STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065423	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTER AT ROCK CREEK, THE	4880 ZIEGLER RD FORT COLLINS, CO 80528

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure freedom from abuse for one (#1) of three sample residents. The facility failed to keep Resident #1 safe from sexual and physical abuse reported on 4/29/2020 and 5/9/2020. The resident yelled rape on the morning of 4/29/2020 when certified nurse aide (CNA) #1 and CNA #5 were providing care. There was no facility follow-up to protect the resident. On 5/9/2020 the resident refused care and reported that she was grabbed during peri care, abused and trapped by staff. The facility's failure to protect the resident from abuse led to a reported sexual abuse, a second instance of reported abuse, and the resident expressed fear of imminent danger. Cross reference F609, failure to report abuse; and F610, failure to investigate, protect and correct. Findings include: I. Facility policy and procedure The Abuse and Neglect Prohibition, dated January 2019, provided by the nursing home administratrator (NHA) on 5/12/2020 at 11:00 a.m., read in pertinent part; Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, and any physical or sexual abuse. Any observations or and allegations of abuse, neglect or mistreatment must be immediately reported to the administrator. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment which result in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual , including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through use of technology. Sexual abuse is non-consensual (the resident doe not consent) sexual contant of any type with a resident. Protection: 1. The facility will protect residents from harm during the investigation. 2. The facility will make referrals to the appropriate state agencies as necessary, to ensure the protection of the resident or residents property. II. Resident #1 status Resident #1, under age 60, was admitted on [DATE] and readmitted on [DATE] after hospitalization and treatment for [REDACTED]. The 5/10/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. There were no behaviors listed. III. Abuse allegations A request was made to the nursing home administrator (NHA) on 5/12/2020 at 1:00 p.m. for any investigation/grievance information related to abuse of any kind from 4/1/2020 to 5/12/2020 for all residents in the facility. None were provided by the NHA. A. Resident allegation #1 - 4/29/2020 The Grievance Concern Report, dated 4/29/2020, completed by the social service assistant (SSA) on 4/29/2020 and signed by the nursing home administrator (NHA) on 4/29/2020 for Resident #1, was provided by the medical records director (MRD) on 5/12/2020 at 3:15 p.m. The grievance read in pertinent part: Resident yelled rape when (CNA #1) assisted her that am (morning). (Licensed practical nurse #2) heard what the resident said and went to check on her and also interviewed the resident. The SSA note attached to the grievance concern, dated 4/29/2020 at 9:24 a.m., documented the SSA went to speak with the resident in regards to yelling rape when CNA #1 assisted her. The resident stated to the SSA that CNA #1 assisted her to take off her pajama top, when he touched her breast without permission. The SSA asked the resident if she felt that the touch was an accident or on purpose. The resident replied that it was accidentally on purpose. The resident was asked if she felt comfortable with CNA #1 coming into her room and assisting her, and she said No. The SSA asked her again if she felt the CNA #1 rubbed up against her breast if it was an accident or on purpose and the resident said it was an accident. The SSA asked the resident again if she felt comfortable with CNA #1 to come assist her and the resident said yes. She asked if anything like that had happened in the past with CNA #1 and the resident said it hadn't. The resident was asked again if she felt comfortable to have CNA #1 come to her room to assist her, and the resident said yes after being asked four times if she felt comfortable. LPN #2 was in the room as a witness during that interview. There were no corresponding nursing progress notes. There was no documentation of further facility follow-up. (Cross-reference F609, failure to report; and F610, failure to investigate) B. Allegation #2 - 5/9/2020 LPN #3 documented a nurse progress note on 5/9/2020 at 10:29 a.m., which read: Resident is refusing cares related to believing staff is being inappropriate while attempting to remove existing brief, clean resident and place new brief on. Upon 2 staff aides (CNA #1 and CNA #5) working with resident to change soiled brief, resident feels that she was inappropriately grabbed and accused aides of making her uncomfortable. Staff informed this writer of situation and when resident questioned about issue, resident began to state that staff are abusing her on purpose and staff is keeping her trapped here and then asked this writer if staff knew that she was raped. This writer immediately asked when this stated incident occurred, resident was unable or unwilling to provide date and time. At this time, resident (was) asked if she knew or could identify the individual responsible? Resident did not reply and began attempting to spell the word rape. This writer again asked if resident could provide the time and place incident occurred and/or individual responsible and residents answer was 'I want to call my mom to tell her how cruel everyone at this location was to her and that all we want to do is keep her locked up in her chair.' Resident continued to deny care and was informed as to consequences of not receiving even basic peri-care . On 5/9/2020 at 11:17 a.m., LPN #3 documented: Resident stated she was aware of consequences. This writer informed ADON of situation and that an attempt was made to call residents parent to discuss issue and phone went to residents mothers voicemail, at which point, resident did not want to leave message. 1115 - At this time, resident is having no issue with staff at all and is in quite a good mood, even joking with staff. Will continue to monitor and document accordingly. No facility investigation was conducted at the time although CNA #1 was involved in both allegations. IV. Record review The resident's impaired cognitive function care plan, initiated 3/8/2020 and revised on 3/10/2020, read in pertinent part: Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. The interventions read: to utilize family for information gathering on triggers, useful supports and effective coping strategies and to keep her routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. The care plan did not reveal the resident had any behaviors, that she yelled, nor accused facility staff of sexual abuse. The care plan did not include trauma history or resident vulnerability/risk for abuse. The care plan did not reveal two caregivers for any care, or the resident's caregiver preferences. The resident's care plan was not updated after the abuse allegations on 4/29 and 5/9/2020. There was no evidence in the resident's medical record of a history of sexual abuse or false accusations against facility staff. Review of staff working schedules revealed CNA #1 worked 4/29/2020, 4/30/2020, 5/5/2020, 5/6/2020, 5/9/2020, 5/10/2020 and 5/12/2020. CNA #1 was not suspended until 5/12/20 (see below). CNA #5 worked 5/9/2020, 5/10/2020 and 5/11/2020. CNA #5 was not suspended until 5/12/2020 (see below). V. Resident observation and interview Resident #1 was interviewed on 5/12/2020 at 3:25 p.m. She sat up in the wheelchair and played her electronic game. She had good eye contact during the interview and said the facility staff had been kind to her. When asked if she had been mistreated by any staff,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) she said she did not want to snitch on anyone, she put her head down, looked away and stopped talking. She said again she did not want to snitch on anyone. VI. Staff interviews CNA #1 was interviewed on 5/13/2020 at 3:43 p.m. He said when he heard Resident #1 yell rape on 5/9/2020 he was providing personal care but did not intentionally touch the resident inappropriately. He said he told LPN #2, and LPN #2 reported what the resident said to the assistant director of nurses (ADON). CNA #1 said he continued to care for the resident with CNA #5. He said CNA #5 assisted with peri care and he assisted CNA #5 with resident transfers. Licensed practical nurse (LPN) #2 was interviewed on 5/12/2020 at 3:15 p.m. She said she heard the resident yell out rape and went to her room to see what happened. She said CNA #1 and CNA #5 reported the resident refused care and yelled out. She said she reported that information to the ADON. -On 5/13/2020 at 1:30 p.m. LPN #2 said Resident #1 had a history of [REDACTED]. She said they had two caregivers to assist the resident with cares. LPN #3 was interviewed on 5/13/2020 at 11:45 a.m. He said he was informed by CNA #1 and CNA #5 on 5/9/2020 that Resident #1 refused care and said she was raped. He said he spoke with the resident to ask more questions and he said the resident started to talk to her stuffed animal and not to him. He said he called the resident's family and then called the ADON to report the information. The SSA was interviewed on 5/12/2020 at 3:11 p.m. She said any grievance concern forms for the facility came to her for follow up. She said no forms of abuse had been reported to her for any residents. When the grievance form dated 4/29/2020 was presented to her on 5/12/2020 for Resident #1, she said she did recall that form. She said she talked to the resident and the resident said CNA #1 touched her by accident. She said the plan was to have two aides assist the resident with cares at all times. She said no other follow up was completed. The ADON was interviewed on 5/13/2020 at 3:50 p.m. She said she notified the director of nurses (DON) via text message on her phone on 5/9/2020 at 8:15 a.m. regarding Resident #1's allegation of abuse. She said she knew there was a time frame for an investigation. She read the policies on abuse on her own when she started at the facility a few months ago. The director of nurses (DON) was interviewed on 5/12/2020 at 5:13 p.m. She said she had no alleged abuse concerns reported to her since 4/1/2020. When asked directly about Resident #1's alleged abuse concerns she said she was aware of that. On 5/13/2020 at 11:00 a.m. the ADON said the resident had a history of [REDACTED]. She said the plan was to have two nurse aides care for her at all times. (See above, no care plan regarding two CNAs for resident care.) The nursing home administrator (NHA) was interviewed on 5/12/2020 at 5:20 p.m. He said he was aware of the 4/29/2020 allegation and said the resident could not confirm if that was true, so the plan was to have two caregivers care for the resident at all times. He said the facility would do an investigation tonight 5/12/2020 on the alleged abuse allegation from 5/9/2020. On 5/13/2020 at 11:05 a.m. the NHA said the investigation was completed last evening for the alleged abuse from 5/9/2020. He acknowledged no investigation was completed for the 4/29/2020 allegation of abuse. The resident's abuse allegations were not investigated until the survey was conducted. VII. Facility follow-up Follow-up was provided by the NHA on 5/13/2020 at 10:00 a.m. to show an investigation was completed and the police were notified of the resident's abuse allegations. CNAs #1 and #5 were suspended on 5/12/2020 until further investigations were completed.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to report alleged sexual abuse to the State survey and certification agency in accordance with State law for one (#1) of three sample residents. Specifically, the facility failed to report allegations of sexual abuse on 4/29/2020 and physical abuse on 5/9/2020. Cross-reference F600, failure to keep residents free from abuse; and F610, failure to investigate allegations of abuse. Findings include: I. Facility policy and procedure The Abuse and Neglect Prohibition policy, dated January 2019, provided by the nursing home administratrator (NHA) on 5/12/2020 at 11:00 a.m., read in pertinent part; Each resident has the right to be free from abuse, neglect, injuries of unknown origin, and any physical or sexual abuse. Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the administrator. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment which result in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual , including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through use of technology. Sexual abuse is non-consensual (the resident doe not consent) sexual contant of any type with a resident. Facility supervisors will immediately investigate and correct reported or identified situations in which abuse, neglect, injuries of unknown origin or misappropriation of resident property is at risk for occurring. Reporting and Response: 1. State reporting obligations said the facility will report all allegations and substantiated occurrence of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administer, State Survey Agency, and law enforcement officials and adult protective services in accordance with Federal and State law through established procedures. Timeline for reporting is as follows: a. If the events that caused the allegation involve abuse or result in serious bodily injury, a report is made not later than 2 hours after the management staff becomes aware of the allegation. II. Resident #1 status Resident #1, under age 60, was admitted on [DATE] and readmitted on [DATE] after hospitalization and treatment for [REDACTED]. The 5/10/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. There were no behaviors listed. III. Abuse allegations A request was made to the nursing home administrator (NHA) on 5/12/2020 at 1:00 p.m. for any investigation/grievance information related to abuse of any kind from 4/1/2020 to 5/12/2020 for all residents in the facility. None were provided by the NHA. A. Resident allegation #1 - 4/29/2020 The Grievance Concern Report, dated 4/29/2020, completed by the social service assistant (SSA) on 4/29/2020 and signed by the nursing home administrator (NHA) on 4/29/2020 for Resident #1, was provided by the medical records director (MRD) on 5/12/2020 at 3:15 p.m. The grievance read in pertinent part: Resident yelled rape when (CNA #1) assisted her that am (morning). (Licensed practical nurse #2) heard what the resident said and went to check on her and also interviewed the resident. The SSA note attached to the grievance concern, dated 4/29/2020 at 9:24 a.m., documented the SSA went to speak with the resident in regards to yelling rape when CNA #1 assisted her. The resident stated to the SSA that CNA #1 assisted her to take off her pajama top, when he touched her breast without permission. The SSA asked the resident if she felt that the touch was an accident or on purpose. The resident replied that it was accidentally on purpose. The resident was asked if she felt comfortable with CNA #1 coming into her room and assisting her, and she said No. The SSA asked her again if she felt the CNA #1 rubbed up against her breast if it was an accident or on purpose and the resident said it was an accident. The SSA asked the resident again if she felt comfortable with CNA #1 to come assist her and the resident said yes. She asked if anything like that had happened in the past with CNA #1 and the resident said it hadn't. The resident was asked again if she felt comfortable to have CNA #1 come to her room to assist her, and the resident said yes after being asked four times if she felt comfortable. LPN #2 was in the room as a witness during that interview. There were no corresponding nursing progress notes. There was no documentation of further facility follow-up. (Cross-reference F610, failure to investigate) B. Allegation #2 - 5/9/2020 LPN #3 documented a nurse progress note on 5/9/2020 at 10:29 a.m., which read: Resident is refusing cares related to believing staff is being inappropriate while attempting to remove existing brief, clean resident and place new brief on. Upon 2 staff aides (CNA #1 and CNA #5) working with resident to change soiled brief, resident feels that she was inappropriately grabbed and accused aides of making her uncomfortable. Staff informed this writer of situation and when resident questioned about issue, resident began to state that staff are abusing her on purpose and staff is keeping her trapped here and then asked this writer if staff knew that she was raped. This writer immediately asked when this stated incident occurred, resident was unable or unwilling to provide date and time. At this time, resident (was) asked if she knew or could identify the individual responsible? Resident did not reply and began attempting to spell the word rape. This writer again asked if resident could provide the time and place incident occurred and/or individual responsible and residents answer was 'I want to call my mom to tell her how cruel everyone at this location was to her and that all we want to do is keep her locked up in her chair.' Resident continued to deny care and was informed as to consequences of not receiving even basic peri-care . On 5/9/2020 at 11:17 a.m., LPN #3 documented: Resident stated she was aware of consequences. This writer informed ADON of situation and that an attempt was made to call residents parent to discuss issue and phone went to residents mothers voicemail, at which point, resident did not want to leave message. 1115 - At this time, resident is having no issue with staff at all and is in quite a good mood, even joking with staff. Will

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) continue to monitor and document accordingly. No facility investigation was conducted at the time although CNA #1 was involved in both allegations. IV. Resident observation and interview Resident #1 was interviewed on 5/12/2020 at 3:25 p.m. She sat up in the wheelchair and played her electronic game. She had good eye contact during the interview and said the facility staff had been kind to her. When asked if she had been mistreated by any staff, she said she did not want to snitch on anyone, she put her head down, looked away and stopped talking. She said again she did not want to snitch on anyone. V. Staff interviews LPN #3 was interviewed on 5/13/2020 at 11:45 a.m. He said he was informed by CNA #1 and CNA #5 on 5/9/2020 that Resident #1 refused care and said she was raped. He said he spoke with the resident to ask more questions and he said the resident started to talk to her stuffed animal and not to him. He said he called the resident's family and then called the ADON to report the information. The ADON was interviewed on 5/13/2020 at 3:50 p.m. She said she notified the director of nurses (DON) via text message on her phone on 5/9/2020 at 8:15 a.m. regarding Resident #1's allegation of abuse. She said she knew there was a time frame for an investigation. She read the policies on abuse on her own when she started at the facility a few months ago. The director of nurses (DON) was interviewed on 5/12/2020 at 5:13 p.m. She said she had no alleged abuse concerns reported to her since 4/1/2020. When asked directly about Resident #1's alleged abuse concerns she said she was aware of that. The nursing home administrator (NHA) was interviewed on 5/12/2020 at 5:20 p.m. He said he was aware of the 4/29/2020 allegation and said the resident could not confirm if that was true, so the plan was to have two caregivers care for the resident at all times. He indicated he was not aware of the additional resident allegation on 5/9/2020. VI. Facility follow-up Follow-up was provided by the NHA on 5/13/2020 at 10:00 a.m. to show an investigation was completed and the police were notified of the resident's abuse allegations. CNAs #1 and #5 were suspended on 5/12/2020 until further investigations were completed. The facility did not report the abuse allegations on 4/29/2020 or 5/9/2020 to the proper authorities as required until the survey was conducted.
F 0610 **Level of harm** - Actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to investigate, prevent and correct sexual and physical abuse reported by one (#1) of three sample residents. Resident #1 reported sexual abuse on 4/29/2020 by certified nurse aide (CNA) #1. The facility failed to investigate, and failed to protect the resident. The facility allowed CNA #1 to continue to provide care to Resident #1, and assigned a second CNA to assist CNA #1 with the resident's care. As a result, the resident demonstrated fear, refused care, and reported a second incident of abuse by CNA #1 and CNA #5 on 5/9/2020. The facility again failed to investigate the resident's second abuse allegation until a survey was conducted on 5/12/2020. The facility's failure to investigate, prevent and correct caused the resident to demonstrate fear and report that she was, in her words, raped, grabbed, abused and trapped. Cross reference F600, failure to ensure residents were free from abuse; and F609, failure to report abuse allegations to the proper authorities. Findings include: I. Facility policy and procedure The Abuse and Neglect Prohibition dated January 2019 provided by the nursing home administratrator (NHA) on 5/12/2020 at 11:00 a.m., read in pertinent part; Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, and any physical or sexual abuse. Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the administrator. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment which result in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual , including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through use of technology. Sexual abuse is non-consensual (the resident doe not consent) sexual contant of any type with a resident. Facility supervisors will immediately investigate and correct reported or identified situations in which abuse, neglect, injuries of unknown origin or misappropriation of resident property is at risk for occurring. Protection: 1. The facility will protect residents from harm during the investigation. 2. The facility will make referrals to the appropriate state agencies as necessary, to ensure the protection of the resident or residents property. Investigation: 1. The facility will timely conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, in accordance with the law. 2. Any employee alleged to be involved in an instance of abuse or neglect will be interviewed and suspended immediately and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated. II. Resident #1 status Resident #1, under age 60, was admitted on [DATE] and readmitted on [DATE] after hospitalization and treatment for [REDACTED]. The 5/10/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. There were no behaviors listed. III. Abuse allegations A request was made to the nursing home administrator (NHA) on 5/12/2020 at 1:00 p.m. for any investigation/grievance information related to abuse of any kind from 4/1/2020 to 5/12/2020 for all residents in the facility. None were provided by the NHA. A. Resident allegation #1 - 4/29/2020 The Grievance Concern Report, dated 4/29/2020, completed by the social service assistant (SSA) on 4/29/2020 and signed by the nursing home administrator (NHA) on 4/29/2020 for Resident #1, was provided by the medical records director (MRD) on 5/12/2020 at 3:15 p.m. The grievance read in pertinent part: Resident yelled rape when (CNA #1) assisted her that am (morning). (Licensed practical nurse #2) heard what the resident said and went to check on her and also interviewed the resident. The SSA note attached to the grievance concern, dated 4/29/2020 at 9:24 a.m., documented the SSA went to speak with the resident in regards to yelling rape when CNA #1 assisted her. The resident stated to the SSA that CNA #1 assisted her to take off her pajama top, when he touched her breast without permission. The SSA asked the resident if she felt that the touch was an accident or on purpose. The resident replied that it was accidentally on purpose. The resident was asked if she felt comfortable with CNA #1 coming into her room and assisting her, and she said No. The SSA asked her again if she felt the CNA #1 rubbed up against her breast if it was an accident or on purpose and the resident said it was an accident. The SSA asked the resident again if she felt comfortable with CNA #1 to come assist her and the resident said yes. She asked if anything like that had happened in the past with CNA #1 and the resident said it hadn't. The resident was asked again if she felt comfortable to have CNA #1 come to her room to assist her, and the resident said yes after being asked four times if she felt comfortable. LPN #2 was in the room as a witness during that interview. There were no corresponding nursing progress notes. There was no documentation of further facility follow-up. There was no evidence of a facility investigation or resident protection. The resident's care plan was not updated. Two-person care was not documented in the care plan or elsewhere in the medical record. There was no evidence of a supervision plan for CNA #1. B. Allegation #2 - 5/9/2020 LPN #3 documented a nurse progress note on 5/9/2020 at 10:29 a.m., which read: Resident is refusing cares related to believing staff is being inappropriate while attempting to remove existing brief, clean resident and place new brief on. Upon 2 staff aides (CNA #1 and CNA #5) working with resident to change soiled brief, resident feels that she was inappropriately grabbed and accused aides of making her uncomfortable. Staff informed this writer of situation and when resident questioned about issue, resident began to state that staff are abusing her on purpose and staff is keeping her trapped here and then asked this writer if staff knew that she was raped. This writer immediately asked when this stated incident occurred, resident was unable or unwilling to provide date and time. At this time, resident (was) asked if she knew or could identify the individual responsible? Resident did not reply and began attempting to spell the word rape. This writer again asked if resident could provide the time and place incident occurred and/or individual responsible and residents answer was 'I want to call my mom to tell her how cruel everyone at this location was to her and that all we want to do is keep her locked up in her chair.' Resident continued to deny care and was informed as to consequences of not receiving even basic peri-care . On 5/9/2020 at 11:17 a.m., LPN #3 documented: Resident stated she was aware of consequences. This writer informed ADON of situation and that an attempt was made to call residents parent to discuss issue and phone went to residents mothers voicemail, at which point, resident did not want to leave message. 1115 - At this time, resident is having no issue with staff at all and is in quite a good mood, even joking with staff. Will continue to monitor and document accordingly. No facility investigation was conducted at the time although CNA #1 was involved in both allegations. IV. Record review The resident's impaired cognitive function care plan, initiated 3/8/2020 and revised on 3/10/2020, read in pertinent part: Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. The interventions read: to utilize family for information gathering on triggers, useful supports and effective coping strategies and to keep her routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. The care plan did not reveal the resident had any behaviors, that she yelled, nor accused facility staff of sexual abuse. The care plan did not include trauma history or resident vulnerability/risk for abuse. The care plan

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F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) did not reveal two caregivers for any care, or the resident's caregiver preferences. The resident's care plan was not updated after the abuse allegations on 4/29 and 5/9/2020. There was no evidence in the resident's medical record of a history of sexual abuse or false accusations against facility staff. Review of staff working schedules revealed CNA #1 worked 4/29/2020, 4/30/2020, 5/5/2020, 5/6/2020, 5/9/2020, 5/10/2020 and 5/12/2020. CNA #1 was not suspended until 5/12/20 (see below). CNA #5 worked 5/9/2020, 5/10/2020 and 5/11/2020. CNA #5 was not suspended until 5/12/2020 (see below). V. Resident observation and interview Resident #1 was interviewed on 5/12/2020 at 3:25 p.m. She sat up in the wheelchair and played her electronic game. She had good eye contact during the interview and said the facility staff had been kind to her. When asked if she had been mistreated by any staff, she said she did not want to snitch on anyone, she put her head down, looked away and stopped talking. She said again she did not want to snitch on anyone. VI. Staff interviews CNA #1 was interviewed on 5/13/2020 at 3:43 p.m. He said when he heard Resident #1 yell rape on 5/9/2020 he was providing personal care but did not intentionally touch the resident inappropriately. He said he told LPN #2, and LPN #2 reported what the resident said to the assistant director of nurses (ADON). CNA #1 said he continued to care for the resident with CNA #5. He said CNA #5 assisted with peri care and he assisted CNA #5 with resident transfers. Licensed practical nurse (LPN) #2 was interviewed on 5/12/2020 at 3:15 p.m. She said she heard the resident yell out rape and went to her room to see what happened. She said CNA #1 and CNA #5 reported the resident refused care and yelled out. She said she reported that information to the ADON. -On 5/13/2020 at 1:30 p.m. LPN #2 said Resident #1 had a history of [REDACTED]. She said they had two caregivers to assist the resident with cares. LPN #3 was interviewed on 5/13/2020 at 11:45 a.m. He said he was informed by CNA #1 and CNA #5 on 5/9/2020 that Resident #1 refused care and said she was raped. He said he spoke with the resident to ask more questions and he said the resident started to talk to her stuffed animal and not to him. He said he called the resident's family and then called the ADON to report the information. The SSA was interviewed on 5/12/2020 at 3:11 p.m. She said any grievance concern forms for the facility came to her for follow up. She said no forms of abuse had been reported to her for any residents. When the grievance form dated 4/29/2020 was presented to her on 5/12/2020 for Resident #1, she said she did recall that form. She said she talked to the resident and the resident said CNA #1 touched her by accident. She said the plan was to have two aides assist the resident with cares at all times. She said no other follow up was completed. The ADON was interviewed on 5/13/2020 at 3:50 p.m. She said she notified the director of nurses (DON) via text message on her phone on 5/9/2020 at 8:15 a.m. regarding Resident #1's allegation of abuse. She said she knew there was a time frame for an investigation. She read the policies on abuse on her own when she started at the facility a few months ago. The director of nurses (DON) was interviewed on 5/12/2020 at 5:13 p.m. She said she had no alleged abuse concerns reported to her since 4/1/2020. When asked directly about Resident #1's alleged abuse concerns she said she was aware of that. On 5/13/2020 at 11:00 a.m. the ADON said the resident had a history of [REDACTED]. She said the plan was to have two nurse aides care for her at all times. (See above, no care plan regarding two CNAs for resident care.) The nursing home administrator (NHA) was interviewed on 5/12/2020 at 5:20 p.m. He said he was aware of the 4/29/2020 allegation and said the resident could not confirm if that was true, so the plan was to have two caregivers care for the resident at all times. He said the facility would do an investigation tonight 5/12/2020 on the alleged abuse allegation from 5/9/2020. On 5/13/2020 at 11:05 a.m. the NHA said the investigation was completed last evening for the alleged abuse from 5/9/2020. He acknowledged no investigation was completed for the 4/29/2020 allegation of abuse. The resident's abuse allegations were not investigated until the survey was conducted. VII. Facility follow-up Follow up was provided by the NHA on 5/13/2020 at 10:00 a.m. to show an investigation was completed and the police were notified of the resident's abuse allegations. CNAs #1 and #5 were suspended on 5/12/2020 until further investigations were completed.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure infection control practices were followed to prevent the spread of COVID-19 infection. Specifically, the facility: Failed to follow droplet precautions with proper personal protective equipment (PPE); and Failed to ensure housekeeping staff: -Properly cleaned surfaces prior to the use of a disinfectant; -Properly cleaned and disinfected the sink/countertop area; -Properly cleaned and disinfected the toilet and commode riser; -Adhered to the appropriate wet/contact/dwell time (the time a chemical must remain in contact on a surface in order to eradicate organisms) for disinfection; Findings include: I. Failure to follow droplet precautions with proper personal protective equipment (PPE). A. Professional reference The Centers for Disease Control (CDC) Key Strategies to Prepare for Coronavirus COVID-19 in Long Term Care Facilities, dated April 2020, read in pertinent part: If COVID-19 was identified in the facility, have health care providers (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. B. Facility policy and procedure The Transmission Based Isolation Precautions Policy, revised on 12/5/2019, was provided by the director of nurses (DON) on 5/13/2020 at 1:00 p.m. It stated in pertinent part: Strict isolation is used in addition to standard precautions (or universal precautions) for patients suspected of a confirmed communicable infection. C. Observations and interviews The speech and language therapist (SLP) was observed on 5/12/2020 at 10:30 a.m. to sit on a chair directly across from the resident in room [ROOM NUMBER]. She wore a surgical mask and eye protection but did not have on a gown or gloves. The sign on the door read droplet precautions. She said the resident was on quarantine precautions as a new admission to the facility. She said she did not have any direction on who was on precautions for that day as the protocol changed day by day. She said isolation droplet precautions required gloves, gown, mask and eye protection. She said she realized she did not wear the right PPE. A physical therapist (PT) was observed on 5/12/2020 at 10:55 a.m. to walk into an isolation room without a gown or gloves on. He said he had not worked in two weeks and needed a refresher on PPE. He said isolation for droplet precautions required a gown, gloves, mask and eyewear. The director of nurses (DON) was interviewed on 5/12/2020 at 5:13 p.m. She said new admissions from the hospital were placed in isolation for 14 days to rule out COVID-19. She said the PPE required was a surgical mask, gown, gloves and eye protection. II. Failure to prevent cross-contamination during resident room cleaning A. Professional standard The Centers for Disease Control (CDC) guidelines for Cleaning and Disinfection for Households: Interim Recommendations for U.S. Households with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19), dated March 2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html, revealed the purpose was to provide recommendations on the cleaning and disinfection of households where persons under investigation or those with confirmed COVID-19 resident or may be in self-isolation. It was aimed at limiting the survival of [MEDICAL CONDITION] in the environment. -Cleaning referred to the removal of germs, dirt and impurities from surfaces. Cleaning did not kill germs, however by removing the germs, the number of germs and the risk of spreading infection was lowered. -Disinfecting referred to using chemicals such as EPA-registered disinfectants to kill germs on surfaces. This process did not typically clean dirty surfaces but it did remove germs. By using a disinfectant after cleaning could further lower the risk of the spread of infection. -Surfaces that were dirty, should be cleaned using a detergent or soap with water prior to disinfection. -Most common EPA-registered household disinfectants should be effective in the removal of germs. Follow the manufacturer's specifications/instructions for cleaning/disinfection for the appropriate concentration, method of application and the contact time. B. Facility policies and procedures The Housekeeping Infection Control COVID-19 policy, issued 3/31/2020, was provided by the Facility Director (FD) on 5/12/2020 at 11:43 a.m. The Policy revealed the facility, consistent with federal regulations, had implemented universal, standard infection control practices for environmental rounds. The policy also revealed the bathroom cleaner used by housekeeping was an alkaline based product and had no disinfectant properties. The disinfectant used by housekeeping had a dwell time of ten minutes. The Cleaning Rooms policy, issued 11/1/18, was provided by the director of nursing (DON) on 5/12/2020 at 11:40 a.m. The policy revealed: -Cleaning with a detergent, scrubs surfaces so dirt comes off easier with a cloth or mop. To kill germs use a disinfectant. Allowing adequate time for a disinfect to sit (dwell) on surfaces assures 100% disinfection. This is known as a kill time. The facility would only use approved cleaners, tracked with an up to date Material Data Safety Sheet (MSDS) in safety binders. All cleaners would be used according to the manufacturer's guidelines. -Always work from the cleanest to the dirtiest areas. Always work from the higher to lower areas. The daily cleaning routine includes high touch areas, that include: the door, door knobs, light switches, sharps table/tray, call lights, phone, call box/cord, commode seat, rim and the flush handle. C. Observations On 5/12/2020 at 11:17 a.m., the housekeeper (HSK) was observed cleaning the bathroom in resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065423	A. BUILDING _____ B. WING _____	**05/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTER AT ROCK CREEK, THE	**4880 ZIEGLER RD FORT COLLINS, CO 80528**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) room [ROOM NUMBER]. At 11:18 a.m., the HSK sprayed a bathroom cleaner on the sink, countertop area, entire toilet and a commode riser. The toilet bowl contained a small amount of water. At 11:20 a.m., the HSK sprayed a disinfectant on a new rag and wiped off the desktop and dresser in the resident's room. She sprayed more disinfectant on the same rag and wiped off the window ledge, bedside dresser and the bed over table. The areas were left wet, except for the bed over table, which she dried off with a new dry rag. At 11:23 a.m. the HSK used the same dry rag to wipe off the sink, countertop area and paper towel dispenser. She used the same rag to wipe off the bottom of the toilet lid, top/bottom lid of the commode riser and the support structures under the commode riser seat. She used the same rag to wipe the toilet bowl rim and the toilet pedestal. She used the same rag to again wipe the toilet rim several times and the commode riser seat. The HSK was not observed to use a toilet brush to clean the inside surface of the toilet bowl and was not observed to clean/disinfect the grab bars or the shower area. D. Staff interviews On 5/12/2020 at 11:30 a.m., the HSK said she used the cleaner to spray the sink, countertop, toilet, commode riser and not the disinfectant. She said she only used the cleaner in the bathroom and the disinfectant on the furniture in the room. She said the dwell time for the disinfectant was ten minutes. She said she used a dry rag to wipe the sink area and a dry rag to wipe the bathroom area. She said she was in-serviced on how to clean and disinfect a room. On 5/12/2020 at 11:47 a.m., the FD said the procedure for cleaning/disinfecting was to start from top areas to the bottom areas using the bathroom cleaner. Once the surfaces were clean, the HSK would use the disinfectant of those areas. The FD said the cleaner used by the HSK contained no disinfectant and did not kill germs. He said the disinfectant had a ten minute dwell time. He said after the chemical dried in the room, the HSK should have dried the surfaces with a new rag. The FD said the outcome for not properly cleaning/disinfecting a resident's room/bathroom was that a resident could get sick from the cross contamination. He said it also provided an unhealthy and unsanitary condition for the resident. He said the grab bars should be cleaned and sanitized. He said the housekeeping staff should follow the dwell time for the products. He said the HSK had been in-serviced on how to properly clean and disinfect resident's rooms/bathrooms. The FD said the HSK should have used one new rag for the sink and countertop area, one new rag for the grab bars, one new rag for the toilet rim, one new rag for the exterior surface of the toilet and one new rag for the commode riser. The staff should use separate new rags for every area. He said the HSK should use as many new rags as necessary. On 5/13/2020 at 12:20 p.m. the DON said that the non-use of the disinfectant in the bathroom could lead to a spread in infection. She said the HSK should have disinfected the bathroom.