STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A196	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NAMASTE ALZHEIMER CENTER	**2 PENROSE BLVD COLORADO SPRINGS, CO 80906**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to promptly notify the resident representative for one (#2) out of five sample residents. Specifically, the facility failed to ensure Resident #2's responsible party was notified of a resident to resident altercation. Findings include: I. Resident #2 status Resident #2, age 82, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 2/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of four out of 15. He required extensive assistance of one person with bed mobility, dressing, toileting and personal hygiene. He required supervision with transfers, eating and walking throughout the corridor. It indicated the resident had hallucinations and delusions. The resident had physical behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually one to three days during the assessment period. II. Record review Resident #2 behavior care plan, initiated on 2/12/2020, revealed the resident would interfere with care at times, not easily redirectable, and may wish to help others resulting in interfering with care and creating potential safety risks. The goal indicated the resident would refrain from potentially physical behaviors. The interventions included to offer the resident a job or activity of interest, snack of beverage of choice, a new environment and redirect the conversation if the resident becomes physically or verbally aggressive. The 2/22/2020 nursing progress note revealed the resident initiated a physically aggressive encounter with Resident #3. Resident #2 was observed with a hand around Resident #3's neck, shaking him, while attempting to strike Resident #3. The certified nurse aide (CNA) separated the residents before Resident #2 was able to strike Resident #3.Cross-reference F600 for failure to keep residents free from abuse. -It did not indicate the resident's responsible party had been notified of the resident to resident altercation. The 2/22/2020 incident report revealed the physician was notified of the incident on 2/22/2020. -It did not indicate the resident's responsible party was notified of the incident. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/5/2020 at 10:18 a.m. She said if an abusive situation was observed between two residents, staff should separate the residents to ensure their safety. She said the registered nurse (RN) should be informed right away to start a physical assessment of each resident involved. She said the director of nursing (DON) and the nursing home administrator (NHA) should be notified immediately to begin the investigation. She said the physician and the resident's responsible party should be notified as soon as possible of any incident or change of condition. The DON, director of social services (DSS) and NHA were interviewed on 8/6/2020 at 10:50 a.m. The NHA said the physician and the resident's responsible party should be notified as soon as possible of any incident or change of condition.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure three (#1, #3 and #5) of five out of five sample residents were kept free from abuse. Specifically, the facility failed to: -Ensure Resident #5 was kept free from resident to resident abuse by Resident #2; -Ensure Resident #3 was kept free from resident to resident abuse by Resident #2; and, -Ensure Resident #1 was kept free from physical abuse by a staff member. Findings include: I. Facility policy and procedure The Abuse policy, revised September 2016, was provided by the nursing home administrator (NHA) on 8/5/2020 at 1:00 p.m. It revealed, in pertinent part, Acknowledgement that no one should be subjected to violent, abusive, humiliating, or neglectful behavior is the single most critical step in detecting and preventing abuse, neglect, misappropriation of patient property. It is necessary for the center to adopt and institute an abuse, neglect and misappropriation prevention system to include screening and training of employees, protection of patients as well as identifying and investigating all allegations of abuse, neglect, mistreatment and misappropriation of patient property. The resident has the right to be free from all types of abuse, including verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Patients must not be subjected to abuse by anyone, including but not limited to facility staff, other patients, consultants, or volunteers, staff of other agencies serving the patient, family members, legal guardians, friends or other individuals. Physical abuse may include not limited to hitting, kicking, slapping, and pinching. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion or sexual assault. II. Failed to ensure residents were kept free from abuse by Resident #2 A. Incident on 2/13/2020 1. Resident status Resident #2, age 82, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 2/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of four out of 15. He required extensive assistance of one person with bed mobility, dressing, toileting and personal hygiene. He required supervision with transfers, eating and walking throughout the corridor. It indicated the resident had hallucinations and delusions. The resident had physical behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually one to three days during the assessment period. It indicated the resident had verbal symptoms directed toward others such as threatening others, screaming at others and cursing at others four to six days during the assessment period. 2. Record review Resident #2's behavior care plan, initiated on 2/12/2020 and revised on 5/8/2020, revealed the resident had shown increased impulsivity and inappropriate behaviors, at times sexual, towards female staff and residents. It indicated the resident was not always redirectable and had become increasingly possessive of various females in his environment. Resident #2 was sexually inappropriate with female residents including physically touching others in a sexual manner. He had sexually inappropriate verbiage towards staff and at times residents. The 2/13/2020 nursing progress note revealed Resident #2 was observed having inappropriate sexual contact with Resident #4. He was observed rubbing his genitals against Resident #4 buttocks. It indicated approximately two minutes later, he was observed massaging the breasts of Resident #5. The 2/13/2020 incident investigation witness form revealed a CNA, while she was giving report to the nurse at 3:20 p.m., saw Resident #2 grab a female resident, Resident #4, from behind. Resident #2 rubbed his genitals on her buttocks in a circular motion. The residents were immediately separated and the staff re-directed Resident #2 back to his unit. A few minutes later, Resident #2 returned and was observed fondling Resident #5 breasts. Resident #2 was redirected again back to his unit. Resident #2's medical record was reviewed on 8/3/2020 at 10:00 a.m. It did not reveal any documentation or interventions other than re-directing Resident #2 back to his unit to prevent any further sexually abusive encounters with female residents on 2/13/2020. B. Incident on 2/22/2020 1. Resident #3 status Resident #3, age 95, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician

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) orders [REDACTED]. The 6/3/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of two out of 15. He required extensive assistance of one person with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident did not have any behavioral symptoms directed towards others during the assessment period. 2. Record review Resident #2 behavior care plan, initiated on 2/12/2020, revealed the resident would interfere with care at times, not easily redirectable, and may wish to help others resulting in interfering with care and creating potential safety risks. The goal indicated the resident would refrain from potentially physical behaviors. The interventions included to offer the resident a job or activity of interest, snack or beverage of choice, a new environment and redirect the conversation if the resident becomes physically or verbally aggressive. The 2/22/2020 nursing progress note revealed the resident initiated a physically aggressive encounter with Resident #3. Resident #2 was observed with a hand around Resident #3's neck, shaking him, while attempting to strike Resident #3. The certified nurse aide (CNA) separated the residents before Resident #2 was able to strike Resident #3. The 2/22/2020 incident investigation witness form revealed a staff member was exiting the shower room when she saw Resident #2 had his hands around Resident #3 neck. Resident #2 was shaking Resident #3 aggressively. She intervened immediately and notified the nurse. It indicated Resident #2 had been agitated all day. The 2/22/2020 skin and wound weekly documentation for Resident #3 revealed the resident did not have any new skin concerns following the incident with Resident #2. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/5/2020 at 10:18 a.m. She said if an abusive situation was observed between two residents, staff should separate the residents to ensure their safety. She said the registered nurse RN) should be informed right away to start a physical assessment of each resident involved. She said the director of nursing (DON) and the NHA should be notified immediately to begin the investigation. She said she had not been working in the facility when Resident #2 was involved in two resident to resident incidents in February 2020. She said when she first started working at the facility, Resident #2 would escalate in his behavior and become verbally aggressive toward staff and would reject care. She said he used to become fixated on female residents often. She said he currently had a female friend who was a resident that he considered his wife. She said they will walk down the hallway together, but so far has not tried anything sexual. She said staff keep a close eye on him because of his history of sexual behaviors toward females. She said, regarding the incident on 2/13/2020, the resident should have been removed from the first female resident and placed on monitoring to ensure he would not harm another female resident. The DON, director of social services (DSS) and the NHA were interviewed on 8/6/2020 at 10:50 a.m. The NHA said she and the DON were not working at the facility when the incident with Resident #2 and two female residents occurred on 2/13/2020. She said she had no further information other than what is in each resident's medical record and on the witness statement. She said after Resident #2 had rubbed his genitals on the first female resident, the staff should have removed Resident #2 and placed him on monitoring to ensure the second female resident was not victimized. The NHA said for the incident between Resident #2 and Resident #3 on 2/22/2020, she was called to the facility when it occurred. She said the CNA came out of the bathroom and saw Resident #2 with his hands on Resident #3 and was shaking him. The staff separated the residents immediately. She said when she arrived at the facility, Resident #2 was still escalating and she asked the CNA to leave the room. She said she was able to calm down Resident #2, gave him a hand massage and put him to bed. She said nursing conducted an assessment of Resident #3 following the incident. She said Resident #3 was not injured. The SSD said Resident #2 was admitted to the facility in February 2020. She said he had a hard time becoming acclimated to the facility. She said Resident #2 had exhibited sexual behaviors toward staff prior to the incident on 2/13/2020. She said Resident #2 had rubbed his genitals on a female resident and then after he was removed from the area, he returned and grabbed the breasts of another female resident. She said after the second resident was touched inappropriately, Resident #2 was placed on monitoring and the physician and psychiatrist were contacted. She said the second incident that day should not have occurred. She said Resident #2 should have been placed on monitoring to ensure the safety of the other residents. IV. Failed to ensure Resident #1 was kept free from physical abuse by a staff member A. Resident #1 status Resident #1, age 70, was admitted on [DATE]. According to the August 2020 CPO, the [DIAGNOSES REDACTED]. She required extensive assistance of two people with bed mobility, transfers, toileting and dressing. She required extensive assistance of one person with eating and personal hygiene. B. Record review The behavior care plan, initiated on 10/17/18 and revised on 7/7/2020, revealed the resident orientation issues related to the progression of dementia. It indicated the resident would cry spontaneously and was not always re-directable and had experienced a functional decline. The anxiety care plan, initiated on 10/19/18 and revised on 7/7/2020 revealed the resident's spouse reported an increase in the resident's anxiety and behaviors of crying and calling out. It indicated the resident may become tearful, resistant with care, rigid and physically aggressive. The resident may yell out due to confusion and grab at staff and materials during care. The risk for impaired skin integrity care plan, initiated on 10/23/18 and revised on 7/7/2020, revealed the resident was at risk for impaired skin integrity due to impaired cognition, impaired mobility, rigidity when being resistive to care and fragile skin. The 2/25/2020 skin observation tool revealed the resident had skin breakdown to the right buttocks. It did not indicate bruising noted to any other areas on the resident. The care plan did not reveal documentation the resident had evidence of any bruising or skin discoloration prior to the 2/26/2020 incident. The 2/26/2020 incident report revealed an employee reported he heard the resident yelling out Oh God, you are hurting me. It indicated the resident had a bruise to the front of the right and left upper thigh, back of the right and left hand, back of the right knee and the front of the left lower leg. The resident had negative vocalization of repeated troubled calling out, loud moaning and crying and a sad and frightened facial expression. The conclusion, indicated on 3/27/2020, indicated the abuse was unsubstantiated. It did not give further documentation to determine the reason behind the conclusion. The 2/26/2020 witness statement by maintenance worker #1 revealed he entered the unit to count linen and he heard screams coming from Resident #1 room. He said he went to the door and knocked, however no one opened the door. The yelling had subsided so he walked away. Then he heard the resident yell out, you're hurting me, you're hurting me. He said he went back to the room and knocked again. The resident continued yelling, Jesus, stop you are hurting me. The 2/26/2020 witness statement by RN #1 revealed she was sitting in the common area of the unit. She observed the resident's door open and CNA #1 wheel the resident out of the room and into the common area. CNA #1 asked if RN #1 had knocked on the door, to which RN #1 replied no. CNA #1 said, Well someone was knocking on the door. The 2/26/2020 statement by CNA #1 indicated she was in the resident's room providing incontinence care. She said she called the RN to come and assist her. She said she heard knocking on the door, but no one came into the resident's room. She said she was unable to change the resident on her own because the resident was resistant to care. She said she notified the nurse, the resident had dark spots on her legs and arms. The 2/26/2020 nursing progress note revealed a skin assessment was initiated following a reportable occurrence. It indicated the resident was found with brown skin discolorations on the top of both hands, yellowish and green bruises to the top of the right and left upper thighs, right anterior knee and the left shin. The resident's medical record was reviewed on 8/3/2020 at 10:00 a.m. It did not reveal any documentation to indicate the bruising and skin discolorations found on the resident on 2/26/2020 were noted or observed prior to the incident on 2/26/2020 (see skin observation tool dated 2/25/2020 above). C. Staff interviews CNA #2 was interviewed on 8/4/2020 at 11:22 a.m. She said Resident #1 was confined to a wheelchair and required staff assistance with all activities of daily living. She said the resident required physical assistance from staff for bed mobility and transfers out of bed. She said the resident had a stiff body and did not move a lot. She said there would be no reason, if a staff member needed help, the resident would not be able to be left for a second, to retrieve another staff member. She confirmed the resident was on the A side of the room, closest to the door. She said the resident had been at that level of care for a long time. She said the resident can lift her head up in bed, but does not move otherwise. She said she did not know why a staff member would not be able to answer the door if there was a knock on the resident's room. She said the resident would not be in danger. Maintenance worker #1 was interviewed on 8/4/2020 at 10:00 a.m. He said he was working in the facility on 2/26/2020 in the early morning. He said he walked onto the unit and began his duty of counting linen. He said he heard screaming coming out of Resident #1 room. He said the door was closed. He said he knocked on the door three times. He said on the third time, the screaming stopped. He said he returned to counting the linen. He said the screaming started again and a loud banging that shook the walls. He said he beat on the door with a fist to get the CNAs attention. He said the CNA never opened the door. He said he looked around for the nurse but she was in with another resident on a different unit. He said he called the NHA and reported the incident. He said she informed him to contact the DON. He said when the DON came into the facility a couple hours later, he had reported when he heard while on the unit. He said he saw the resident about 45 minutes to an hour after the incident. He said she looked traumatized. He said he had been working at the facility for a long time and had been around the resident. He said the resident often called out and cried. He said the screaming he heard that night

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) was a sound like he had never heard before from the resident. CNA #1 was interviewed on 8/4/2020 at 2:10 p.m. She said she worked the night shift, caring for Resident #1 on 2/26/2020. She said she did rounds and found the resident soiled around 5:00 a.m. She said Resident #1 was screaming so she got RN #1 to assist. She said her and RN #1 provided incontinence care together. She said when she returned to work the next day, she was told someone had reported her hurting the resident. She said she was suspended during the investigation but was back working at the facility on another unit. She said RN #1 was in the room with Resident #1 the entire time she was providing care. RN #1 was interviewed on 8/4/2020 at 2:56 p.m. She said she remembered working on 2/26/2020. She said she was in and out of the nursing station and both units doing her nightly duties and assisting residents. She said around 2:00 a.m., she assisted CNA #1 in providing continence care to Resident #1. She said the resident did not have any bruising or skin discolorations on her body at that time. She said when she was finished helping, she left the room to continue with her other duties. She said later in the shift, her feet were hurting so she sat down in one of the chairs in the common area. She said she observed CNA #1 exit Resident #1's room with the resident. CNA #1 asked her if she had knocked at the door. RN #1 said she told her she had not knocked on the door. She said CNA #1 never reported the resident had any bruising. She said the resident had a history seeing children and spontaneously crying, but never screaming out for help on her shift. She said she had never seen the resident be combative during care. She said the resident was confined to a wheelchair and in bed during her shift. She said CNA #1 never asked for assistance the rest of the shift after 2:00 a.m. She said she did not enter Resident #1 room after assisting at 2:00 a.m. The DON, director of social services (DSS) and the NHA were interviewed on 8/6/2020 at 10:50 a.m. The NHA said the former DON conducted the investigation for the allegation of abuse by CNA #1 to Resident #1. She said it was reported by maintenance worker #1, Resident #1 was yelling and screaming. She said staff did not open the door when the maintenance worker knocked. She said the former DON concluded the abuse was unsubstantiated because both CNA #1 and RN #1 were in the room together during the alleged abuse. She confirmed, after re-reading the statement by RN #1, that RN #1 was not in the room with CNA #1 during the alleged abuse. She agreed since RN #1 witnessed CNA #1 exit the room with the resident, she could not have been in the room. She said she did not see the bruising on the resident. She said she was aware the resident's medical record did not have documentation to indicate the bruising had been observed prior to the incident on 2/26/2020.