STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY NURSING & REHAB CENTER	5301 W FIRST AVE LAKEWOOD, CO 80226

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** - 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, resident and staff interviews, the facility failed to take the necessary steps to ensure three (#2, #3 and #4) of five sample residents were free from resident to resident abuse. Specifically, the facility failed to: -Ensure Resident #2 and Resident #3 were free from physical abuse by Resident #1; and -Ensure Resident #4 was free from physical abuse by Resident #5. Findings include: I. Facility policy The Abuse and Investigation and Reporting policy was provided by the nursing home administrator (NHA) on 3/11/2020 at 2:34 p.m. It read in pertinent part, All reports of resident abuse, neglect, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. II. Resident #1 A. Resident status Resident #1, age 66, was admitted on [DATE] and readmitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/18/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BI[CONDITION]) score of 5 out of 15. He required limited assistance with activities of daily living (ADLS). B. Record review The care plan, dated 10/23/19, and revised on [DATE] revealed Resident #1 exhibited behavior problems related to being easily agitated and would physically strike out at other residents when he felt his space was being invaded. Interventions included to redirect the resident, redirect other residents away from him and his personal areas, encourage him to participate in activities outside of his room and validate his feelings as concerns as needed. The nurses note on [DATE]20 documented that the resident was assessed after an altercation with another resident. The assessment revealed he was not injured in the altercation. The nurses note dated 2/28/19 at 2:32 a.m., documented that staff had witnessed Resident #1 hitting Resident #3 after he had attempted to go into his room. The residents were immediately separated by staff. III. Resident #3 A. Resident status Resident #3, age 88, was admitted to the facility on [DATE]. According to the March 2020 CPO, the [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident had a severe cognitive impaired with a BI[CONDITION] score of 5 out of 15. He required limited assistance with ADLs. B. Record review The care plan, dated 10/22/19, and revised on [DATE], revealed Resident #3 had a cognitive impairment, a history of wandering and resided on the secure unit of the facility for safety. Interventions included to reassure the resident if he was confused and reorient him to the situation. The nurses note dated [DATE]20 at 11:05 a.m., documented the resident was assessed after an altercation with another resident and had a reddened area on the right side of his face. The alert charting follow up note dated [DATE] at 2:24 a.m. documented that the resident had a small scratch on the right side of his face after being struck in the face by Resident #1. Staff interventions included to keep the two residents separated and observe for any further contact. IV. Facility reported incident on [DATE]20 The facility reported incident investigation revealed Resident #3 was physically abused by Resident #1 (perpetrator). The facility reported on [DATE]20 that a certified nurses aide (CNA) witnessed Resident #3 attempt to open the door to Resident #1's room. Resident #1 then came out of the room and struck Resident #3 in the face. The residents were separated and redirected by staff. Police, family, resident's physician, NHA, director of nursin (DON), and social services director (SSD) were notified of the incident. Resident #3 was assessed by a nurse following the incident and found to have a small abrasion to his right cheek. Resident #1 statement by the facility read, he saw someone out on the front lawn walking back and forth in front of the house. The resident did not provide any additional comments about the incident but made it clear he felt his space had been invaded. Resident #3 statement by the facility read, that he did not recall the incident but stated he was fine and having a good day. Resident stated he was not in pain. Resident appeared calm and free of distress. The facility substantiated that resident-to-resident abuse had occurred due to the fact it was witnessed by staff. V. Resident #2 A. Resident status Resident #2, age 93, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the March 2020 CPO, the [DIAGNOSES REDACTED]. The 1/27/2020 MDS assessment revealed the resident had a severe cognitive impairment and was rarely understood. A BI[CONDITION] was unable to be completed with the resident due to the severity of her cognitive impairment. She required extensive assistance with ADLs. B. Record review The care plan, dated 12/27/18, and revised on 12/4/2020, revealed Resident #2 became aggressive at times towards other residents, had a cognitive impairment, impaired verbal communication and disturbed sensory perception. Interventions included redirection of the resident to a quiet space and away from other residents, to reassure the resident if she was confused and orient her to her surroundings. The nurses note dated [DATE] at 7:11 p.m., documented that the resident was heard by staff calling for help, and staff then witnessed Resident #1 repeatedly hitting the resident in the face. The residents were separated and she was assessed by a nurse. The nurse's assessment revealed the resident had a skin tear on her left cheek. VI. Facility reported incident on [DATE] The facility reported incident investigation revealed Resident #2 was physically abused by Resident #1 (perpetrator). The facility reported on [DATE] that a resident-to-resident altercation on the memory care unit had occurred. Resident #1 hit resident Resident #2 in the face. The residents were separated immediately and redirected by staff. Police, family, resident's physician, NHA, DON and SSD were notified of the incident. Resident #2 was assessed following the incident and found to have a small abrasion to her left cheek. CNA #2's statement by the facility read, she was working at the nurse's station when she heard Resident #2 yelling, stop, stop!. She said she stood up and witnessed Resident #1 hitting Resident #2 in the face approximately four times. She then immediately separated the residents. Resident #1 statement by the facility read, that Resident #2 kept going past me. He went on to state that Resident #2 was trying to run over my toes. After these statements, he reported he had calmed down following the incident. Resident #2 statement by the facility read, she did not comment on the incident but stated I don't like him (in reference to Resident #1). When asked if she was afraid or had concerns for her safety she said,no. The facility's actions in response to the incident included Resident #1 being placed on one-to-one staff supervision and instructional cards were given to staff with one-to-one responsibilities specific to Resident #1. Cards included his likes and dislikes, suggested activities, means for redirection, and suggestions to improve psycho-social well being. The facility substantiated that resident-to-resident abuse had occurred due to the fact it was witnessed by staff. VII. Staff interviews CNA #2 was interviewed on 3/11/2020 at 1:49 p.m. She said that Resident #1 would strike out at other residents when he felt like they were in his personal space. She said that he did not strike out at staff and she felt that he could differentiate staff from other residents. She said she worked on [DATE] and heard Resident #2 yelling out stop; when she went to see what was happening, she saw Resident #2 in the hallway sitting in her wheelchair and Resident #1 repeatedly hitting her in the face. She intervened and separated the residents. She said Resident #2 was in the middle of the hallway in her wheelchair and in the path of Resident #1 as he was walking to the dining room. She said that Resident #1 was cognitively impaired but was able to have basic conversations. She said he

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) would become agitated when other residents would attempt to go in his room or go near his door. She said several of the residents on the secured memory unit would wander throughout the unit and go into other residents rooms. She said Resident #3 would frequently wander on the unit and go into the other resident's room. Licenced practical nurse (LPN) #1 was interviewed on 3/11/2020 at 1:33 p.m. He said that the staff utilized instructional cards for Resident #1 with prompts for his individualized likes, interests and effective redirection strategies. He said that he did not work on the secured unit very often but he recalled that Resident #1 had been on one-to-one staff supervision in recent months due to striking out at other residents. CNA #1 was interviewed on 3/11/2020 at 1:26 p.m. She said that she was providing one-to-one supervision for Resident #1 that day. She said that the staff utilized laminated cards with suggestions for redirection for Resident #1. She said the cards provided prompts for his likes, interests and information about the resident. She said that all the CNAs had received training on how to provide one-to-one supervision. The SSD was interviewed on 3/11/2020 at 3:25 p.m. She said that she conducted a follow up interview with Resident #1 after the incident on [DATE] when he struck Resident #2 while she was sitting in the hallway in her wheelchair. She said he told her that he wanted to go to jail and that he thought that continuing to hit people could get him there. She said she was unsure of his full history but said that she thought he had spent time in prison during his life. She said it was difficult to recognize triggers for him. She said he had received one-to one supervision of staff after previous incidents of striking residents; however, was not receiving one-to-one staff supervision when the incident occurred on [DATE]20 when he struck Resident #3 or during the [DATE] incident when he struck Resident #2. She said that the facility had not completed behavioral tracking or monitoring for Residents #1 or #3 which could have helped identify triggers for resident behaviors; however, the facility had initiated a corrective plan for documenting behavior tracking and monitoring for all residents earlier that day. The NHA was interviewed on 3/11/2020 at 4:29 p.m. He said that the interdisciplinary team (IDT) at the facility would meet after resident-to-resident altercations occurred to evaluate and implement resident interventions and update care plans as needed. He said IDT would look at resident behavior tracking and monitoring to determine if there is a pattern of behaviors. He said the facility had not completed behavior tracking and monitoring for Residents #1 and #3, however, they had initiated a corrective plan to ensure behavior tracking was being completed. He said the facility had placed wallpaper on Resident #1's door to make it appear to be a bookshelf, with the intention that it would deter other residents from trying to open his door. He said the facility had also created laminated cards for staff which provided individualized cues to redirect Resident #1 and included information about his likes and interests. He said the facility planned to continue to evaluate behavioral interventions for Resident #1. VIII. Resident #4 A. Resident status Resident #4, [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/22/2020 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired and unable to participate in a brief interview for mental status (BI[CONDITION]) assessment. She required supervision of one-person assistance with most ADLs. B. Record review The care plan, revised on [DATE] revealed the resident had potential complications with mood and behavior secondary to [MEDICAL CONDITION]. She required a secure unit secondary to wandering. She had a history of [REDACTED]. The nurse progress note dated 2/13/2020 at 4:13 p.m., revealed Resident #4 was hit in the face by resident #5 causing her to have a nose bleed and later some bruising to her face. IX. Resident #5 A. Resident status Resident #5, age 73, was admitted on [DATE] and readmitted [DATE]. According to March 2020 CPO, [DIAGNOSES REDACTED]. The 2/16/2020 MDS assessment revealed Resident #5 was cognitively impaired with a BI[CONDITION] score of two out of 15. He required one-person limited assistance with bed mobility, dressing, hygiene and toileting. B. Record review The care plan, revised on [DATE]7/19 revealed Resident #5. He required a secure unit secondary to wandering. He had a history of [REDACTED]. Interventions included attempt to identify triggers for behaviors, redirect the resident to a quiet area, 15 minute checks, social services as needed and 1:1 as needed. The nurse progress note dated 2/13/2020 at 4:28 p.m., revealed Resident #5 struck Resident #4 in the face. Resident #5 said a man was in his bed and he asked the man to get out, when Resident #4 (the man) did not get out he punched her in the face. X. Facility reported incident on 2/13/2020 The 2/13/2020 facility reported incident was provided by the nursing home administrator (NHA) on 3/11/2020 at 11:00 a.m. It revealed Resident #4 had entered Resident #5's room. Resident #5 became agitated and hit Resident 4 in the face. The physician, police and the family were notified. At the time the residents could not recall the incident. The residents did not express any fear, anxiety or withdrawn behaviors. Residents #4 and #5 were placed on behavior monitoring to assess any changes in their baseline behavior. Resident #5 was interviewed by the social services assistant (SSA) on 2/13/2020. Resident #5 was asked what occurred during the exchange that took place on 2/13/2020 with Resident #4. He stated There was a man in my bed and I asked him to get out, he would not leave so I hit him in the face and he left. Resident #4 was interviewed by the SSA on 2/13/2020; however, she was unable to participate due to poor cognition. CNA #2 who was providing 1:1 observation of Resident #4 during the time of the incident was interviewed on [DATE]. She said she allowed Resident #4 to wander while in line of sight. She said she stayed outside the doorway of Resident #5's door and did not realize Resident #5 was in the room. Resident #5 was in the bathroom, came out of the bathroom and then Resident #5 struck Resident #4. CNA #2 was provided education not to assume the room was empty but to check all areas of the room in which Resident #4 wandered into. The incident was substantiated. XI. Staff interviews The NHA and CNC were interviewed on 3/11/2020 at 11:00 a.m. They acknowledged all three FRI's reviewed were substantiated. They said they realized the increase in altercations in the secure unit and that was the reasoning for implementing a performance improvement plan (PIP). The PIP was initiated on 11/28/2020 in which the facility identified problem areas in the secure unit. The most recent in-service training included education provided to the staff was about updates to resident's activity cards, (training for 1:1 cards stated likes, dislikes, hand in hand dementia training and fun activities for each individual resident). The SSD was interviewed on 3/11/2020 at 3:50 p.m. She said they considered Residents #4 and #5's altercation to be isolated as Resident #4 wandered into Resident #5's room and Resident #5 thought there was a man in his bed. XII. Follow-up Although the facility had started a PIP to ensure safety of the residents they acknowledged two of the three resident's reviewed for resident to resident altercations did not have behavior monitoring which should have been identified during their IDT review to help identify any triggers for behaviors.