STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065391	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorado Veterans Community Living Ctr at Homelake	3749 Sherman Ave Monte Vista, CO 81144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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** 31821 Based on record review and staff interviews, the facility failed to ensure one (#1) of four residents reviewed for abuse out of four sample residents was kept free from abuse. Resident #2 and Resident #1 were involved in an altercation on 11/7/23. Resident #2 attacked Resident #1 and Resident #1 had injuries that included a scratch to his left forehead that was cleaned, a scratch on his nose, an abrasion to his left face/cheek, left jawline, left ear and bruising to the top of his left shoulder. There was redness around his neck and Resident #1 complained of severe left shoulder pain. Interventions added after the altercation were to move Resident #2 to a different hall and the resident was to be in the staff's line of sight. However, those interventions were not effective due to another altercation that occurred on 1/3/24. According to Resident #1, on 1/3/24 Resident #2 pulled him down and hit him. Resident #2 had redness/possible bruising to the right hand at the base of the third finger knuckle and an abrasion on the back of his left hand. Resident #1 sustained a bloody nose, a skin tear to his nose and left hand and two abrasions to the forehead. He also sustained a fracture to one of the fingers on his right hand. Resident #1 was sent to the hospital for evaluation and treatment. The facility failed to implement measures to protect Resident #1 from abuse perpetrated by Resident #2, who was known to be physically aggressive. Findings include: I. Facility policy The Abuse policy, revised 10/16/23, was provided by the nursing home administrator (NHA) on 2/13/2024 at 4:05 p.m. It documented in pertinent part, It is the policy of the (corporation) to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent mistreatment, abuse, neglect and exploitation. The (facility) will take necessary precautions to prevent resident abuse by anyone including staff members, other residents, volunteer, contracted staff, family members, resident representatives, visitors, and other individuals. II. Resident-to-resident altercation involving Resident #1 and Resident #2 on 11/7/23 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to the investigation, Resident #2 entered the room that adjoined his and went to the bed where Resident #1 was sleeping and began attacking him. Resident #2 attempted to choke Resident #1 but the Resident #1 was able to make enough noise to alert staff of the situation. Staff reported a certified nurse aide (CNA) attempted to pull the Resident #2 from Resident #1 and when she did, Resident #2 pushed her away from him. The CNA called for assistance and when staff entered the room they were able to get the Resident #2 away from Resident #1 and out of the room. Resident #2 was brought to the rotunda (common area) where he slept for the next hour. The medical doctor (MD), the NHA, the director of nursing (DON), the social services staff and family were notified of the incident. Law enforcement was notified at 5:20 p.m. Resident #1 sustained a scratch to his left forehead that was cleaned, dried and covered with protective dressing. He had a scratch on his nose, an abrasion to his left face/cheek, left jaw line, left ear and bruising to the top of his left shoulder. There was redness around his neck and the resident complained of severe left shoulder pain. The facility's action for the assailant was to add Resident #2's behaviors to the care plan and implement an intervention for the resident to be in the line of sight of the staff. Resident #2 was moved to a different hall. The conclusion of the internal investigation documented Resident #2 attacked and choked Resident #1. Resident #1 did not remember the incident. The CNA witnessed the incident and separated the residents immediately. III. Resident-to-resident altercation involving Resident #1 and Resident #2 on 1/3/24 According to the investigation, there was an unwitnessed altercation between Resident #1 and Resident #2 on 1/3/24. Resident #1 thought Resident #2 may have punched him. The registered nurse (RN) in charge thought maybe Resident #1 attempted to stand up and fell and hit his nose and side of his head due to injury marks and where he was found. A CNA observed what she thought was a resident had fallen. Resident #1 was mostly out of his wheelchair next to the wall with Resident #2 holding him by his shirt collar. The CNA redirected Resident #2 down to his hallway and called a RN to assess injuries in both residents. Resident #1 was interviewed by a police officer and, due to the resident having an abrasion to head, he was sent to the emergency room for further evaluation. The nature of suspected abuse was physical with hitting and Resident #1 having a fractured finger. The facility's action for Resident #2 was for the resident to be in the line of sight of the staff. Resident #2 was moved to a room at the end of the hall. The facility documented the incident was inconclusive due to the cognition of the residents. -However, the CNA did witness the resident being pulled by his collar which caused the fall and injuries to Resident #1 (see progress notes below). In addition, Resident #2 had redness/possible bruising to the right hand at the base of the third finger knuckle and an abrasion on the back of his left hand. IV. Resident #1 (continued on next page)

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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	A. Resident status Resident #1, age 87, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), dementia and age related physical disability, According to the 1/25/24 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The resident had verbal and physical behaviors directed towards others. B. Resident observation and interview Resident #1 was interviewed on 2/13/24 at 9:50 a.m. Resident #1 was lying down in his bed looking out the window. He said he stayed in his room most of the time as he liked to spend time alone. Resident #1 said, I don't want to talk about it but I tell you if I would not have been lying down I would have let him have it because I know [NAME] arts. C. Record review The care plan, initiated 5/15/23 and revised 1/25/24, identified the resident had impaired cognition function/dementia or impaired thought processes and dementia with behaviors. Interventions included keeping resident's routine consistent and trying to provide consistent caregivers as much as possible and monitor/document/report as needed any changes in cognitive function, specifically changes in decision making ability. The nurse note dated 1/3/24 at 7:53 p.m. documented in pertinent part, This nurse heard a CNA yelling for a nurse. Upon arrival to the hallway the resident was found lying on the floor with his head against the wall with nose bleeding, skin tear to nose and skin tear to left hand with two abrasions to the forehead. The resident was stating another resident made him fall and hit him. The resident complained of shoulder pain which was chronic. Administration and medical doctor notified with order to send the resident to the emergency room (ER) for evaluation. Social service notified as well as family of possible altercation. The Sheriff's office notified and came into the facility to interview residents. The ambulance arrived to transport to hospital. Report called to nurse at hospital. The resident was alert smiling and talking to emergency medical technicians (EMT). The EMT asked the resident if he hit his head and he stated, 'I don't remember as my memory isn't very good anymore'. The 72-hour follow up notes dated 1/4/24 at 6:31 a.m. documented in pertinent part, The resident was back from hospital altercation with another resident. The resident received his tetanus shot, had some lacerations, bruising and a fracture to his finger on the right hand. The resident complained of pain and received medication without complications. The physician note dated 1/6/24 at 3:54 p.m. documented in pertinent part, Follow up ER visit from 1/3/24. Unwitnessed incident resulted in skin tear, abrasions and fracture that is not displaced of the finger. Splint on for at least three weeks. V. Resident #2 A. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #2, age 76, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included dementia and adult failure to thrive. According to the 12/7/23 MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. The resident had no behavioral symptoms. B. Record review The care plan, initiated 7/22/22 and revised 12/7/23, identified the resident had potential to be physically aggressive. Interventions include providing physical and verbal cues to alleviate anxiety and give positive feedback. Document observed behaviors and attempt interventions and behaviors. When the resident becomes agitated, intervene before agitation escalates. Guide way from source of distress, engage calmly in conversation. If the response was aggressive, the staff were to walk away calmly and approach later. The behavior note dated 11/7/23 at 10:47 a.m. documented in pertinent part, The resident made verbal threats toward this registered nurse (RN) while rounding on him this morning. This RN left the room immediately to de-escalate the situation. Later this resident was apologetic towards this RN. Social services staff notified. The 72 hour follow up note dated 11/8/23 at 6:23 a.m. documented in pertinent part, The resident stood in the door of his room wrapped in his blanket peeking down the hallway for a while during the night. He later came toward the rotunda and went down the blue hall entering another resident's room where he was caught just before attempting to get into an occupied bed. He was redirected back to his room where he stayed for about an hour. During this time, the CNA attempted to assist him with his clothing as he had his pants on backwards and he raised his hand at her and stated, 'Don't tell me what to do.' The CNA felt unsafe so she left the room. After she left he exited his room and went toward the rotunda. She exited another room and saw him attempting to enter a female resident's room. He was again redirected and brought to the rotunda and offered a snack and apple juice. He ate and then fell asleep in a recliner in the rotunda. The nurse note dated 1/3/24 at 7:53 p.m. documented in pertinent part, Resident #2 wandered at night and was half way down the hall and a CNA came out of another room seeing Resident #2 was leaning over the other resident with his hands on his sweater to try and lift the resident up. Resident #1 was lying on the floor against the wall next to the wheelchair. Resident #1 was assisted by CNA to the rotunda. Resident #2 said, 'I was trying to help him up.' Resident #2 was observed to have redness/possible bruising to the right hand at the base of the third finger knuckle and abrasion on the back of his left hand. VI. Staff interviews CNA #1 was interviewed on 2/13/24 at 10:52 a.m. CNA #1 said Resident #1 did not like to go out of his room as he did not feel comfortable around others. She said the resident had his good and bad days but was good with her and she had no problems with him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA #2 was interviewed on 2/13/24 at 11:02 a.m. CNA #2 said she was familiar with Resident #2. She said the resident had a lot of behaviors especially when providing care. She said he would yell and cuss at staff and did not like to be bothered. She said she was not working any of the times any of the resident incidents happened but she was told of the resident to resident altercations between Resident #1 and Resident #2. She said the residents did not have any interventions or guidelines to follow that she was aware of to prevent further altercations. She said she would find out. CNA #2 was interviewed again on 2/13/24 at approximately 11:15 a.m. CNA #2 said the interventions for Resident #2 were to monitor him and keep him within line of sight. RN #1 was interviewed on 2/13/24 at 11:15 a.m. RN #1 said he was familiar with both Resident #1 and Resident #2 and was aware of the resident to resident altercations between them. He said the residents did not have any interventions in place. He said Resident #2 did not have any behaviors. The social service director (SSD) and NHA were interviewed together on 2/13/24 at 1:29 p.m. The SSD said he was the abuse coordinator for the facility. He said the resident to resident altercation on 11/7/23 between Resident #1 and Resident #2 was substantiated as it had been witnessed by staff. He said he was called into the facility for the second incident on 1/3/24. He said the two residents were found together and a CNA witnessed Resident #2 grabbing the collar of Resident #1 while he was on the ground. He said Resident #1 was sent to the hospital due to his injuries and Resident #2 had reported no injuries but after the nurse assessed Resident #2 he had some bruising]and scraped knuckles on his hands. He said both residents were confused and they were not really with it. He said the investigation identified Resident #1 was hit but he could not recall the specifics of the incident. The NHA said Resident #1 had short term memory because he could not remember what happened five minutes ago. She said Resident #1 could not recall the incidents but would not say what really happened.