STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065258	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HORIZONS CARE CENTER	**11411 HWY 65 ECKERT, CO 81418**

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** Based on observation, staff interviews and record review, the facility failed to ensure two (#3 and #5) out of five sample residents were free from resident-to-resident abuse. The facility's failures to implement timely interventions for residents with Alzhiemer's, dementia and aggressive behaviors put all residents in the memory care unit at risk and in an unsafe environment. These failures contributed to multiple resident-to-resident altercations involving Resident #3, Resident #9, Resident #5 and Resident #7. The facility failed to protect these residents from abuse. Furthermore as a result of an altercation with Resident #9 and Resident #3, Resident #3 sustained loss of consciousness of an unknown duration with multiple episodes of vomiting, hematoma, contusion and a concussion. See Emergency department note dated 7/20/2020 below. The facility substantiated the allegation of abuse, see section II-D, and III-C altercation. Findings include: I. Facility policy The Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation policy and procedure, revised May 2020, was provided by the nursing home administrator (NHA) via email on 7/30/2020 at 9:58 a.m., included: Each individual has the right to be free from verbal, sexual, physical and mental abuse . The policy defined physical abuse as: The use of force that may result in bodily injury, physical pain or impairment. II. Resident #9 to Resident #3 physical abuse A. Resident #3 status Resident #3, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 6/10/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment with a BIMS score of two out of 15. No behavioral or wandering symptoms were noted. She required supervision to walk in the corridor and locomotion on and off the unit. B. Resident #9 status Resident #9, age 77, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/28/2020 minimum data set (MDS) revealed the resident had a severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. Verbal and physical behaviors were noted to have occurred one to three days of the look back period. The resident required supervision for walking in the corridor and was independent, with no help or staff oversight for locomotion on and off the unit. C. Observations On 7/28/2020 at 12:35 p.m. Resident #9 was observed in the memory support unit (MSU) seated at a table in the common area. Certified nurse aide (CNA) #1 was seated directly behind the resident and said she was doing one-to-one observations. On 7/29/20 at approximately 9:50 a.m. Resident #9 was observed in the MSU. She walked from the common area to the end of the hallway and entered her room. She was observed and followed by CNA #4. Resident #9 shut the door to her room and CNA #4 positioned herself in a vacant room across the hall in view of Resident #9's room. D. Altercation 7/20/2020 A provider progress note dated 7/20/2020 at 4:54 p.m., revealed the provider was asked to check on Resident #9 after she had pushed Resident #3 who fell back and hit her head. Resident #9 was noted to be a danger to others with aggression and was started on an atypical antipsychotic medication. A post incident note dated 7/20/2020 at 6:26 p.m. revealed Resident #9 had an individual-to-individual altercation on 7/20/2020 at 3:30 p.m. A nurses note dated 7/20/2020 at 6:35 p.m. revealed Resident #9 had pushed another resident down after her door was opened by the other resident. An emergency department note dated 7/20/2020 and electronically signed by the emergency room physician at 11:32 p.m., was provided by the nursing home administrator via email on 7/30/2020 at 9:54 a.m. The note revealed a chief complaint of a fall with a head injury. There was a reported loss of consciousness of an unknown duration with multiple episodes of vomiting while in the emergency room . Her discharge problems included hematoma, contusion and a concussion. The facility abuse investigation file was provided by the NHA for review on 7/28/2020 at approximately 1:34 p.m. Review on the facility's investigation revealed a timely and thorough investigation in which the allegation of physical abuse was confirmed. -One-to-one staff supervision was initiated for Resident #9 on 7/22/2020 (two days after the incident occurred). E. Resident #9's progress notes A review of progress notes preceding the incident documented on 7/20/2020 included the following: A nurses note dated 6/16/2020 at 6:48 p.m. revealed Resident #9 was lying on the sofa in the sun room. Another resident entered the sunroom and threw a sandwich at Resident #9 and she retaliated by hitting the other resident with her shoe. The AA intervened and separated the two residents and no injuries were reported. A behaviors and mood note dated 6/19/2020 at 1:34 p.m. revealed Resident #9 grabbed a chair from another resident and sat down in the same chair. It was noted the resident continues to refuse to wear her oxygen and when she did not wear her oxygen her behaviors would increase. A nurses note dated 6/24/2020 at 6:52 p.m. documented a nurse entered the MSU unit at 2:30 p.m. Resident #9 was noted to be walking in front of Resident #1 and repeatedly looking over her shoulder. The nurse wrote she was made aware earlier in the day of the need to keep these two residents separated. She asked regular staff if intervention was needed and staff did not appear alarmed and did not intervene. Shortly after, the activities assistant (AA) reported Resident #9 approached Resident #1 from behind and pushed her. Resident #1 did not fall and was not injured. An interdisciplinary team (IDT) post investigative note dated 6/29/2020 at 9:55 a.m. revealed the resident had an individual-to-individual altercation with with Resident #1. The root cause was determined to be Resident #9 did not like her personal space invaded and has a strong dislike for Resident #1. The plan was to continue to provide a safe environment and redirect other residents when possible. -However, no specific interventions were implemented by the IDT to keep Resident #1 safe from Resident #9. A social services note dated 7/7/2020 at 1:24 p.m. revealed Resident #9 was standing in Resident #1's doorway laughing at her and calling her an old hag. A social services note dated 7/17/2020 at 4:30 p.m. revealed Resident #9 was assessed due to her making suicidal threats. Staff was advised to observe the resident frequently without actually engaging with her as this would escalate her attention seeking behavior. F. Resident #9's care plan A behavioral care plan was initiated on 5/5/19 and revised on 1/13/2020. Noted behaviors included wandering, a history of hitting other residents and being very territorial over her personal space and room. Interventions initiated on 5/5/19 were to administer medications as ordered and anticipate and meet her needs. Further interventions initiated on 5/23/19 included approaching the resident in a calm manner, explaining all procedures before starting, providing emotional support and a program of activities of interest. -There were no behavioral interventions specific to the history of hitting other residents and being territorial until after the resident-to-resident incident on 7/20/2020. One-to-one supervision of Resident #9 was initiated on 7/22/2020. Interventions related to previous instances of aggressive behavior specific to Resident #3 were initiated on 7/22/2020 and Resident #1 on 7/23/2020. Interventions included keep Resident #9 separated from these residents and provide close observation if they are even in the general area of each other. A vulnerability care plan was initiated on 4/25/19 and revised on 5/11/2020. The resident was noted to yell and push other residents if they were in her personal space. An intervention to redirect residents if they go near Resident #9's room or if they invade her personal space was initiated on 7/19/19. An escalation care plan was initiated on 7/23/2020. The resident was noted to have a history of hitting, shoving and throwing objects at other residents. She was noted to be very territorial over her space and room and did not like other residents near her room. -Interventions included one-to-one staff supervision while the

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) resident was awake that was started on 7/22/2020. G. Staff interviews CNA #1 was interviewed on 7/28/2020 at approximately 12:40 p.m. She said she was assigned one-to-one observation for Resident #9 due to aggressive behaviors. She said she was unaware of any supervision requirements for Resident #9 prior to the incident on 7/20/2020. LPN #1 was interviewed on 7/29/2020 at approximately 10:30 a.m. She said she was not working the day of the altercation between Resident #9 and Resident #3. She said Resident #9 was the only resident currently assigned one-to-one supervision. She said it takes all of the staff to monitor the hallway, common area and sunroom. She said the general rule was to keep an eye on everyone and try to keep Resident #9 and Resident #1 separated. The director of the memory support unit (DMS) was interviewed on 7/29/2020 at approximately 10:40 a.m. She said Resident #9 was increasingly more behavioral. She said she had a history of [REDACTED].#1 in particular. She said Resident #9 had no specific history with Resident #3. She said staff tried to keep Resident #9's door closed and all of the other residents away from her door. She said one-to-one supervision was initiated after the incident with and resulting injuries to Resident #3. The NHA was interviewed on 7/28/ 8 at approximately 3:30 p.m. She said the residents involved in resident-to-resident altercations were separated immediately. She said Resident #3 was recovering in a room outside of the MSU. She said Resident #9 would continue on one-to-one supervision for the safety of all the residents while the facility continued to pursue placement for a geriatric psychiatric evaluation. III. Resident #7 to Resident #5 physical abuse A. Resident #5 status Resident #5, age 83, was admitted on [DATE]. According to the July 2020 CPO [DIAGNOSES REDACTED]. The 7/15/2020 MDS revealed a severe cognitive impairment from the staff assessment for mental status. He required extensive assistance of one person for eating and two person assistance for bed mobility, transfers and activities of daily living (ADL). B. Resident #7 status Resident #7, age 72, was admitted on [DATE]. According to the July 2020 CPO [DIAGNOSES REDACTED]. The 7/15/2020 MDS revealed the resident had a moderate cognitive impairment with a BIMS score of 10 out of 15. He displayed verbal behavioral symptoms directed towards others one to three days in the look back period. He was independent with no staff help or oversight at any time to walk in the corridor or for locomotion on and off the unit. He had received antipsychotic, antianxiety, antidepressant medications seven out of seven days prior to the assessment. C. Altercation 5/28/2020 Review of the facility's recent abuse investigations revealed a resident-to-resident altercation between Resident #5 and Resident #7 on 5/28/2020. At approximately 5:33 p.m., the DMS unit contacted the NHA to report the incident. The NHA entered the MSU and witnessed Resident #5 on the floor being assessed by the nurse on duty and assisted by two CNAs. Staff members reported Resident #5 was self-propelling his wheelchair by Resident #7's room as he was exiting. Resident #7 grabbed the back of Resident #5's wheelchair and pulled it backwards causing the resident to fall to the floor. Resident #5 expressed some feeling of pain at the time of the altercation and felt somewhat better once assisted back into his wheelchair. There were no documented injuries. The residents were separated and Resident was put on one to one supervision to ensure the safety of all residents. Resident #7 was interviewed by the NHA and he admitted to being angry about something that had happened earlier in the day and for that reason he pulled the chair away from Resident #5. The facility investigation substantiated the physical abuse. D. Resident #7's progress notes A social services note dated 5/4/2020 at 2:29 p.m., revealed he raised his fist at a female resident to get out of his physical space and he did not make contact. A behaviors and mood note dated 5/8/2020 at 5:40 p.m., revealed he was seated in the television room approximately six to eight feet from a female resident and he told her: I wish you would (expletive) die already. Just (expletive) die, just (expletive) die. A behaviors and mood note dated 5/10/2020 at 5:20 p.m., revealed he raised his fist as to hit a female resident as she moved towards him. Staff intervened and redirected the female resident. A nursing note dated 5/10/2020 at 10:31 p.m., revealed the resident became angry with another resident and stuck his hand in his glass of water and started flicking water at her and yelling: Get back! A provider note dated 5/11/2020 at 12:02 p.m., read the provider was asked to see the resident due to recent increased anxiety and some aggressive statements. A nursing note dated 5/15/2020 at 2:26 p.m., revealed he threw three cups at another resident which struck her in the chest. He said the resident had touched his back but two staff members witnessed the event and indicated he had not been touched. An IDT note dated 5/18/2020 revealed the root cause to be resident became agitated when his personal space was invaded. A behaviors and mood note dated 5/22/2020 at 5:16 p.m., revealed the resident displayed threatening behaviors and directed comments towards a female resident that: She's going to die tonight. A post incident note dated 5/28/2020 at 5:35 p.m., revealed the resident had been in an individual-to-individual altercation with Resident #5. E. Resident #7's care plan The resident's care plan was reviewed in detail. Despite six separate documented instances of verbal and/or physical aggression in May 2020 there were no revisions made to his behavioral, mood or vulnerability care plans until after the resident-to-resident altercation on 5/28/2020. Increased risk for agitation was initiated in Resident #7's care plan on 6/3/2020. F. NHA interview The NHA was interviewed on 7/29/2020 at approximately 12:30 p.m. She said Resident #7 remained on one-to-one supervision until he ultimately was transferred out of the MSU to the general area of the facility on 6/9/2020. She said Resident #7 was adjusting well and had no further aggressive behaviors.