STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065168	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPEN LIVING CENTER	1795 MONTEREY RD COLORADO SPRINGS, CO 80910

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 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 record review, resident interview and staff interviews, the facility failed to report alleged violations of potential abuse to the state survey and certification agency in accordance with state law involving one (#1) of three residents reviewed for abuse. Specifically, the facility failed to report an alleged violation timely of potential abuse from certified nurse aide (CNA) #2 to Resident #1. Findings include: I. Facility policy and procedure The Abuse and Neglect Prohibition policy and procedure, revised July 2018, was provided by the nursing home administrator (NHA) on 8/27/2020 at 10:00 a.m. The policy read in pertinent part, The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, state survey agency, and law enforcement official and adult protective services. II. Failure to report alleged violations of potential abuse to the state survey and certification agency A. Resident status Resident #1, age under 70, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/3/2020 minimum data set (MDS) assessments, revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She made herself understood and the ability to understand others. The resident had no rejection of care. She required extensive assistance with bed mobility, transfer, dressing, hygiene and toileting. B. Resident interview Resident #1 was interviewed on 8/26/2020 at 1:35 p.m. She was observed sitting in her electric wheel chair in her room. She said about couple of weeks ago, certified nurse aide (CNA) #2 was rough with her while she was providing care to her. She said she pushed and pulled on her. She said she slapped her left hip about three times. She said she was upset and it had hurt her. She said she told her to stop being rough with her. She said CNA #2 said to her, you cannot do anything to me. She said she was upset and reported the incident to the NHA. She said she told the NHA either she would leave the facility or CNA #2 leave because she was tired of being abused by CNA #2. She said after she reported the incident to the NHA, CNA #2 had not worked with her. She said no one came to follow up with her after she reported the incident. She said she was not interviewed about what happened. She said at the time of the incident, she was afraid of CNA #2 but she was not afraid anymore because CNA #2 had not worked with her since she reported the incident. She said the NHA said CNA #2 would not be assigned to her 200. C. Record review The initial investigation package dated 8/1/2020 was provided by the NHA on 8/26/2020 at 1:00 p.m. The package included a concern form and five resident's interviews. The concern form documented Resident #1 reported to the NHA that CNA #2 tossed her across the room when she was providing care to the resident. The concern form also documented no one was present but CNA #2. It documented the resident was not scared but she did not appreciate it. It further documented the resident would like to personally meet with someone about the concern. However, there was no evidence to show someone follow-up with the resident regarding her concern. The action section of the concern form documented, the NHA spoke with CNA #2. It documented CNA #2 said Resident #1 was to be provided care in pairs (two staff) and she had another staff with her when she provided care to her. It documented CNA #2 and CNA #1 changed Resident #1 and it was uneventful on 8/1/2020. It also documented the resident did not cry out or asked them to stop caring for her at any time. It documented the nurse will educate on cares in pairs. On 8/27/2020 at 9:00 a.m., the NHA provided additional interviews from staff that were completed on 8/26/2020. The package also included a form that revealed CNA #2 was suspended on 8/26/2020 at 2:45 p.m. which was 25 days after the allegation was reported. Cross-reference F610 for failure to investigate an alleged abuse violation. A summary section of the investigation documented CNA #2 was not assign on hall 200 (the hall where Resident #1 resided). It documented CNA #2 was assigned to hall 300 and she had not assisted the resident that day (8/1/2020). It documented CNA #2 said the last time she worked with the resident, she did not report any concerns. It documented licensed practical nurse (LPN) #1 reported to the NHA that Resident #1 reported to her that CNA #2 was rough with her but the resident did not allow the nurse to assess her. According to the July 2020 nursing schedule, CNA #2 worked with the resident 7/31/2020, the day before the resident reported the allegation. -However, the initial concern form (see above) provided by the NHA documented that CNA #2 had worked with CNA #1 on 8/1/2020 assisting Resident #1 with care. The conclusion section of the investigation documented the staff were unsure if abuse occurred due to no visible marks and the resident refused to allow the nurse to assess her body for bruises. The resident did not mentioned to CNAs working with her subsequently on the hall of the allegation of abuse and CNA #2 had not worked on hall 200 since 8/1/2020. A hand written statement dated 8/26/2020 written by LPN #1 documented on 8/1/2020, Resident #1 made accusations about CNA #2 that she was rough with her. It documented CNA #2 had not been working on hall 200 with the resident. It documented resident expressed no fear of CNA #2 or any staff and refused a skin check. LPN#1's statement was written 25 days after the reported allegations. A typed document dated on 8/26/2020 documented the NHA called CNA #4 and asked her if she recall any issues with Resident #1 on or around the weekend of 8/1/2020. It documented CNA #4 said she did not remember anything significant or if the resident accused staff of being rough or hurt her. CNA #4 was interviewed 25 days after the abuse allegation. According to the nursing schedule, CNA #3 and #4 were assigned to hall 200 on 8/1/2020. E. Failure to report There was no evidence provided by the facility to show the 8/1/2020 abuse allegation made by Resident #1 was reported to the state licensing and certification agency or law enforcement officials. III. Staff interviews LPN #1 was interviewed on 8/27/2020 at 10:30 a.m. She said she was the nurse on 200 hall the day of the alleged allegations against CNA #2. She said Resident #1 reported to her that CNA #2 was rough with her while she provided care to the resident. She said CNA #2 was not assigned to 200 hall where the resident resided. She said she called the NHA and reported the allegation. She said the resident refused to be assessed for injury. -However, there was no evidence in the medical records that the nurse attempted to assess the resident. Social service director (SSD) was interviewed on 8/27/2020 at 1:30 p.m. She said if she received a report on an alleged abuse allegation, then she would interview all staff and residents involved in the allegation. She said she was not notified of the alleged abuse allegation reported by Resident #1 so she was not involved with the investigation. The NHA was interviewed on 8/27/2020 at 2:30 p.m. She said LPN #1 called her and reported the abuse allegation. She said it was over the weekend. She said she proceeded to the facility to investigate the allegation. She said the abuse allegation was not reported to the state agency because it did not meet the state occurrence requirements for reporting. She said there was no injury and the resident was not afraid.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview and staff interviews the facility failed to thoroughly investigate a potential abuse involving one (#1) of three residents reviewed was thoroughly investigated and steps were taken to prevent further abuse. Specifically, the facility failed to follow-up with Resident #1 after she reported an alleged abuse allegation against a staff member to obtain a written statement as to what had happened; obtain a written statement from all staff

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) that had worked with the resident on the day of the allegation; and, to assess the resident for any injuries. Findings include: I. Facility policy and procedure The Abuse and Neglect Prohibition policy and procedure, revised July 2018, was provided by the nursing home administrator (NHA) on 8/27/2020 at 10:00 a.m. The policy read in pertinent part, The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property in accordance with state law. Any employee alleged to be involved in an instance(s) of abuse and/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 is unsubstantiated. II. Resident status Resident #1, age under 70, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/3/2020 minimum data set (MDS) assessments, revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She made herself understood and the ability to understand others. The resident had no rejection of care. She required extensive assistance with bed mobility, transfer, dressing, hygiene and toileting. III. Resident interview Resident #1 was interviewed on 8/26/2020 at 1:35 p.m. She was observed sitting in her electric wheel chair in her room. She said about couple of weeks ago, certified nurse aide (CNA) #2 was rough with her while she was providing care to her. She said she pushed and pulled on her. She said she slapped her left hip about three times. She said she was upset and it had hurt her. She said she told her to stop being rough with her. She said CNA #2 said to her, you cannot do anything to me. She said she was upset and reported the incident to the NHA. She said she told the NHA either she would leave the facility or CNA #2 should leave because she was tired of being abused by CNA #2. She said after she reported the incident to the NHA, CNA #2 had not worked with her. She said no one came to follow up with her after she reported the incident. She said she was not interviewed about what happened. She said at the time of the incident, she was afraid of CNA #2 but she was not afraid anymore because CNA #2 had not worked with her since she reported the incident. She said the NHA said CNA #2 would not be assigned to her 200. IV. Record review The initial investigation package dated 8/1/2020 was provided by the NHA on 8/26/2020 at 1:00 p.m. The package included a concern form and five resident's interviews. The concern form documented Resident #1 reported to the NHA that CNA #2 tossed her across the room when she was providing care to the resident. The concern form also documented no one was present but CNA #2. It documented the resident was not scared but she did not appreciate it. It further documented the resident would like to personally meet with someone about the concern. -However, there was no evidence to show someone followed-up with the resident regarding her concern. The action section of the concern form documented, the NHA spoke with CNA #2. It documented CNA #2 said Resident #1 was to be provided care in pairs (two staff) and she had another staff member with her when she provided care to her. It documented CNA #2 and CNA #1 changed Resident #1 and it was uneventful on 8/1/2020. It also documented the resident did not cry out or asked them to stop caring for her at any time. It documented the nurse will educate on cares in pairs. On 8/27/2020 at 9:00 a.m., the NHA provided additional interviews from staff that were completed on 8/26/2020. The package also included a form that revealed CNA #2 was suspended (facility protocol) on 8/26/2020 at 2:45p.m. which was 25 days after the allegation was reported. Cross-reference F609 for failure to investigate an alleged abuse violation. A summary section of the investigation documented CNA #2 was not assign on hall 200 (the hall where Resident #1 resided). It documented CNA #2 was assigned to hall 300 and she had not assisted the resident that day (8/1/2020). It documented CNA #2 said the last time she worked with the resident, she did not report any concerns. It documented licensed practical nurse (LPN) #1 reported to the NHA that Resident #1 reported to her that CNA #2 was rough with her but the resident did not allow the nurse to assess her. According to the July 2020 nursing schedule, CNA #2 worked with the resident 7/30/2020 and 7/31/2020 two days before the resident reported the allegation. -However, the initial concern form (see above) provided by the NHA documented that CNA #2 had worked with CNA #1 on 8/1/2020 assisting Resident #1 with care. The conclusion section of the investigation documented the staff were unsure if abuse occurred due to no visible marks and the resident refused to allow the nurse to assess her body for bruises. The resident did not mentioned to CNAs working with her subsequently on the hall of the allegation of abuse and CNA #2 had not worked on hall 200 that weekend. The facility had determined the allegation of abuse was unsubstatiated. A hand written statement dated 8/26/2020 written by LPN #1 documented on 8/1/2020, Resident #1 made accusations about CNA #2 that she was rough with her. It documented CNA #2 had not been working on hall 200 with the resident. It documented resident expressed no fear of CNA #2 or any staff and refused a skin check. -LPN#1's statement was written 25 days after the reported allegations. A typed document dated on 8/26/2020 documented the NHA called CNA #4 and asked her if she recall any issues with Resident #1 on or around the weekend of 8/1/2020. It documented CNA #4 said she did not remember anything significant or if the resident accused staff of being rough or hurt her. CNA #4 was interviewed by the NHA via phone 25 days after the abuse allegation. According to the nursing schedule, CNA #3 and #4 were assigned to hall 200 on 8/1/2020. -There was no evidence that CNA #3 was interviewed. V. Failures in facility's response There was insufficient evidence the facility thoroughly investigated the 8/1/2020 abuse allegation in order to determine what actions were necessary to prevent its recurrence and to ensure resident's safety and well-being. Record review revealed no evidence the facility attempted an interview after the initial allegation was documented on a concern form with Resident #1 and after she reported the allegation to LPN #1. The progress notes for Resident #1 did not include any notes from nurses or social services regarding the alleged allegation. Also, there was no documented evidence the nurse attempted to assess the resident after she reported the alleged allegation of abuse. There was no evidence LPN#1 was interviewed on 8/1/2020 about what Resident #1 reported to her. Also, there was no evidence that CNA #3 and #4 were interviewed about the alleged allegation on 8/1/2020. VI.Staff interviews LPN #1 was interviewed on 8/27/2020 at 10:30 a.m. She said she was the nurse on 200 hall the day of the alleged allegations against CNA #2. She said Resident #1 reported to her that CNA #2 was rough with her while she provided care to the resident. She said CNA #2 was not assigned to 200 hall where the resident resided. She said she called the NHA and reported the allegation. She said the resident refused to be assessed for injury. -However, there was no evidence in the medical records that the nurse attempted to assess the resident. The social service director (SSD) was interviewed on 8/27/2020 at 1:30 p.m. She said if she received a report on an alleged abuse allegation, then she would interview all staff and residents involved in the allegation. She said she was not notified of the alleged abuse allegation reported by Resident #1 so she was not involved with the investigation. The director of nursing (DON) was interviewed on 8/27/2020 at 2:00 p.m. She said if an alleged abuse allegation was reported to her, she would interview all individuals involved in the allegation. She said the nurse would complete a SBAR, (situation, background, assessment and recommendation) a tool used to facilitate prompt and appropriate communication. The DON said when LPN #1 reported the allegation to her, she instructed the nurse to complete the SBAR. She said she felt the allegation was not thoroughly investigated. She said she instructed the NHA to re-investigate the allegations to include interviews from all staff who worked with the residents. The NHA was interviewed on 8/27/2020 at 2:30 p.m. She said she was about six months in her position. She said LPN #1 called her and reported the abuse allegation. She said it was over the weekend. She said she proceeded to the facility to investigate the allegation. She said Resident #1 frequently called the police and accused staff of not being nice to her. She said the resident said she was not afraid. She said she did not interviewed CNA #3 and #4 on 8/1/2020. She said she should have interviewed both CNAs because they worked with the resident on the day of the allegation and any other additional staff and residents.
F 0659 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to have qualified staff perform nursing tasks that affected residents residing in three out of five hallway units. Specifically, the facility failed to ensure qualified staff administered medications to residents. Findings include: I. Professional reference The Code of Colorado Regulations, section CNA (certified nurse aide) Expanded Scope of Practice/Not Considered Delegation of Nursing Tasks, effective 6/14/17, Accessed on 8/31/2020 from https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8756&fileName=3%20CCR% -1. It read in pertinent part, The following tasks included in the CNA's expanded scope of practice as set forth in section 12-260-110(1)(a), (b), and (c), C.R.S., are not considered delegated nursing tasks provided that a registered nurse (RN) has deemed the CNA competent to perform such tasks: Placement in a client's mouth of presorted medication that has been boxed or packaged by a Registered Nurse, a Licensed Practical Nurse, or a Pharmacist for clients/patients with stable health conditions and are not considered high risk. The CNA may only perform this task if the boxed or packaged medication has been stored in a secure manner and showing no sign of tampering. II. Facility policy and procedures The Medication Administration policy, revised June 2008, was received from the nursing home administrator (NHA) on 8/27/2020 at 1:05 p.m. It read in pertinent part, Authorized personnel- Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. The Code

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F 0659 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) of Colorado Regulation Section 5- Medical Acts Allowed by EMTs (emergency medical technicians), 6/14/13, was provided by the director of nursing (DON) on 8/28/2020 at 2:00 p.m It read in pertinent part, An EMT may, under the supervision and authorization of a medical director, perform emergency medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT. Code of Colorado Regulations 24 5.2 An EMT may, under the supervision and authorization of a medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B (over the counter medication, oxygen, [MEDICATION NAME], nerve agent antidote, aspirin, oral glucose, decontaminants-activated charcoal and [MEDICATION NAME] auto-injector, and topical [MEDICATION NAME] agents) and D (documented EMTs could not administer any medications in this appendix) of these rules for an EMT. Senate Bill 19-052, 4/17/19, was received from the DON on 8/28/2020 at XX. It read in pertinent part Section 25-3.5-207. Ability of certified emergency medical service providers to work in clinical settings - restrictions - definitions - rules. Clinical setting- means a health facility licensed or certified by the department pursuant to section 25-1.5-103 (1)(a). In-scope tasks and procedures- means tasks and procedures performed by an emergency medical service provider within the emergency medical service provider's scope of practice; The emergency medical service provider may perform only tasks and procedures that are within the emergency medical service provider's applicable scope of practice; Nothing in this section alters the authority of a physician or registered nurse in a clinical setting to delegate acts, including the administration of medications, that are outside of an emergency service provider's scope of practice pursuant to section 12-36-106 or 12-38-132, as appropriate. III. Record review The emergency medical technician and certified nurse aide (EMT/CNA) was certified as both an EMT and CNA. The schedule documented her as a nurse. A review of the Medication Administration Record [REDACTED]. The employee file was reviewed on 8/26/2020. Her file revealed she was an EMT registered with the National Registry of Emergency Medical Technicians and a CNA with the Colorado Department of Regulatory Agencies (DORA). She did not have a medication administration certification with DORA. The facility schedule was received from the DON on 8/27/2020 at 1:30 p.m. It documented the EMT/CNA was scheduled as a nurse and administered medications on the 7:00 p.m. to 7:00 a.m. shift: - 3/1, 3/2, 3/3, 3/8, 3/9, 3/10, 3/15, 3/16, 3/17, 3/22, 3/23, 3/24, 3/29, 3/30, and 3/31/2020, on hallway four; - 4/3, 4/5, 4/6, 4/7, 4/13, 4/14, 4/15, 4/20, 4/21, 4/22, 4/26, and 4/27/2020 on hallway four and five; - 6/12, 6/13, 6/14, 6/18, and 6/25/2020, on hallway four and five; - 7/2/2020, on hallway four and five; and, - 8/3, 8/4, 8/5, 8/10, 8/11, 8/12, 8/16, 8/17, 8/18, 8/23, 8/24, 8/25, and 8/26/2020, on hallway two, four and five. IV. Staff interviews CNA #1 was interviewed on 8/27/2020 at 9:17 a.m. She said nurses were the only staff in the facility who could administer medications. She said CNAs did not administer medications. She said if the residents requested a medication the CNAs would report it to the nurse. Licensed practical nurse (LPN) #1 was interviewed on 8/27/2020 at 9:24 a.m. She said nurses were the only ones allowed to administer medications in the facility. She said there is an emergency medical technician (EMT) who was allowed to administer medications within the facility. She said the facility allowed the EMT to administer medications because the EMT had been signed off and trained with the medical director and nursing management. EMT/CNA was interviewed on 8/27/20 at 10:00 a.m. via phone. She said she was an EMT and she was also a CNA. She said she was intravenous(IV) certified. She said she worked on the night shift. She said her duties were administration of medication and conducted resident's assessments. She said she did a skills training with the DON before she started to administer medications. She said she was not aware she had to be a medication aide certified through DORA. The DON was interviewed on 8/27/2020 at 10:35 a.m. She said EMT/CNA worked the night shift and was assigned to a unit in the facility. She said EMT/CNA worked as a nurse on the unit she was assigned and administered medications to residents. She said they were given a crosswalk from the state identifying what duties an Emergency medical technician (EMT) could perform in the nursing home. She said the documentation that was provided from the state revealed an EMT could administer medications in the nursing home. She said she was not aware that an EMT, who was also a certified nurse aide (CNA), needed to have a certification through DORA to administer medications in the nursing home. She said the facility wanted to do what was right according to the regulations. She said she would investigate more and if the EMT needed to have the approved training through DORA, then she would not schedule her until she took the medication aide training.