STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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** 38185 Based on record review and interviews, the facility failed to ensure four (#2, #9, #10 and #8) of four resident reviewed for abuse out of 10 sample residents were kept free from abuse. Specifically, the facility failed to ensure multiple residents, including Resident #2 and Resident #8, were kept free from physical abuse by addressing Resident #1's physically aggressive behavior. Resident #1 physically assaulted Resident #2 on four occasions and continuously targeted Resident #2. The facility was aware Resident #1 was territorial over his space and did not like to be touched. Facility staff failed to intervene timely on multiple occasions to prevent multiple physical abuse incidents by Resident #1 toward Resident #2. By failing to put effective person-centered interventions into place, Resident #1 physically assaulted multiple residents on both secured units on eight occasions within less than three months, including Resident #2 on four occasions. Findings include: I. Facility policy and procedure The Resident to Resident Altercation policy and procedure, revised September 2022, was provided by the nursing home administrator (NHA) on 9/17/24 at 12:31 p.m. It revealed, in pertinent part, All altercations, including those that may represent resident to resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to the staff. Behaviors that may provoke a reaction by residents or others include: verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing; taking, touching or rummaging through other's property; and wandering into others' rooms/space. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	If two residents are involved in an altercation, staff: separate the residents, and institute measures to calm the situation; identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; notify each resident's representative and attending physician of the incident; review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of interventions meant to address distressed behavior for one or both residents; consult with the attending physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; make any necessary changes in the care plan approaches to any or all of the involved individuals; document in the resident's clinical record all interventions and their effectiveness; consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team. II. Failure to address Resident #1's physically aggressive behavior A. Resident #1 1. Resident status Resident #1, age 73, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included dementia with behavioral disturbance and major depressive disorder. The 6/13/24 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory impairment and had severe impairment in making decisions regarding tasks of daily life. He required supervision with all activities of daily living. It indicated that the resident exhibited verbal behavioral symptoms and rejection of care one to three days out of the assessment period. 2. Record review The September 2024 CPO documented the following prescribed medications: -Risperdal oral tablet (antipsychotic medication) 1 mg (milligram), give one tablet by mouth two times a day for agitation; ordered on 8/7/24; -Sertraline (Zoloft) HCl oral tablet (antidepressant medication) 50 mg, give 50 mg by mouth every day shift for unspecified dementia, unspecified severity with behavioral disturbance, ordered on 8/26/24; -Trazodone HCl oral tablet (antidepressant medication) 50 mg, give 100 mg by mouth at bedtime for dementia with severe behavioral disturbance, ordered on 8/26/24; -Trazodone HCl oral tablet 50 mg, give 25 mg by mouth two times a day for dementia with severe behavioral disturbance, ordered on 8/27/24; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-14 day behavior monitoring related to change in environment from moving units every day and night, ordered 8/22/24; and, -Monitor behaviors for antipsychotic use as exhibited by (aeb) physical aggression, agitation every shift and as needed, ordered on 8/6/24. The activities of daily living (ADL) care plan, revised on 2/8/24, documented Resident #1 had a self-care deficit and required assistance with ADLs related to cognitive impairment. It documented Resident #1 ambulated independently but required supervision for safety on the secured unit due to the resident's elopement risk. The cognition care plan, revised on 6/20/24, documented Resident #1 exhibited cognitive loss related to a diagnosis of dementia with behavioral disturbance. The interventions included encouraging routine daily decision making; explaining all care before providing to reduce resident tension and promote a comfortable experience; inviting, encouraging, reminding and escorting the resident to activity programs; monitoring changes in cognition and notifying the physician. The behavioral care plan, revised on 5/30/24, documented Resident #1 exhibited physically aggressive behaviors and had a history of a physical altercation with another resident. The interventions included diverting Resident #1 by giving him alternative objects or activities (5/30/24); if the resident becomes physically aggressive, staff to attempt to de-escalate the situation through use of separation, redirection, distraction and other appropriate methods to ensure safety of both parties. If de-escalation attempts are unsuccessful, the resident will be placed on one to one observation until the situation has resolved (5/30/24); listening to the resident and try to calm him (5/30/24); observing for non-verbal signs of physical aggression e.g., rigid body position, clenched fist, etc. (5/30/24); removing the resident from the environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice (5/30/24); if the resident becomes agitated, activities to take the resident off the 700 hall to a less stimulating environment in the facility until he is able to calm down (7/19/24); referring the resident to a long-term care dementia unit that suites the residents' needs (8/5/24); redirecting the resident with snacks and activities to de-escalate and distract the resident (8/6/24); medication review and adjustment (8/7/24); ensuring a functioning door knob on the resident's room door to ensure personal space was reserved for the resident per personal preference (8/7/24); and moving Resident #1 to the 900 hall (8/20/24). The 7/7/24 physician progress note documented that Resident #1 was discussed during the interdisciplinary team (IDT) meeting on 6/20/24. The physician documented that the resident had been admitted to the facility for four months and he became aware of his significant behavioral issues on 6/20/24. The physician documented, When seen, he presents as a large man weighing 240 lbs (pounds). He stated that he does not belong here and that he would like to leave this facility. He has significant impairments of cognition, insight and judgment. Given the repeated incidents of aggressive behavior which occurred over a timeframe of four and half months, one can conclude that he is not merely adjusting. He was given a significant amount of time to adjust to his new environment but his behaviors do not appear to be lessening without a trial of psychotic medication. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Given his repeated episodes of physical aggression, this writer chose to prescribe Risperidone. Risperidone was ordered at 0.25 mg in the morning and 0.5 mg in the evening. This writer had been informed by nursing staff that the treatment with Risperidone appeared to be effective. There were still occasions where he became agitated, but he was more easily redirected and he does not appear to have become physically aggressive. III. Incidents of physical abuse A. Incident of verbal abuse toward Resident #9 on 7/8/24 The 7/8/24 nursing progress note documented, at lunch at approximately 12:20 p.m. in the dining room, Resident #1 was sitting at a table and Resident #9 was sitting at another table. Resident #1, yelled at Resident #9, You are a [expletive] [expletive] that needs to leave. He gets on my nerves making that sound with his [expletive] tongue hanging out. The progress note documented Resident #1 was told by the nursing staff that while he was in the dining room, he needed to be respectful, however Resident #1 continued making statements towards the other resident. The nurse documented she moved Resident #9 closer to her and engaged him in watching the television so he would not hear Resident #1's comments. An abuse investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the verbal abuse incident by Resident #1 toward Resident #9 on 7/8/24. There was no further documentation of the incident. -The facility failed to provide documentation that person centered interventions had been implemented to prevent further incidents of abuse. B. Incident of physical abuse toward Resident #2 on 7/8/24 The 7/8/24 IDT progress note documented the nurse watched as the aggressor (Resident #1) was talking to another nurse on the unit. Resident #2 tapped Resident #1 on the shoulder, as sometimes she did to other residents on the unit. Resident #1 turned around and shoved Resident #2 into the wall with his left arm on her chest before the nurse could stop him. Resident #2 hit the wall with the back of her head. An abuse investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the physical abuse incident by Resident #1 toward Resident #2 on 7/8/24. There was no further documentation of the incident. -The facility failed to provide documentation that person-centered interventions were put into place to prevent further incidents of abuse. C. Incident of physical abuse toward Resident #2 on 7/13/24 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 7/13/24 e-interact change of condition assessment documented when Resident #1 was asked why he punched Resident #2, he said Resident #2 does not belong here. The nurse encouraged the resident to avoid Resident #2 and removed him from the area. The NHA and director of nursing (DON) were notified. The 7/13/24 e-interact change of condition documented the nurse was talking to Resident #1 when Resident #2 walked up and touched Resident #1 on the back. Resident #1 turned around and punched Resident #2 in the abdomen. Resident #2 cried for a little bit and then was redirected back to her room with no further signs or symptoms of pain or grimacing. The 7/16/24 IDT progress note documented that Resident #1 was talking to the nurse when Resident #2 came behind him and touched his back. Resident #1 moved around and punched Resident #2 on the abdomen. The intervention included for the resident to be seen by the physician and adjust medications as necessary. The 7/14/24 abuse investigation documented Resident #1 was talking with the nurse when Resident #2 came from behind Resident #1 and touched his back. Resident #1 turned around and punched Resident #2 in the abdomen, saying Resident #2 did not belong there. The facility document]ed that based on the internal investigation, it did not seem there was contact made between Resident #1 and Resident #2. -However, according to the nurses' documentation, Resident #1 punched Resident #2 in the abdomen using his left arm, which would indicate physical abuse. Resident #2, who had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15, was able to express pain immediately after being punched, but unable to recall the incident the next day, and, therefore, likely unable to remember that in touching Resident #1 on his back, she would trigger an aggressive response from Resident #1. D. Incident of physical abuse toward Resident #2 on 7/20/24 The 7/21/24 nursing progress note in Resident #2's medical record documented that there were no issued post altercation on 7/20/24 when a male resident (Resident #1) slapped the left side of Resident #2's face before dinner. -There was no further documentation in Resident #2's medical record. The 7/22/24 nursing progress note in Resident #1's medical record documented there were no issues post altercation on 7/20/24 with a female resident. -There was no further documentation in Resident #1's medical record of the incident. An abuse investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the physical abuse incident by Resident #1 toward Resident #2 on 7/20/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 7/24/24 nursing progress note documented Resident #1 attempted to swat at another resident that evening when the other resident was in his space. Resident #1 also began cursing at the other resident. The nurse provided Resident #1 re-direction and he calmed down. The 7/29/24 nursing progress note documented Resident #1 had been exit seeking multiple times throughout the day and exhibiting multiple episodes of aggressive verbal behaviors toward other residents. It indicated Resident #1 made verbal statements such as, Get the [expletive] away. E. Incident of physical abuse toward Resident #2 on 8/3/24 The 8/3/24 nursing progress note documented the nurse saw Resident #1 holding Resident #2's throat with his right hand while pushing Resident #2 against the wall. The nursing staff immediately intervened and separated the residents. Resident #1 was exit seeking, stating, I need to get out of here. Resident #1 said, I told her to get away from me. The IDT progress note documented Resident #1 was found holding Resident #2's throat and pushed her up against the wall. The interventions included reviewing Resident #1 during the psych-pharm meeting to address medication changes and possible transfer to another facility. The 8/4/24 abuse investigation documented the conclusion with the following: Documentation review concluded that there were no prior indicators that any physical aggression would be displayed by either parties. Staff was unharmed and able to redirect residents after the incident with no complications. -However, this incident of physical aggression by Resident #1 toward Resident #2 had not been the first occurrence and Resident #1 was frequently aggressive toward Resident #2. In addition, Resident #1 was witnessed by staff grabbing Resident #2 by the throat and pushing her up against the wall, which indicated physical abuse. F. Incident of physical abuse toward Resident #10 on 8/7/24 The 8/8/24 nursing progress note documented Resident #1 was pulling another male resident (Resident #10) backwards with his hands around the other male residents' waist out of Resident #1's room. The nurse was at the other end of the hallway and told Resident #1 to stop. Resident #1 then threw Resident #10 to the floor, he landed on his left side and slid toward the wall from the force of Resident #1's throw. Resident #1 said, What the [expletive] are you doing in my room. The nurse and the certified nurse aide (CNA) removed Resident #10 away from Resident #1. Resident #1 entered his room and shut the door. Frequent monitoring of Resident #1 was put into place. The 8/7/24 IDT progress note documented the interventions included ensuing functioning of the door knob on Resident #1's room door to ensure personal space is reserved for Resident #1. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 8/7/24 abuse investigation documented Neither resident showed the ability to have willful intent in the situation and neither resident showed any type of distress following the situation. Residents were monitored and never showed signs of baseline behavior or mood changes or injuries from the event. -However, Resident #1, who was consistently physically aggressive when other residents entered his personal space, physically grabbed Resident #10, pushed him out of his room, and then threw him across the hallway, so forcefully, that Resident #10 fell to the ground and slid into the opposite wall. Resident #1 clearly and willfully chose to remove Resident #10 from his room in a physically aggressive manner, which indicated physical abuse. The 8/7/24 nursing progress note documented after dinner, Resident #1 was verbally aggressive and tried to stomp his feet at another resident who was standing in front of him outside of the dining room. G. Incident of physical aggression toward another resident on 8/8/24 The 8/8/24 nursing progress note documented Resident #1 was seen by staff attempting to kick and hit another resident throughout the day. -Resident #1's medical record did not include any further documentation of the incidents. H. Additional incidents of verbal and physical aggression displayed by Resident #1 The 8/16/24 nursing progress note documented Resident #1's power of attorney (POA) was informed of the resident's behavior and a possible room change to another secured unit within the facility, when a room became available. The POA was agreeable, however voiced Resident #1 would not do well with a roommate. The 8/17/24 behavior monitoring documented Resident #1 was aggressive toward some residents until he went to bed. It did not include any other information regarding Resident #1's aggressive behavior. The 8/18/24 behavior monitoring documented Resident #1 became frustrated with another resident yelling and attempted to hit. It did not include any further information. The 8/19/24 nursing progress note documented Resident #1 was more agitated than usual that morning. Resident #1 kept trying to exit the door and asked when he was able to leave. Resident #1 was irritated by other residents and commented a couple of times, What are those [expletive] doing here. The 8/20/24 psychiatrist progress note documented a recommendation to increase the Risperidone to 1.5 mg daily (0.75 mg in the morning and 0.75 mg in the evening) due to Resident #1's increased agitation. The psychiatrist recommended active monitoring of the resident and his surroundings to minimize known stressors such as loud noises, excessive lighting and multiple residents being too close. The 8/20/24 nursing progress note documented at night on 8/19/24, Resident #1 was speaking with a female resident in a wheelchair. Resident #1 became agitated and raised his right hand toward the female resident. The facility staff intervened quickly and removed the female resident prior to being struck. The resident was later moved to the 900 unit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 8/22/24 nursing progress note documented Resident #1 was restless, was rearranging things in his bedroom, verbally aggressive and agitated. Resident #1 was looking for a knife to cut his oxygen tubing. The oxygen tubing was removed after Resident #1 attempted multiple times to tie the tubing around his neck. I. Incident of physical abuse toward Resident #8 on 9/6/24 The 9/4/24 nursing progress note documented Resident #1 was cursing and pushing on the doors, asking to leave. Resident #1 was swatting at another resident for being loud on the phone. The 9/6/24 abuse investigation documented Resident #1 appeared agitated while he was sitting next to Resident #8, who was talking on the phone. The nurse heard three punching sounds and saw Resident #8 with his left arm raised, trying to block Resident #1. Resident #8, who insisted he stayed on the phone with his spouse, was assisted to his room to talk on the phone. Resident #8 said he did not know why Resident #1 hit him, as he was just speaking to his spouse on the phone. Resident #8 was observed with two skin tears on his left arm (left wrist and left forearm). Resident #1 was discharged to another facility. The conclusion documented the following: The facility does not believe that abuse occurred in this situation. It was reported due to the unknown nature of the skin tears and the fact that the resident was unable to share how it happened. The interviews show no knowledge of how this may have occurred and no allegations towards any person. There has been no baseline behavioral changes and the resident denies being in pain or fear. -However, the nurse distinctly heard three punching sounds, saw Resident #8 with his left arm raised to block Resident #1 and Resident #8 had skin tears to his left wrist and left forearm. Resident #8 was interviewed in the moment, for which he said he did not know why Resident #1 hit him for speaking on the phone with his spouse, which would indicate physical abuse. The 9/9/24 IDT progress note documented staff and the resident were educated on providing a cordless phone to Resident #8 to use in his room during personal communication with his spouse. Resident #8 was hard of hearing and spoke loudly, interrupting others. IV. Staff interviews The clinical consultant (CC) and the DON were interviewed on 9/16/24 at 12:45 p.m. The CC said every resident had the right to be free from abuse. She said Resident #1 had been a difficult resident because he was very physically and verbally aggressive since his admission to the facility. She said Resident #1 no longer resided at the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The assistant director of nursing (ADON), the DON and the CC were interviewed on 9/16/24 at 2:14 p.m. The DON said Resident #1 was a difficult resident. She said he was physically and verbally aggressive toward other residents and sometimes staff. She said there were oftentimes Resident #1 was easily re-directed away from an aggressive situation. The DON said Resident #1 did not like anyone in his personal space, did not like it if another resident entered his room and did not like loud noises. She said when triggered, Resident #1 would become physically and verbally aggressive. The CC said the facility had not investigated several incidents of physical abuse documented in the medical record. She said there had been turnover in the NHA and the DON position and felt that led to the lack of investigations and follow through. Cross reference F610: the facility failed to conduct an investigation after incidents of physical aggression by Resident #1. Cross reference F609: the facility failed to report incidents of abuse to the state survey agency (SSA) which involved Resident #1. The DON said Resident #1 had a tendency to go after Resident #2. She said Resident #1 was easily triggered by Resident #2. The DON acknowledged Resident #1 had physically assaulted Resident #2 on multiple occasions. She said they both had resided on the same secured unit. The DON said Resident #1 was not moved off the secured unit (700 unit) to the other secured unit (900 unit) until 8/20/24 because there was not an available bed. She said once a bed became available, the facility moved Resident #1. The DON said the staff on the secured unit (700 unit) were aware Resident #2 triggered Resident #1. She said Resident #1 should have been within line of sight at all times. She said she did not know if that was consistently happening, other than when they scheduled a one to one staff member with Resident #1 immediately following an incident of abuse. She said the one to one staff member would typically last three days. The DON said on 9/4/24, Resident #1 was swatting at Resident #8 because Resident #8 was talking to his spouse on the phone and saying the same thing over and over. She said Resident #1 was irritated and swatted at Resident # 8. She said on 9/4/24, Resident #1 did not make contact. The DON said on 9/6/24, Resident #1 made contact with Resident #8 when he was talking on the phone with his spouse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The CC said the facility missed an opportunity on 9/4/24 to identify that Resident #8 talking on the phone with his spouse was a trigger for Resident #1 and a precursor to the incident of abuse that took place on 9/6/24, two days later. The CC said the facility management had not been reviewing progress notes as part of their daily practice to review and identify circumstances such as the 9/4/24 to the 9/6/24 incident and placed Resident #1 on an immediate one to one to prevent physical abuse. She said she had not realized this until the survey process. The CC said she had assisted the facility, during the survey process, in developing a performance improvement plan which centered around identifying these triggers and circumstances and putting preventative measures in place to prevent physical abuse. The CC said the incidents involving Resident #1 on 7/13/24, 8/3/24, 8/7/24 and 9/6/24 were considered physical abuse. She said she had provided training to the management at the facility during the survey process. The social services director (SSD) was interviewed on 9/16/24 at 2:33 p.m. The SSD said the facility had been trying to move Resident #1 to another facility, however because of his payor status and the resident's family living out of town, it was difficult. She said the facility had identified that Resident #1 had a friend from Alcoholics Anonymous (AA) that would visit. She said after the friend would visit, Resident #1 was easily triggered and would attempt to leave the secured unit. The SSD said she communicated that trigger to Resident #1's family and they had an in-person meeting to speak with the friend where it was determined if the friend came to visit, they needed to sit in a common area. The SSD said Resident #1 was very territorial. She said he did not like to be touched, someone to enter his personal space, nor enter his room. She said it was difficult to manage his triggers at times since he was on a secured unit where residents would wander. The SSD said the ultimate goal of Resident #1's family was to move him out of state to be with them, but that would be in the future. She said Resident #1 was discharged to another facility which was fully secured instead of being on a smaller unit. She said she felt that he would have more space in that environment.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38185 Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for three (#1, #9 and #2) of four residents reviewed for abuse out of 10 sample residents. Specifically, the facility failed to report incidents of physical abuse involving Resident #1 to the State Survey Agency (SSA). Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy and procedure, revised September 2022, was provided by the nursing home administrator (NHA) on 9/17/24 at 12:31 p.m. It revealed in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of investigations are documented and reported. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility. II. Record review A. Incident of verbal abuse toward Resident #9 on 7/8/24 The 7/8/24 nursing progress note documented, at lunch at approximately 12:20 p.m. in the dining room, Resident #1 was sitting at a table and Resident #9 was sitting at another table. Resident #1, yelled at Resident #9, You are a [expletive] [expletive] that needs to leave. He gets on my nerves making that sound with his [expletive] tongue hanging out. The progress note documented Resident #1 was told by the nursing staff that while he was in the dining room, he needed to be respectful, however Resident #1 continued making statements towards the other resident. The nurse documented she moved Resident #9 closer to her and engaged him in watching the television so he would not hear Resident #1's comments. The facility was unable to provide documentation that the incident of verbal abuse was reported to the SSA. B. Incident of physical abuse toward Resident #2 on 7/8/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	09/17/2024

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/8/24 interdisciplinary team (IDT) progress note documented the nurse watched as the aggressor (Resident #1) was talking to another nurse on the unit. Resident #2 tapped Resident #1 on the shoulder, as sometimes she does to other residents on the unit. Resident #1 turned around and shoved Resident #2 into the wall with his left arm on her chest before the nurse could stop him. Resident #2 hit the wall with the back of her head. The facility was unable to provide documentation that the incident of verbal abuse was reported to the SSA. C. Incident of physical abuse toward Resident #2 on 7/20/24 The 7/22/24 nursing progress note in Resident #1's medical record documented there were no issues post altercation on 7/20/24 with a female resident. The facility was unable to provide documentation that the incident of verbal abuse was reported to the SSA. D. Incident of physical aggression toward another resident on 8/8/24 The 8/8/24 nursing progress note documented Resident #1 was seen by staff attempting to kick and hit another resident throughout the day. The facility was unable to provide documentation that the incident of verbal abuse was reported to the SSA. III. Staff interviews The clinical consultant (CC) and the director of nursing (DON) were interviewed on 9/16/24 at 12:45 p.m. The CC said, during the survey process, the facility had realized they did not have a good amount of abuse investigations, which were requested. She said there had been turnover in the NHA and the DON position recently and they were unable to determine if some incidents of abuse had been investigated. The CC said some of the incidents of abuse that were requested during the survey process were not reported to the state survey agency. The CC said the incidents involving Resident #1 on 7/8/24, 7/20/24 and 8/8/24, 8/7/24 should have been reported to the SSA. The CC said she had called the NHA, who was not at the facility, and provided over the phone education on the process of reporting abuse to the SSA. The CC said all incidents of abuse or allegation of abuse should be reported to the SSA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 38185 Based on record review, the facility failed to investigate incidents of physical aggression involving one (#1) of four residents reviewied out of 10 sample residents. Specifically, the facility failed to conduct investigations of physical abuse involving Resident #1. Findings include: I. Facility policy and procedure The Resident to Resident Altercations policy and procedure, revised September 2022, was provided by the nursing home administrator (NHA) on 9/17/24 at 12:31 p.m. It revealed in pertinent part, All altercations, including those that may represent resident to resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. II. Incidents of abuse A. Incident of verbal abuse toward Resident #9 on 7/8/24 The 7/8/24 nursing progress note documented, at lunch at approximately 12:20 p.m. in the dining room, Resident #1 was sitting at a table and Resident #9 was sitting at another table. Resident #1, yelled at Resident #9, You are a [expletive] [expletive] that needs to leave. He gets on my nerves making that sound with his [expletive] tongue hanging out. The progress note documented Resident #1 was told by the nursing staff that while he was in the dining room, he needed to be respectful, however Resident #1 continued making statements towards the other resident. The nurse documented she moved Resident #9 closer to her and engaged him in watching the television so he would not hear Resident #1's comments. An abuse investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the verbal abuse incident by Resident #1 toward Resident #9 on 7/8/24. There was no further documentation of the incident. B. Incident of physical abuse toward Resident #2 on 7/8/24 The 7/8/24 interdisciplinary team (IDT) progress note documented the nurse watched as the aggressor (Resident #1) was talking to another nurse on the unit. Resident #2 tapped Resident #1 on the shoulder, as sometimes she did to other residents on the unit. Resident #1 turned around and shoved Resident #2 into the wall with his left arm on her chest before the nurse could stop him. Resident #2 hit the wall with the back of her head. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An abuse investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the physical abuse incident by Resident #1 toward Resident #2 on 7/8/24. There was no further documentation of the incident. C. Incident of physical abuse toward Resident #2 on 7/20/24 The 7/22/24 nursing progress note in Resident #1's medical record documented there were no issues post altercation on 7/20/24 with a female resident. -There was no further documentation in Resident #1's medical record of the incident. An abuse investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the physical abuse incident by Resident #1 toward Resident #2 on 7/20/24. D. Incident of physical aggression toward another resident on 8/8/24 The 8/8/24 nursing progress note documented Resident #1 was seen by staff attempting to kick and hit another resident throughout the day. -Resident #1's medical record did not include any further documentation of the incidents. An investigation was requested on 9/16/24, during the survey process. The facility was unable to provide documentation that an investigation had been completed following the incident of physical aggression by Resident #1 toward another resident. III. Staff interviews The clinical consultant (CC) and the director of nursing (DON) were interviewed on 9/16/24 at 12:45 p.m. The CC said, during the survey process, the facility had realized they did not have a good amount of abuse investigations, which were requested. She said there had been turnover in the NHA and the DON position recently and they were unable to determine if some incidents of abuse had been investigated. The CC said some of the incidents of abuse that were requested during the survey process were not investigated. The CC said the incidents involving Resident #1 on 7/8/24, 7/20/24 and 8/8/24, 8/7/24 should have been investigated. The CC said she had called the NHA, who was not at the facility, and provided over the phone education on the process of investigating abuse and reporting abuse to the SSA. The CC said all incidents of abuse or allegation of abuse should be investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assistant director of nursing (ADON) was interviewed on 9/16/24 at 2:59 p.m. The ADON said she had reported the incident on 7/20/24 involving Resident #1 and Resident #2 to the DON and the NHA. She said she had documentation on her cell phone that she contacted the former DON on 7/20/24 at 4:35 p.m. and the current NHA at 4:38 p.m.