STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANDROCK RIDGE CARE AND REHAB	**943 W 8TH DR CRAIG, CO 81625**

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 -** Minimal harm or potential for 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** Based on record review and interviews, the facility failed to ensure one (#14) of four residents reviewed for abuse was free from physical abuse. Specifically, the facility failed to protect Resident #14 from physical abuse by Resident #12. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation policy and procedure, undated, was provided by the nursing home administrator (NHA) on 8/5/2020 at 10:30 a.m. The intent was to provide a safe environment for residents and to enhance their quality of life. Abuse was defined as the willful infliction of pain, injury, unreasonable confinement, deprivation, intimidation, punishment with resulting physical harm or mental anguish. II. Resident status A. Resident #14 status Resident #14, age 69, was initially admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/28/2020 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems with severely impaired cognitive skills for daily decision-making. She required limited assistance for locomotion off the unit and supervision for eating. B. Resident #12 status Resident #12, age 71, was initially admitted on [DATE] and readmitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 7/17/2020 MDS assessment revealed the resident was mildly cognitively impaired with a brief interview for mental status (BIMS) score of 10 of 15. She demonstrated verbal behaviors addressed towards others on a daily basis. III. Record review A. Care plan A behavioral care plan, initiated on 11/14/19 identified Resident #12 as verbal/physical aggression, cursing, yelling, hitting. Interventions initiated at the time included: -Intervene as necessary to protect the rights and safety of others; -Approach the resident and speak in a calm manner; -Divert her attention and take her to alternate location as needed; and, -Monitor behavior episodes and attempt to determine the underlying causes. B. Investigative report Based on a review of the facility's investigative reports, an incident of resident to resident physical abuse occurred on 6/25/2020 at 9:00 a.m. The investigation was reviewed and included an alleged victim interview (Resident #14), an alleged assailant interview (Resident #12), notes of interviews with other residents and an interview with the certified nurse aide (CNA) who witnessed and intervened in the incident. A summary of the facility's findings, which substantiated the alleged abuse, read in pertinent part as follows: Resident #14 walked past Resident #12 in the dining room on the secured care unit (SCU) and Resident #12 said: Get away from me. CNA #1 entered the area between the two residents and tried to calm Resident #12. Resident #12 reached forward and hit Resident #14 in the forehead. CNA #1 removed Resident #14 from the situation and notified the unit coordinator (UC). CNA #2 assisted with Resident #12 who remained seated in the dining room. Both residents were assessed by the UC and Resident #12 remained seated at the table and did not demonstrate any anger or aggression to other residents. Resident #14 was noted to have a light bruise on her forehead and an ice pack was applied. Neither resident expressed fear or anger toward the other resident. The family members of both residents, the physician, and the police department were all notified. Resident #12 and #14 both resided on a secured care unit, cross-reference F744 for treatment and services for dementia care. IV. Staff interviews The unit coordinator (UC) was interviewed on 8/5/2020 at 10:56 a.m. She said she assessed Resident #14 after the incident but did not witness the event. She said Resident #14 expressed no fear or anger. She said she could remember she had been hit but did not remember by whom. She said Resident #14 was placed on neurological monitoring per facility policy and did not verbalize or demonstrate any behaviors associated with pain. The director of nursing (DON) was interviewed on 8/5/2020 at 11:33 a.m. She said Resident #12 was on line of sight supervision prior to this incident. She said Resident #12 was placed on one-to-one staff supervision immediately after the incident with every 15 minute checks while she was in her room. She said Resident #12 was transferred to a room outside of the SCU on 7/30/2020 and this was a good change for the resident. CNA #1 was interviewed via telephone on 8/6/2020 at 2:21 p.m. She said she was seated across the dining room on 6/25/2020 so she could keep an eye on the resident hallway. She said she saw and heard Resident #12 become agitated when Resident #14 approached her table. She said she stood between the two residents and attempted to calm Resident #12 when she reached around her an struck Resident #14 in the forehead. She said Resident #12 had been easily agitated in the past but to her knowledge she had not been physically aggressive. She said after this event the facility instituted visual checks on Resident #14 every 15 minutes in addition to keeping her in line of sight when out of her room until she transferred out of the SCU.
F 0744 **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 dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure one (#14) of four residents reviewed for dementia care, received the appropriate treatment and services to maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to effectively identify person-centered approaches for dementia care to prevent resident to resident altercations. Findings include: I. Facility protocol The Dementia-Clinical Protocol, revised November 2018, was provided by the nursing home administrator (NHA) on 8/5/2020 at 10:30 a.m. The protocol revealed the assessment and recognition of dementia performed by the staff and physician would review the current physical, functional and psychosocial status of residents with dementia. The staff and physician would collaborate to define the decision-making capacity of someone with dementia, including the extent to which an individual could participate in making everyday decisions. II. Resident status A. Resident #14 status Resident #14, age 69, was initially admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/28/2020 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems with severely impaired cognitive skills for daily decision-making. She required limited assistance for locomotion off the unit and supervision for eating. B. Resident #12 status Resident #12, age 71, was initially admitted on [DATE] and readmitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 7/17/2020 MDS assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 of 15. She demonstrated verbal behaviors addressed towards others on a daily basis. III. Record review A. Care plan A behavioral care plan, initiated on 11/14/19 identified Resident #12 as verbal/physical aggression, cursing, yelling, hitting. Interventions initiated at the time included: -Intervene as necessary to protect the rights and safety of others; -Approach the resident and speak in a calm manner; -Divert her attention and take her to alternate location as needed; and, -Monitor behavior episodes and attempt to determine the underlying causes. The care plan for Resident #12 initiated 2/25/2020 and revised 6/5/2020, read the resident required secured care unit (SCU) placement related to exit seeking and wandering into other resident rooms. The goal initiated on 2/25/2020 and revised on 6/5/2020 was for Resident #12 to remain safe within the facility. Interventions initiated on

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

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.

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 2/25/2020 included: -Avoid unfamiliar situations; -Redirect as possible; and, -Maintain her daily routine as much as possible. Resident #12's care plans failed to identify specific approaches for dementia care to prevent resident to resident altercations with her known behaviors of wandering into other resident rooms and verbal and physical aggression. B. Progress notes A behavior progress note dated 6/5/2020 and signed by the unit coordinator (UC) read: Resident #12 and Resident #14 were in the dining room. Resident #14 yelled at Resident #12 to get out of the way at which time Resident #14 stepped forward and punched Resident #12 in the forehead. A new plan of care (POC) was implemented with staff to increase monitoring. Cross-reference F600 failure to prevent resident abuse. C. Investigative report Based on a review of the facility's investigative reports, an incident of resident to resident physical abuse occurred on 6/25/2020 at 9:00 a.m. The investigation was reviewed and included an alleged victim interview (Resident #14), an alleged assailant interview (Resident #12), notes of interviews with other residents and an interview with the certified nurse aide (CNA) who witnessed and intervened in the incident. A summary of the facility's findings, which substantiated the alleged abuse, read in pertinent part as follows: Resident #14 walked past Resident #12 in the dining room on the secured care unit (SCU) and Resident #12 said: Get away from me. CNA #1 entered the area between the two residents and tried to calm Resident #12. Resident #12 reached forward and hit Resident #14 in the forehead. CNA #1 removed Resident #14 from the situation and notified the UC. CNA #2 assisted with Resident #12 who remained seated in the dining room. Both residents were assessed by the UC and Resident #12 remained seated at the table and did not demonstrate any anger or aggression to other residents. Resident #14 was noted to have a light bruise on her forehead and an ice pack was applied. Neither resident expressed fear or anger toward the other resident. The family members of both residents, the physician, and the police department were all notified. IV. Staff interviews The UC and social services director (SSD) were interviewed on 8/5/2020 at 10:56 a.m. They said neither of them had witnessed the incident on 6/25/2020. They said Resident #14 could remember she had been hit but did not remember by whom. They said Resident #12 had one-to-one staff supervision initiated after the altercation on 6/25/2020. They said there were no further incidents between these two residents since the altercation on 6/25/2020 since Resident #12 had moved off of the SCU. The director of nursing (DON) was interviewed on 8/5/2020 at 11:33 a.m. She said staff received additional education and reinforced the need to watch residents closely at all times. She said Resident #14 was placed on neurological monitoring after the event and she did not demonstrate any signs of fear or pain. CNA #1 was interviewed via telephone on 8/6/2020 at 2:21 p.m. She said she was seated across the dining room on 6/25/2020 so she could keep an eye on the resident hallway. She said she saw and heard Resident #12 become agitated when Resident #14 approached her table. She said she stood between the two residents and attempted to calm Resident #12 when she reached around her an struck Resident #14 in the forehead. She said Resident #12 had been easily agitated in the past but to her knowledge she had not been physically aggressive.