STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065252	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKMOOR VILLAGE HEALTHCARE CENTER	3625 PARKMOOR VILLAGE DR COLORADO SPRINGS, CO 80917

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 observations, record review and interviews, the facility failed to ensure residents' right to be free from abuse for one (#1) of three residents investigated for abuse out of seven sample residents. Resident #1 was not protected from physical abuse resulting in lacerations and abrasions on the left hand and left elbow, and the resident expressed fear and imminent danger. The facility failed to ensure the safety of residents in the facility. Findings include: I. Facility policy and procedure The Abuse policy revised November 2019, provided by the director of nurses (DON) on 5/21/2020 at 11:42 a m. revealed in part, (The facility) does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members . Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking . II. Resident #1 status Resident #1, age 70, was admitted on [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 4/20/2020 minimum data set (MDS) assessment revealed the resident had a moderate cognitive deficit with a brief interview for mental status (BIMS) score of 12 out of 15. Behaviors were not exhibited. The resident required supervision for transfers, walking in room, walking in corridor, locomotion on and off the unit, dressing, eating and toilet use. His ability to hear was marked as having moderate difficulty. Hearing aid: yes. III. Observations, record review and interviews Review of the care plan, revised 5/13/2020, revealed Resident #1 had become physically and verbally aggressive with staff during attempts for redirection. Interventions included: Always approach in a calm manner .Attempt to de-escalate outbursts with voice of understanding .Offer (Resident #1) options to avoid saying 'no' to his statements . Review of the care plan, initiated and revised 5/21/2020, revealed Resident #1 used antipsychotic medication for symptoms/ behaviors associated with the [DIAGNOSES REDACTED].'can't.' Review of the progress notes revealed on 5/15/2020 At approximately 1845 (6:45 p.m.) resident became agitated awaiting smoke break. He picked up a portable oxygen tank and raised it in the air in an attempt to throw it in the direction of another resident. A staff member stopped him from throwing the tank. He then became physically aggressive with a staff member. Towards the end of the physical altercation he again grabbed another oxygen tank and attempted to throw it again. Review of the hospital records on 5/16/2020 revealed the following: -Chief complaint: Assault victim -Context: This is a [AGE] year old male who presents to the emergency department (ED) via ambulance after altercation with staff .Per emergency medical services (EMS) he has a history of dementia with violence in the past. Today he became physically aggressive with staff and staff defended themselves against the patient with an oxygen tank. On arrival the patient has superficial lacerations and abrasions to his left hand and left elbow. No head injury or loss of consciousness .Patient was transferred to the ED for mental health evaluation. -Skin: Superficial laceration to the left metacarpal head which is non suturable. Abrasion to base of left thumb. Abrasion to left elbow. The resident was observed on 5/21/2020 at 9:20 a.m. in the elevator, in his wheelchair. He was with a sitter and heading to his room. He was observed again at 9:25 a.m. sitting on his bed. He appeared calm. The resident was interviewed on 5/21/2020 at 9:25 a.m. He said someone had harmed him during his stay at the facility. He had scabbed areas on his left hand and his elbow. He said a lady took a water bottle and hit him with it. He said many people saw what happened. He said he did not know her name and did not know why she hit him. Review of the May CPO revealed the following: -5/18/2020: treatment for [REDACTED].and cover with gauze daily. Monitor for signs and symptoms of infection . -5/19/2020: [MEDICATION NAME] tablet 25 milligram (mg). Give 25 mg by mouth one time a day for augmentation of depression. -5/19/2020: [MEDICATION NAME] tablet 50 mg. Give 50 mg by mouth one time a day for depression. -5/15/2020: [MEDICATION NAME] tablet 0.5 mg. Give one tablet by mouth every 12 hours for anxiety. -5/8/2020: [MEDICATION NAME] tablet 0.5 mg. Give 0.5 mg by mouth every six hours as needed for anxiety for 14 days. -4/23/2020: [MEDICATION NAME] oxalate ([MEDICATION NAME]) tablet 10 mg. Give one tablet by mouth one time a day for depression. IV. Facility investigation Review of the incident report, dated 5/15/2020, revealed the following: -Date of alleged incident: 5/15/2020; -Is there evidence of injury: Yes; -Name of alleged perpetrator: Licensed practical nurse (LPN) #1 -Alleged assailant and victim have been separated; -Victim assessed and treated by staff; -Relationship of alleged perpetrator to the resident: facility staff member; -Name of witnesses: LPN #2; certified nurse aide (CNA) #1, #2 and #3 and resident #6 and #7. -Physical abuse: hitting; hit with object; -Verbal abuse: continued to curse at resident after separation; -Substantiated: Yes; -Summary: Resident struck with portable oxygen tank three times with video evidence. Resident with wounds present to bilateral hands and arms; -Follow up: Assailant escorted from premises and suspended. -Resident interview: 5/16/2020 at 1000: That lady hit me. She hit me with that thing (points at the oxygen canister). I am not going to let this go. If I were to hit her, I would go to jail. Why isn't she in jail .She said I was a B---- and her husband knows and he's going to hurt me too . -LPN #1 interview: 5/15/2020 at 1934: At approximately 1845; (Resident #1) was asking for cigarettes. The CNA told him to wait 15 more minutes until 1900. He picked up the oxygen tank (portable) and went to throw it in the direction of the other residents so I knocked it to the ground, out of his hand. He got mad and stood up. He turned around and started swinging at me with his fists. Other people tried to intervene but he kept coming and I picked up the oxygen tank and I hit him three times because he kept coming. I was afraid because he hurt me that last time. I wasn't going to let him hurt me again. -CNA #1 interview: 5/16/2020 at 1038: .(Resident #1) came up to us asking about his smoke break. Everyone said it's not time. You're going to have to wait. A couple of times. Then CNA #3 said, if you don't wait then you won't go at all . (Resident #1) did not like the way she said it and got riled up. He grabbed an oxygen tank and proceeded to throw it at her. LPN #1 quickly came up behind him and swiped the tank from him before he could hit her. He quickly got up and stood in a defensive 'boxer' pose. LPN #1, with the tank still in her hand, told him 'you ain't never touching me again, come on! .' So then the physical altercation really starts. I run over to them to try and break them up .I scream (LPN #2's) name and he comes to help. We finally separate the two and LPN #1 said 'I told you, I wasn't going to let you touch me again.' (Resident #1) said, 'I'm going to kill you (LPN #1)' He then grabbed another oxygen tank and tried hitting her again. I quickly grabbed the tank from him and we were playing tug-a-war. I was telling him to let go, (Resident #1) you are ok. He released it. Then LPN #1 was in the background calling him a B---- and said 'F--- you .' Finally the elevator comes and LPN #2 takes him on it and gets bandages for his wounds . -Resident #6 interview: 5/18/2020: .That man (Resident #1) is crazy and mean. He hurts people for no reason because he doesn't get his way .He wanted to smoke early and was told he had to wait. He got really mad and he grabbed the oxygen on the chair. I was afraid because I thought he might have hurt me .The nurse (LPN #1) took it from him and he went chasing after her saying 'I will kill you, I will kill you.' I could not see anything after that because the staff was all around. -CNA #2 interview: 5/15/2020: I turned around and (resident #1) had an oxygen tank lifted over his head about to launch it towards some other residents. (LPN #1) tried to grab it but ended up knocking it out of his hands. She picked it up. (Resident #1) jumped out of his chair, fists raised ready to fight. He lunged towards her and she swung the portable at him .Everyone tried to stop

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) him but he then threatened to kill (LPN#1). Lunged again and she swung the oxygen tank again stating, 'You're not going to put your hands on me again.' (Resident #1) tried grabbing another tank but we managed to get it from him. (LPN #2) came up and ended up taking him downstairs to smoke and be bandaged. V. Additional record review and interviews Review of LPN #1's personnel records on 5/21/2020 at 10:53 a.m. revealed she was terminated on 5/18/2020. Family for Resident #1 was interviewed on 5/21/2020 at 10:56 a.m. She said she had not talked to the resident after the incident happened. She said he was being aggressive; he swung the oxygen at a nurse and she had swung it back. She said he got hit and was transferred for stitches. The occurrence coordinator (OC) was interviewed on 5/21/2020 at 11:45 a.m. She said Resident #1 was told it wasn't time to smoke. She said he got agitated, picked up the oxygen canister to hit someone and (LPN #1) grabbed it. She said the resident turned around and went after her. She said many of the residents on the floor were difficult to interview related to their cognitive status. She said she watched the video of the occurrence. She said she did not know why (LPN #1) did not leave the area. She said LPN #1 felt like her life was in danger. The DON was interviewed on 5/21/2020 at 11:52 a.m. She said she was not in the building when it happened but she arrived within 20 minutes. She said (LPN #1) called her and told her the resident attempted to throw the oxygen tank at another resident and she hit him. LPN #1 confirmed to the DON that she hit the resident. She said she got LPN #1's statement and then walked her out of the building. She said she watched the video of the incident. She said he had grabbed the oxygen tank and (LPN #1) grabbed the tank from behind the resident. She said it fell to the floor and LPN #1 picked it up from the floor. She said he kept coming after her and she was swinging the tank at him. The DON said this resident had difficulty with being told No or can't. She said that was a big trigger for him. She said they educated the staff on avoiding those words. She said they changed his medications and he was doing well. She said the only previous incident she was aware of was when LPN #1 tried to pull him out of the elevator and he grabbed her hands. She said he didn't want her to pull him out of the elevator. She said there were no injuries. The nursing home administrator was interviewed on 5/21/2020 at 12:15 p.m. He said after reviewing all of the statements and evidence, he concluded that the incident was substantiated. He said the resident suffered physical harm and he expressed fear and imminent danger.