STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL COLUMNS NURSING CENTER	1340 E FILLMORE ST COLORADO SPRINGS, CO 80907

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 interviews and record review, the facility failed to ensure four (#1, #2, #3, and #4) out of six sample residents were kept free from abuse. Specifically, the facility: -Failed to prevent a resident-to-resident physical abuse incident between Resident #3 and #4; and, -Failed to ensure Resident #2 was kept free from physical abuse from Resident #1. Findings include: I. Facility policy and procedure The Abuse policy and procedure, revised August 2017, was provided by the administrator in training (AIT) on 8/3/2020 at 12:10 p.m. It revealed, in pertinent part, Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. II. Resident #3 and #4 A. Resident #3 1. Resdient status Resident #3, age 73, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 4/30/2020 minimum data set (MDS) assessment revealed the resident was moderately cognitively intact with a brief interview for mental status (BIMS) score of nine out of 15. No behaviors were noted. She needed extensive assistance with some activities of daily living (ADLs) and she needed supervision with locomotion on and off the unit. 2. Record review The behavior care plan, revised on 11/18/19, revealed the resident had behaviors of verbal aggression, yelling out, cursing, and name calling urination/defecation, in common areas, lying/sitting in common areas improperly clothed related to (r/t) [MEDICAL CONDITION] and dementia. Interventions included: -Allow choices within an individual's decision making abilities. -Intervene as necessary to protect the rights and safety of others. Approach/speaking a calm manner. Divert attention. Remove from the situation and take to an alternate location as needed. The behavior care plan, previously revised on 10/26/18, revealed the resident had the potential to be/was verbally and physically aggressive. Interventions included: -Remind resident to check her surroundings when mobilizing in common areas. Resident's seating in the dining room has been changed to prevent resident to resident conflict. B. Resident #4 1. Resident status Resident #4, younger than 65, was admitted on [DATE]. According to the August 2020 CPO, the [DIAGNOSES REDACTED]. The 3/13/2020 MDS assessment revealed the resident had no cognitive impairment with a brief interview for mental status score of 15 out of 15. She was required supervision with ADLs. No behaviors were noted. 2. Record review The behavior care plan, revised on 4/19/18, identified the resident had the potential to be verbally aggressive toward other residents and staff related to ineffective coping skills, dementia, and depression. Interventions included: -Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. C. Incident on 3/9/2020 between Resident #3 and Resident #4 1. Record review The 3/9/2020 situation, background, assessment, recommendation (SBAR) summary note revealed Resident #3 was sitting in a chair in the front dining room when Resident #4 approached Resident #3 and told Resident #3 get out of Resident #4's chair. When Resident #3 didn't respond, Resident #4 sat on Resident #3's lap. Resident #4 got up and stood beside Resident #3. When Resident #3 did not get up Resident #4 slapped Resident #3 in face and grabbed Resident #3's left hand and left three scratches on the back of her hand. The 3/9/2020 incident report, completed by the assistant director of nursing (ADON) revealed Resident #3 was in the area before sitting at the table before Resident #4 entered the dining room. Certified nurse aide (CNA) #2 observed Resident #4 push Resident #3's walker away from her and attempted to sit on her. Resident #3 was observed pushing Resident #4 away when Resident #4 started to slap Resident #3 in the face. Resident #3 defended herself by punching Resident #4 in the upper lip, causing a skin tear to Resident #4. Resident #4 grabbed Resident #3's hand and wrist causing three skin tears on left hand with her fingernails. Residents immediately separated and assessed for injuries. Residents immediately separated and assessed for injuries. Resident #4 immediately placed on one to one supervision for 72 hours. Notified police, families and providers. Resident #4 verbalized multiple times she was aware to stay out of Resident #3's personal space and to get a staff member if needed. The facility had to rearrange the dining room. The identified seat was removed. The conclusion of the investigation documented, 'physical abuse substantiated, meets elements, injury sustained.' The facility failed to prevent a resident-to-resident physical abuse altercation. D. Staff interviews The AIT was interviewed on 8/3/2020 at 2:14 p.m. She said she was not at the facility at the time of the incident. The ADON was interviewed on 8/3/2020 at 2:41 p.m. She said Resident #3 had a history of [REDACTED].#4. She said immediately following the episode, both residents were assessed for injuries, Resident #4 was placed on a one-to-one staff supervision, and the facility rearranged the dining room, removing the seat. The facility asked Resident #3 to keep clear of Resident #4. She said since the incident the residents have stayed away from each other. She said staff were educated to keep the two residents away from each other. She said there had been no further incidents between the two residents. The nursing home administrator (NHA) was interviewed on 8/3/2020 at 3:13 p.m. by telephone. She said she had reviewed the investigation, and after talking to both residents, neither stated they were fearful. She said neither wanted to press charges, and since the incident the facility had kept the two separated and had no further problems or interactions with each other. III. Resident #2 and Resident #1 A. Resident #2 1. Resident status Resident #2, age 82, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. According to the 6/18/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The resident had minimal depression with the resident scoring three of 27 on the patient health questionnaire (PHQ-9). The resident had no behavioral symptoms. She required extensive assistance for bed mobility, transfers, grooming and toilet use. She was frequently incontinent of the bladder and bowel. 2. Record review The care plan, initiated 10/17/16 and revised 7/20/2020, the resident had potential for behavior Problems, verbally aggressive, makes accusations about other residents which increases her agitation level and history of delusions related to (r/t) dementia, impulsive disorder and being in a new environment. Interventions include allowing choices within her decision making abilities. Explain all procedures to her before starting and allow her time to adjust to changes. Her triggers for aggressive behavior are her confusion, frustration, loud surrounding, over stimulation, or challenging behaviors from others. The resident's behavior is de-escalated by (calm surrounding, allowing her to talk, remove her from the situation, one to one attention, calling her niece). Observe behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. 3. Incident between Resident #2 and #1 The resident incident report dated 7/7/2020 at 4:05 p.m. documented, Resident #1 was still up at the start of shift. She had eaten a snack and got up out of her chair. Resident #2 was ambulating slowly by the table and stopped at the chair where Resident #1 had been sitting. Resident #1 pushed Resident #2 and Resident #2 fell on to the floor on her buttocks. Resident #1 then sat down in the chair as though nothing had

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) happened. Resident #1 receives [MEDICATION NAME] 50 mg(milligram) Q(every) eight hours for anxiety. Will continue to monitor behaviors. The statement from registered nurse (RN) (CNA) #5 dated 7/7/2020 included, Resident #1 was still up at the start of shift. She had eaten a snack and got up out of her chair. Resident #2 was ambulating slowly by the table and stopped at the chair where Resident #1 had been sitting. Resident #1 pushed Resident #2 and Resident #2 fell on to the floor on her buttocks. Resident #1 then sat down in the chair as though nothing had happened. Resident #1 receives [MEDICATION NAME] 50 mg Q eight hours for anxiety. Will continue to monitor behaviors. The facility failed to protect Resident #2 from physical abuse by Resident #1. B. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/3/2020 at 10:40 a.m. She said Resident #1 wanders all day. She said the resident would go into other residents' rooms. She said Resident #1 was very hard to redirect at times. She said she was moved into the memory care unit because she was pushing other residents on the long term care (LTC) side of the building. Licensed practical nurse (LPN) #1 on 8/3/2020 at 10:55 a.m. She said Resident #1 had a history of [REDACTED]. She said Resident #1 was on the LTC side but had to be moved from LTC to the secured unit. She said she was not present for the incident on 7/7/2020 but had been informed to monitor Resident #1. She said the facility had been adjusting the resident [MEDICATION NAME] to help with her behaviors' and had recently changed her medication from [MEDICATION NAME] two times a day to [MEDICATION NAME] three times a day. She said Resident #1 had been doing well with the change of medication and her aggressiveness had been slowing down. She said Resident #1 was easily redirected with minimal behaviors' currently. LPN #1 said Resident #2 had not displayed fearfulness of Resident #1. The nursing home administrator (NHA) was interviewed on 8/3/2020 at 2:15 p.m. The NHA said she was the person who completed the investigation on 7/7/2020. She said the incident happened when Resident #1 got up from her table and Resident #2 tried to sit in her chair. She said Resident #1 was just protecting her area and pushed Resident #2 down with her falling on her buttocks. She said she thought Resident #2 had tripped over her walker and fell but would have to check for sure. The NHA said Residents #1 care plan should have identified the physical aggression and pushing of other residents prior to the incident on 7/7/2020. The NHA said they have educated all staff on behaviors and aggression. She said all residents had the right to be free from any harm. She said the facility worked very hard to prevent any form of abuse to all the residents in the facility. The NHA said they have educated all staff on behaviors and aggression. She said all residents had the right to be free from any harm. She said the facility worked very hard to prevent any form of abuse to all the residents in the facility. No follow up by NHA identifying if Resident #2 had tripped on a walker.