STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure residents were kept free from abuse for three (#1, #2 and #3) of six residents reviewed for abuse out of six sample residents. Resident #1, who had a diagnosis of Alzheimer's disease and a tendency to wander, had a plan of care which documented the resident had impaired safety awareness and wandered aimlessly. The interventions were to offer Resident #1 pleasant diversions, structured activities, food, conversation, television and card games. On 2/28/24 Resident #1 wandered into Resident #2's room. Resident #2 told Resident #1 he was in the wrong room and told him to leave. Resident #1 refused to leave the room which caused Resident #2 to push Resident #1 to the floor. A staff member, who was informed that Resident #1 went to the wrong room, rushed to the room but she was unable to open the door. Resident #1 was on the floor in front of the door and was moaning in pain. The staff member eventually opened the door. Resident #1 and Resident #2's roommate informed the staff member that Resident #2 pushed Resident #1. Resident #1 was sent to the hospital and was diagnosed with a fracture to his right femoral neck (the thigh bone below the hip joint). Resident #1 was admitted to the hospital and required surgical repair to heal the fracture. On 3/8/24 Resident #1 readmitted to the facility. The resident was placed on 15-minute checks for supervision related to Resident #1 being non-weight bearing when he returned to the facility. On 7/9/24 Resident #1, who remained on 15-minute safety checks, went into Resident #3's room. Resident #3 and his roommate asked Resident #1 to leave the room. Resident #1 refused and Resident #3 attempted to push Resident #1's wheelchair out of the room. Resident #1 hit Resident #3 in the face and pulled Resident #3's hair. A staff member intervened and removed Resident #1 from the room after the altercation occurred. Due to the facility's failure to prevent Resident #1 from wandering into another resident's room, Resident #1 was involved in a resident to resident altercation with Resident #2, which resulted in Resident #1 sustaining a right hip fracture and being sent to the hospital for surgical repair of his hip. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Additionally, after the resident to resident altercation with Resident #2, the facility again failed to implement person-centered interventions to prevent Resident #1 from wandering into other resident's rooms, which resulted in a resident to resident altercation between Resident #1 and Resident #3. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 8/6/24 at 3:00 p.m. It read in pertinent part, Residents have the right to be free from abuse. The resident abuse prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: -Identify and investigate all possible incident of abuse; -Investigate and report any allegations within timeframes required by federal requirements; -Protect residents from any further harm during investigations; -Establish and implement a quality assurance and performance improvement (QAPI) review and analysis of reports, allegations or findings of abuse; and, -Involved the resident council in monitoring and evaluating the facility's abuse prevention program. The Abuse and Neglect Clinical protocol, revised March 2018, was provided by the NHA on 8/6/24 at 3:00 p. m. It read in pertinent part, The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The physician and staff will order measures required to address the consequence of an abuse situation. The physician and staff will address appropriately causes of problematic resident behavior where possible. The staff and physician will monitor individuals who have been abused to address any issues regarding their medical condition, mood and function. The medical director will advise facility management and staff about ways to ensure that basic medical, functional and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately. The physician will advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. II. Incident of physical abuse between Resident #1 and Resident #2 on 2/28/24 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility abuse investigation documented that on 2/28/24 at 7:08 p.m. a resident informed the nurse that Resident #1 wandered into Resident #2's room. Resident #2 and his roommate asked Resident #1 to leave the room. Resident #1 refused to leave the room. Resident #2 got out of his recliner, walked over to Resident #1 and pushed Resident #1 to the floor. When staff arrived to the room, Resident #1 was on the floor in front of the room door moaning in pain. Resident #2 said Resident #1 fell . Resident #2's roommate and Resident #1 motioned that Resident #2 pushed Resident #1. The summary of the incident documented Resident #1 had a history of wandering and wandered into Resident #2's room and refused to leave. Resident #1 was sent to the hospital via an emergency ambulance. Resident #1 sustained a right femur fracture and required surgery to repair the injury. Upon Resident #1's return to the facility on [DATE], 15-minute safety checks were implemented for Resident #1. The facility substantiated the incident. III. Incident of physical abuse between Resident #1 and Resident #3 on 7/9/24 The 7/29/24 facility abuse investigation documented Resident #1 ambulated via his wheelchair into Resident #3's room. Resident #3 and his roommate told Resident #1 he was in the wrong room, but Resident #1 refused to leave. Resident #3 attempted to push Resident #1's wheelchair backwards out the door. Resident #1 swung at Resident #3 with his hands and hit Resident #3 in the face. Resident #1 then pulled Resident #3's hair. Resident #3 yelled out and staff entered Resident #3's room. Resident #1 was sitting in his wheelchair with his head down and Resident #3 was standing next to Resident #1. Both residents were assessed and no injuries were noted. Resident #1 did not answer questions about the incident. Resident #3 and his roommate were interviewed on 7/29/24 and said Resident #1 wandered into their room and refused to leave. Resident #3 and his roommate said Resident #1 hit Resident #3 and pulled Resident #3's hair before staff entered the room. The investigation documented the previous interventions included Resident #1 was on 15-minute safety checks. The investigation documented no new recommendations or interventions were implemented. -The facility failed to implement a new effective person-centered intervention to prevent Resident #1 from wandering into other resident's rooms in order to prevent an additional resident to resident altercation. The facility did not substantiate this allegation because it was not identified as abuse. -However, physical abuse occurred due to Resident #1 willfully hitting and pulling Resident #3's hair. IV. Observations During a continuous observation on 8/7/24, beginning at 10:50 a.m. and ending at 11:15 a.m. The following was observed: At 10:50 a.m., Resident #1 was laying on his bed with his head under a blanket. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	At 10:52 a.m., licensed practical nurse (LPN) #1 walked down one of the two hallways and completed 15-minute checks on other residents. LPN #1 failed to go down the hallway where Resident #1's room was located to complete a 15-minute check for the resident. At 11:00 a.m., Resident #1 was laying on his bed with his head under a blanket. At 11:05 a.m. LPN #1 assisted a resident and passed by Resident #1's room but did not look in Resident #1's room. At 11:15 a.m., Resident #1 was laying on his bed with his head under a blanket. Staff did not complete a 15-minute check. -The facility failed to complete a 15-minute check on Resident #1 from 10:50 a.m. to 11:15 a.m. V. Resident #1 A. Resident status Resident #1, age 89, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnosis included Alzheimer's disease. The 6/19/24 minimum data set (MDS) assessment revealed Resident #1 was unable to complete a brief interview for mental status (BIMS). A staff assessment for mental status revealed the resident was rarely understood, had moderate cognitive impairments, and was unable to identify the current season, the location of his room and staff names or faces. B. Resident #1's representative interview Resident #1's representative was interviewed on 8/7/24 at 11:58 a.m. The resident's representative said he understood the facility was not able to provide one on one attention to each resident but he felt Resident #1 needed a little more supervision. He said Resident #1 worked his entire life and did not like to sit still. The resident's representative said Resident #1 needed fulfilling activities such as being helpful instead of arts, crafts or games. The resident's representative said when he visited Resident #1 he took the resident outside on walks and it helped with limiting the resident from attempting to self-transfer. The resident's representative said he felt the supervision the facility provided for the resident could have been better. He said he was not sure what the facility did for Resident #1 when he was not at the facility visiting regarding care, activities and supervision. The resident's representative said he did not see staff complete 15- minute checks when he visited the facility. He said he felt Resident #1 did not get enough activities that he enjoyed or to keep him busy. C. Record review The elopement care plan, revised 2/5/24, revealed Resident #1 was an elopement risk and wandered. The intervention included Resident #1 had a wander guard for safety. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The facility failed to update Resident #1's care plan to include an intervention to keep Resident #1 from wandering into other residents' rooms after the resident to resident altercations on 2/28/24 and 7/29/24. The behavior care plan, revised 7/25/24, revealed the resident had behavioral issues that were due to his diagnosis of dementia, aggression and exit seeking behaviors. Interventions included the following: administering medications as ordered (7/26/21), anticipating and meeting the resident's needs (7/26/24), being aware of the resident's triggers and which of his behaviors triggered other residents (5/9/22), providing the opportunity for positive interactions and attention (8/18/22), explaining all procedures to the resident before starting cares and allowing him a few minutes to adjust to changes (7/26/21), intervening as necessary to protect the rights and safety of others (7/26/21), monitoring behavior episodes and attempting to determine an underlying cause (7/26/21) and providing an activities program that was of interest and accommodated the resident's status. -However, the facility failed to implement new interventions following the resident to resident altercations on 2/28/24 and 7/9/24. The care plan last had new interventions implemented on 6/18/22. The intervention documented on 7/25/24 had was already been implemented on 6/18/22. The 2/28/24 progress note documented the NHA was notified of an incident and arrived at the facility to start an investigation. The 2/29/24 progress note documented the staff were directed to a resident's room that Resident #1 had entered. Resident #1 was on the floor in front of the room door and was yelling out in pain. The staff opened the door and Resident #2's roommate pointed at Resident #2 and motioned that the resident pushed Resident #1. Resident #1 said Resident #2 pushed him to the floor. Resident #2 denied pushing Resident #1. The staff called 911 and Resident #1 was transferred to the emergency room for medical treatment. The 2/29/24 progress note documented the hospital notified the facility that Resident #1 had fractured his right hip and the resident was being admitted to the hospital. The 3/8/24 progress note documented the resident was admitted back to the facility. VI. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE] and discharged to a hospital on 4/14/24. According to the April 2024 CPO, diagnoses included heart failure and dementia. The 4/15/24 MDS assessment documented, based on staff assessment, the resident had a memory problem, experienced inattention and disorganized thinking. The assessment documented Resident #2 had physical behaviors directed towards others and verbal behaviors directed at others. B. Record review (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #2's cognitive care plan, revised 3/5/24, revealed he was at risk for impaired thought process due to dementia. Interventions included asking yes or no questions to determine the resident's needs, communicating with the resident and his family regarding his capabilities and needs and monitoring for changes in his cognitive function. Resident #2's behavioral care plan, revised 3/5/24, revealed the resident displayed conflictual and difficult behaviors with other residents due to adjusting to his living situation and his diagnosis of dementia. Interventions included intervening when the resident demonstrated inappropriate behaviors, helping the resident identify his stressors which led to behaviors and referring to counseling as needed. -The facility failed to update Resident #2's care plan after the resident to resident incident occurred on 2/28/24 and failed to inform staff the resident had a problem with other residents wandering into his room. A review of Resident #2's electronic medical record (EMR) did not reveal documentation regarding the resident to resident altercation with Resident #1 on 2/28/24. VII. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included Huntington's disease (neurological disorder that causes nerve cells in the brain to break down), muscle weakness and abnormalities of gait and mobility. According to the 7/18/24 MDS assessment, Resident #3 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. B. Record review Resident #3's communication care plan, revised 7/12/19, documented he had a communication problem due to Huntington's disease and was slow to find his words. Interventions included anticipating and meeting the resident's needs, being conscious of the resident's position when in groups to promote proper communication with others, discussing the resident's concerns or feelings regarding his communication difficulty and validating Resident #3's message by repeating what he said out loud. Resident #3's cognitive care plan, revised 7/12/19, documented he had an impaired thought process due to Huntington's disease. Interventions included administering medications as ordered, asking yes or no questions in order to determine the resident's needs and presenting just one thought at a time. Resident #3's neurological care plan, revised 7/16/19, documented he had an alteration in his neurological status due to Huntington's disease. Interventions included completing assessments for side effects of psychotropic medications, cueing and reorienting the resident as needed, giving medications as ordered and obtaining and monitoring lab or diagnostic work as ordered. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-A review of Resident #3's EMR did not reveal documentation regarding the resident to resident altercation with Resident #1 on 7/9/24. VIII. Staff interviews The NHA was interviewed on 8/7/24 at 10:00 a.m. The NHA said Resident #1 constantly wandered. She said Resident #1 wandered into the storage closet in the NHA's office when Resident #1 had to use the restroom. The NHA said she wondered if Resident #1 wandered into other rooms when he needed to use the restroom. The NHA said Resident #1 was placed on 15-minute checks when he returned from the hospital on 3/8/24. She said the facility felt 15-minute checks were a good intervention for Resident #1's wandering and because he was a high fall risk because it provided increased rounding and supervision for the resident. The activity director (AD) was interviewed on 8/7/24 at 1:43 p.m. The AD said she updated the activity calendar for each month and scheduled four to five group activities each day. She said she updated the activity care plans but she was pretty far behind. The AD said she reviewed the residents' diagnoses and cognitive levels to determine if a resident was independent or dependent upon staff of activities. The AD said Resident #1 was dependent upon staff to meet his emotional, intellectual, physical and social needs. The AD said she had not updated Resident #1's care plan. The AD said she was not aware Resident #1 enjoyed working. She said she planned to update his preferred activities to job-like activities. She said Resident #1 enjoyed participating in the ball toss groups but other activities did not interest him. The director of nursing (DON) and the NHA were interviewed together on 8/7/24 at 1:59 p.m. The DON said if a resident sustained several falls the facility implemented 15-minute safety checks. The DON said Resident #1 was a high fall risk and wandered which was why he was placed on an enhanced supervision level. The DON said the nurses and the CNAs completed the 15-minute checks. She said all of the staff were aware of the supervision levels for each resident and which residents were on 15-minute safety checks. The DON said the staff included Resident #1 in as many activities as possible and Resident #1 enjoyed walking. She said the staff were told if Resident #1 started walking then staff needed to follow behind him with his wheelchair. The DON said she was not aware Resident #1's care plan was not updated. The NHA said Resident #1 understood English but preferred speaking Spanish. The NHA said the facility had quite a few staff members who were fluent in Spanish and it helped when communicating with Resident #1. She said Resident #1 did not respond well to female staff whether the female staff spoke Spanish or not. She said Resident #1 usually only spoke to male staff who spoke Spanish. The NHA said she was not aware the staff who did not speak Spanish did not attempt to communicate with Resident #1 at all and just asked the male staff to translate for them. She said all staff needed to attempt to communicate with the resident. The NHA said she did not think to add the resident's preferred communication and staff to the resident's care plan. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON said she was not aware the staff signed off on the 15-minute checks without looking at the residents each time. The NHA said she was not aware the staff signed off on the15-minute checks without looking at the residents each time.