adult protective services (APS), the resident's families, the ombudsman, the resident's providers and the special victims unit were notified of the alleged incident. The investigation documented the plan of action included moving Resident #92 to a different unit and floor. It also documented Resident #92 was placed on one-to-one observation with 15-minute checks. It also included obtaining orders to send Resident #45 to the emergency room for further evaluation. The investigation documented Resident #45 had a sexual assault nurse examination completed in the emergency room . There was no documentation in the investigation indicating whether the abuse was substantiated or not. -However, sexual abuse occurred due to Resident #92's willful touching of Resident #45's genital area without her consent. B. Incident on 9/16/24 The investigation report, dated 9/16/24, documented the alleged event occurred on 9/16/24 at 10:00 a.m. It documented the activities director (AD) observed Resident #45 and Resident #92 leaving an activity. The AD observed Resident #92 going up to Resident #45 and touching her breasts. The AD told Resident #92 to stop the inappropriate behavior in a public area and he did. The residents were immediately separated. The police, APS, the ombudsman, the resident's family and the residents' providers were notified of the alleged incident. The investigation documented Resident #45 was interviewed on 9/16/24 at 12:20 p.m. by the SSD, the SSA and the UM. Resident #45 said Resident #92 propelled his wheelchair to her and promptly grabbed her breast with his hand. She said she did not ask him to do this and told him no, not here, after which he stopped. It documented that no changes in Resident #45's behavior were observed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation documented Resident #92 was interviewed on 9/16/24 at 2:00 p.m. by the SSD and the SSA. It documented Resident #92 initially said no when asked if anything unusual occurred after the facility activity, however, he later admitted to touching Resident #45 when he was informed that facility staff knew about the incident. It documented Resident #92 got defensive when informed Resident #45 did not provide consent and that she did not like being intimately touched in public areas. It documented the SSD educated Resident #92 on the definition of consent. The investigation documented the AD was interviewed on 9/16/24 at 1:16 p.m. The AD said she observed Resident #92 roll up to Resident #45 without saying anything and touch her breasts. The AD said she told Resident #92 to keep his hands to himself and he stopped touching Resident #45 after the AD repeated herself a second time. The investigation documented the plan of action included immediately educating Resident #92 about consent, boundaries and inappropriate behaviors in public areas. It also documented Resident #92's intimacy care plan was updated to reflect he would obtain staff assistance to ensure any future intimate encounters were consensual, safe and private. The investigation concluded the abuse was substantiated. VII. Resident #92 - assailant A. Resident status Resident #92, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included major depressive disorder, type 2 diabetes mellitus, dementia, spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord), anxiety disorders and obesity. The 9/9/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. He was dependent on staff for total assistance for oral and toileting hygiene, dressing and all transfers. He needed moderate assistance with bathing and moving from a lying to a sitting position, and was independent with eating and moving left to right in bed. The MDS assessment documented the resident had a hearing aide or other hearing appliance. B. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavior care plan, initiated 5/29/24 and revised 9/17/24, revealed Resident #92 had previously had an intimate relationship with a female resident on the second floor. The care plan documented that due to an allegation by the female resident that his sexual behavior toward her in May 2024 was not wanted at the time it occurred, he was moved to the first floor. The care plan indicated Resident #92 had some decline in cognition due to dementia and he might have been experiencing disinhibition of sexual expression as a result. The care plan documented Resident #92 touched the female resident in a nonconsensual sexual manner on 9/16/24. The care plan documented Resident #92 and the female resident had expressed a desire to have intimate encounters at times in a private area and not in the female resident's room. The care plan documented Resident #92 needed reminders of the environment in which he could have consensual intimate encounters that were appropriate and safe such as a private area, not in a public place and away from the female resident's room. Pertinent interventions included discussing Resident #92's behavior with him and explaining or reinforcing what behavior was appropriate if he wished to have an intimate experience with the female resident, such as a private place to meet, obtaining consent from the female resident and honoring her choice if she did not wish to engage in an intimate encounter at any given time (initiated 5/29/24 and revised 9/18/24), staff to address the resident's needs for intimacy and sexual expression in safe and socially appropriate way (initiated 5/31/24) and encouraging the resident to approach social services or nursing staff if he needed assistance locating a safe and private area to engage in an intimate encounter with the female resident (initiated 9/18/24). The cognitive deficit care plan, initiated 9/17/24, documented Resident #92 had a decline in his cognition due to his diagnosis of dementia and he had slight difficulty recalling information at times. He forgot at the moment but might recall it later. He needed staff to provide reminders of information that was important to him. Pertinent interventions included encouraging the resident to seek out staff if he needed information about recent events and appointments. An additional behavior care plan, initiated 9/19/24, documented Resident #92 had used sexual gestures with female staff showing his middle finger and asking if staff wanted some and had tried to hold the hands of staff when they administered him medications or other items. He had been identified as having poor impulse control due to his progression of dementia and needed reminders of the staff's role and to have limits set with sexual behavior. He was able to understand communication from others despite his cognitive deficit. Pertinent interventions included staff were to inform Resident #92 what care was being provided so he knew what to expect, if Resident #92 used sexually-suggestive language or tried to hold staff's hand in an inappropriate manner, staff was to tell the resident in a calm way that staff's role was to address his care needs and request he refrain from using this language or trying to touch staff in a sexual manner (initiated on 11/1/24). Resident #92's sexual intimacy capacity for consent assessment was completed on 5/9/24. The assessment documented the resident showed the ability to answer yes/no questions accurately, was physically able to leave an undesirable situation and verbally or non-verbally able to alert others when needing help. The interaction pattern documented his interactions with resident #45 as friendly. (continued on next page)

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	065380	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Community Living Center at Fitzsimons	1919 Quentin St Aurora, CO 80045

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, the facility failed to complete an updated assessment after it was noted the resident had a decline in cognition due to his diagnosis of dementia. A nurse progress note, dated 5/29/24 at 6:43 a.m., documented Resident #92 was seen coming out of Resident #45's room. Resident #92 got nervous when he saw the nurse and kept hushing her. The note said the nurse would report the incident to the day shift for them to notify social services notification. A nurse progress note, dated 5/29/24 at 4:23 p.m., documented the UM and the director of nursing (DON) discussed the incident with Resident #92. He was notified that they were told he inappropriately touched Resident #45. Resident #92 said it was true and he would not do it again. The social worker, Resident #92's power of attorney and his provider were notified. Fifteen minute checks were started. -A review of Resident #92's electronic medical record (EMR) did not reveal documentation regarding the incident on 9/16/24. VIII. Resident #45 - victim A. Resident status Resident #45, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 CPO, diagnoses included multiple sclerosis (degenerative muscle disease), mild cognitive impairment of unknown origin, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood and morbid obesity. The 9/16/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for assistance with toileting hygiene, transfers, dressing and bathing. She was independent in eating and oral hygiene. B. Resident interview Resident #45 was interviewed on 11/19/24 at 12:30 p.m. Resident #45 said Resident #92 went into her room around 2:00 a.m., the night of the incident and inappropriately touched her genital area. She said she did not feel afraid of Resident #92 and said she told him no and to get out when she caught him. She said a nurse saw Resident #92 leaving her room and the police were notified. Resident #45 said she did not want to press charges because he's a good guy, but she did want Resident #92 to be reprimanded. C. Record review The behavior care plan, initiated 4/21/21 and revised 6/4/24, documented Resident #45 was at risk for financial exploitation due to her previously sending money to men overseas. The care plan also documented she was involved in a three-way relationship with herself and two peers and all had consented to sexual intimacy. Pertinent interventions included discussing Resident #45's behavior with her and explaining or reinforcing why the behavior was inappropriate or unacceptable and educating Resident #45 to yell for help, use her call light and report any non-consensual sexual behavior towards her. (continued on next page)

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Resident #45's cognitive decline care plan, initiated 4/23/21 and revised 8/11/21, documented she had impaired cognitive functioning due to her diagnosis of multiple sclerosis and she had difficulty making decisions and some short-term memory issues. Pertinent interventions included communicating with Resident #45 and her guardian regarding the resident's capabilities and needs, cueing, reorienting and supervising as needed and presenting just one thought, idea, question or command to the resident at a time.

A sexual intimacy capacity for consent assessment form was completed on 5/9/24. The assessment documented the resident showed the ability to answer yes/no questions accurately, was physically able to leave an undesirable situation and verbally or non-verbally able to alert others when needing help. The interaction pattern documented she had no concerns with her interactions with Resident #92, however, she was having fewer interactions with him because she did not want to upset her other partner/roommate.

A second sexual intimacy capacity for consent assessment form was completed on 9/18/24. The assessment documented the resident showed the ability to answer yes/no questions accurately, was physically able to leave an undesirable situation and verbally or non-verbally able to alert others when needing help. The interaction pattern documented her interactions with resident #92 as friendly, and that both residents wished to be friends and have intimate encounters. However, Resident #45 said she wanted parameters in place which included no sexual activity in a public place, no surprises and for her to give consent.

An interdisciplinary team (IDT) risk management review note, dated 5/29/24 at 2:00 a.m. documented Resident #45 was inappropriately touched by a male resident. The resident's provider and guardian were notified and physician's orders were obtained to send Resident #45 to the emergency room for evaluation and treatment. It also documented that interventions included placing Resident #45 on another unit for her safety upon return from the emergency room .

-Resident #45 had a sexual assault nurse examination completed in the emergency room . She was discharged back to the facility with orders to continue previously ordered antibiotic therapy for a urinary tract infection.

-A review of Resident #45's EMR did not include documentation regarding the incident on 9/16/24.

IX. Staff interviews

The SSD and the SSA were interviewed together on 11/21/24 at 3:05 p.m. The SSD said the situation between Resident #45 and Resident #92 was very complex. She said Resident #92 was moved to a different unit and floor after the incident in May 2024. She said Resident #45 was seen making contact with Resident #92 after the May 2024 incident.

The SSD said Resident #45 was not great at setting boundaries for herself and that she encouraged both residents to remain apart, however, they both voiced they still wanted to be friends. The SSD said she was unsure if Resident #92 fully understood the provided education on boundaries and consent.

The SSA said Resident #45 was interested in a romantic relationship with Resident #92, however, she was not okay with surprise interactions and him not asking beforehand. He said he was unsure if Resident #92 fully understood the education staff provided on boundaries and consent.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA and the divisional social worker (DSW) were interviewed together on 11/22/24 at 5:02 p.m. The NHA and the DSW both said Resident #45 and Resident #92 considered themselves boyfriend and girlfriend before the incident on 5/29/24 and it was the first time he approached her at night. The DSW said Resident #45 was not cognitively impaired. She said she could be manipulative. She said Resident #92 was less cognitively intact and he was intermittently confused. She said Resident #92 had sexual impulses and poor impulse control due to cognitive decline. She said he was receptive to education regarding consent prior to contact with others. The DSW said that the facility's sexual intimacy capacity for consent assessment form did not need to be signed by residents and was based on the resident's observed body language, the providers' input and the residents' statements. The DSW said the assessments were filled out by the SSD and the unit social worker and were completed quarterly or for a change of condition. She did not specify why a new assessment was not completed for Resident #92 after the incident in May 2024 or when his cognitive decline was observed. The NHA said Resident #92 was moved to a separate unit immediately after the first incident on 5/29/24. She said it was easier for staff to identify when Resident #92 was going to a different unit and help ensure Resident #45's safety. She said it had been more effective having both residents on separate floors and that new staff were alerted to potential issues when oriented to the floor. She said it was ultimately the nurse's responsibility to alert staff of any issues before their shift. 47151

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review, and interviews, the facility failed to revise and review comprehensive care plans for five (#122, #104, #81, #46 and #65) of 11 residents reviewed out of 45 total sample residents. Specifically, the facility failed to: -Ensure Resident #122, Resident #104 and Resident #81's care plans were reviewed and revised to reflect the use of an anticoagulant (blood thinner) medication; -Ensure Resident #46's care plan included prescribed medications for antianxiety, opioids, and anticoagulants; and, -Ensure Resident #65's skin treatment care plan was implemented. Findings include: I. Facility policy and procedure The Comprehensive Care Planning policy, 9/30/24, was received from the nursing home administrator on 11/21/24 at 5:00 p.m. It read in pertinent part, It is the policy to develop and implement a comprehensive person-centered care plan for each resident consistent with resident right that includes measurable objects and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly minimum data set (MDS) assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out interventions, initially and when changes are made. II. Resident #122 A. Resident status Resident #122, age 68, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits and cerebrovascular disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/7/24 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. The MDS assessment indicated the resident as receiving an anticoagulant. B. Record review The November 2024 physician's orders revealed a physician's order for Apixaban (anticoagulant) 5 milligrams (mg) twice a day for cerebral infarction, ordered on 10/1/24. The care plan last revised on 10/25/24 failed to show a care plan was developed for the use of the anticoagulant. III. Resident #104 A. Resident status Resident #104, age 86, was admitted on [DATE]. According to the November 2024 CPO diagnoses included, atherosclerotic heart disease, type 2 diabetes and congestive heart failure. The 10/8/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident was receiving an anticoagulant. B. Record review The November 2024 physician's orders revealed a physician's order for Apixaban (anticoagulant) 5 mg twice a day for aortic aneurysm (a bulge in the heart) with a start date of 10/3/23. The care plan last revised on 10/8/24 failed to show a care plan was developed for the use of the anticoagulant. IV. Resident #81 A. Resident status Resident #81, age greater than 65, was admitted on [DATE]. According to the 10/31/24 clinical care plan, the diagnoses included cerebrovascular accident with seizures, and hypertension. The 7/24/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a BIMS score of 10 out of 15. The MDS assessment documented the resident was receiving an anticoagulant. B. Record review (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The November 2024 physician's orders revealed a physician's order for Apixaban (anticoagulant) 2.5 mg twice a day for cerebral infarction, ordered on 10/21/24. The care plan last revised on 10/31/24 failed to show a care plan was developed for the use of the anticoagulant. C. Staff interviews The assistant director of nursing (ADON) was interviewed on 11/21/24 at 3:45 p.m. The ADON said residents who were prescribed an anticoagulant such as the Apixaban should have a care plan regarding the prescribed medications. She said the care plan was important because the Apixaban was a high risk drug. She said the care plans were a collective work of art which meant that each department was responsible to keep the care plans up to date. The ADON said the care plans were reviewed during the MDS assessment. The ADON said she reviewed the care plans for Resident #122, Resident #104 and Resident #81 and said there were no care plans for the use of the anticoagulant. IV. Facility follow up On 11/21/24 at 5:00 p.m., the ADON said she had the care plans updated and that she had completed an audit on all residents who receive an anticoagulant. 47151 VI. Resident #46 A. Resident status Resident #46, age greater than 65, was admitted on [DATE] and readmitted [DATE]. According to the November 2024 CPO, diagnoses included heart disease, chronic kidney disease stage 3, type 2 diabetes mellitus, post traumatic stress disorder, depressive episodes and anxiety disorders. The 8/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He needed supervision with shower transfers and bathing and was independent with all other activities of daily living. The MDS assessment documented the resident received the following medications: antianxiety, antidepressant, opioids and a diuretic. B. Record review A review of Resident #46's November 2024 CPO revealed he was prescribed the following medications: -Apixaban (an anticoagulant) 5 mg tablet to be taken by mouth twice daily, ordered on 8/17/24. -Oxycodone (an opioid medication) 15 mg three times a day, ordered on 10/16/24. -Lorazepam (anti-anxiety medication) 0.5 mg at bedtime, ordered on 8/19/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Escitalopram Oxalate (Lexapro an anti-depressant) 20 mg, ordered on 8/17/24. A review of Resident #46's comprehensive care plan revealed the facility failed to include focus care plan areas for the resident's use and monitoring of anticoagulant, opioid, antianxiety and antidepressant medications. 48114 VII. Resident #65 A. Resident status Resident #65, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included Alzheimer's disease, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and neurocognitive disorder with lewy bodies (a brain disorder that can lead to problems with thinking, movement, behavior and mood). The 10/15/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. He required substantial/maximal assistance with oral hygiene, toileting, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. B. Resident interview Resident #65 was interviewed on 11/18/24 at 3:18 p.m. Resident #65 said he developed a pressure sore on his bottom two weeks ago. He said he knew he had a sore on his bottom because the staff were putting cream on his bottom. He said sometimes it hurt and sometimes it did not hurt. C. Record review The November 2024 CPO revealed the resident had a physician's order for triad hydrophilic wound dress external paste (wound dressings), apply to buttocks topically two times a day, ordered on 10/18/24. The care plan for skin, initiated on 1/12/24 and revised on 11/21/24 documented, Resident #65 had a history of shearing between buttocks and moisture associated skin damage (MASD) to bilateral buttocks. Interventions included alternating pressure air therapy mattress to promote skin integrity, providing frequent repositioning as the resident would allow, observing the resident's skin weekly, notifying the medical doctor (MD) if any changes were noted in the resident's skin integrity. On 11/21/24 (during the survey) an intervention was added to include providing treatment to buttocks as ordered, wound doctor to follow up weekly and notifying MD as needed if no improvement. -Review of the resident's comprehensive care plan revealed the facility failed to identify the resident was receiving external paste two times a day. D. Staff interviews (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social services director (SSD) and the social services assistant (SSA) were interviewed together on 11/21/24 at 3:14 p.m. The SSD and The SSA said care plans were completed upon admission. The SSD and The SSA said the resident's care plans were updated quarterly and as needed. The SSD and the SSA said depending on the care plan focus, they would assist in making sure they were completed. The SSD said the unit managers, restorative, therapy were responsible for writing the care plans pertinent to their department. The SSD said the nursing staff were responsible for creating care plans specific to the resident's skin conditions. The unit manager (UM) was interviewed on 11/21/24 at 3:28 p.m. The UM said the nurses were responsible for implementing a care plan for the resident's skin. The UM said anybody who noticed issues with the resident's skin could implement a skin care plan and interventions. The UM said all of the nurses could update the care plan especially if there were any new skin issues. The UM said today (11/21/24) there was a MASD wound on Resident #65's bottom. The UM said she called the doctor and the daughter and notified them of the new skin issues. The UM said she did education with her staff on timely reporting of wound/pericare. The UM said she knew nursing staff were following the order to apply triad cream twice a day, but did not know how bad his condition had became. The UM said the nurse did not tell her how bad it was. The UM said she did not know how Resident #65's skin issues were missed. The assistant director of nursing (ADON) was interviewed on 11/21/24 at 4:40 p.m. The ADON said the nursing staff implemented basic care plans upon admission. The ADON said different departments would put in their own care plans. The DON said the UM and the minimum data set coordinator (MDSC) updated the skin care plans. The ADON said updating the care plans was a group effort. The ADON said Resident #65 had a skin care plan in place. She said she was not aware that the care plan was not updated to include the physician's order on 10/18/24. She said she did not know how it was missed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review, observation and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (#65) of three residents reviewed out of 45 sample residents. Specifically, the facility failed to ensure a certified nurse aide (CNA) reported Resident #65's new skin alterations timely. Findings include: I. Resident #65 A. Resident status Resident #65, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician's orders (CPO), diagnoses included Alzheimer's disease, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and neurocognitive disorder with lewy bodies (a brain disorder that can lead to problems with thinking, movement, behavior and mood). The 10/15/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. He required substantial/maximal assistance with oral hygiene, toileting, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS assessment documented Resident #65 was at risk for developing pressure ulcers. B. Observations and interviews On 11/21/24 at 10:05 a.m. a wound observation was completed with registered nurse (RN) #1 and the unit manager (UM). Resident #65 was repositioned to the left side and his brief was removed. The dressing was removed, a thick cream and powder was observed over bilateral buttocks. There were several small excoriated, shallow abrasion appearing areas were noted over Resident #65's left and right buttock. RN #1 and the UM said they were not aware of Resident #65's new skin issue. -However, the resident's new skin issues were noted prior to the observation by a CNA (see the UM's interview below). D. Record review The care plan for skin, initially initiated on 1/12/24, and revised on 11/21/24 documented, Resident #65 had a history of shearing between buttocks and moisture associated skin damage (MASD) to bilateral buttocks. Interventions included alternating pressure air therapy (APM) two mattress to promote skin integrity, providing; frequent repositioning as the resident would allow, observing skin weekly and, notifying the medical doctor (MD) if any changes in skin integrity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24, interventions were added was to include providing treatment to buttocks as ordered, having the wound doctor to follow up weekly and notifying the MD as needed if no improvement. The November 2024 CPO revealed the resident had a physician's order for triad hydrophilic wound dressing external paste (wound dressings) apply to buttocks topically two times a day, ordered on 10/18/24. The 11/19/24 weekly skin assessment documented Resident #65's skin was dry and warm to a touch, fair turgor, the left thigh donor site was okay, no drainage or discoloration was noted. Observation of skin at the sacrum/coccyx/ischial pressure areas documented intact, triad paste was applied liberally during incontinence care. II. Staff interviews Registered nurse (RN) #1 was interviewed on 11/21/24 at 11:48 a.m. RN #1 said the certified nurse aides (CNA) reported any new skin conditions to the nurse on duty. She said she would call and notify the UM and the UM would see the resident to address the concern. She said she or the UM would notify the wound doctor of the new issues. She said the wound doctor came in every week to check wounds. RN #1 said the nurses assessed the resident's skin every week or twice a week. She said when the residents received a shower CNAs should be assessing the resident's skin. RN #1 said Resident #65 had MASD on his bottom. She said she checked Resident #65 two days ago (11/19/24) and his bottom was intact. She said Resident #65 has had ongoing issues with his skin where his skin would heal and then the areas would come back. She said Resident #65's skin was monitored during incontinence care. She said resident #65's skin was assessed twice or more during a shift and depending on how often he needed to be changed. RN #1 said Resident #65 was alert and oriented. RN #1 said Resident #65 did not tolerate pain and would let staff know if he was experiencing pain. She said Resident #65 did not report having any pain or discomfort on his bottom. She said the staff repositioned Resident #65 every two hours. CNA #2 was interviewed on 11/21/24 at 12:06 p.m. CNA #2 said if she saw any problems or changes in a resident's skin she would report the changes to the nurse on duty. She said she always let the nurse know of any changes in skin conditions. CNA #2 said she knew Resident #65 had an opened area on his bottom. CNA #2 said sometimes Resident #65's skin looked red and other times it looked fine. She said cream was applied to Resident #65's bottom every time after incontinence care was provided. She said Resident #65's skin was checked at least three times a shift. The UM was interviewed on 11/21/24 at 3:28 p.m. The UM said the nurses were responsible for following the physician's orders of putting the cream on Resident #65's bottom. The UM said if the CNAs were changing the residents and saw any issues they would call the nurse and let them know. The UM said today (11/21/24) Resident #65 was noted to have MASD on his bottom. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The UM said she called the doctor and the daughter to notify them of the skin issues. The UM said she did education with her staff on timely reporting of wound/pericare. The UM said she knew the nursing staff were following the order to apply triad cream twice a day, but did not know how bad the skin had become. The UM said the staff did not report to her how bad it was. The UM said she provided education to the CNAs regarding reporting skin issues to the nurses immediately. The UM said she did not know how Resident #65's skin issues were not reported to the nurse immediately upon the CNA discovering the area. The assistant director of nursing (ADON) was interviewed on 11/21/24 at 4:40 p.m. The ADON said Resident #65 had weekly assessments done to monitor his skin. She said the staff would have found out if Resident #65 was having issues during his weekly skin assessments. The ADON said the CNA who was providing care should have seen the skin wound and reported it the UM right away. She said Resident #65's last skin observation was on 11/19/24. She said the weekly skin assessment did not report Resident #65 having any issues going on at that time. III. Facility follow up On 11/21/24 at 11:30 a.m. the UM provided documentation on timely reporting of wound/pericare that two CNAs were given and received education on. It read in pertinent part, During pericare, please gently wipe the skin and dab, especially after bowel movement, most of our resident's skin are fragile and thin and can easily rub off and be open. If you notice any open area, notify the nurse right away and the nurse would notify the medical doctor and family. Treatment order should be put in place and monitored as ordered until resolved. Open wounds could be painful, lead to infection and could be fatal if not treated in a timely manner.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51710 Based on record review and interviews, the facility failed to ensure one (#45) of one resident, out of 45 sample residents, with limited range of motion (ROM) received appropriate treatment and services to prevent further decrease in ROM. Specifically, the facility failed to ensure the physician's order for Resident #45 to use the facility's exercise bike was followed. Findings include: I. Resident #45 A. Resident status Resident #45, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 computerized physician's orders (CPO), diagnoses included multiple sclerosis (degenerative muscle disease), mild cognitive impairment of unknown origin, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood and morbid obesity. The 9/16/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She was dependent on staff for total assistance with toileting hygiene, transfers, dressing, bathing. She needed maximal assistance rolling left and right, and moderate assistance with personal hygiene. She was independent in eating and oral hygiene. The MDS assessment indicated the resident required a hoyer lift (mechanical lift) with two-person assist for transfers. B. Resident interview Resident #45 was interviewed on 11/19/24 at 1:12 p.m. She said she had difficulty bending and flexing both of her knees. Resident #45 said the staff did not assist her with ROM exercises. She said she wanted to get on the exercise bike. She said she was told by the therapy team that she was not cleared nor had a physician's order to use the exercise bike. C. Record review A physician's order, dated 9/6/24, documented Resident #45 was to use the facility's bike for knee pain. The order did not specify how frequently this should occur, or if staff assistance was required to assist her. A physician's order, dated 5/28/24, documented the discharge of Resident #45 from physical therapy. It documented Resident #45 would participate in her updated facility maintenance plan with restorative nursing three to five times weekly to maintain lower extremity strength and mobility. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall care plan, initiated on 5/6/21 and revised 6/16/22, documented Resident #45 was at risk for falls related to gait/balance problems due to multiple sclerosis. Pertinent interventions included restorative occupational therapy (OT) exercises one to three times weekly as tolerated, and restorative physical therapy (PT) exercises three to [NAME] times weekly. A review of Resident #45's restorative facility maintenance plan task, dated 10/22/24 to 11/20/24 documented she was actively receiving restorative physical and occupational therapy approximately three to five times weekly. -No documentation in Resident #45's care plan found discussing her potential risk for limited ROM secondary to diagnoses of multiple sclerosis and morbid obesity. II. Staff interviews RN #1 was interviewed on 11/21/24 at 12:03 p.m. RN #1 said Resident #45 had limited ROM in upper and lower extremities due to her diagnosis of multiple sclerosis. RN #1 said Resident #45 did go for restorative therapy services, however, he was unsure what services she actually received. RN #1 said the facility's therapy gym did have a hoyer lift (mechanical lift) and two different types of exercise bikes for residents to use. The physical therapist (PT) was interviewed on 11/21/24 at 1:23 p.m. The PT said that the exercise bikes can only be used by residents with a physician's order. He said the residents were unable to use the exercise bikes if they needed a hoyer lift to get onto the exercise bike and that alternative exercise options were utilized instead. The PT said when residents were screened for therapy services, they went through an assessment to determine appropriate exercises. He said once the assessment was completed , a resident-specific facility maintenance plan was generated to instruct the restorative services team on what therapies the resident should receive. He stated that Resident #45 had completed an assessment and that a facility maintenance plan had been generated for her. The restorative manager (RM) was interviewed on 11/21/24 at 1:30 p.m. The RM said the facility's therapy department created a ROM program for residents and decided what treatments and exercises are most suitable for them. The RM confirmed that residents needing a hoyer lift could not use the facility's exercise bikes. She said that the facility staff were limited due to the time constraints of therapy treatments and treatment sessions were 15 minutes each. The RM said Resident #45's facility maintenance plan instructed her to use the standing table for approximately 10 to 15 minutes. She said Resident #45 actively participates in therapies approximately 75 to 100% of the time. The RM said Resident #45 was potentially deconditioning due to her disease process and weight gain.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51915

Based on observations, record review and interview, the facility failed to assist a resident in obtaining routine or emergency dental services, as needed for three (#81, #45, and #93) out of 45 sample residents.

Specifically, the facility failed to:

-Ensure a referral to dental services was completed three days after Resident #81 broke two of his teeth and started to experience pain when he ate;

-Ensure Resident #45 was seen by the dentist in a timely manner after the resident reported dental pain; and,

-Assist Resident #93 in obtaining new dentures or fixing his broken dentures to address the mouth pain he was having.

Findings include:

I. Facility policy and procedure

The Dental Services policy, last revised on 9/30/24 was received from the nursing home administrator (NHA) on 11/21/24 at 6:36 p.m. The policy read in pertinent part, It is the policy to provide oral health care and dental services to each resident. Dental services will be offered upon admission, annual and as needed and upon request.

If the resident is experiencing mouth pain the DON (director of nursing) or designee will be notified. Nursing should complete an oral assessment and notify social services staff to schedule a dental screening if indicated. All assessments should be documented in the medical record.

II. Resident #81

A. Resident status

Resident #81, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician's order (CPO), diagnoses included cerebrovascular accident with seizures, and gastroesophageal reflux disease.

The 10/23/24 clinical care plan stated that the resident had impaired cognitive function related to neurological symptoms following CVA. The resident was dependent on staff for oral care.

B. Observations and resident interview

Resident #81 was interviewed on 11/18/24 at 3:29 p.m. The resident said he had two broken teeth and nobody was helping him to get them fixed. He said they hurt and that he had trouble eating. The resident was observed to have broken teeth on the bottom of his mouth.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review A nurse note, dated 11/8/24 at 11:35 p.m., documented Resident #81 complained of oral pain. The nurse gave him an as-needed oxycodone and notified the social worker via email to schedule an appointment with dental services. -A review of Resident #81's comprehensive care plan did not reveal a person centered focus for the resident's oral needs. -A review of Resident #81's electronic medical record (EMR) did not indicate documentation that the resident had been referred to see the dentist related to his broken teeth. D. Staff interviews The social service director (SSD) and social worker (SW) #1 were interviewed on 11/22/24 at 3:00 p.m. The SSD said she was not aware that a referral to a dentist needed to be completed within three days. The SSD and SW #1 were not aware Resident #81 was having dental pain. The SSD said if the resident had severe pain the resident could be taken to a dentist outside of the facility. The SSD said the facility contracted with a dentist, however, he only came once a month. The SSD said the visiting dentist could not see every resident on the monthly visit. She said Resident #81 was not scheduled for the dentist visits to the facility on [DATE] or 11/18/24. 51710 II. Resident #45 A. Resident status Resident #45, age less than 65, was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. According to the November 2024 CPO, diagnoses included multiple sclerosis (degenerative muscle disease), mild cognitive impairment of unknown origin, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood and morbid obesity. The 9/16/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for assistance with toileting hygiene, transfers, dressing and bathing. She was independent in eating and oral hygiene. No dental concerns were documented in the MDS assessment. B. Resident interview Resident #45 was interviewed on 11/19/24 at 12:46 p.m. Resident #45 said she had dental pain in her upper right jaw. She said she did not have any difficulty eating due to the pain. She said it was painful for her to drink cold water. Resident #45 said she mentioned the dental pain to the facility's staff. She said she never received follow-up from the staff nor had a dental appointment been scheduled. C. Record review (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nutrition/dietary note, dated 9/11/24, documented Resident #45 reported a tooth in the upper right side of her mouth was causing discomfort and caused her to chew on the left side of her mouth. It documented that the facility's social services team was notified of Resident #45's pain. A social services note, dated 9/18/24, documented Resident #45's quarterly review. It documented that Resident #45 was cognitively intact and she reported mild depressive symptoms. It documented Resident #45 was to receive counseling and psychiatric medication review services. It also documented that Resident #45 attended facility activities and also enjoyed activities in her room. -The 9/18/24 note contained no documentation regarding Resident #45's dental pain, or indicate a referral had been made for Resident #45 to see the dentist. The ancillary service care plan, initiated on 4/23/21 and revised on 7/22/21, documented Resident #45 would be seen for ancillary services as needed. Pertinent interventions included: encouraging Resident #45 to alert staff when she has an ancillary need. D. Staff interviews The SSD and the social services assistant (SSA) were interviewed on 11/21/24 at 3:05 p.m. The SSA said the residents notified either himself or the nursing staff if they had a dental concern. The SSA said ancillary appointment requests for the residents were scheduled by the transportation department. He said if the transportation department was unable to schedule an appointment for a resident, the facility's social services team would assist in scheduling the resident for an ancillary provider visit at the facility. The SSA said the social services staff would attempt to schedule resident appointments as soon as possible. For emergencies they would try for same-day appointments, and minor concerns/requests would be scheduled for the next available appointment. The SSD confirmed the transportation department scheduled residents for ancillary service appointments. She said this was done to ensure the department had the availability to transport residents to their appointments. The SSD said if there were dental emergencies, the social services team would attempt to get an ancillary provider to go to the facility. The SSD and the SSA said they were not sure why Resident #45 had not been scheduled for a dental appointment since her complaint was first reported in September 2024. 42838 III. Resident #93 A. Resident status Resident #93, age 68, was admitted on [DATE]. According to the November 2024 CPO, the diagnoses included low back pain and major depressive disorder. The 8/28/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent with oral care. The MDS assessment did not indicate if Resident #93 had any dental problems. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, Resident #93 had missing teeth from his dentures. B. Resident interview and observation Resident #93 was interviewed on 11/21/24 at 12:00 p.m. Resident #93 said he had reported to the staff his mouth discomfort that was caused by his missing front teeth on his dentures and discomfort on the bottom of his mouth. Resident #93 said he was told that he would have to pay $1600 for new dentures and was not provided any other information. Resident #93 was missing front teeth from his upper dentures. C. Record Review The dental care plan, updated on 11/14/24, documented the resident had an upper denture that was in disrepair that did not cause him pain or difficulty chewing. Pertinent interventions were for the resident to see a dentist yearly and to monitor for weight loss. The nurse progress note, dated 8/29/24, documented the social service department was notified Resident #93 needed new dentures due to pain on the bottom of his mouth and the missing teeth on the top. -A review of Resident #93's EMR did not reveal any follow up to the referral for the dentist. D. Staff interview SW #1 was interviewed on 11/21/2024 at 2:21 p.m. SW #1 said he had seen a dentist but there was a $1600 cost, as he was not covered 100% through the veterans administration. SW said she was unsure why there was no follow up to the 8/29/24 progress note where Resident #93 reported pain and discomfort and stated in house dentists got behind due to not coming into the facility due to COVID-19 and influenza outbreaks recently. SW #1 said they were behind on getting residents appointments and treatment due to recent outbreaks causing the in house dentist to cancel.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to provide food that accommodated resident preferences for one (#10) of one resident out of 45 sample residents. Specifically, the facility failed to provide food choices according to Resident #10's preference. Findings include: I. Resident #10 A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included unspecified osteoarthritis (degenerative bone and joint disease), dementia and protein-caloric malnutrition. The 9/11/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for a mental status (BIMS) score of six out of 15. He required assistance with toileting, showers, dental hygiene, dressing, and personal hygiene. Resident #10 also required set-up assistance for his meals. B. Resident interview Resident #10 was interviewed on 11/20/24 at 10:15 a.m. Resident #10 said he did not like the food the facility served. He said he did not receive the food which he liked to eat. He said he liked refried beans, possole and other cultural Mexican food. Resident #10 said he was not asked what he wanted to eat and the staff just brought him his meals. C. Record review The care plan, dated 11/20/24, documented the resident was at risk for nutritional weight loss related to protein caloric malnutrition. Pertinent approaches included offering food choices, cutting up the resident's food and providing hot sauce with meals. The resident's meal ticket documented two hot sauce packets were to be served with his meal tray and a coke with each meal. The meal ticket identified the resident liked Mexican food and to serve it to the resident when on the menu. D. Observations On 11/19/24 at 2:09 p.m. the resident received his meal which consisted of a grilled cheese sandwich and an applesauce. He did not receive any hot sauce with his meal. The resident was sleeping when his meal was served, and when he awoke he was assisted up into his wheelchair. The unidentified certified nurse aide (CNA) left the room and then returned with the grilled cheese sandwich. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The unidentified CNA did not ask the resident what he wanted to eat and brought him a grilled cheese. On 11/20/24 at 6:06 p.m. the dinner meal was served. He was served chicken nuggets cut up with gravy over the top of french fries and a dinner roll. The resident did not receive a coke or hot sauce as indicated on his meal ticket. E. Staff interview The registered dietitian (RD) was interviewed on 11/22/24 at approximately 3:00 p.m. The RD said Resident #10 was at nutritional risk. She said the resident liked to eat Mexican food. She said that he should be offered Mexican food a few times a week. She said the hot sauce should be served with each meal. The dietary manager (DM) was interviewed on 11/22/24 at 6:30 p.m. The DM said the resident did like to eat Mexican food. He said that the menu did have Mexican food weekly. He said hot sauce was available in the dining room. The DM reviewed the meal ticket and confirmed it documented he was to receive two hot sauces and also a coke were to be served with his meal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and staff interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicatable diseases and infections. Specifically, the facility failed to: -Ensure the facility's water management program (WMP) described the building water systems, identified specific areas where legionella could grow and spread and decided where and how to monitor control measures to prevent Legionella and waterborne pathogen growth; and, -Ensure scissors were cleaned in a sanitary manner after wound care. Findings include: I. Water management program A. Professional reference The Center for Disease Control and Prevention (CDC) recommendations for Legionella (3/15/24) was retrieved on 11/25/24 from https://www.cdc.gov/control-legionella/php/wmp/index.html. It read in pertinent part, Many buildings need a water management program (WMP) for their building water system or specific devices. WMPs identify hazardous conditions and outline steps to minimize the health impact of waterborne pathogens. Developing and maintaining a WMP is a multi-step process that requires continuous review. The seven steps of a Legionella WMP are to: Establish a WMP team; describe the building water systems; identify areas where legionella could grow and spread; decide where to apply and how to monitor control measures; establish interventions when control limits are not met; ensure the program runs as designed and is effective and document and communicate all the activities. Use flow diagrams and a written description to describe the building water systems. Include details like: How water enters the building, how water is distributed in the building, location of hot tubs, water heaters or boilers, and cooling towers, and where the building connects to the municipal water supply. Identify where potentially hazardous conditions could occur in the building water systems. Examples include areas where water temperature could promote Legionella growth or where water flow might be low. Establish control measures and limits for each hazardous condition. Control measures are actions taken in the building water systems to limit growth and spread of Legionella. They can include adding disinfectant, cleaning, and heating. Control limits are acceptable values for the control measures being monitored. They can include a maximum, minimum, and range of values. Control points are locations where control measures are applied. B. Facility policy and procedure (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

The Legionella Surveillance policy, revised 8/14/23, was provided by the nursing home administrator (NHA) on 11/18/24 at 1:30 p.m. The policy read in pertinent part, Legionella surveillance is one component of the facility's water management plans for reducing the risk of legionella and other opportunistic pathogens in the facility's water systems. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies.

Primary prevention strategies include: Cooling towers and potable water systems shall be routinely maintained. At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations. Non-potable water systems shall be routinely cleaned and disinfected. Nebulation devices shall be filled only with sterile fluid. Cold water shall be stored above 140 degrees Fahrenheit (F)and circulated at a minimum return of 124 (F).

-The Legionella Surveillance policy did not describe the building water systems; identify specific areas and locations where legionella could grow and spread; and decide where to apply and how to monitor control measures. The policy failed to include specific facility locations monitored such as water heaters, water filters, electronic and manual faucets, showerheads and hoses, ice machines, pipes, valves and fittings, cooling towers, medical devices (such as CPAP machines) and evaporative coolers. The policy did not include how often the cooling towers, potable water system, at-risk medical equipment, and non-potable water systems should be cleaned and disinfected and how to monitor the control measures.

C. Observations

On 11/18/21 at 9:30 a.m. the first floor Heritage Left wing, resident rooms #105 to room [ROOM NUMBER], were observed to be empty of residents. The rooms were observed as closed off or utilized as storage space.

D. Staff interviews

The NHA, the facility director of maintenance (FDM) and the deputy director (DD) were interviewed together on 11/21/24 at 5:08 p.m. The NHA said the facility's legionella surveillance policies were reviewed annually and during the monthly quality assurance and performance improvement meeting (QAPI). The NHA said she had not seen the CDC legionella toolkit (kit on developing water management programs to reduce risk for Legionnaires' disease) prior to the survey.

The FDM said he thought the facility's previous leadership team created the current legionella surveillance policy that was in use. The FMD said when he began as the maintenance director at the facility building he discovered multiple documents missing from the maintenance department and said it was possible the previous water management plan disappeared at that time. The FDM said he had not seen the legionella tool kit prior to the survey and said he was not aware a flow chart describing the facility water system and corresponding monitoring points were required for the facility's legionella surveillance policy.

The DD said the facility had a hallway of unoccupied resident rooms and these rooms contained dead legs (plumbing system with infrequent water flow).

The FMD said a housekeeping staff member went weekly to the unoccupied resident rooms to flush the toilets, sinks and showerheads and run the water.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Quentin St Aurora, CO 80045	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-However, the unoccupied resident hallway and monitoring activities were not included in the facility's legionella surveillance policy. 47350 II. Wound care A. Manufacturer guidelines The PDI Super Sani Cloth disinfecting wipes manufacturer guidelines (2024), were retrieved on 12/1/24 from https://pdihc.com/in-service/super-sani-cloth-disinfecting-wipes/. It included the following recommendations in pertinent part, Bactericidal, Tuberculocidal and Virucidal, effective for 30 microorganisms with a contact time of two minutes. May be used on hard nonporous surfaces. B. Observations Registered nurse (RN) #2 was providing wound care to Resident #8's bilateral heel wounds on 11/21/24 at 10:20 a.m. RN #2 obtained scissors and placed them on the clean work surface with the clean supplies. -She failed to clean the scissors before laying the scissors on her clean field. RN #2 removed the border dressing on the left heel and cleansed the wound with a wound cleanser, performed hand hygiene and placed new gloves on her hands. She opened a clean calcium alginate dressing and cut the dressing with the scissors to size to fit the wound on Resident #8's left heel. RN #2 was observed after wound care leaving the room with the scissors and returned to the medication cart. She was observed wiping the scissors down with PDI Sani hand wipes and immediately placed them back on the counter. She did not return to the room with the scissors. -She failed to sanitize and disinfect the scissors appropriately after use. C. Staff interviews RN #2 was interviewed on 11/21/24 at 11:00 a.m. RN #2 said the scissors that were used for wound care were to be cleaned and sanitized with bleach wipes or the purple top Sani Cloth germicidal wipes. She said the scissors should remain wet for five to ten minutes. She said the scissors were Resident #8's designated scissors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065380	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Community Living Center at Fitzsimons	1919 Quentin St Aurora, CO 80045

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The unit manager (UM) was interviewed on 11/21/24 at 11:03 a.m. The UM said all of the residents that required wound care had their own dedicated scissors that were kept with their wound supplies in their room. She said, after the scissors were used, they should be cleaned with the appropriate germicidal wipes, which were the PDI Super Sani Cloth germicidal wipes and stay wet for the correct amount of time. She said the PDI Sani Hand wipes were not the approved wipes for the disinfection and sanitization of the scissors after wound care. She said she instructed RN #2 to dispose of those scissors since RN #2 now had two scissors and could not differentiate which scissors belonged to Resident #8.