STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065213	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTH CENTER AT FRANKLIN PARK	1535 PARK AVE DENVER, CO 80218

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 record review and staff interview, the facility failed to ensure five residents (#1, #2, #3, #6, and #10) reviewed for abuse were free from resident-to-resident altercations out of eleven sample residents. The facility failed to ensure Resident #1 was free from physical abuse by Resident #2, a resident with several known altercations as the aggressor on 10/29/19, 11/3/19, 11/14/19 and 11/17/19 prior to the incident that occurred on 11/20/19 where Resident #1 was pushed to the floor by Resident #2. The facility failed to provide line of sight supervision of Resident #2 implemented in a safety plan on 11/13/19. Furthermore, due to the facility failures Resident #1 was pushed to the floor by Resident #2, and sustained a left [MEDICAL CONDITION] with subsequent decline in medical condition. Furthermore, the facility failed to ensure Resident #10 was free from physical abuse by Resident #11 and Resident #2 was free from physical abuse by Resident #11 with a history of physical resident to resident altercations. Additionally, the facility failed to ensure Resident #3 was free from physical abuse by Resident #4 and Resident #6 was free from physical abuse by Resident #5. Findings include: I. Facility policy The Abuse Prevention Program policy, revised October 2018, was provided by the nursing home administrator (NHA) on 9/1/2020 via email at 10:41 a.m. It read, in pertinent part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. As part of the resident abuse prevention, the staff will protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual .Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior . III. Resident #2 A. Resident status Resident #2, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 9/23/2019 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. He did not exhibit any behavioral symptoms. Specifically there were no physical behaviors directed towards others. He required supervision with transfers, walking in the room, walking through the corridor and walking on and off the unit. He required extensive one-person assistance with toileting and dressing. He was frequently incontinent of urine and always incontinent of bowel. B. Resident-to-resident altercations prior to 11/20/19 1. 10/29/19 The 10/29/19 at 10:53 p.m. behavior note documented at 5:10 p.m. Resident #2 was in the dining room. Resident #2 started yelling at another resident and said Why are you here. Resident #2 pushed the table and was trying to hit the other resident. Staff intervened as Resident #2 was angry. Resident #2 pushed the other resident and hit him on his hand with no injury. The residents were kept apart and monitored for the behavior. -The plan was to monitor Resident #2 by completing frequent checks and the resident was assessed by the nurse practitioner on 10/30/19 for abdominal pain. 2. 11/3/19 The 11/3/19 at 7:17 p.m. behavior note documented at 5:20 p.m. staff saw Resident #2 hit another resident on the right arm in the dining room. Both residents were eating dinner at the same table in the dining room. -Resident #2 was placed on 15 minute checks. 3. 11/14/19 The 11/14/19 at 8:29 p.m. behavior note documented Resident #2 was on monitoring for physical aggression initiated toward another resident. -However, there was no documentation of what occurred in Resident #2's medical record except for in the behavior care plan revised on 11/13/19 (see below). The 11/15/19 at 4:50 a.m. behavior note documented Resident #2 was being monitored for a resident to resident altercation. -The plan was to continue to monitor the resident for physical aggression and a safety plan was put into place; however, it was not followed and Resident #2 had a physical altercation with Resident #1 on 11/20/19 causing him injury (see record review below). 4. 11/17/19 The 11/17/19 at 7:18 p.m. behavior note documented at 4:30 p.m. staff saw Resident #2 was walking by the nursing station and another resident was walking towards the nursing station. Without provocation, Resident #2 used his left shoulder and hit the other resident on the left shoulder area causing that resident to fall to the floor. -Resident #2 was placed on 15 minute checks. 5. Behavior care plan The behavior care plan, initiated on 11/14/19 and revised on 5/22/2020 revealed the resident had a history of [REDACTED]. He was triggered by invasion of personal space, loud vocalization, someone sitting in his dining spot, and other residents who touch items in his environment. Interventions included to approach the resident in a calm manner, monitor for signs and triggers for aggression such as invasion of personal space, threatening remarks, irritability around certain people; and, keep in line of sight if he was showing signs of aggression remove the resident from others and area to keep them safe. The acute behavioral care plan, initiated 11/14/19, updated 11/15/19 and 11/18/19 revealed Resident #2 was involved in a physical altercation with other residents, which he was the aggressor on 10/29, 11/3, 11/13 (I was involved in a physical altercation I shoved another resident two times in the arm), 11/14 and 11/17/2019. Interventions included the following: -Approach in a calm manner. Provide the resident with choice/options -Provide time to de-escalate, offer to take for a walk off the secured neighborhood or offer conversation. -Monitor for signs, triggers for aggression such as invasion of personal space, threatening remarks and irritability around certain people. -Keep the resident in line of sight if he is showing signs of aggression. Remove others from the area to keep safe. C. Resident-to-resident altercation involving Resident #1 and Resident #2 on 11/20/19 1. Secure unit layout The secure unit where the altercation occurred on 11/20/19 was located on the third floor. The lounge area and dining area were adjacent to each other. The lounge area was on the east side of the third floor and the dining area was on the west side of the third floor; however there were two pillars in between the areas, which could obstruct view to either area. 2. Resident #1 status Resident #1, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the July 2020 CPO, [DIAGNOSES REDACTED]. The 10/22/19 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of one out of 15. He did reject care four to six days and exhibited behaviors towards staff or others of hitting, kicking, scratching one to three days. He required extensive two-person assistance with bed mobility, dressing, transfers and toileting. He required limited one-person assistance with walking in the corridor and in the room. He was always incontinent of bowel and bladder. His ability to hear was highly impaired, he wore a hearing device and his vision was severely impaired. The 12/20/19 MDS assessment for Resident #1 revealed he did not reject care. He declined in his ability to perform activities of daily living (ADLs) compared to the 10/22/19 MDS assessment. He required extensive two-person assistance with bed mobility, dressing, transfers, toileting and extensive one-person assistance with locomotion on the unit and walking through the corridor. Walking in the room did not occur. 3. Altercation between Resident #1 and Resident #2 on 11/20/19 The 11/20/19 facility documentation of the altercation was provided by the NHA on 8/26/2020 at 12:55 p.m. It documented in pertinent part, Resident #2 was sitting at the table in the dining room at 11:37 a.m. and Resident #1 was sitting in a chair in the lounge area. Resident #1 got up from the chair and walked over to the dining area

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) towards the kitchen window. Resident #2 turned around in his seat and looked toward Resident #1. Resident #2 then got up from his chair at 11:38 a.m. and grabbed Resident #1 by his left arm. Resident #1 tried to pull his arm away from Resident #2 and they both struggled with each other for a moment. Resident #1 turned around facing away from Resident #2. Resident #2 then pushed Resident #1 from behind and he fell to the floor. Video footage reviewed from 11:25 a.m. to 11:41 a.m. On 11/20/19 at 11:36 a.m. Resident #2 was sitting at the table in the dining room at 11:37 a.m. and Resident #1 was seen sitting in a chair in the lounge area. Resident #1 got up from the chair and walked over to the dining area towards the kitchen window. At 11:37 a.m., Resident #2 noticed Resident #1 walk in the dining room area. At 11:38 a.m., Resident #2 turned around in his chair and got up from his chair, and grabbed Resident #1 by his right arm. Resident #1 tried to pull his arm away from Resident #2 and they both grabbed onto each other's arms. Resident #2 seemed to be guiding Resident #1 out of the dining room area while talking to him (unable to make out the words spoken). Resident #2 continued to hold onto Resident #1's left arm and Resident #1 appeared to begin walking out of the dining room area. Resident #2 let go of Resident #1's arm and at this time appeared to push Resident #1 on the middle of his back. Resident #1 stopped and turned back around toward the dining area and walked back into the dining area. Resident #2 then pushed Resident #1 with both hands on his right upper arm/back area causing Resident #1 to fall to the floor. At 11:39 a.m., a staff member intervened and separated residents. The time frame for the altercation was from 11:38 a.m. to 11:39 a.m. The 11/20/19 at 1:26 p.m. x-ray of the left femur revealed Resident #1 had a [MEDICAL CONDITION] femoral neck with superior displacement of the distal fragment. 4. Safety plan The 11/13/19 safety plan revealed Resident #2 ambulated independently interacting with staff and other residents on the unit. The current interventions to prevent physical altercations between Resident #2 and other residents were unsuccessful. Staff were to be hyper aware of antecedents and triggers. Staff had been educated after each incident to ensure they were present in common areas, communicated with co-workers if they needed to leave the area so there was replacement monitoring. Staff were to redirect other residents who invaded Resident #2's space, provide the resident with independence with personal cares and supervise to decrease the likelihood of agitation, use tools and resources to get to know the resident for meaningful engagement. Staff were to position themselves throughout the day to be in line of sight of Resident #2 when he was in common areas around other residents. -However, this was not done after the education was provided to the staff to ensure they understood the expectation of keeping Resident #2 in line of sight while in the common areas around other residents (see interviews below). Cross-reference F744 for treatment and services for dementia care. 5. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/26/2020 at 2:20 p.m. She said she worked the secure unit on day shift full time. She said there were a couple of residents who they had to monitor for increased behaviors one being Resident #2. She said he had to remain in line of sight. She said Resident #2 used have increased behaviors but he had been okay/calm lately. Licensed practical nurse (LPN) #1 was interviewed on 8/26/2020 at 2:25 p.m. She said she worked the secure unit for seven months on the day shift. She said if the unit was noisy Resident #2 would get agitated. She said prior to admitting to the facility the resident had severe behaviors and prior facility could not care for him because he was hitting other residents. Activity assistant (AA) #1 was interviewed on 8/27/2020 at 12:29 a.m. He said he worked at the facility for two years. He said he worked in the secure unit full time from 9:00 a.m. until 3:30 p.m. for the past couple of months and his previous work hours were 8:00 a.m. until 4:00 p.m. He said he was working the day Resident #2 had an altercation with Resident #1 on 11/20/19. He said on 11/20/19 he did not witness the altercation between Resident #1 and #2. He said he remembered that he was engaged with a resident in a coloring activity. He said he and the resident were seated at a table in the lounge area. He said he was seated facing east with his back towards the dining room and outside patio. He acknowledged the pillars would have obscured his view of Residents #1 and #2 during their altercation as they were located in the southwest corner of the dining room and he was seated on the lounge area close to one of the two pillars that blocked his sight of the residents when the altercation happened. He said he did not hear any of their conversation, but he heard a thud and he saw Resident #1 on the floor and he went to get the nurse to come and help. He said he received education and training regarding Resident #2's safety plan; however, he said he did not receive education or instruction on staff to position themselves throughout the day to be in line of sight of Resident #2 when he was in the common areas around other residents until after the altercation occurred between Residents #1 and #2 on 11/20/19. He said since he had received numerous staff trainings on dementia and behaviors and the need to keep a close eye on individual residents with behaviors. He said since then staff position themselves, one at the nurse's station and one in the dining area to keep the whole unit in view. LPN #2 was interviewed on 9/1/2020 3:10 p.m. He said he worked at the facility for many years on the secure unit. He said he was caring for Resident #1 and Resident #2 the afternoon on 11/20/19. He said that day Resident #1 was pushed by another resident. He said he was assisting another resident and did not see what had happened. He said a staff member notified him Resident #1 was on the floor and he called an registered nurse (RN) to come and assess Resident #1 as he could not stand or walk. He said they received orders to get an x-ray which showed he had a fracture and they sent him to the hospital. The activity director (AD) was interviewed on 9/1/2020 at 5:45 p.m. She said during the facility's morning clinical call with the interdisciplinary team (IDT) (all managerial department heads) they talked about resident behaviors or safety concerns and she notified the activity department staff during afternoon huddles. She said she informed them of any changes with residents, if residents were engaged or not engaged in the activities. She said if her staff shared anything with her in the huddle then she would share it with the IDT the following morning. The NHA, director of nursing (DON) and social services director (SSD) were interviewed on 9/2/2020 at 11:00 a.m. They acknowledged Resident #2 was involved with several altercations prior to an incident which caused injury to Resident #1. The SSD said staff would document if the resident had increased behaviors, needed 15 minute checks (which would typically last for 72 hours), what helped settle the resident down and what would help with the behaviors such as a snack or a walk. The NHA said residents were reviewed in morning meetings as an interdisciplinary team (IDT) for any pertinent changes (behavioral or clinical) and managers would disperse any pertinent information to their departments such as the need for increased monitoring. The DON said she felt Resident #2 was being monitored appropriately for his increased behaviors. They acknowledged Resident #2's safety plan was not followed as it was not communicated in its entirety to all staff which resulted in him pushing another resident to the floor causing injury. The NHA said the reason AA #1 did not know to keep Resident #2 in line of sight prior to his altercation with Resident #1 on 11/20/19 was because the AD sent the education regarding Resident #2's safety plan via email and she did not ensure AA #1 understood keeping the resident in line of sight. She said immediately after the incident she went to all the floors to complete on the spot training with the staff to ensure they understood what was expected of them when monitoring a resident for increased behaviors. III. Resident-to-resident altercation involving Resident #10 and Resident #11 A. Resident #10's status Resident #10, age 83, was admitted on [DATE] and discharged on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 6/12/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of zero out of 15. He required extensive assistance of two people with all activities of daily living. It indicated the resident had physical behavioral symptoms not directed toward others for four to six days, rejection of care one to three days and wandering daily during the assessment period. B. Resident #11's status Resident #11, age 89, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 8/28/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of three out of 15. He required supervision with all activities of daily living. It indicated he had behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, and grabbing one to three days during the assessment period. C. Resident altercation 6/7/2020 The 6/7/2020 at 3:35 p.m. skin/wound note for Resident #10 revealed the CNA reported to the nurse that Resident #10 was found in Resident #11's room. Resident #10 complained of pain to his right shin and said he was kicked by Resident #11. Resident #11 told the CNA he kicked Resident #10 and would have hit him with the table if she was not present. Resident #10's right shin was assessed and the area was red. The physician, family and law enforcement was notified. Review of the facility documentation dated 6/7/2020 was provided by the NHA on 9/16/2020 at 3:08 p.m. It documented resident to resident altercation happened on memory care neighborhood (secured unit). It appeared that Resident #10 wandered into Resident #11's room at which time Resident #11 kicked Resident #10 in the shin, no injuries were observed. -However, Resident #10's right shin was assessed as being red (see 6/7/2020 skin/wound note above). In conclusion, the facility was unable to substantiate or unsubstantiate specific details regarding physical altercation due to the incident occurring in a resident room, staff had not witnessed it, and poor cognitive status of both residents. However, they did substantiate there was form of contact made to Resident #10's right shin area post nurse assessment. The intervention was to continue to monitor Residents #10 and #11's behaviors and staff were to have specific charting stations in areas that allowed staff to have full view of assigned areas. IV. Resident-to-resident altercation

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) involving Resident #2 and Resident #11 A. Resident altercation 8/27/2020 Review of the facility documentation dated 8/27/2020 was provided by the NHA on 9/16/2020 at 3:08 p.m. It documented both residents on the memory care neighborhood (secure unit) were found on the floor next to each other and there was a possible physical altercation. Both residents were assessed by the registered nurse (RN)and separated. The facility's review of video footage revealed an altercation had occurred between both residents. Staff were interviewed as they did not observe the incident. It was documented the staff left their assigned areas and did not notify any other staff member when the incident occurred. The staff were provided education not to leave the area without notification to another staff member. -However, the staff were to be in line of sight of Resident #2 implemented 11/13/19 and staff were to have specific charting stations in areas that allowed staff to have full view of assigned areas that was implemented 6/7/2020. B. Record review 1. Resident #2's progress notes The 8/27/2020 post fall evaluation at 4:05 p.m., documented Resident #2 had an unwitnessed fall in the hallway. The 8/27/2020 falls detailed report at 9:40 p.m., documented heard a loud thud from the dining area at 4:05 p.m. staff observed Residents #2 and #11 on the floor by the elevator. The assistant director of nursing came to assess the resident, notifications were made to the physician and family, 15 minute checks and frequent monitoring was implemented. 2. Resident #11's progress notes The 8/27/2020 falls detailed report at 10:09 p.m., documented heard a loud thud from the dining area at 4:05 p.m. staff observed Residents #2 and #11 on the floor by the elevator. Resident #11 was assessed by the ADON, found to have a bruise to his right lower leg, the nurse practitioner (NP) also assessed the resident, ordered an x-ray of his leg (negative for fracture) and the family was notified. In conclusion, verbal education was provided to staff to stay in their assigned areas to monitor the residents and prevent resident to resident altercations and if they left the area they were to notify another staff member. C. Staff interviews The DON and NHA were interviewed on 9/16/2020 at 3:08 p.m. The NHA said the staff lacked training/education with caring for the dementia resident and she planned to ensure they did understand. She said they had been interviewing internally and externally for staff who were certified in dementia care. The facility purchased a new dementia care training, they were reviewing each resident's plan of care, their activity programming, and implementing an evening program specifically for those residents who had behavioral issues. She said they would start training with staff on 9/28/2020 and 10/2/2020. V. Resident-to-resident altercation involving Resident #3 and Resident #4 A. Resident #3's status Resident #3, older than 85, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 5/30/2020 MDS assessment revealed the resident was cognitively impaired with a BIMS five out of 10. She required extensive one-person assistance with toileting and dressing and required supervision with bed mobility, transfers and walking in her room. B. Resident #4's status Resident #4, age less than 60, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 6/23/2020 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She required supervision and set up with most ADLs. C. Resident altercation 8/19/2020 The 8/19/2020 at 9:00 a.m. behavior note for Resident #4 documented at 4:45 a.m. a staff member was called to the second floor regarding an incident that occurred between Resident #3 and Resident #4. Resident #4 said Resident #3 was in the bathroom for an hour and she needed to use the restroom, I'm the one that pushed her. She said she moved her out of the way, It wasn't even really a push. Review of the facility documentation dated 8/19/2020 was provided by the NHA on 8/26/2020 at 5:22 p.m. It documented in pertinent part, the house supervisor was called to the second floor by the nurse on duty found Resident #3 on the floor in her room. Resident #3 said Resident #4 pushed her. Resident #3 was assessed and found to have a hematoma to the back of her head. Resident #4 was interviewed and she stated I'm the one that pushed her, Resident #3 was taking too long in the bathroom so I moved her out of the way. In conclusion, the facility substantiated Resident #4 put her hands on Resident #3; however, the facility did not substantiate she was pushed. The intervention was to provide Resident #4 with education to call staff for help if she needed assistance if another resident was toileting. Resident #4 was moved to a different neighborhood and offered counseling options to return to the community. IV. Resident-to-resident altercation involving Resident #6 and Resident #5 A. Resident #6's status Resident #6, age 75, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 6/26/2020 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He required supervision with most ADLs. He had minimal difficulty hearing and required hearing devices. B. Resident #5's status Resident #5, age less than 50, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 7/22/2020 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with all ADLs. C. Altercation 8/11/2020 Review of the facility documentation dated 8/11/2020 was provided by the NHA on 8/26/2020 at 5:22 p.m. It documented in pertinent part, Resident #5 asked Resident #6 to stop messing with the television (the residents were roommates). Resident #5 stood up walked over to Resident #6 and slapped him in the face and threw an apple at him. Resident #6 left the room and went to tell the nurse. Law enforcement was notified and an investigation was started. In conclusion, it documented the verbal and physical altercation between Resident #5 and Resident #6 was substantiated. Resident #5 and Resident #6 engaged in a verbal altercation in which Resident #6 was hit in the right eye with a closed fist by Resident #5. Resident #6 did not realize the remote he was using to change his television (TV) was also changing Resident #5's TV. Resident #5 was moved to another room and offered counseling options to return to the community. Resident #6 was encouraged to wear his hearing aids as he did not hear his roommate ask him to stop changing his TV.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that one (#2) of one out of nine sample residents received treatment and care in accordance with professional standards of practice and comprehensive person-centered care. Specifically, the facility failed to monitor Resident #2's change in condition timely since he was at risk for developing urinary tract infections (UTIs) due to having [MEDICAL CONDITION] stents which overall contributed to his increased behaviors. Cross-reference F600-failed to protect residents from abuse Cross-reference F744- failed to ensure treatment and services were provided for resident with dementia to maintain their highest practicable physical, mental and psychosocial well-being Findings include: I. Facility policy The Change in a Resident's Condition or Status policy and procedure, revised December 2019, was provided by the nursing home administrator (NHA) on 9/1/2020 at 10:41 a.m. It documented, in pertinent part, A 'significant change' of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not 'self-limiting'); Impacts more than one area of the resident's health status; Requires interdisciplinary review and or revision to the care plan; and Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. II. Resident #2 Resident status Resident #2, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 9/23/2019 MDS revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. He did not exhibit any behavioral symptoms. Specifically, there were no physical behaviors directed towards others. He required supervision with transfers, walking in the room, walking through the corridor and walking on and off the unit. He required extensive one-person assistance with toileting and dressing. He was frequently incontinent of urine and always incontinent of bowel. III. Failure to monitor Resident #2's change in condition A. Record review 1. Care plans Resident #2's behavioral care plan, initiated 11/14/19, updated 11/15/19 and 11/18/19 revealed Resident #2 was involved in a physical altercation with other residents, in which he was the aggressor on 10/29, 11/3, 11/13 (I was involved in a physical altercation I shoved another resident two times in the arm), 11/14 and 11/17/2019. Interventions included the following: -Approach in a calm manner. Provide the resident with choice/options -Provide time to de-escalate, offer to take for a walk off the secured neighborhood or offer conversation. -Monitor for signs, triggers for aggression such as invasion of personal space, threatening remarks and irritability around certain people. -Keep the resident in line of sight if he is showing signs of aggression. Remove others from the area to keep safe. Resident #2 was incontinent of bladder, had [MEDICAL CONDITION] and [MEDICAL CONDITION]. Interventions included to monitor for and report increased difficulty starting urine flow, monitor for signs/symptoms of infection: Hematuria, back pain, low grade fever, urinary frequency, burning with urination, chills, lethargy, anorexia, falls, changes in behaviors, strong

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) smelling urine, and concentrated urine. 2. Behavior notes The 10/29/19 at 10:53 p.m. behavior note documented at 5:10 p.m. Resident #2 was in the dining room. Resident #2 started yelling at another resident and said Why are you here. Resident #2 pushed the table and was trying to hit the other resident. Staff intervened as Resident #2 was angry. Resident #2 pushed the other resident and hit him on his hand. The residents were kept apart and monitored for the behavior. -The plan was to monitor Resident #2 by completing frequent checks and the resident was assessed by the nurse practitioner on 10/30/19 for abdominal pain. The 11/3/19 at 7:17 p.m. behavior note documented at 5:20 p.m., staff saw Resident #2 hit another resident on the right arm in the dining room. Both residents were eating dinner at the same table in the dining room. -Resident #2 was placed on 15 minute checks. The 11/14/19 at 8:29 p.m. behavior note documented Resident #2 was on monitoring for physical aggression initiated toward another resident. -However, there was no documentation of what occurred in Resident #2's medical record except for in the behavior care plan revised on 11/13/19 (see above). The 11/15/19 at 4:50 a.m. behavior note documented Resident #2 was being monitored for a resident to resident altercation. -The plan was to continue to monitor the resident for physical aggression and a safety plan was put into place. The 11/17/19 at 7:18 p.m. behavior note documented at 4:30 p.m. staff saw Resident #2 was walking by the nursing station and another resident was walking towards the nursing. Without provocation Resident #2 used his left shoulder and hit the other resident on the left shoulder area causing that resident to fall to the floor. -Resident #2 was placed on 15 minute checks. 3. NP notes The 10/30/19 NP note documented Resident #2 was being assessed for complaints of lower abdominal suprapubic pain which he stated traveled across his back. On exam Resident #2 had suprapubic tenderness and complaints of dysuria. The plan was to check stat (immediate) CBC (complete blood count), CMP (complete metabolic panel) and urinalysis, along with abdominal x-ray. The resident was afebrile and stable since a decrease in his medication [MEDICATION NAME] (antipsychotic) to 2.5 mg by mouth daily. The 10/31/19 NP note documented follow-up to labs and x-ray. Resident #2's CBC and CMP were normal, BUN and Creatinine (blood ratio test used to diagnose acute or chronic renal kidney disease or damage) were elevated at 32 and 1.9 and with his baseline creatinine being 1.6 to 2.0. Staff continued to attempt to collect a urinalysis due to complaints of dysuria and suprapubic pain and can discontinue (urinalysis) if unable to obtain the sample. The 11/1/19 NP note documented follow-up to x-ray of abdomen 10/31/19 . Conclusion was non-obstructive bowel gas pattern, no ileus or obstruction and he had right-sided double J [MEDICAL CONDITION] stent. Resident #2 denied pain. Staff continued to attempt to collect a urinalysis due to complaints of dysuria and suprapubic pain and can discontinue (urinalysis) if unable to obtain the sample. The 11/4/19 NP note documented the reason for the visit was because Resident #2 had an altercation with another resident. Per the staff, reported a resident was being intrusive and Resident #2 took a clipboard and hit him with it. Nursing reported Resident #2 continued to complain of lower abdominal pain, however they were unable to obtain a urinalysis due to patient refusal and behaviors. Resident #2 continued on a low dose of [MEDICATION NAME] and had no previous behaviors before that incident. -However, Resident #2 had documented behaviors on 10/29/19 (see above). Further documented in the NP note, it was discussed with nursing if Resident #2 continued to have resident-to-resident altercations the [MEDICATION NAME] may need to be increased. The plan was to redirect the resident as needed and continue non-pharmacological interventions. Will continue to monitor and attempt to obtain a urinalysis if Resident #2 developed a fever as the previous work-up was unremarkable. 4. Progress notes from 10/31/19 to 11/4/19 The 10/31/19 at 5:01 a.m. behavioral note revealed Resident #2 was very confused, awake all night wandering, moving from his room to the day, from the chair to another chair. He refused to be checked and changed, a snack and fluids were offered. The 10/31/19 at 4:50 p.m. behavioral note revealed Resident #2 had no unusual behaviors and he was cooperative with care. Resident nice and pleasant this shift. The 11/1/19 at 5:04 a.m. behavioral note revealed Resident #2 was awake wandering most of the night, he refused to eat or drink. The 11/1/19 at 3:07 p.m. behavioral note revealed Resident #2 was quiet and calm, moving to and from his room and dining area most of the day. He was cooperative with care. The 11/2/19 at 7:00 a.m. behavioral note revealed Resident #2 refused care from staff. The 11/2/19 at 6:24 p.m. behavioral note revealed Resident #2 was cooperative with care. The 11/3/19 at 9:30 p.m. behavioral note revealed Resident #2 was observed in the dining for an hour after the incident (see resident-to resident altercation above), he denied pain and went to bed. The 11/4/19 at 5:11 a.m. behavioral note revealed Resident #2 was cooperative with care, remained in his room all shift and denied any pain or discomfort (contrary to the 11/4/19 NP note above). The 11/4/19 at 2:43 p.m. behavior note revealed Resident #2 was cooperative with care and he denied pain or discomfort (contrary to the 11/4/19 NP note above). Resident #2 refused care or to be checked and changed two times out of 12 shifts from 10/31/19 to 11/4/19. The expectation was to attempt to obtain the urinalysis from 10/31/19 through 11/4/19; however, there was no documentation that collection of a urinalysis was attempted during all shifts Resident #2 was cooperative with care, he continued to have behaviors and then on 11/20/19 had an altercation with Resident #1 causing him injury. 5. Medication Administration Record [REDACTED]. -Tylenol 325 mg tablet, give 650 mg by mouth every six hours as needed for pain 1-5 document non-pharmacological interventions tried prior to giving medication to relieve pain. It was documented on 11/4/19, evening shift the resident had a pain scale of one out of 10. On all other days and shifts for the month of November 2019 it was documented the resident had zero pain. Moreover, Resident #2 had persistent abdominal pain, there was not a pain assessment to include frequency, intensity, characteristics of pain, what made the pain better/worse, what non-pharmacological and if the resident exhibited restlessness, aggressive/physical or verbal behaviors completed after his initial complaint of pain on 10/30/19 or after. -It was documented on 10/1/19, evening shift the resident had a pain scale of 1 out of 10. On all other days and shifts for the month of October 2019 it was documented the resident had 0 pain and Tylenol was not given in the month of October and November 2019. 6. Resident #2's CPO The November 2019 CPO revealed the following: -11/20/19 Discontinue [MEDICATION NAME]. -11/20/19 [MEDICATION NAME] 1 mg (milligram) by mouth twice daily for dementia with behavioral disturbance. -11/22/19 CBC, BMP (basic metabolic panel) UA, and Bactrim DS tablet 800/160 mg one by mouth every 12 hours until 11/24/19 for UTI. -11/26/19 Ultrasound to abdomen one time a day for persistent pain/tenderness. -11/26/19 Encourage fluids three times a day for abnormal labs. The interventions above were implemented after Resident #2 had several (five) altercations in a three week period with the altercation 11/20/19 causing injury to Resident #1. 7. NP follow-up note 11/21/19 and 11/27/19 The 11/21/19 NP note documented Resident #2 was assessed for readmission and urinary tract infection. On assessment Resident #2 was afebrile; however, complained of severe lower abdominal/suprapubic pain and he had abdominal distention. The urinalysis was negative for [MEDICATION NAME], positive for leukocytes white/red blood cells (possible infection) with culture and sensitivity still pending. Due to his complaint of severe suprapubic tenderness the plan was to start Batrim DS one by mouth every 12 hours for three days until culture and sensitivity results were available and may straight catheterize as [MEDICAL CONDITION] was suspected. The 11/27/19 NP note documented Resident #2 had acute on [MEDICAL CONDITION] his baseline creatinine was 1.7 to 1.9 and his current creatinine was 2.4 with an elevated BUN which was 32. Due to the resident's combative tendencies the plan would be to encourage fluids and repeat a BMP as the resident likely would not tolerate IV (intravenous) fluids or IV placement. 8. SBAR (situation, background, assessment and recommendation) The 12/5/19 at 5:15 p.m. SBAR documented Resident #2 complained of abdominal pain for the past three weeks. The resident needed to be evaluated for right kidney swelling and persistent abdominal pain. 9. Hospital documentation The 12/7/19 hospital discharge summary documented Resident #2 was diagnosed with [REDACTED]. A urology referral was recommended which he attended on 1/14/2020. B. Staff interview Licensed practical nurse (LPN) #1 was interviewed on 8/26/2020 at 2:25 p.m. She said she worked the secure unit for several months day shift. She said Resident #2 was on monitoring the past couple of weeks for his behavior and recent change in condition as he had a recent urinary tract infection and blood clots in his lungs. LPN #1 was interviewed a second time on 9/1/2020 at 10:25 a.m. She said if a resident had a change in condition the staff would complete an SBAR (situation, background, assessment, and recommendation) form. She said this would include if a resident had an increase or new complaint of pain or increased behaviors, or they would document changes in a progress note or behavior note. She said if a resident had an increase in behaviors she would notify the physician and document in the clinical record one-to-one (1:1) observations, close monitoring, and if the resident was kept in line of sight. III. Altercation involving Resident #1 11/20/19 A. Resident #1 Resident status Resident #1, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the July 2020 computerized physician order [REDACTED]. The 10/22/19 minimum data set (MDS) revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of one out of 15. He did reject care 4-6 days and exhibited behaviors towards staff or others of hitting, kicking, scratching 1 to 3 days. He required extensive two-person assistance with bed mobility, dressing, transfers and toileting. He required limited one-person assistance with walking in the corridor and in the room. He was always incontinent of bowel and bladder. His ability to hear was highly impaired, he wore a hearing device and his vision was severely impaired. The 12/20/19 MDS revealed he did not reject care. He declined in his ability to perform activities of daily living (ADLs). He required

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	065213	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTH CENTER AT FRANKLIN PARK	1535 PARK AVE DENVER, CO 80218

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) extensive two-person assistance with bed mobility, dressing, transfers, toileting and extensive one-person assistance with locomotion on the unit and walking through the corridor. Walking in the room did not occur. B. Record review for Resident #2 1. Physician note The 11/20/19 physician note documented Resident #2 was being assessed for another resident altercation in which he pushed a resident to the ground and that resident suffered a [MEDICAL CONDITION]. The physician discussed with facility staff Resident #2 becoming increasingly unpredictable and aggressive towards other residents. Resident #2 was occasionally resistive to care by staff and made threats of violence toward staff; because of his cognitive deficits he was difficult to redirect. The resident was sent to the hospital for a mental evaluation of his behaviors and determination of safety to return to the facility. 2. SBAR (situation, background, assessment, and recommendation) The 11/20/19 at 11:50 a.m. SBAR form documented the physician was contacted regarding Resident #2's increased aggression which started 11/20/19 at 11:40 a.m., since the condition started it had worsened. Resident #2 had a history of [REDACTED]. IV. Administrative interviews The NHA, director of nursing (DON) and social services director (SSD) were interviewed on 9/2/2020 at 11:00 a.m. The DON said if a resident had a change in condition staff should be assessing and monitoring them as a whole for any changes clinically (this includes pain) or behavior with notification to the physician and the family. The DON said she felt Resident #2 was being monitored appropriately for his increased behaviors. They acknowledge Resident #2 had an increase in behaviors, refusals of care and certain treatments such as the urinalysis ordered 10/30/19. The DON said the staff did not need a physician order [REDACTED]. She said if a resident refused treatment or the staff were unable to collect a specimen, staff should have documented the information in the resident's clinical record and notified the physician. They acknowledged Resident #2 was involved with several altercations prior to an incident which caused injury to Resident #1. The NHA said they felt Resident #2's increased behaviors initially were clinical in nature and he had been assessed by the NP. The NP was interviewed on 9/2/2020 at 3:50 p.m. She said she assessed Resident #2 for continued abdominal pain and dysuria. She said it was possible the staff were unable to obtain the x-ray and urinalysis initially due to resident refusal; however, the staff often continued to encourage and redirect the resident. She said this was why a straight catheterization was not ordered because the resident was more cooperative with certain staff than others. She said Resident #2 remained at increased risk for UTI because he had urethral stents and hydro[DIAGNOSES REDACTED] which was chronic. She said she would not treat a resident empirically with antibiotics due the antibiotic stewardship program, and she would wait until test results were back to treat with an antibiotic. She said she was not sure if staff were to encourage fluids as she did know the facilities policy or procedure with pushing fluids. She said giving extra fluids would be done on a case by case basis because you would not want to give a resident with [MEDICAL CONDITIONS] extra fluids as an intervention for his dysuria. -However, Resident #2 did not have [MEDICAL CONDITION] and pushing fluids would not have been contraindicated. Resident #2 was also treated with an antibiotic from 11/22/19 to 11/24/19 for a UTI pending culture and sensitivity results.
F 0744 **Level of harm** - 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** Based on record review and interview, the facility failed to ensure residents who resided in the secure unit, received the appropriate treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being to include four (#1, #2, #10 and #11) of four residents reviewed with a [DIAGNOSES REDACTED].#2 with a [DIAGNOSES REDACTED]. Resident #2 had a gradual dose reduction (GDR) of his [MEDICATION NAME] (antipsychotic) from 2.5 milligrams (mg) by mouth twice daily to 2.5 mg by mouth daily at bedtime on 9/12/19. Resident #2 had an increase in behaviors as early as 10/29/19. He had several altercations thereafter on 11/3/19, 11/14/19, 11/17/19 and then on 11/20/19 he had an altercation with Resident #1 which resulted in a fall with injury (see record review below). The facility failures to implement appropriate interventions timely for Resident #2, who had an increase of unprovoked behaviors and physical aggression towards multiple residents, contributed to the physical harm of Resident #1 with a [DIAGNOSES REDACTED]. Furthermore, the facility was aware Resident #11 with [DIAGNOSES REDACTED]. Resident #11 had six resident-to-resident altercations from 8/9/19 to 8/27/2020 that involved hitting, kicking and chest butting and the facility did not review the overall plan of care to ensure that interventions in place were effective. Additionally, the facility was aware Resident #1 with [DIAGNOSES REDACTED].#10 with [DIAGNOSES REDACTED]. Repeated incidents of resident-to-resident aggression, staff's limited responses to resident aggression and behaviors, and incomplete staff training placed all of the residents on the secure unit with symptoms of dementia at risk for physical, mental, and psychosocial harm. Findings include: I. Professional reference The Alzheimer's Association (last updated 3/30/2020) Coronavirus (COVID-19): Tips for Dementia Caregivers in Long-Term or Community-Based Settings, retrieved on 9/15/2020 from: https://www.alz.org/professionals/professional-providers/coronavirus-covid-19-tips-for-dementia-caregivers?_ga=2XXX 437XXX XXX - XXX &_gac=1XXX 9244XXX .eaiaiqobchmiqfd6qvlr6wivqdbach2thgoceaayasaaegl_8pd_bwe. It read in pertinent part, Nonverbal dementia-related behaviors may be an option or response for a person living with dementia to communicate a feeling, unmet need or intention. These behaviors are triggered by the interaction between the individual and his or her social and physical environment. A response may include striking out, screaming, or becoming very agitated or emotional. The dementia care provider's role is to observe and attempt to understand what the person living with dementia is trying to communicate. Root causes of dementia-related behaviors may include: -Pain; -Hunger; -Fear, depression, frustration; -Loneliness, helplessness, boredom; -Hallucinations and/or overstimulation; -Changes in environment or routine; -Difficulty understanding or misinterpreting the environment; -Difficulty expressing thoughts or feelings; and, -Unfamiliarity with personal protective equipment or clothing, such as gowns or masks. Strategies to observe and respond to dementia-related behaviors include: -Rule out pain, thirst, hunger or the need to use the bathroom as a source of agitation; -Speak in a calm low-pitched voice; -Try to reduce excess stimulation; Ask others what works for them; -Validate the individual's emotions. Focus on the feelings, not necessarily the content of what the person is saying. Sometimes the emotions are more important than what is said; -Understand that the individual may be expressing thoughts and feelings from their own reality, which may differ from generally acknowledged reality. Offer reassurance and understanding, without challenging their words, can be effective; -Through behavioral observation and attempted interventions, try to determine what helps meet the person's needs and include the information in the individualized plan of care; Be aware of past traumas (veterans, abuse survivors, survivors of large-scale disasters); and, Never physically force the person to do something. Proactive strategies for addressing dementia-related behaviors It can be difficult to anticipate and respond to dementia-related behaviors in a changing environment - especially in emergency situations. However, applying some of the following strategies may help: -Provide a consistent routine; -Use person-centered care approaches for all individuals living with dementia during activities of daily living - every interaction or task is an opportunity for engagement; -Promote sharing of person-centered information across the care team; -Encourage all staff to treat individuals living with dementia with dignity and respect; and, -Put the person before the task. II. Secure unit residents and layout The secure unit where the altercation occurred on 11/20/19 was located on the third floor, where 21 residents resided. The lounge area and dining area were adjacent to each other. The lounge area was on the East side of the third floor and the dining area was on the West side of the third floor; however there were two pillars in between the areas which could obstruct view to either area. III. Resident #2 A. Resident status Resident #2, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 9/23/2019 MDS assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. He did not exhibit any behavioral symptoms. Specifically, there were no physical behaviors directed towards others. He required supervision with transfers, walking in the room, walking through the corridor and walking on and off the unit. He required extensive one-person assistance with toileting and dressing. B. Behavior care plan The behavior care plan, initiated on 11/14/19 and revised on 5/22/2020 revealed the resident had a history of [REDACTED]. He was triggered by invasion of personal space, loud vocalization, someone sitting in his dining spot, and other residents who touch items in his environment. Interventions included to approach the resident in a calm manner, monitor for signs and triggers for aggression such as invasion of personal space, threatening remarks, irritability around certain people; and, keep in line of sight if he was showing signs of aggression remove the resident from others and area to keep them safe. The acute behavioral care plan, initiated 11/14/19, updated 11/15/19 and 11/18/19 revealed Resident #2 was involved in a physical altercation with other residents, which he was the aggressor on 10/29, 11/3, 11/13 (I was involved in a physical altercation I shoved another resident two

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F 0744 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 5) times in the arm), 11/14 and 11/17/2019. Interventions included the following: -Approach in a calm manner. Provide the resident with choice/options -Provide time to de-escalate, offer to take for a walk off the secured neighborhood or offer conversation. -Monitor for signs, triggers for aggression such as invasion of personal space, threatening remarks and irritability around certain people. -Keep the resident in line of sight if he is showing signs of aggression. Remove others from the area to keep safe. The [MEDICAL CONDITION] care plan, initiated on 1/2/19 and revised on 11/20/19 revealed the resident took antipsychotic medication for dementia with behaviors. Interventions included to monitor effectiveness of medication, observe the resident's gait for steadiness, balance, muscle coordination, ability to position and turn; and monitor resident's mood and behavior and notify the physician for significant changes. C. Resident #2's safety plan The 11/13/19 safety plan revealed Resident #2 ambulated independently interacting with staff and other residents on the unit. The current interventions to prevent physical altercations between Resident #2 and other residents were unsuccessful. Staff were to be hyper aware of antecedents and triggers. Staff had been educated after each incident to ensure they were present in common areas, communicated with co-workers if they needed to leave the area so there was replacement monitoring. Staff were to redirect other residents who invaded Resident #2's space, provide the resident with independence with personal cares and supervise to decrease the likelihood of agitation, use tools and resources to get to know the resident for meaningful engagement. Staff were to position themselves throughout the day to be in line of sight of Resident #2 when he was in common areas around other residents. -However, this was not done after the education was provided to the staff to ensure they understood the expectation of keeping Resident #2 in line of sight while in the common areas around other residents (see interviews below). D. Physician orders [REDACTED]. The 10/30/19 NP note documented Resident #2 was being assessed for complaints of lower abdominal suprapubic pain which he stated traveled across his back. On exam Resident #2 had suprapubic tenderness and complaints of dysuria. The plan was to check stat (immediate) CBC (complete blood count), CMP (complete metabolic panel) and urinalysis, along with abdominal x-ray. The resident was afebrile and stable since a decrease in his medication [MEDICATION NAME] (antipsychotic) to 2.5 mg by mouth daily. The 11/4/19 NP note documented the reason for the visit was because Resident #2 had an altercation with another resident. Per the staff, reported a resident was being intrusive and Resident #2 took a clipboard and hit him with it. Nursing reported Resident #2 continued to complain of lower abdominal pain, however they were unable to obtain a urinalysis due to patient refusal and behaviors. Resident #2 continued on a low dose of [MEDICATION NAME] and had no previous behaviors before that incident. Further documented in the NP note, it was discussed with nursing if Resident #2 continued to have resident-to-resident altercations the [MEDICATION NAME] may need to be increased. The plan was to redirect the resident as needed and continue non-pharmacological interventions (such as activities, a walk outside or facetime call with his sister). Will continue to monitor and attempt to obtain a urinalysis if Resident #2 developed a fever as the previous work-up was unremarkable. -However, Resident #2 had documented behaviors on 10/29/19 (see behavioral above). The NP addressed that if the resident continued to have resident-to-resident altercations the [MEDICATION NAME] was going to be increased, which was not a person-centered approach to dementia care. The 11/20/19 physician note documented Resident #2 was being assessed for another resident altercation in which he pushed a resident to the ground and that resident suffered a [MEDICAL CONDITION]. The physician discussed with facility staff Resident #2 becoming increasingly unpredictable and aggressive towards other residents. Resident #2 was occasionally resistive to care by staff and made threats of violence toward staff; because of his cognitive deficits he was difficult to redirect. The resident was sent to the hospital for a mental evaluation of his behaviors and determination of safety to return to the facility within 24 hours. E. Social service note The 11/15/19 social service note documented Resident #2 was reviewed in the [MEDICAL CONDITION] committee and an increase was recommended. -However, an increase was not implemented until 11/20/19 after the altercation with Resident #1. F. Resident-to-resident altercations with Resident #2 preceding 11/20/19 Resident #2 had been involved in resident-to-resident altercations on 10/29/19, 11/3/19, 11/14/19, 11/17/19 that often occurred in the dining room, in which he was triggered by an invasion of personal space, loud vocalization, someone sitting in his dining spot, and other residents who touch items in his environment (see behavior care plan above). The interventions implemented by the indisplionary team (IDT) were 15 minute checks for 72 hours and line of sight vision that was implemented on 11/13/19. Cross-reference F600 for failure to ensure residents remained free from abuse. G. Resident to resident altercation 11/20/19 1. Resident #1 status Resident #1, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the July 2020 CPO, [DIAGNOSES REDACTED]. The 10/22/19 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of one out of 15. He did reject care four to six days and exhibited behaviors towards staff or others of hitting, kicking, scratching one to three days. He required extensive two-person assistance with bed mobility, dressing, transfers and toileting. He required limited one-person assistance with walking in the corridor and in the room. He was always incontinent of bowel and bladder. His ability to hear was highly impaired, he wore a hearing device and his vision was severely impaired. 2. Record review a. Care plan The communication care plan, initiated 10/22/19 and revised on 2/12/2020 revealed Resident #1 had a communication issue related to hearing and vision deficits (he was legally blind and very hard of hearing). Interventions included to speak loudly into his right ear, anticipate and meet his needs and be conscious of his position when in groups, activities, dining room to promote proper communication with others. The [MEDICAL CONDITION] care plan, initiated 2/3/2020 and 2/5/2020 for use of medications [MEDICATION NAME] and [MEDICATION NAME] (antipsychotics) revealed Resident #1 had dementia with behaviors and [MEDICAL CONDITIONS], he could be aggressive as evidenced by kicking and attempting to hit staff during personal cares and he had a history of [REDACTED]. He was also impulsive, had poor safety awareness and required frequent redirection, step by step instruction to encourage participation in day to day care. Interventions included to approach the resident from the front due to vision deficit and speak clear into his right ear to explain what you want or need from the resident, assist the resident with ambulation as needed, monitor and document signs and symptoms of agitation, monitor and document triggers to assist with establishing approach that will not escalate the agitation, anticipate and meet the resident's needs, attempt to keep the environment calm and quiet, and monitor for any signs and symptoms of [MEDICAL CONDITION]: flashbacks, nightmares, difficulty sleeping, feeling jumpy and being easily irritated or angered. The fall care plan, initiated 10/21/19 and revised on 7/12/2020 revealed Resident #1 was high risk for falls related to impaired balance, poor coordination, poor safety awareness, unsteady gait, use of [MEDICAL CONDITION] medication and visual deficit. Interventions included to walk with him when he got up from his seat, check him frequently to ensure safety, encourage him to use handrails in halls properly and inform him of each new area he was taken to such as (dining room day room) so that he knew where he was and what was near him. However, the facility did not assess and implement appropriate interventions prevent Resident #1 from wandering into a common area dining room where Resident #2 was sitting, who did not like others in his personal space which caused an altercation. b. Facility documentation The 11/20/19 facility documentation of the altercation was provided by the NHA on 8/26/2020 at 12:55 p.m. It documented in pertinent part, Resident #2 was sitting at the table in the dining room at 11:37 a.m. and Resident #1 was sitting in a chair in the lounge area. Resident #1 got up from the chair and walked over to the dining area towards the kitchen window. Resident #2 turned around in his seat and looked toward Resident #1. Resident #2 then got up from his chair at 11:38 a.m. and grabbed Resident #1 by his left arm. Resident #1 tried to pull his arm away from Resident #2 and they both struggled with each other for a moment. Resident #1 turned around facing away from Resident #2. Resident #2 then pushed Resident #1 from behind and he fell to the floor. The 11/20/19 at 1:26 p.m. x-ray of the left femur revealed Resident #1 had a [MEDICAL CONDITION] femoral neck with superior displacement of the distal fragment. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/26/2020 at 2:20 p.m. She said she worked the secure unit on day shift full time. She said there were a couple of residents who they had to monitor for increased behaviors, one being Resident #2. She said he had to remain in line of sight. She said Resident #2 used have increased behaviors but he had been okay/calm lately. Licensed practical nurse (LPN) #1 was interviewed on 8/26/2020 at 2:25 p.m. She said she worked the secure unit for several months on the day shift. She said if the unit was noisy Resident #2 would get agitated. She said prior to admitting to the facility the resident had severe behaviors and prior facility could not care for him because he was hitting other residents. Activity assistant (AA) #1 was interviewed on 8/27/2020 at 12:29 a.m. He said he worked at the facility for two years. He said he worked in the secure unit full time from 9:00 a.m. until 3:30 p.m. for the past couple of months and his previous work hours were 8:00 a.m. until 4:00 p.m. He said he was working the day Resident #2 had an altercation with Resident #1 on 11/20/19. He said on 11/20/19 he did not witness the altercation between Resident #1 and #2. He said he remembered that he was engaged with a resident in a coloring activity. He said he and the resident were seated at a table in the lounge area. He said he was seated facing east with his back towards the dining room and outside patio. He acknowledged the pillars would have obscured his view of Residents #1 and #2 during their altercation as they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065213	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTH CENTER AT FRANKLIN PARK	1535 PARK AVE DENVER, CO 80218

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 0744 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 6) were located in the southwest corner of the dining room and he was seated on the lounge area close to one of the two pillars that blocked his sight of the residents when the altercation happened. He said he did not hear any of their conversation, but he heard a thud and he saw Resident #1 on the floor and he went to get the nurse to come and help. He said he received education and training regarding Resident #2's safety plan; however, he said he did not receive education or instruction on staff to position themselves throughout the day to be in line of sight of Resident #2 when he was in the common areas around other residents until after the altercation occurred between Residents #1 and #2 on 11/20/19. He said since he had received numerous staff trainings on dementia and behaviors and the need to keep a close eye on individual residents with behaviors. He said since then staff position themselves, one at the nurse's station and one in the dining area to keep the whole unit in view. LPN #2 was interviewed on 9/1/2020 3:10 p.m. He said he worked at the facility for many years on the secure unit. He said he was caring for Resident #1 and Resident #2 the afternoon on 11/20/19. He said that day Resident #1 was pushed by another resident. He said he was assisting another resident and did not see what had happened. He said a staff member notified him Resident #1 was on the floor and he called an registered nurse (RN) to come and assess Resident #1 as he could not stand or walk. He said they received orders to get an x-ray which showed he had a fracture and he was sent to the hospital. The activity director (AD) was interviewed on 9/1/2020 at 5:45 p.m. She said during the facility's morning clinical call with the interdisciplinary team (IDT) which included all managerial department heads, they talked about resident behaviors or safety concerns. She said then she notified the activity department staff during afternoon huddles. She said she informed the activity department staff of any changes with residents, if residents were engaged or not engaged in the activities. She said if her staff shared anything with her in the huddle then she would share it with the IDT the following morning. She said they completed education on sensory activities, monitoring and positioning of themselves to watch residents in the secure unit. She said she provided training to her staff when to document in progress notes if residents had new or increased behaviors. The NHA, director of nursing (DON) and social services director (SSD) were interviewed on 9/2/2020 at 11:00 a.m. The SSD said if a resident received a gradual dose reduction (GDR) of an antipsychotic the nursing staff and social services would monitor the resident for 14 days for any signs or symptoms of any increased behaviors. She said staff documented if the resident had increased behaviors, needed 15 minute checks and what helped settle the resident down to help with the behaviors. The SSD said staff would document if the resident had increased behaviors, needed 15 minute checks that lasted for 72 hours, what helped settle the resident down and what would help with their behaviors such as a snack or a walk. The NHA said residents were reviewed in morning meetings as an interdisciplinary team (IDT) for any pertinent changes (behavioral or clinical) and managers would disperse any pertinent information to their departments such as the need for increased monitoring of certain residents. She said the IDT met every Friday to complete a quarterly comprehensive review of residents ' care plans for updates. She said Resident #2's sister and power of attorney (POA) felt his behaviors were due to his dementia. She said his POA did not provide much if any input regarding his plan of care. The DON said she felt Resident #2 was being monitored appropriately for his increased behaviors. They acknowledged Resident #2 had an increase in behaviors, refusals of care and certain treatments such as the urinalysis ordered 10/30/19. She said if a resident refused a treatment or they were unable to collect a specimen, staff should have documented the information in the resident's clinical record and notified the physician. She said Resident #2 would not have benefitted from an increase in his antipsychotic medications. They acknowledged Resident #2's safety plan was not followed as it was not communicated in its entirety to all staff which resulted in him pushing another resident to the floor causing injury. The NHA said the reason AA #1 did not know to keep Resident #2 in line of sight prior to his altercation with Resident #1 on 11/20/19 was because the AD sent the education regarding Resident #2's safety plan via email and she did not ensure AA #1 understood keeping the resident in line of sight. She said immediately after the incident she went to all the floors to complete on the spot training with the staff to ensure they understood what was expected of them when monitoring a resident for increased behaviors. IV. Altercations involving Resident #11 A. Resident #11 1. Resident status Resident #11, age 89, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 8/28/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of three out of 15. He required supervision with all activities of daily living. It indicated he had behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, and grabbing one to three days during the assessment period. 2. Record review The behavioral care plan, initiated 8/16/19 and revised on 7/20/2020 revealed Resident #11 was involved in resident-to-resident altercations on 10/30/19, 1/22/2020, 4/25/2020, 6/8/2020, 8/27/2020, and for the last three altercations was the aggressor. Interventions included the following: -Approach in a calm manner; -Monitor for signs and symptoms of agitation, pacing, asking to leave, verbal expressions of anger and fidgeting; -Monitor reaction toward other residents and redirect or remove from area if showing signs of agitation; -I have a stop sign across my doorway to deter other residents from entering my room. I am able to enter and exit my room by demonstrating removing sign and placing it back up across the doorway; -Monitor for triggers that may escalate a physically abusive reaction, such as invasion of personal space, others going into my room or taking something from me; and -Speech therapy to conduct staff education on cognitive decline to implement interventions. The September 2020 Medication Administration Record [REDACTED]. B. Resident #10 1. Resident status Resident #10, age 83, was admitted on [DATE] and discharged on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 6/12/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of zero out of 15. He required extensive assistance of two people with all activities of daily living. It indicated the resident had physical behavioral symptoms not directed toward others for four to six days, rejection of care one to three days and wandering daily during the assessment period. 2. Record review The elopement care plan, initiated 5/26/17 and cancelled on 8/31/2020 as the resident was no longer in the facility, revealed Resident #10 was an elopement risk as evidenced by his history of to leave the facility unattended and his [DIAGNOSES REDACTED]. Interventions included he resided on the secure unit for safety, anticipate his needs and he required 24/7 supervised care in the memory unit. The physical altercation care plan, initiated 6/8/2020 and cancelled on 8/31/2020 (due to discharge) revealed Resident #10 was involved in a resident-to-resident altercation. Interventions included Resident #10 would benefit from positive redirection and encouragement to not invade others personal space. Interventions included to monitor the resident's whereabouts and keep resident from going into other resident's room by using positive redirection and to remove him gently from area and engage him in an appropriate activity. However, the facility did not assess and implement appropriate interventions prevent Resident #10 from wandering into Resident #11's room which caused an altercation between the two (see below). C. Resident #11's altercations on 6/7/2020 and 8/27/2020 Resident #11 was involved with altercations on 6/7/2020 and 8/27/2020 on the secured unit where he resided. Another resident wandered into his room and he kicked the resident on 6/7/2020 and revealed the resident had an altercation on 8/27/2020 by an elevator that was not witnessed by staff. Cross-reference F600 for failure to ensure residents remained free from abuse. Although Resident #11's care plans were reviewed after the resident-to-resident altercation 6/7/2020 and 8/27/2020, there was no documentation if the interventions were effective and/or if a new intervention or approach was needed. D. Staff interviews AA #1 was interviewed on 9/16/2020 at 12:30 p.m. He said Resident #11 had altercations with other residents if they were in his way and Resident #11 was easily provoked because he believed he owned the place; so they tried to give him one-to-one attention. CNA #1 was interviewed on 9/16/2020 at 12:38 p.m. She said Resident #11 was involved with many resident-to-resident altercations and was a known aggressor. She said the staff watched him closely because he was easily agitated when people invaded his space. V. Administrative interview The DON and NHA were interviewed on 9/16/2020 at 3:08 p.m. The NHA and DON acknowledged they had a systemic problem with caring for the residents in the secure unit and had started an action plan to include dementia care training videos to be provided to the staff. The NHA said the staff lacked training/education with caring for the residents with dementia and she planned to ensure they did understand. She said they had been interviewing internally and externally for staff who were certified in dementia care. The facility purchased a new dementia care training, they were reviewing each resident's plan of care, their activity programming, and implementing an evening program specifically for those residents who had behavioral issues. She said they would start training with staff on 9/28/2020 and 10/2/2020.