STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOMFIELD SKILLED NURSING AND REHABILITATION CTR	12975 SHERIDAN BLVD BROOMFIELD, CO 80020

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(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** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to ensure three (#1, #2, and #3) of three out of 11 residents who were investigated were free from abuse. Specifically, the facility failed to: -Prevent resident to resident altercation for Resident #2, and Resident #3 on 1/5/2020 with physical abuse injury to Resident #3 being hit in the right side of his head; and -Prevent resident to resident altercation for Resident #1, and Resident #2 on 2/15/2020 with physical abuse injury to Resident #1 right arm causing bleeding. Record review and staff interviews revealed the facility was aware of Resident #2 and Resident #3 verbal and physical behaviors against others. The facility had interventions such as 15 minute checks, medication management and redirection; however, both residents' behaviors continued to escalate based on staff interviews with no positive response to the interventions. The facility did not ensure the residents were safe towards others from escalating behaviors and did not ensure the residents did not negatively interact with other residents while using the smoking area. However the facility did not put a plan in place to protect residents until 2/3/2020 which was 28 days after the incident. During this time another incident occurred when Resident #2 hit Resident #1 which caused an injury to Resident #1 ' s right arm. Findings include: I. Facility policies and procedures The Abuse policy and procedure, undated, was provided by the nursing home administrator (NHA) on 3/5/2020 at 2:00 p.m. The policy read in the pertinent part: 1. According to the federal guidelines: Nursing home residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Nursing home residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. II. Resident #3 status Resident #3 under the age of 60, was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 12/13/19 minimum data set (MDS) assessment revealed the resident had no cognitive deficit with a brief interview for mental status (BIMS) score of 15 out of 15. He had verbal behaviors marked as daily but no rejection of care marked. For functional status, the resident was extensive two person assistance for bed mobility, transfers, toileting, and personal hygiene. He was independent for eating. A. Record review The behavior care plan, revised 12/18/19, revealed, Resident #3 had behaviors at times when he became upset and yelled, threatened or cursed others. He had little patience and felt things should be done in a certain way. If there was a delay or change in routine he became verbally aggressive. He had a history of [REDACTED].#3 had several incidents of physical altercations when he hit other residents. Interventions included: Put resident on 15 minute checks. On 1/22/2020 interdisciplinary team met to review behaviors. Allow resident to express feelings anytime. If resident was yelling or cursing; attempt to redirect, encourage the resident to take a walk. Do not try to reason with the resident when he was yelling as this was ineffective in the past. Review of the abuse investigation revealed the following: -Date of incident: 1/5/2020. Time of incident: 7:15 a.m. -Date the investigation initiated: 1/5/2020. Time investigation was initiated: 12:05 p.m. -Residents involved: Resident #2, and Resident #3. Type of investigation: Physical abuse. -Suspected perpetrator: Resident #2 -Description: Resident #3 reported to staff that he was hit in the head by Resident #2. This incident was not witnessed by staff, and witnessed by an unknown resident. The facility reported that Resident #2, and Resident #3 were kept separated during the investigation. Resident #3 reported mild headache, declined interventions for pain. Physician, responsible parties, administrator and assistant director of nursing (ADON) notified. -Staff interviewed: 11 staff were interviewed. The staff in their statements about the incident stated they had not witnessed or saw any injuries to Resident #3 during 1/5/2020. -Residents interviewed: four residents were listed including Resident #2, and #3. The Resident statements revealed the majority of the residents interviewed did not witness Resident #2 hit Resident #3 in the head. A unknown resident witnessed Resident #2 hit Resident #3. He said, I did not hear anything but I saw Resident #2 pass close to Resident #3 and hit him in the side of the head. -According to interviews there were conflicting stories about the severity of what happened. However, the facility took into account the interview with the unknown resident and the incident was substantiated. -Conclusion: The incident was substantiated. -Action: Facility said it provided a plan of correction where residents could not go outside at the same time and both residents would be placed supervised smoking. However the facility provided staff in-service and resident plan on 2/3/2020 a month after the incident. The in-service training was a plan for prevention of altercations. However these plans were put into effect 28 days after the incident. Review of the progress notes revealed the following: -1/5/2020: Nursing note Resident #3 reported at 7:15 a.m. that another resident hit him on the right side of the head in the lobby when he was coming in from smoking and another resident was going out. No injuries noted. Skin intact with no bruising or redness. Pain: mild headache one out of ten, denies need for anytime pain medication after it was offered. Medical doctor and brother were notified of the incident. Administrator and ADON notified immediately after the resident reported to nursing. The progress note did not address how the resident was going to be kept safe. -1/6/2020 to 3/5/2020 there were no progress notes on interventions or plans for keeping residents safe. Medication Administration Record [REDACTED]. Prevention of altercations in-service The prevention of altercations in-service dated 2/3/2020 revealed staff were educated on plan created to prevent altercations between Resident #2 and Resident #3. This included: 1. Both residents need to sign out with the nurse before leaving the unit. 2. Nurse will document that the resident is leaving the unit on the log and sign off stating that they called the front desk and notified the receptionist that either resident is on their way down. 3. The receptionist will check to see if Resident #2 or Resident #3 are already outside. B. Resident interview Resident #3 was interviewed on 3/4/2020 at 2:25 p.m. He said, Resident #2 just walked up and hit him in the head. He said he was not fearful of him but was glad he no longer lived at the facility. He also said, Resident #2 had become physical with other residents in the facility. V. Staff interviews Nurse manager (NM) #1 was interviewed on 3/5/2020 at 11:10 a.m. She said she knew how to report abuse immediately and was not present when incidents with Resident #2 and Resident #3 occurred. She said any of the staff could report incidents of abuse without reporting directly to her. She said residents behaviors could escalate and there was no plan at the time in place for incidents that occurred between Resident #2 and Resident #3. She also said, staff not receiving training, especially abuse could end up with staff not protecting residents. She also said there was no documentation of Resident #2 and Resident #3 signing off unit or unit notifying front desk personnel. Social services assistant (SSA) #1 was interviewed on 3/5/2020 at 11:45 a.m. She said, Resident #2 and Resident #3 had constant behaviors whether verbal or physical. She said staff should follow care plan interventions when dealing with residents. She said the facility did not have any behavior monitoring for Resident #2 and Resident #3 that tracked residents leaving the unit. SSA#2 was interviewed on 3/5/2020 at 11:30 a.m. She said, After the incident with Resident #2 and Resident #3. The facility created an action plan to correct the deficiencies. She said since the residents lived on different floors, the facility did not think there was a big concern. She said, she did not know where documentation to show the created action

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** - Some	(continued... from page 1) plan initiated was kept for staff to look at. Assistant director of nursing (ADON) was interviewed on 3/5/2020 at 12:00 p.m. She said she was present when the altercation between Resident #2 and Resident #3 occurred. She said the residents were separated and kept safe. She said, The facility did one on ones with residents, made sure the residents did not go to smoke cigarettes together, reported the incident to the state reporting agency, and did not worry additionally since residents lived in different units. She said she did not have documentation that showed where the facility kept residents safe from Resident #2 as there was no documentation of monitoring Resident #2 from 1/5/2020 to 2/3/2020. The director of nursing (DON) was interviewed on 3/5/2020 at 12:45 p.m. She confirmed the residents in the investigations did not receive appropriate interventions care to prevent abuse. She agreed that name calling, cursing, and hitting others whether staff to resident or resident to resident was abuse. She said any staff member on any unit can report allegations of abuse. The DON said, the reporting system was working but acknowledged there were some areas to correct, and also create better interventions to keep residents safe. She also said she should review and keep documents discussed as interventions with investigation to see if they are working. The nursing home administrator (NHA) was interviewed on 3/5/2020 at 1:55 p.m. He said the facility had been trying to implement changes to the units to assist with decreasing resident to resident conflicts. These changes included not rushing to fill the memory care units, more supervision, and increasing activities so residents would feel engaged in their unit. He said after the quality assurance meeting the facility created a plan and training on how to help with residents discussed in the occurrence. However he said he could not show based on documentation that a plan was previously put in place. Findings include: III. Resident #1 A. Resident status Resident #1, under [AGE] years of age, was admitted on [DATE]. The February 2020 computerized physician orders [REDACTED]. According to the 2/5/2020 minimum data set (MDS) assessment he had severe cognitive deficits with a brief interview for mental status (BIMS) score of seven out of 15. He required limited assistance to ambulate in his room, and used a walker and a wheelchair for mobility. B. Observations An observation made on 3/4/2020 at 4:38 p.m. revealed Resident #1 had: bandage dressings on both forearms, faded bruising on his left hand and on his head behind his right ear. He denied pain in these areas. C. Resident #1 and family representative interview Resident #1 and his family representative were interviewed on 3/4/2020 at 4:38 p.m. Resident #1 said his roommate, Resident #2, came up to him and grabbed his arms while he spoke to the housekeeping aide (HA) about clothes he was missing. The HA left their room after he was finished talking to her about his missing clothes. He said he did not fear Resident #2 and did not fear any staff or residents in the facility. After Resident #2 grabbed him he said the facility staff kept Resident #2 away from him. His family representative said she was immediately notified of what Resident #2 did to her dad (Resident #1). The facility moved her dad to another room; away from Resident #2. The facility treated the injuries her dad sustained from Resident #2: his arms bled and he had a bump on his head. She felt the facility did everything they needed to do to keep her dad safe after the incident with Resident #2. Both Resident #1 and his family representative confirmed no other residents have mistreated him, verbally or physically, since the incident with Resident #2. D. Incident from 2/15/2020 A resident to resident incident, involving two residents (#1 and #2) occurred on 2/15/2020 at 11:45 a.m. Pertinent staff and residents were interviewed;the residents interviewed confirmed they felt safe. Resident #2 was interviewed and said he tried to push Resident #1 out of his room and he restrained Resident #1. Resident #1 was interviewed and he said Resident #2 came at him and stood over him. He was not afraid of Resident #2. The HA was interviewed and she said she was in Resident #1's hall, delivering clothes to other residents, when Resident #1 requested to speak with her in his room about his missing clothes. While she was in Resident #1's room discussing his missing clothes, his roommate (Resident #2) yelled at Resident #1 to 'Shut the expletive up! Then he (Resident #1) yelled back at Resident #2 to 'Shut the expletive up! She remained in the room and continued to talk to Resident #1 about his missing clothes. After they were done talking about his missing clothes, she left the room to deliver clothes to other residents. While she was out of their room she heard Resident #1 and Resident #2 screaming at each other, so she went back into their room. When she returned to their room, Resident #2 stood in front of Resident #1's face as he yelled at Resident #1; she saw blood on one of Resident #1's arms. The 2/15/2020 weekly skin observation tool for Resident #1 reflected he had bruising to: the right side of his head behind his ear, left and right forearm, and left dorsal hand. All of Resident #1's skin tears to his right forearm were cleansed and all bruised areas were dressed. Resident #1 denied pain at injury sites. Resident #2 received an arrest warrant for assault on Resident #1. Resident #1 was immediately placed on 15 minute checks. Resident #2 was immediately placed on one-to-one monitoring until he was discharged on [DATE]. The facility determined: it could not substantiate the physical abuse because staff members were not in the room when it occurred, it identified Resident #2 as the aggressor, and documented Resident #1 as the victim and Resident #2 as the assailant in the report. The facility identified it had conducted resident-to-resident abuse training on 2/3/2020 for a prior resident-to-resident altercation which involved Resident #2. E. Group interview In a group interview on 3/4/2020 at 3:00 p.m., eight residents (#4, #5, #6, #7, #8, #9, #10, and #11) identified facility staff were aware Resident #2 would cuss at residents. Two residents (#4 and #6) said the facility moved Resident #1 to another room after the incident between Resident #1 and Resident #2. In addition they said staff followed Resident #2 everywhere (they never left him alone), every day, throughout all shifts, until he left the facility; after the incident between Resident #1 and Resident #2. All eight residents said they felt safe in the facility, they knew who Resident #2 was and did not fear him, staff respected them and provided dignified care, and there were no residents in the facility who were mistreating them nor abusing them in any way. F. Record review The care plan, initiated on 8/1/2019 and revised on 11/13/2019, identified Resident #1 had a risk for self-care deficit related to impaired mobility. Interventions included he self-propelled in a wheelchair for mobility. The care plan, initiated on 6/20/2019 and revised on 8/15/2019, identified he had impaired cognition related to dementia. Interventions included to supervise as needed. IV. Resident #2 A. Resident status Resident #2, less than [AGE] years of age, was admitted on [DATE]. The February 2020 CPO revealed [DIAGNOSES REDACTED]. According to the 10/18/2019 MDS assessment he had no cognitive deficits with a BIMS score of 15 out of 15. He required limited assistance to ambulate in his room, and used a walker and a wheelchair for mobility. B. Record review The care plan, initiated on 8/26/2019 and revised on 1/31/2020, identified Resident #2 had a mood disorder related to a history of verbal and physical aggression: hitting, yelling, and cursing. Interventions included to provide behavioral health consults. According to the 2/15/2020 nurses note, it reflected staff responded to commotion in Resident #2's room and saw him standing over Resident #1, whose right arm was bleeding. Resident #2 had no injuries. Staff provided 1:1 supervision of Resident #2 for the remainder of the shift. According to the nurses notes from 2/15/2020 through 2/20/2020, the facility provided 1:1 monitoring for Resident #2 until he (Resident #2) was discharged . According to the 2/20/2020 at 3:21 p.m. discharge summary, it reflected Resident #2 was discharged . C. Staff education According to the 5/7/2019 through 5/30/2019 Behavioral Health and Dementia In-service, provided by the NHA on 3/5/2020 at 12:00 p.m., reflected facility-wide staff (all departments) were educated on these topics. According to the 2/3/20 Plan for prevention of resident-to-resident altercations, provided by the NHA on 3/5/2020 at 12:00 p.m., reflected facility-wide staff (all departments) were educated on these topics. F. Staff interviews Interviews with various direct care staff revealed they had abuse and dementia training, were able to identify steps to take: for resident-to-resident altercations and engaging dementia residents to keep them free from distress, altercations, and abuse. HA was interviewed on 3/4/2020 at 3:58 p.m. She said, while talking to Resident #1 about missing clothes, his roommate Resident #2 cussed and screamed at Resident #1 and told him that he and HA were talking too loudly. After Resident #2 became quiet, she resumed talking to Resident #1 about missing clothes. After their discussion, she left their room to deliver clothes to other residents; she did not report them yelling at each other at this time. While out of their room she heard Resident #1 and Resident #2 screaming at each other, again. She returned to their room to see Resident #2 in his (Resident #1's) face. She left the room, again, to get registered nurse (RN) #2. RN #2 removed Resident #1 from their room and took him to the nurses station to look at his (Resident #1's) injuries. The HA said by this time she saw Resident #1's arm (she did not specify which arm) was bleeding and he (Resident #1) had a small bruise on the side of his head she did not specify which side). She said she received training from facility staff, before the incident between Resident #1 and Resident #2 occurred, on how she was to notify staff if she saw residents yelling at each other. The facility provided resident-to-resident training on 2/3/2020 (see Staff education above). Nurse manager (NM) #2 was interviewed on 3/4/2020 at 5:22 p.m. She identified Resident #2 had a history of [REDACTED]. Staff were to separate residents when this occurred and immediately notify the NHA when there was a resident-to-resident altercation of any kind. Phone call attempts were made to speak to RN #2, who the facility identified as the nurse who assessed Resident #1 after the incident involving Resident #2; there was no answer and no return phone call. The dietary aide (DA) was interviewed on 3/5/2020 at 9:01 a.m. He said staff were not to leave residents alone when

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) there was an altercation between them; staff were to immediately intervene and notify their supervisor to prevent harm. Certified nurse aide (CNA) #4 was interviewed on 3/5/2020 at 9:10 a.m. He said staff were to separate residents if they were yelling at each other, report it to a manager; residents were to be separated to keep them safe and prevent them from fighting. CNA #3 was interviewed on 3/5/2020 at 9:17 a.m. She said staff were to separate residents when they yelled at each other; if they were not separated they could get more irritated and hit each other. Then staff were to immediately notify their supervisor. RN #3 was interviewed on 3/5/2020 at 9:33 a.m. She identified Resident #1 had a [DIAGNOSES REDACTED]. She heard from other staff that Resident #2 fought with residents. She identified Resident #2 was impulsive if he did not get his way, that he got upset, raised his voice, hollered, and cursed at other residents. She considered Resident #1 to be more vulnerable than Resident #2 because he (Resident #2) was aggressive. Residents were to be separated when they yelled at each other to prevent verbal abuse escalating into physical abuse. The NHA was to be notified immediately when it happened. The maintenance assistant (MA) was interviewed on 3/5/2020 at 9:41 a.m. She said staff were to separate residents when they yelled at each other, to stop tension or violence, and notify the head nurse. LPN #1 was interviewed on 3/5/2020 at 9:46 a.m. She said staff were to separate residents when they yelled at each other, to keep them safe, and to report it to the NHA so he could begin an investigation. She said CNAs have told her that Resident #2 argued with other residents in the smoking area. She saw the bruises on Resident #1's arms on the day of the incident; she identified him as a dementia resident. The facility moved him to her unit (which was different from where he lived). She said and her staff did 15 minute checks on him for every shift for three days. The activity director (AD) was interviewed on 3/5/2020 at 11:31 a.m. She identified Resident #1 participated in activities of his choosing like the exercises, had no behaviors, enjoyed his family time, and interacted with residents. She was aware that Resident #2 had been involved with resident-to-resident verbal altercations and identified he did not participate in activities due to his preference to engage in his own activities of choice. The SSA #1 was interviewed on 3/5/2020 at 12:03 p.m. She identified Resident #2 had a history of [REDACTED].#2 about the incident between him and Resident #1. In it, an interview which she said she did not document nor report to the NHA, Resident #2 told her he walked up to Resident #1 and put his hands on him to get him to stop talking because he was trying to sleep; Resident #1 was talking to HA who was in their room. He (Resident #2) told her he grabbed Resident #1 by the arms and pushed him back. Regarding the incident between Resident #1 and Resident #2, the SSA #1 said the nursing staff told her Resident #2 got very angry and assaulted Resident #1; that he (Resident #1) had an injury on his head; near his ear. When she saw Resident #1 after the incident, the SSA #1 said he (Resident #1) had bandages on both his wrists; she could not see his forearms because he wore a long sleeved shirt. She said the nursing staff handled the incident: they moved Resident #1 to another room, and monitored Resident #2's whereabouts. She identified Resident #2 could walk with a walker. She interviewed Resident #1 about the incident between him and Resident #2. In it he (Resident #1) told her Resident #2 came at him for no reason while he talked to the HA. Resident #1 told her he did not fear Resident #2. She identified Resident #1 had some confusion, could communicate his needs clearly, had no moods or behaviors or aggression, interacted with her daily, and only walked with a walker while in therapy. The NHA was interviewed on 3/5/2020 at 12:40 p.m. He said he was the abuse coordinator and staff were to immediately intervene in resident-to-resident verbal altercations to prevent physical altercations, and to report them to a charge nurse and to him. If a staff member (as with SSA #1's interview with Resident #2) was told by a resident that they put their hands on another resident, and pushed that other resident, he would want to know about it immediately so he could investigate it. He said SSA #1 did not tell him about her interview with Resident #2 which would have been pivotal to help the facility to determine whether to substantiate the physical abuse or not. He said, initially, he had determined that it was unsubstantiated because no staff was present when the physical abuse occurred.