STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821 Based on observations, resident and staff interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment for resident rooms and on two of six hallways. Specifically, the facility failed: -To ensure walls, ceilings, doors, and floors were repaired, painted and properly maintained; and, -To ensure water temperatures were maintained at safe and comfortable temperatures. Findings include: I. Resident environment A. Initial observations Observations of the resident living environment, conducted on 11/30/22 at 11:45 a.m., revealed: room [ROOM NUMBER]: The wall next to the restroom had two dime sized holes. The floor next to the resident's bed was stained with brown dried liquid. The baseboard cove had a section approximately eight inches long pulling away from the wall. room [ROOM NUMBER]: The wall in the restroom had a large hole approximately eight inches long by four inches wide. The baseboard cove was missing a section approximately eight inches long. The restroom light was burned out. The window blind was broken and hanging on the right side of the window. The lights in the hall next to room [ROOM NUMBER] did not have light bulbs and the cover was not in place on two lights. room [ROOM NUMBER]: The heater vent, approximately five feet long, was falling off the wall next to the resident's bed. (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: 065100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2022
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: The wall next to the restroom had damaged sheetrock approximately 12 inches by four inches and the baseboard cove was missing a section. The restroom door was damaged from the wheelchair hitting it. There was damaged sheetrock behind the door with a missing baseboard cove approximately six inches long. The floor next to the dresser had spilled and dry liquid. The electrical box outside of room [ROOM NUMBER] had exposed wires from the junction box to the ceiling, which were exposed. room [ROOM NUMBER]: The wall next to the resident's bed had peeling wall stickers. The heater vent next to the headboard had sharp and jagged edges with no cover. The floor next to the head board was dirty and stained with red dried liquid. The wall above the resident's bed had several dime- sized holes. The north side shower room in the secured unit had a broken towel rack. The wall next to the shower had exposed corner metal and sheetrock which was being repaired but not completed. The wall next to the mirror had two nickel sized holes where the paper towel dispenser had been relocated. room [ROOM NUMBER]: The wall next to the restroom had a damaged corner from the wheelchair hitting it. The door lament was peeling away from the door from the wheelchair hitting it; the section was approximately 38 inches long by two feet high. The paint above the resident's bed had four large areas where the paint had been touched up but not finished. room [ROOM NUMBER]: The next to the resident's bed had several areas of chipped and peeling sheetrock approximately six inches long and two inches wide. The nursing station on the secured unit had a corner piece approximately four feet high by six inches wide with damaged sheetrock with the metal corner piece exposed. The corner wood baseboard next to room [ROOM NUMBER] had chipped and splintered pieces from the wheelchairs hitting the corner. room [ROOM NUMBER]: The wall next to the entrance door had an area approximately four feet wide and three feet high with chipped and damaged plaster. The wall also had approximately seven nickel sized holes. The toilet tank was missing. The floor next to the commode had water damage approximately four feet wide by three feet long. room [ROOM NUMBER]: The heater vent had an area approximately 14 feet long, which was damaged from the mechanical lift being pushed against the vent. The wooden baseboard between room [ROOM NUMBER] and room [ROOM NUMBER] had bubbling and peeling paint. The south side shower room in the secured unit had a damaged wooden door frame with splintering and chipped wood from equipment hitting it. The fiberglass shower insert had an area of rust and brown stains approximately five feet wide by 16 inches wide. The floor underneath was soft from water damage. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: The restroom had an area of water damage on the floor next to the commode. The damage was approximately four feet wide by three feet long. The window seal was missing three cement tiles. B. Environmental tour and staff interview The environmental tour was conducted with the maintenance director (MTCE) on 12/1/22 at 8:30 a.m. The above detailed observations were reviewed. The MTCE documented the environmental concerns. The MTCE said he did not have any repair requisition requests from staff for the above-mentioned items. The MTCE said the above-mentioned damage should have been repaired and addressed in a timely manner. III. Water temperatures A. Observations 11/28/22 -At 10:58 a.m., the temperature of the tap water were obtained in room [ROOM NUMBER]. The water was found to be 125 degrees Fahrenheit (F); -room [ROOM NUMBER]'s water temperature was 125 degrees F. -room [ROOM NUMBER]'s water temperature was 125 degrees F. -room [ROOM NUMBER]'s water temperature was 125 degrees F. -room [ROOM NUMBER]'s water temperature was 125 degrees F. -North shower on the secured unit faucet was 124 degrees F. -At 11:12 a.m., CNA #5 observed the temperature of water in the north secured unit shower. The temperature was 125 degrees F. CNA #5 was unsure what the water temperature was supposed to be kept at. -At 11:21 a.m. the maintenance director (MTCE) entered room [ROOM NUMBER] and observed water temperatures in the resident's room to be 124 degrees F. He was told of water temperatures of rooms listed above. He exited the room immediately and went to check the boilers. B. Interviews LPN #2 was interviewed on 11/28/22 at 11:27 a.m. The LPN #2 said the resident in room [ROOM NUMBER] was mobile and was able to utilize the water independently. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance supervisor (MTCE) was interviewed on 11/28/22 at 12:00 p.m. He said the facility had just replaced the pipes to the systems. He said the facility immediately purged all the hot water from the lines. The MTCE said he had recently replaced the mixing valve and it had not been set correctly. The MTCE said the water had been holding at 107 degrees F and he would continue to monitor the water temperatures. The MTCE said the water temperatures should be set at 107 degrees F to 115 degrees F. He said a negative outcome would be skin burns. -At 12:23 p.m. MTCE reported water temperatures at 107 degrees F. -At 1:57 p.m. MTCE reported water temperatures at 109 degrees F. The MTCE was interviewed again on 12/1/22 at 10:30 a.m. He said the mixing valve setting had been corrected and was being monitored daily. The MTCE reported water temperatures at 109 degrees F.

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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 - Immediate jeopardy to resident health or safety 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, observations, and interviews, the facility failed to create an environment that protected two (#37 and #124) of six residents reviewed for abuse out of 38 sample residents. Resident #69, with moderate cognitive impairment, exhibited inappropriate sexual behavior toward one resident (#37) who had severe cognitive impairment. Resident #37 was sexually abused on 8/6/22 by Resident #69. In response to the 8/6/22 incident, the facility temporarily moved Resident #69 to another unit and provided one-on-one staff supervision for six days. Resident #69 returned to his original unit and 15 minute checks were instituted from 8/13/22 to 8/19/22. Supervision was changed to 30 minute checks between 8/20/22 and 8/31/22. The resident was returned to 15 minute checks on 8/31/22 however, this level of supervision was ineffective in protecting female residents on the unit from Resident #69's inappropriate sexual advances. Following the sexual abuse that occurred on 8/6/22, Resident #69 attempted to bring Resident #37 and other female residents to his room on 8/14/22, 8/21/22, 8/23/22, 9/5/22, and 9/8/22. On 10/3/22, Resident #69 removed Resident #37's pants and attempted to touch her vagina while the two residents were in the front lobby. They were separated by staff, however Resident #69 attempted to take Resident #37 to his room approximately five minutes later. The facility's failure to develop and implement effective interventions to prevent cognitively impaired residents from being repeatedly subjected to inappropriate sexual behavior by Resident #69 made serious harm likely if the situation was not immediately corrected. In addition, the facility failed to protect Resident #124 from physical abuse by Resident #123. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Resident #69, with moderate cognitive impairment, exhibited inappropriate sexual behavior toward one Resident (#37), who had severe cognitive impairment on multiple occasions. Resident #37 digitally penetrated Resident #69 in his room on 8/6/22. On 10/3/22, Resident #69 pulled Resident #37's pants down in the lobby and attempted to put his hand in the resident's vagina. Documentation revealed Resident #69 also attempted to take other female residents to his room or enter their rooms on multiple occasions. The facility's failure to develop and implement effective interventions to prevent cognitively impaired residents from being repeatedly subjected to inappropriate sexual behavior by Resident #69 made serious harm likely if the situation was not immediately corrected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/14/22 at 4:05 p.m., the nursing home administrator (NHA) was notified the facility's failure created an immediate jeopardy situation. B. Facility plan to remove immediate jeopardy On 12/15/22 at 2:45 p.m., the facility submitted a plan to remove the immediate jeopardy. The plan read: Immediate Action: Resident #69 remained on the secured unit and the facility initiated one-to-one (1:1) supervision on 12/14/22 at 4:00 p.m. All employees that provided 1:1 supervision to Resident #69 were trained by the staff development coordinator (SDC) in regards to identifying escalating behaviors and indicators of psychosocial distress. This training initiated on 12/14/22 at 4:00 p.m., and would continue until complete on or before 12/22/22. Facility staff to assist in providing 1:1 supervision starting on 12/14/22 at 4:00 p.m. Employees will be trained prior to providing services in regards to Resident #69's escalating behaviors and indicators. Education will include interventions to assist in resident care and education will be provided by RN (registered nurse) and/or social services (SS). Resident #69-care-plan-updated on 12/14/22 to reflect 1:1. Pharmacist completed a medication review for Resident #69 on 12/14/22. Medical Director completed a chart review on Resident #69 on 12/14/22. Designated Psychiatrist, scheduled to assess and evaluate Resident #69 on 12/16/22. Resident #37 was assessed by social services on 12/14/22, and showed no signs or symptoms of distress or psychosocial harm and was provided with additional psychosocial support. Resident #69 will be evaluated monthly during the psychotropic committee meeting. The IDT completed a sexual intimacy capacity for consent assessment, on Resident #69 and Resident #37. Resident care plan updated with results of assessment. This was completed by IDT on 12/14/22. Systematic changes: Facility initiated all staff education on specific interventions for Resident #69. This education was initiated on 12/14/22, and all staff will be completed prior to beginning their assigned shift. All education will be completed on or by 12/22/22. Resident #69 and Resident #37 will be evaluated by counseling services on 12/16/22. Identification of residents' affected or likely to be affected: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All female residents on the secured unit are at risk to be affected. Completed observations of all residents on the secured unit on 12/14/22 to identify if any residents show signs of psychosocial distress and agitation. Observations completed by SDC. No issues identified from the audit. Actions to Prevent Occurrences/Recurrences: All staff to be educated on how to identify aggressive and unwanted sexual behaviors and intervene as needed. Staff education to be provided by either SS (social services), and/or RN. All education to be provided to staff prior to direct care with the resident. All staff to be educated in person by 12/22/22. If staff are out of town, they will be educated prior to returning to their scheduled shifts. Education listed below was initiated on 12/14/22 at 4:00 p.m. The education was initiated 12/14/22 at 1600 (4:00 p.m.). Facility educated on results of intimacy assessments for Resident #69 and Resident #37 to all staff currently working. Monitoring: Social services, RN, or designee to observe the secured unit every shift for five days starting 12/14/22 until 12/18/22 to monitor female residents for psychosocial distress or behaviors outside of their baseline. The secured unit observation audit was initiated on 12/14/22 during day shift and completed by SDC/ RN. If no issues identified with every shift observation for five days, will decrease audit to five times weekly on various shifts for 12 weeks. This will determine if 1:1 supervision for Resident #69 is effective. In the event of any future resident to resident sexual abuse, the perpetrating resident will immediately be placed on 1:1 supervision until primary care, nursing, and psych evaluations can be complete. Outcomes of these evaluations will result in continued 1:1 supervision or the initiation of discharge planning to a facility with a focus on behavior management. C. Removal of immediate jeopardy On 12/15/22 at 3:35 p.m. the NHA was notified that based on review of the facility plan, the immediate jeopardy situation had been removed. However, deficient practice remained at a scope and severity of G, harm that was isolated. II. Facility policy The Abuse policy, modified October 2022, was received from the director of nursing (DON) on 11/28/22 at 9:47 a.m. It read in pertinent part: It is the policy of this facility that reports of abuse, neglect, misappropriation of property, and exploitation are promptly and thoroughly investigated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedures: When an incident or suspected incident of abuse or neglect is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. A licensed nurse will examine the resident upon receiving reports of alleged physical or sexual abuse and will record findings in the resident's medical record The investigation will consist of at least the following: A review of the completed Complaint Report; An interview with the person (s) reporting the incident; Interviews with any witnesses to the incident; An interview with the resident if possible; A review of the resident's medical record; An interview with staff members working on/in the unit where alleged incident took place if applicable; Interviews with the resident's roommate, family members, and visitors if applicable; A review of all circumstances surrounding the incident. All phases of the investigation will be kept confidential in accordance with the facility's policies governing the confidentiality of medical records and privilege of quality assurance/ quality improvement programs. The Administrator will keep the resident or his/her representative informed of the progress of the investigation as necessary. The summary of the investigation will be recorded and attached to the report. The Administrator would report such allegations to the State Licensing Agency as necessary, health department within (24) hours and police department within (2) hours as necessary with the results of the completion of the investigation. The Administrator or designee will complete a copy of the Resident Abuse Investigation Report Form within five (5) working days of the reported incident. III. Failure to create an environment that protected Resident #37 from sexual abuse by Resident #69. A. Resident #37 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #37, age 80, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included chronic respiratory failure, dementia, anxiety, and history of falls. According to the 11/7/22 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident had no behaviors. She required extensive assistance for bed mobility, transfers, grooming and toilet use. 2. Record review The care plan, initiated 9/25/2020 and revised 10/17/22, identified the resident was at risk for elopement/wandering related to dementia. Interventions included distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is the resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. -Resident #37 did not have a person-centered care plan or interventions to evaluate the effectiveness of the interventions to protect her from the potential risk for sexual abuse. Incident 8/6/22 The nurse documented the following, I and another coworker were in the dining room and the housekeeper came in to the dining room asking for the Resident #37. She stated she and the nurse could hear crying and screaming. She was saying 'please let me up, help me up' so I got up and went to look for her at this time. The nurse located her in Resident #69's room. We removed him from his room. Resident #37 was lying in his bed crying. He removed her brief had it was thrown on the other side of the room. He was touching her with his fingers in her vagina the nurse examined her with my help. She was really red and had some blood. We removed her from the room. Took her to her room and cleaned her up and put her in her bed. The nurse documented the following, The housekeeper and this nurse were looking for Resident #37. She was looking for Resident #37 and she was missing. I went down the girl's hall and the housekeeper was going down the men's hall when we heard 'HELP, HELP me up.' Resident #69's room was the first room we entered to check to see if someone had fallen. What we found was Resident #69 standing with the side of his bed and Resident #37 was lying in his bed. Her adult pad had been taken off and thrown on the other side of the bed. Resident #37 was screaming 'Let me Up' and crying. Resident #69 had his fingers or his hand in her vagina plunging it in and out (thrusting). When Resident #69 saw me and immediately left the room, wiping his hand on his shirt. The housekeeper and I immediately went to Resident #37 comforting her and assessing her. No injuries could be seen. The housekeeper and certified nurse aide (CNA) helped Resident #37 stood and placed her in a wheelchair. We then took her to her room and further assessed her. My director of nursing (DON) was notified, police and families called. Incident on 10/3/22 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing log note dated 10/3/22 at 6:45 p.m., documented in part: This nurse observed Resident #69 had pulled Resident #37 pants down in the lobby and was attempting to put his hand in the resident's vagina. When approached by this nurse and asked the resident to stop and let him know what he was doing was inappropriate. Resident #69 responded 'I am not doing anything you (expletive). Resident #37 was separated from this resident and taken to the other side of the lobby. Approximately five minutes later resident was attempting to take Resident #37 to his room, this nurse intervened and took Resident #37 to her room and again let the resident know this was inappropriate behavior. Resident #69 responded 'What are you talking about?' and walked off and sat down in a chair in the lobby. Fifteen minute checks implemented for the resident. No other incidents occurred during the night. Social service log note dated 10/4/22 at 12:12 p.m., documented in part: This writer met with the resident and explained the importance of keeping his hands to himself, he stated he did not know what this writer was talking about. He expressed understanding. Spoke with staff and they stated he has been keeping to himself and has been pleasant and has had appropriate interactions with other residents. Will continue to follow up with resident. B. Resident #69 (assailant) 1. Resident status Resident #69, age 83, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included fracture of the left femur, Alzheimer's, diabetes, dementia, and depression. According to the 9/5/22 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident had no behavioral symptoms. He required supervision for bed mobility, transfers, grooming and toilet use. 2. Record review The care plan, initiated 9/6/19 and revised 9/12/22, identified the resident had potential for a mood & behavior problem related to dementia and Alzheimer's disease, insomnia, and history of alcohol abuse. The resident was at risk for irritability, social withdrawal, flat affect, increased depression and difficulty sleeping. He at times becomes agitated and has shown aggressiveness to other residents. He at times will become territorial of the recliner in the day hall area and doesn't want others to sit on certain chairs. He will at times ask others to move out of the recliner so he can sit there. At times the resident will invite female residents into his room. At times resident becomes agitated when asked to take a shower. At times resident will attempt to clean his own BM (bowel movement) and will wipe it on inappropriate things (for example: the curtain in his room, hand rails outside) At times resident makes inappropriate sexual comments/gestures towards females Triggers include: overstimulation, loud noises. Interventions include document behaviors, and resident response to interventions. If reasonable, discuss behavior. Explain/reinforce why inviting the female resident to his room was inappropriate and/or unacceptable. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The social service director (SSD) log note dated 8/6/22 at 3:46 p.m. documented in part: this writer met with a resident in the lobby area, asked the resident if he recalled the earlier incident. He stated he did not know what this writer was talking about. This writer asked the resident if he was hungry and if he had dinner. He stated no, that he had not had dinner. Offered him a peanut butter and jelly sandwich and a cup of milk. He stated he would like that and I brought a resident a sandwich and milk. He thanked this writer. Will continue to follow up. The SSD log note dated 8/8/22 at 3:44 p.m. documented in part: This writer met with the resident once he arrived back at the secured unit. He stated he was fine and he was going to his room to take a nap. He does not appear to recall a resident to resident altercation. He has not exhibited any current mood or behaviors. Will continue to follow up. The nurse log note 8/6/22 at 5:33 p.m., documented in pertinent part: a female resident was missing from the common area. As we were looking for her, someone heard help me up. Resident #69 was found to have a female resident in his room, she was laying on his bed and he was standing over her with his fingers in her vagina, finger thrusting vigorously. The resident's shirt was found to have blood on it and it was taken for evidence. The director of nursing (DON), police, family, and provider were notified. Resident shirt found to have blood on it and it was taken for evidence. Nurse log note dated 8/14/22 at 11:43 p.m. documented in part: Resident continues on 15 min (minute) checks. Resident made an attempt to grab and stop Resident #37 while she was passing by this resident in her wheelchair after dinner. When approached by this nurse, the resident denied trying to do anything yelling at this nurse to leave him alone. Later in the evening at this time the resident came out to the lobby and attempted to grab another female resident by the hand to go to his room. The female resident resisted and he let go of her after this nurse intervened and asked him what he was doing. He stated 'nothing' then retreated to his room. Nurse log note dated 8/21/22 at 4:58 p.m., documented in part: observed resident has made some sexual comments to female residents as they were passing by this resident such as 'you get laid in my bed, and you'll get paid.' The resident also attempted to grab one of the female residents. This writer intervened & separated them immediately. Reoriented & redirected resident. Given peanut butter sandwich & a cup of juice. The resident was eating supper at this time. Nurse log note dated 8/23/22 at 1:23 p.m., documented in part: resident continues on 30 minute checks talking to a few ladies trying to talk them into going into his room with him. Nurse note dated 9/5/22 at 6:10 p.m., documented in part: resident attempted one time to pull a female resident into his room. The two were separated and Resident #69 was instructed that this was inappropriate. He denied the incident. Nurse note dated 9/8/22 at 2:57 p.m., documented in part: resident needed redirection after attempting to take female resident into his room. Female resident removed from room. On 12/14/22 at 10:20 a.m., a written request for the investigation for the incident on 10/3/22 was (documented in Resident #37's record, see above) given to NHA. IV. Staff interviews (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Housekeeping (HSK) #2 was interviewed on 11/30/22 at 8:28 a.m. She said, About two to three months ago we had a missing female resident. I and another nurse heard someone yelling out but we couldn't figure out where the screaming was coming from. We walked the women's side of the unit and then to the men's side. This was where I heard screaming coming from Resident #69's room. She said, I opened the door and found Resident #37 lying down in the bed with Resident #69 standing over her with his fingers in her private area. She said Resident #69 wiped his hand on his shirt and then he left the room. Licensed practical nurse (LPN) #2 was interviewed on 11/30/22 at 8:44 a.m. She said Resident #69 liked to go into female rooms. She said she did not really know the specifics of the incident on 8/6/22 but Resident #69 was placed on one-to-one supervision. She said Resident #69 had been okay. Certified nurse aide (CNA) #3 was interviewed on 11/30/22 at 8:57 a.m. She said she was new to the secured unit. She said she was not familiar with Resident #69 and did not know anything about his history. CNA #4 was interviewed on 11/30/22 at 9:08 a.m. She said she was familiar with the incident on 8/6/22 but did not really know the details. She said Resident #69 was sent to the long term care side for some time after the incident. She said, I just monitor him and redirect him but he has not had any of the behaviors lately. The nursing home administrator (NHA) was interviewed on 11/30/22 at 9:16 a.m. He said he was the abuse coordinator for the facility. He said the staff had found Resident #37 in Resident #69's room on 8/6/22. He said she was partially naked from the waist down and he had his hands in her vagina. He said they were immediately separated and all necessary parties contacted. He said the investigation was inconclusive because they could not define if the sexual act was consensual or non-consensual. He said neither resident was interviewable. He said all care plans were updated to address Residents #69 and Resident #37's behaviors. He said, I wouldn't classify her yelling out for help as a sign of non-consensual as she had a history of yelling out. He said, I would have to review the investigation further. CNA #4 was interviewed on 11/30/22 at 9:43 a.m. She said Resident #69 was pretty quiet and he has recently kept to himself. She said he would sit in the chair in the common area and then go back to his bed and sleep. She said she did hear he was moved across the street after the incident but did not really know much more about that. She said, I was not told of any interventions for Resident #69 or Resident #37. The social service director was interviewed on 11/30/22 at 9:53 a.m. She said the incident was reported to her and she was informed to ensure all residents were safe. She said staff had found Resident #37 in Resident #69's bed and he was touching her inappropriately. She said, I spent some time with Resident #37 but she appeared to be at her baseline. She said facility had moved Resident #69 over to the long term side of the facility and I continue to monitor him. She said she would provide documentation regarding the interaction with Resident #37 and Resident #69. -However, the documentation was not provided by the SSD. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The MDS coordinator was interviewed on 11/30/22 at 11:55 a.m. She said she was familiar with Resident #69. She said she Resident #69 liked to be on his own and he would visit her office. She said, I remember hearing about the incident on 8/6/22 and the facility had to separate the residents. We updated their care plans but I do not know what or if there were any interventions in place for Resident #69. HSK #1 was interviewed on 11/30/22 at 12:12 p.m. She said, Resident #69 was caught molesting one of the female residents in his bed and he was touching her inappropriately. She said Resident #37 was screaming help, help! The NHA and DON were interviewed on 12/1/22 at 12:49 p.m. The NHA said the incident on 8/6/22 was unsubstantiated as both residents had a history of wandering into other residents' rooms. He said the reason for it being unsubstantiated was due to the facility not determining if the sexual contact was consensual or non-consensual. Resident #37 yelling out and calling for help could not be determined as non-consensual as the staff discussed before she had a history of yelling out. He said, Law enforcement found it unsubstantiated as well. The DON said, Resident #37 had a good idea but when the good idea went south it was clear it was not a good idea at the time. She said the facility could not distinguish if the blood on Resident #69 was his or Resident #37. She said, I cannot conclusively say that blood came from Resident #37 as there were no injuries. The NHA said, all of our policies and procedures were followed in a timely manner. He said Resident #69 was transferred for three to four days to long term care to ensure the safety of the residents on the secure unit. A Pueblo police officer was interviewed on 12/6/22 at 12:44 p.m. He said he was the investigating officer for the incident on 8/6/22. He said his investigation was passed on to the special victims units as an open ongoing investigation, which may result in filing of charges. He said he reviewed the file and it was pending for formal charges. He said at this point it was still listed as an open investigation. The nurse practitioner was interviewed on 12/14/22 at 11:47 a.m. She said she was familiar with Resident #37 and Resident #69. She said she was familiar with the incident of 8/6/22. She said she had examined both residents approximately two days after the incident. She said she did not observe any marks or wounds to Resident #37's private area. She said she had not completed a genital exam of Resident #37 as she did not have a nurse to assist during a genital exam. She said she had not been informed of blood being found on Resident #37's vagina on 8/6/22. She reviewed her notes and said she did not find any communication from the facility in reference to vaginal bleeding. She said, If I would have been given that information I would have completed a genital exam on Resident #37. She said she did a physical exam and a skin assessment on Resident #69 with no issues or concerns. She said Resident #69 did not have any scratches or wounds anywhere on him. She said she was not aware of the incident on 10/3/22. She said, If I was informed I would have written a note. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA was interviewed again on 12/14/22 at 2:00 p.m. The NHA stated he did not have the key to the filing cabinet which contained the soft investigation files. He said the DON was the only staff member who had a key to the cabinet and she was out of the facility. The NHA stated the facility investigated the incident on 10/3/22 but no contact was made by Resident #69 and staff intervened before contact was made. The NHA stated, it could not be proven that Resident #69 pulled down Resident #37's pants as she had a history of stripping down in the facility. -However, the progress note had documented the nurse observed Resident #69 pulling down Resident #37's pants and attempting to touch her vagina. V. Resident to resident physical altercation between Resident #124 and #123 A. Resident's #124 (victim) 1. Resident status Resident #124, age 86, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included dementia, anxiety, and altered mental state. According to the 11/7/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had no behavioral symptoms. She required extensive assistance for bed mobility, transfers, grooming and toilet use. 2. Record review The care plan, initiated 11/4/22 and revised 11/7/22, identified the resident was involved in a resident-to-resident altercation and received skin tears to bilateral arms. Interventions include avoiding scratching her hands and body parts from excessive moisture. Keep fingernails short and encourage good nutrition and hydration in order to promote healthier skin. Monitor and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, and maceration. Nurse note dated 11/12/22 at 10:55 p.m. documented in part, resident taken out of room to nursing station. The resident had two skin tears on each forearm. Each wound was cleaned with wound cleaner and four by four (gauze), dried, iodine applied, steri strips applied and covered with band aid. Resident taken out of (from his room to another room) for tonight. The supervisor called the police department, and the on-call medical doctor on the non-urgent line called. Nurse noted dated 11/13/22 at 9:34 a.m. documented in part, No fearful episode noted. No negative behaviors noted. No further resident to resident altercations noted. No distress noted. Provided wound treatment as physician ordered. The SSD note date 11/16/22 at 12:56 p.m. documented in part, this writer sat with Resident #124 out in the day hall area as she was pleasant and did not appear in distress and did not appear to be expressing any fear. She was smiling and watching television. No current concern at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SSD note date 11/14/22 at 10:53 a.m. documented in part, This writer sat with Resident #124 out in the day hall area, she was pleasant and smiling. She did not appear to recall the resident to resident altercation when she was asked about it. She did not appear in any distress and was not expressing any current fear. B, Resident #123 (assailant) 1. Resident status Resident #123, age 75, was admitted on [DATE] and passed away 11/18/22. According to the November 2022 computerized physician orders (CPO), diagnoses included senile degeneration of the brain, dementia, cognitive communication deficit, anxiety, and depression. According to the 11/7/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had wandering behaviors, which may put others at risk. She required supervision for bed mobility, transfers, grooming and toilet use. 2. Record review The care plan, initiated 11/4/22 and revised 11/7/22, identified the resident had potential for a behavior problem. At times she becomes physically aggressive with staff, attempting to bite them. Interventions include administering medications as ordered. Monitor and document for side effects and effectiveness. If reasonable, discuss behavior. Explain and reinforce why behavior was inappropriate and/or unacceptable. Intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from the situation and take to alternate locations as needed. Residents placed on one-on-one observation until behavior was under control. The SSD note dated 11/12/22 at 11:33 p.m. documented in part, The resident was found on the floor kneeling next to another resident's bed across the room. The other resident standing up behind this resident holding arms. This resident with blood on hands and under fingernails. The resident was removed from the room. The SSD note dated 11/14/22 at 2:23 p.m. documented in part, This writer attempted to meet with a resident to discuss a resident to resident altercation, she just stared at this writer. Offered her a drink and she drank water. She was not willing to have a conversation. Met with staff resident no current behaviors at this time. VI. Staff interview Licensed practical nurse (LPN) #2 was interviewed on 11/30/22 at 8:44 a.m. She said there was an altercation where Resident #123 scratched Resident #124 on her arms. She said Resident #124 wounds continue to be monitored with no problems. The social service director (SSD) was interviewed on 11/30/22 at 9:53. a.m. She said Resident #123 and #124 did have a resident to resident altercation. She said Resident #123 grabbed Resident #124's arm and made it bleed. She said they were separated immediately and moved. She said the facility was monitoring both residents and had them on 15 minute checks. She said Resident #124 appeared to be doing fine. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA and DON were interviewed on 12/1/22 at 12:49 p.m. The NHA said the incident was unsubstantiated as there were no injuries. The DON said the resident to resident altercation did happen but it was unsubstantiated as the facility could not find intent as each one of the residents' involved were at their baseline. She said Resident #123 had passed away on 11/18/22 of natural causes. -However, the incident should have been substantiated due to Resident #123 grabbing Resident #124 willfully and causing her arm to bleed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31820

Based on observations, record review and interview, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services and assistance during showers and baths for one (#82) of three residents reviewed for hygiene assistance of 38 sample residents.

Specifically, the facility failed to provide scheduled showers and baths or offer an alternative for Resident #82.

Findings include:

I. Facility policy

The Activities of daily living (ADLs), with no review date, was provided by the director of nursing (DON) on 11/30/22 at 12:12 p.m. The policy read in part,

The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.

Care and services will be provided for the following activities of daily living:

1. Bathing, dressing, grooming, and oral care.

3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

II. Resident #82

A. Resident status

Resident #82, age 63, was admitted on [DATE] and readmitted on [DATE]. According to the November 2022 computerized physician order (CPO), diagnoses included motor neuron disease, post COVID-19 condition, and chronic respiratory failure.

The 11/9/22 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. No mood or behavior symptoms were noted. No rejection of cares noted. He required total assistance with personal hygiene.

B. Resident interview

Resident #82 was interviewed on 11/28/22 at 10:21 a.m. He said he preferred a bed bath to a shower because he would get cold in the shower.

B. Record review

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan, dated 8/6/22 and revised on 9/6/22, identified an ADL self care performance deficit. Interventions included: -Encourage to participate to the fullest extent possible with each interaction. -Bathing: Requires one to two staff participation with bathing. The care plan did not identify interventions if Resident #82 refused a shower. The November 2022 point of care (POC) documentation utilized by the certified nurse assistants (CNAs), identified the bathing task to occur on Wednesdays and Saturdays. The documentation identified the resident received one sponge bath in the last 30 days. The paper shower sheets provided by the director of nursing (DON) on 11/30/22 at 11:34 a.m. The shower sheets from the last 30 days documented one shower. C. Interviews Hospitality aide (HA) #1 and CNA #1 were interviewed on 11/30/22 at 9:45 a.m. They said the resident had a history of refusing cares. They said he was scheduled twice a week for a shower. They said if he refused any type of care they reported the refusal to the nurse. Registered nurse (RN) #1 was interviewed on 11/30/22 at 10:00 a.m. She said the resident had a history of refusing cares. She said he was scheduled for two showers a week. She said when the aides reported a refusal, she would make a progress note. The DON was interviewed on 11/30/22 at 10:16 a.m. She said the staff document the showers in the POC and on the shower sheets. She said each resident was scheduled for two showers a week. She said the resident often refuses cares, but alternatives should have been offered and documented.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820 Based on observations, record review and interviews, the facility failed to ensure that a resident who displayed or was diagnosed with mental disorder received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for two (#82 and #60) of three residents out of 38 sample residents. Specifically, the facility: -Failed to address Resident #60's ongoing depression. -Failed to develop person-centered individualized interventions for verbal aggression and non-compliance for Resident #82; -Failed to track aggression and non-compliance behaviors to help drive person-centered interventions and evaluate efficacy of said interventions for Resident #82; and, -Failed to train staff on person-centered individualized interventions for Resident #82. Findings include: I. Resident #60 A. Resident status Resident #60, age 66, was admitted on [DATE]. According to the [DATE] computerized physicians orders (CPO), diagnoses included type II diabetes mellitus, major depressive disorder, cerebral infarction (stroke), and anxiety. The ,d+[DATE]//22 minimum data set (MDS) assessment revealed the resident had a mild cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. The patient health questionnaire (PHQ-9) assessment for depression scored four out of 24 which indicated mild depression. -This was an increase from the score on [DATE] of zero out of 24. B. Resident interview (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #60 was interviewed on [DATE] at 11:14 a.m. She was lying in her bed with the lights off and her curtain drawn. The resident requested that LPN #3 be present in the room for the interview. The resident was initially reluctant to participate in the interview, stating she did not know why she was at the facility; she did not know if she was ever discharging, and could not recall if she received counseling. The resident revealed she had been at the facility since her spouse died and became tearful at that point in the conversation. The resident stated that she had been married for many years and her husband was the only person she had trusted. She said it had always been difficult for her to be around people or trust them. She expressed it had also been difficult for her to adjust to being in the facility and how her life had changed since her spouse passed. The resident then became too emotional to continue further with the interview. C. Record review The Colorado preadmission screening and resident review (PASRR) level II notice of determination for mental illness dated [DATE] showed the resident had a level II condition of major depressive disorder. The PASRR evaluation completed on [DATE] identified multiple areas of traumatic life events for the resident: -Recent loss of spouse, -Loss of ability to remain in the community and necessity of facility placement, -Elder exploitation, -Detrimental family relationships, -Childhood abuse, and, -History of suicide attempt. Psychological therapy notes dated [DATE]-[DATE] document high levels of depressive symptoms and an increase since resident ' s failure at attempting a lower level of care in assisted living. Social services progress notes dated [DATE] reveal the resident returned to long term care from the hospital after failing at assisted living [DATE]. At the time of return, her PHQ-9 score was a seven out of 24. C. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on [DATE] at 10:30 a.m. She said that Resident #60 came to the facility from the hospital after her husband passed away. LPN #3 stated that the resident requested medication whenever she saw her facility doctor in order to numb her depression. The resident did not want to come out for meals, did not want to participate in facility activities, and usually kept her light off and stayed in bed. LPN #3 said she often sat with the resident when she became tearful and needed support. LPN #3 was not aware of any past trauma or additional stressors other than failing at the assisted living and the passing of her spouse. LPN #3 denied receiving any education from the SSD regarding interventions or approaches for the resident. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on [DATE] at 10:57 a.m. The DOR said that the resident did well in therapy when she participated but had difficulty with some of the therapists and would not participate with them. The resident had a flat affect and was not responsive to many of the therapists. Some of the other therapists had had conflicts with the resident ' s personality, which interfered with the amount of therapy she received. The DOR said that the therapy department had not received any education from the social worker regarding interventions or approaches they could utilize with the resident. The SSD was interviewed on [DATE] at 11:36 a.m. The SSD said that Resident #60 was at the facility for long term care because she could not care for herself and did not have family support. The resident had been able to go to their affiliated assisted living but had not been able to manage her insulin by herself and had to return to the facility for long term care. The SSD said that the resident had not shown any difficulty with the transition to long term care, was happy at the facility, and had developed relationships. The SSD stated that the resident had triggered for a level II due to her depression score and the diagnosis of major depressive disorder. The SSD revealed she was aware the resident had trauma over her spouse passing. Certified nursing aide (CNA) # 6 was interviewed on [DATE] at 2:03 p.m. CNA #6 said that the resident had been extremely depressed. She often did not want to change her clothes, bathe, or eat. She would not leave her room for activities or meals. Sometimes the staff could only get her to eat one meal a day even after offering to get her anything she would like to eat. The resident had shown decreases in her appetite and increases in her sleeping. The more the staff tried to encourage her to leave her room, the more agitated the resident became, expressing to them that there was no point in leaving her room or engaging with others. CNA #6 said the resident had become much more depressed since failing at assisted living and having to return. II. Resident #82 A. Resident status Resident #82, age 63, was admitted on [DATE] and readmitted on [DATE]. According to the [DATE] computerized physician order (CPO), diagnoses included motor neuron disease, post COVID-19 condition, and chronic respiratory failure. The [DATE] minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. No mood or behavior symptoms were noted. No rejection of cares noted. He required total assistance with personal hygiene. B. Record review The care plan, dated [DATE], identified the potential to demonstrate verbally abusive behaviors related to ineffective coping skills as evidenced by verbally abusive behaviors toward staff. Interventions included: -Allow time for the resident to express self and feelings towards the situation. -Document observed behavior and attempted interventions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Give resident time to express his needs with patience. -Staff will be empathetic towards Resident #82's situation. -Review of the progress notes did not identify consistent documentation of any verbally abusive behaviors toward staff (see interviews below). -The facility did not have a system in place to track behaviors to establish person-centered interventions and evaluate effectiveness of interventions to develop training for staff. C. Interviews Hospitality aide (HA) #1 and certified nurse aide (CNA) #1 were interviewed on [DATE] at 9:45 a.m. They said Resident #82 displayed verbal aggression daily. They said when he displayed verbal aggression, they would remind him it was inappropriate to talk to another person in those terms. They would ensure the resident was safe, and give the resident time to calm down. They said they would report the behaviors to the nurse for documentation. They said they did not know of a different way to document any behaviors. They said they had not received any training specific to Resident #82's behaviors. Registered nurse (RN) #1 was interviewed on [DATE] at 10:00 a.m. She said the resident yelled and used profanities at staff. She said when Resident #82 displays verbal aggression, she would ensure the resident was safe and let the resident know she would return after he had a chance to calm down. She would let him know it was not ok to use that kind of language. She said she did not always write a progress note when the behavior was displayed. She said a progress note was the only way to document his behaviors. The social services assistant (SSA) was interviewed on [DATE] at 10:04 a.m. She said the resident had not had any behaviors recently. She said she knew he had displayed behaviors two months prior, but was not currently displaying behaviors. She said he previously displayed verbal aggression to staff. She said she had not asked staff about their approaches because he had not had any current behaviors. She said she was not aware he was currently displaying any verbal aggression. She said if he displayed verbal aggression, she would want staff to approach him calmly and listen to his problems and concerns. She said the facility only formally tracked behaviors when a resident was on psychoactive medications. She said Resident #82 was not taking psychoactive medications, so the facility utilized progress notes for his behaviors. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on [DATE] at 10:16 a.m. She said Resident #82 did have behaviors of verbal aggression. She said he had a history of being verbally aggressive with staff. She said staff were to provide care in pairs for the safety of everyone. She said when the resident was being verbally abusive, she wanted staff to make sure the resident was safe and let him know his behavior was unacceptable and give him time to calm down. She said the facility only tracked behaviors when a resident was taking psychoactive medications. She said staff should write a note when he had a verbal aggressive outburst. She said staff should have been documenting his behaviors as they happened. She said staff should be consistently addressing the behaviors. She said he had a care plan for his verbal aggression, but the interventions did not include what staff and expectations of staff were currently doing. The MDS coordinator was interviewed on [DATE] at 2:11 p.m. She said during the look back period for the coding on the MDS there was no documentation of behaviors. She said she did not interview staff, that she only based her coding on documentation. 46849

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821 Based on record review and interviews, the facility failed to ensure residents who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for two (#69 and #73) of three residents reviewed for dementia care out of 38 sample residents. Specifically, the facility failed: -To provide person-centered approaches to Resident #69's dementia care services to address his sexual behaviors towards staff and other residents in order to prevent sexual abuse incidents on the secured unit; and, -To effectively identify person-centered approaches for dementia care and wandering for Resident #73. Findings include: I. Census and Conditions demographic The 11/28/22 Census and Condition form documented that 120 total residents resided at the facility. The form further documented there were 43 residents with a dementia diagnosis and two residents with behavioral healthcare needs. II. Professional reference The Gerontologist (February 2018), retrieved from on 12/7/22: https://academic.oup.com/gerontologist/article/58/suppl_1/S1/4816759?login=true The Alzheimer's Association Dementia Care Practice Recommendations included the following foundations for person-centered care: 1. Know the person living with dementia. It is important to know the unique and complete person, including his/her values, beliefs, interests, abilities, likes, and dislikes-both past and present. This information should inform every interaction and experience. 2. Recognize and accept the person's reality. It is important to see the world from the perspective of the individual living with dementia. Doing so recognizes behavior as a form of communication, thereby promoting effective and empathetic communication that validates feelings and connects with the individual in their reality. 3. Identify and support ongoing opportunities for meaningful engagement. Engagement should be meaningful to, and purposeful for, the individual living with dementia. It should support interests and preferences, allow for choice and success, and recognize that even when the dementia is most severe, the person can experience joy, comfort, and meaning in life. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Build and nurture authentic, caring relationships. Persons living with dementia should be part of relationships that treat them with respect and dignity, and where their individuality is always supported. This type of caring relationship is about being present and concentrating on the interaction, rather than on the task. It is about 'doing with' rather than 'doing for' as part of a supportive and mutually beneficial relationship. 5. Create and maintain a supportive community for individuals, families and staff. This allows for comfort and creates opportunities for success. 6. Evaluate care practices regularly and make appropriate changes. III. Resident #69 A. Resident status Resident #69, age 83, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included fracture of the left femur, Alzheimer ' s, diabetes, dementia, and depression. According to the 9/5/22 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident had no behavioral symptoms. He required supervision for bed mobility, transfers, grooming and toilet use. B. Observations On 11/29/22 at 10:07 a.m., Resident #69 was observed wandering in the common area. He would leave his room and find his chair next to the west exit of the secured unit. He would then get up and go back to bed. -At 10:28 a.m., licensed practical nurse (LPN) #2 escorted Resident #69 back to his room. On 11/30/22 12:36 a.m., Resident #69 was wandering in the area of the common area. He stood up and proceeded to go towards the women's hall but was escorted back to his room by certified nurse aide (CNA) #2. -At 2:32 p.m., Resident #69 was sleeping in his bed. C. Record review Resident #69 was involved in a sexual abuse incident involving a female resident on 8/6/22 (cross-reference F600 for abuse). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, initiated 9/6/19 and revised 9/12/22, identified the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to Dementia. The resident was unable to utilize the call light system and would have potential for injury by getting tangled in the call bell. Interventions included Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions such as turning off TV, radio, close doors etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Provide a program of activities that accommodates abilities. The care plan, initiated 9/6/19 and revised 9/12/22, identified the resident was an elopement risk/wanderer related to impaired safety awareness, at times will ask staff to open the gate for him and states that he wants to leave. Interventions include distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. The care plan, initiated 9/6/19 and revised 9/12/22, identified the resident had potential for a mood & behavior problem related to dementia and Alzheimer's, insomnia, and history of alcohol abuse. The resident was at risk for irritability, social withdrawal, flat affect, increased depression and difficulty sleeping. He at times becomes agitated and has shown aggressiveness to other residents. He at times will become territorial of the recliner in the day hall area and doesn't want others to sit on certain chairs. He will at times ask others to move out of the recliner so he can sit there. At times the resident will invite female residents into his room. At times the resident becomes agitated when asked to take a shower. At times resident will attempt to clean his own BM and will wipe it on inappropriate things (for example: the curtain in his room, handrails outside) At times resident makes inappropriate sexual comments/gestures towards females Triggers include: overstimulation, loud noises. Interventions include document behaviors, and resident response to interventions. If reasonable, discuss behavior. Explain/reinforce why inviting female residents to his room is inappropriate and/or unacceptable. -The facility was aware the resident had inappropriate behaviors identified after 8/6/22, however the resident had attempted to bring female residents to his room (cross-reference F600). The facility failed to provide personalized interventions to prevent the resident from victimizing female residents on the secured unit. D. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 11/30/22 at 8:44 a.m. She said Resident #69 had one-to-one staff supervision after incident on 8/6/22 with Resident #37 on the secured unit. She said Resident #69 had one-to-one staff supervision to prevent further abuse incidents. She said Resident #69 was also on a 15 minute checks and then changed to 30 minutes checks. IV. Resident #73 A. Resident status Resident #73, age 84, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included Alzheimer's, dementia, depression, and wandering. (continued on next page)

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

According to the 7/4/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had no behavioral symptoms. He required extensive assistance for bed mobility, transfers, grooming and toilet use. The resident had several falls since admission.

B. Record review

The care plan, initiated 5/24/21 and revised 10/17/22, identified the resident was an elopement risk and wanderer related to dementia, and had a history of wandering. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Document wandering behavior and attempted diversional interventions.

C. Observations

On 11/28/22 at 10:37 a.m., Resident #73 was wandering in and out of residents' rooms on the north hall. He was observed sleeping in an empty bed in room [ROOM NUMBER] while a female resident was sleeping in her bed. Resident #73 was observed to lay down for approximately one minute and got up and exited the room.

On 11/29/22 at 10:09 a.m., Resident #73 was observed sleeping in room [ROOM NUMBER]. No female residents were in the room at the time. The resident slept in the room for approximately six minutes. No staff were observed to redirect the resident out of the room to his own room.

On 11/30/22 at 8:30 a.m. Resident #73 was observed wandering into room [ROOM NUMBER]. Resident #73 was observed grabbing a snack from the bedside dresser. The social service director (SSD) was observed to redirect the resident and place him in his room.The resident was observed to immediately leave his room after the SSD closed the door.

-At 8:45 a.m., the SSD took Resident #73 by the arm and placed him in his room again.

-At 12:28 p.m., Resident #73 entered Resident #84's room and went to take some snacks. Resident #84 stopped him from taking his snacks. Resident #84 told Resident #73 to get out of his room. Resident #84 closed his door and stormed out of the south exit door. Resident #84 exited the door with the door alarm sounding. Licensed practical nurse (LPN) #2 and certified nurse aide (CNA) #2 were within hearing range and did not see who had exited the building.

D. Staff interviews

Licensed practical nurse (LPN) #2 was interviewed on 11/29/22 at 12:07 p.m. She said Resident #73 gets so anxious he would constantly wander the facility. She said he would get agitated and start looking for his lost money. She said he wanders into other residents' rooms and would sleep in their beds and that would cause problems as other residents would get agitated.

Certified nurse aide (CNA) #3 was interviewed on 11/30/22 at 8:57 a.m. She said she received

training every year. She said she could not recall the last time she did have dementia training as well as abuse training.

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