STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065311	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UPTOWN HEALTH CARE CENTER	**745 EAST 18TH AVE DENVER, CO 80203**

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 record review, and interviews, the facility failed to ensure two (#1, and #2) of two out of six residents who were investigated were free from abuse. Specifically, the facility failed to prevent resident to resident altercation between Residents #1 and #2. Cross-reference: F744 the facility failed to provide services to residents with dementia Findings include: I. Facility policies and procedures The Abuse policy and procedure, revised November 2019, was provided by the quality insurance specialist (QIS) #1 on [DATE]20 at 1:30 p.m. The policy read in the pertinent part: 1. Providing a safe environment for the resident is one of the most basic and essential duties of our facility. 2. Employees have a unique position of trust with vulnerable residents. 3. This facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, friends, or other individuals. 4. Identification of abuse shall be the responsibility of every employee. II. Resident #1 A. Resident status Resident #1 [AGE], was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/28/2020 minimum data set (MDS) assessment revealed the resident had a moderate cognitive deficit with a brief interview for mental status (BI[CONDITION]) score of eight out of 15. She had no verbal behaviors marked as daily and no rejection of care marked. For functional status, the resident was independent for bed mobility, transfers, toileting, and eating. She was supervision for personal hygiene. Record review and staff interviews revealed the facility was aware of Resident #1 had verbal and physical behaviors against others. The facility had interventions such as have resident do activities she liked throughout the day, medication management and redirection; however, Resident #1 behaviors continued to escalate based on nursing progress notes, and staff interviews with no positive response to the interventions. The facility did not ensure Resident #1 was safe from escalating behaviors. The facility did not ensure the resident did not negatively interact with other residents, and continued to try exit doors to leave the facility. B. Record review The behavior care plan, revised 4/29/19, revealed, Resident #1 had impaired cognitive function and impaired thought process related to [MEDICAL CONDITION] disorder [MEDICAL CONDITION] type, and unspecified dementia without behavioral disturbance. Interventions included: engage the resident in simple structured activities that avoid overly demanding tasks and elopement attempts. Discuss concerns about confusion, and disease processes. Staff invite, encourage, and assist resident with getting to and from all activities of her interest. She enjoyed sharing stories, reading, social groups, live entertainment, singing in the uptown band, trivia, socializing with peers and staff. Review of the abuse investigation revealed the following: -Date of incident: 2/20/2020. Time of incident: 2:30 p.m. -Date the investigation initiated: 2/20/2020. Time investigation was initiated: 2:30 p.m. -Residents involved: Resident #1, and Resident #2. Type of investigation: Physical abuse. -Suspected perpetrator: Resident #1 -Description: Resident #1 and resident #2 engaged in an altercation over a book. Resident #1 was holding the book. Resident #2 grabbed the book. Resident #2 fell to the floor. Immediate safety measures implemented: The residents were redirected and placed on increased monitoring. Both residents were evaluated by a nurse. Resident#1 and Resident #2 are at risk individuals and the police were notified. -Staff interviewed: three staff were interviewed but were not at the facility during the survey. -Residents interviewed: seven residents were listed including Resident #1, and #2. -Summary: There were conflicting stories about the severity of what happened. However, the facility took into account, that Resident #2 was on the floor and the incident was substantiated. -Action: Immediate safety measures implemented: The residents were redirected and placed on increased monitoring. Both residents were evaluated by a nurse. Resident#1 and Resident #2 are at risk individuals and the police were notified. Review of the progress notes revealed the following: -1/14/2020: Nursing Note Resident #1 often checks the doors, trying to get out of the facility to go home. The nursing note did not show any attempts by staff to avoid elopement attempts, engage or redirect the resident. -[DATE]: Nursing Note Resident#1 paces between doors checking to see if they are unlocked so she can get out of the facility to go home. The nursing note did not show any attempts by staff to avoid elopement attempts, engage or redirect the resident. -2/20/2020: Nursing note Resident #1 was sitting reading a book and Resident #2 came up to her and insisted that she give it to her. Resident #1 got agitated and stood up and pushed Resident #2 to the floor. The two residents were separated and Resident #1 was taken to a different floor. Resident #1 was unharmed by the incident. The director of nursing (DON), medical doctor (MD), and family were notified. -2/22/2020: Nursing note Resident #1 follow-up for an altercation with another resident: Resident remains on 15 minute checks. No increased agitation noted. Resident #1 was noted sitting next to Resident #2 and having a calm conversation. Resident #1 was observed walking up and down the hall checking doors to see if they were locked. The nursing note did not show any attempts by staff to avoid elopement attempts, engage or redirect the resident. Medication Administration Record [REDACTED]. C. Resident interview Resident #1 was interviewed on [DATE] at 11:45 a.m. She said, she was not fearful of Resident #2. She said she would like to do more of what she liked to do. V. Staff interviews Activities assistant (AA) was interviewed on [DATE]20 at 12:15 p.m. She said she was not present when Resident #1 and Resident #2 had the altercation. She said she knew how to report abuse allegations. She said she knew resident #1 liked activities, and they calmed her behaviors. She also said there was not enough activity staff to conduct all of the activities on every floor all day long. She said it was very hard to work with residents with dementia and had not gone to every room to see if residents wanted to participate in activities. She said there were no specialized activities for the residents in the memory care unit. She said residents would benefit from more activities geared to dementia residents such as music or do one-to-ones with residents. She said it was a team effort and staff on the unit could also provide activities. Certified nurse aide (CNA) #1 was interviewed on [DATE]20 at 10:58 a.m. She had been a CNA for [AGE] years. She said she knew how to report allegations of abuse. She said she was not working when Resident #1 and Resident #2 had an altercation. She said she had completed some dementia training for the facility. She said the activities staff do not do enough with the residents to keep them busy and decrease behaviors. She said she felt more training would be helpful for staff to decrease residents physical, mental, and wandering behaviors. She also said, Resident #1 will sit by the television room and will often look bored. Registered nurse (RN) #1 was interviewed on [DATE]20 at 11:05 a.m. She said she knew how to report allegations of abuse and the different types of abuse. She said she sometimes would try to provide some activities with a couple of the residents. However she said, not enough activities are offered to the residents. She also said more comprehensive activities would decrease residents from wandering the units and decrease behaviors. The activities director was interviewed on [DATE]20 at 12:25 a.m. He said he had worked at the facility only a couple of months. He said he knew the different types of abuse. He said a lot of activities were not conducive to benefit the residents in the memory care unit. He said, he knew dementia was related to behavior care including purposeful and meaningful activities addressing the residents interests, and preferences. He said most of the activities on the schedule

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) were not geared to that, but he was working hard to correct that. He also said, Residents who are bored and have nothing to interest themselves will often have behaviors. He said I am working hard in his department to create meaningful activities for residents. The nursing home administrator (NHA) was interviewed on [DATE]20 at 1:45 p.m. She said she was the abuse coordinator for the facility. She said staff can call her phone 24 hours a day with allegations of abuse. She said appropriate activities could decrease abusive behaviors on the units. She confirmed the residents were not receiving appropriate activities for dementia care on the units from staff. She said this could be seen in residents not engaging in activities and having behaviors. She also said there was a plan in place to increase meaningful activities for the residents on the units. However, she could not show me the plan at that time during survey. Findings include: III. Resident #2 A. Resident status Resident #2, less than [AGE] years of age, was admitted on [DATE]. The March 2020 computerized physician orders [REDACTED]. According to the 1/7/2020 minimum data set (MDS) assessment she had severe cognitive impairment to the extent in which she could not understand nor complete the brief interview for mental status (BI[CONDITION]). She experienced delusions and had no adverse moods. B. Observation An observation made on [DATE] at 11:30 a.m. revealed Resident #2 was standing in her room not engaged in a person-centered activity at this time; there was no staff member in her room providing a one-to-one activity for her. An observation made on [DATE]20 at 12:24 p.m. revealed Resident #2 sat across from Resident #1 in the common area, neither of them engaged in a person-centered activity, and there was no staff offering person-centered activities for them. C. Resident interview Resident #2 was interviewed on [DATE] at 11:01 am. She said she was safe, other residents were nice to her, and staff were respectful. She did not recall when Resident #1 pushed her to the floor; when she wanted a book back from her. She said she wanted to go to church but the facility told her it was too far to take her. She felt she did not belong on the secured floor because she had more knowledge than the other residents who lived on there. D. Record review According to the March 2020 CPOs, it reflected she had an order to be on the secured floor since 8/27/2019 due to she was a high risk for elopement. The care plan, initiated and revised on 12/9/2019, identified she had dementia behavior verbal and physical combativeness. Interventions included to anticipate her needs. The care plan, initiated on [DATE]9/2019 and revised on 2/4/2020, identified she had a communication problem related to her significant memory impairment due to dementia. Interventions included to anticipate and meet her needs. The care plan, initiated and revised on 4/24/2019, identified she wanted more independence, to make her own decisions; she wanted to join a book club with the activities department. She was intellectual, was very emotional about living in the facility and having lost her independence, and wanted to have a volunteer job to have a sense of purpose in life. Interventions included to assist and arrange community activities. The care plan, initiated on 11/29/2019 and revised on 12/09/19, identified she had behaviors of verbal and physical aggression due to dementia and ineffective coping skills. Interventions included to give her as many choices as possible about activities. According to the Resident #2 ' s activity tasks for February 2020 and March 2020, there was no documentation of regularly structured activities which reflected her interests or her participation. According to the 2/20/2020 at 3:10 p.m. incident note, it reflected Resident #1 stood up and pushed her to the floor. She sustained a s[REDACTED]e to her right elbow. She was placed on 15 minute checks; protocol for a neurological assessment. According to the 2/20/2020 at 3:54 p.m. incident note, it reflected Resident #2 said in her interview that she tried to get a book back from Resident #1; a book she lent to Resident #1. Resident #1 got upset, pushed her, she fell to the floor, and hit her right elbow. She denied pain or discomfort. According to the February 2020 progress notes, it reflected the facility completed their neurological assessment of her, the assessments were within normal limits, the facility monitored her mood and behavior and she did not display adverse moods or behaviors after the incident. E. Staff interviews The certified nurse aide (CNA) #2 was interviewed [DATE]10 at 10:45 a.m. She said Resident #2 was not aggressive, she was forgetful, and confused. She said she and Resident #1 were good friends and they did not interact every day. She said if staff observed behaviors they were to immediately report to the nurse if there were any behaviors between residents. CNA #1 and registered nurse (RN) #1 were interviewed on [DATE]10 at 10:45 a.m. they said Resident #2 could be inpatient, required redirection, and there was no tension between her and Resident #1. The activities assistant (AA) was interviewed on [DATE]20 at 12:05 p.m. She said she heard Resident #1 and Resident #2 yelling and saw a nurse go to them. They were fine today on the elevator; neither of them recalled the incident and had no tension between them. Some days they interacted with each other appropriately. She said when there was a resident-to-resident incident, she would redirect them to calm them down, separate them, get help from staff, distract them, alert staff, and notify the NHA. I would have staff stay with residents or I would take one with me, we do this to keep them safe and protect them. The social service director (SSD) was interviewed on [DATE]20 at 12:00 p.m. She said Resident #1 resided in the secured unit because she was an elopement risk. She refused to wear a wander guard but was not physically aggressive. Resident #2 told her Resident #1 pushed her and she got a scratch. She said staff were responsible to keep residents safe, separate them when necessary for their safety, immediately report concerns of abuse, and do 15 minute checks or 1:1 monitoring when necessary. The NHA was interviewed on [DATE]20 at 1:24 p.m. She was notified the day of the allegation of physical abuse in the hallway which involved Resident #1 and Resident #2; who were not roommates. Staff protected both residents through redirection and increased monitoring. As the abuse coordinator she monitored residents for potential for abuse. She or staff intervened if they observed a potential for an argument; they knew their residents ' tendencies. Her number was easily accessible, she was available 24/7, or staff could report abuse concerns to the director of nursing (DON). The activity department were the eyes and ears of the facility and were going to start a program (which did not exist at this time) designed to engage the residents who lived on the secured floor to address the time between organized activities. She did not want residents who lived on the secured floor to just watch television. She expected the staff to identify boredom amongst them and get them engaged in an activity of their choice. The interdisciplinary team continued to discuss whether Resident #2 was appropriately placed on the secured floor. She planned to have the activities department provide spiritual services for Resident #2.
F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one unit of 17 dementia residents out of 74 total residents. Specifically, the facility failed to ensure: -Necessary care and services were person-centered and reflected the resident goals, while maximizing Resident #1 ' s dignity, privacy, socialization, choice and safety. -The facility identified person-centered approaches to utilize, including purposeful and meaningful activities addressing the residents customary routines, interests, preferences, and choices to enhance the residents well-being. Cross-reference: F600 Failure to prevent abuse and neglect Findings include: I. Facility policy and procedure The Dementia Clinical Protocol policy and procedure, revised November 2018, was provided by the quality insurance specialist (QIS) #1 on [DATE]20 at 1:30 p.m. The policy read in pertinent part: Direct care staff will support the resident in initiating and completing activities and tasks of daily living. A. Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. II. Resident #1 status Resident #1 [AGE], was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/28/2020 minimum data set (MDS) assessment revealed the resident had a moderate cognitive deficit with a brief interview for mental status (BI[CONDITION]) score of eight out of 15. She had no verbal behaviors marked as daily and no rejection of care marked. For functional status, the resident was independent for bed mobility, transfers, toileting, and eating. She was supervision for personal hygiene. A. Resident interview Resident #1 was interviewed on [DATE] at 11:45 a.m. She said, she did some activities like singing and reading but was currently bored. She said, she got into a disagreement with Resident #2 over a book she was holding. She said she would like to do more of what she liked to do instead of just sitting in a chair. B. Observations Residents in the memory care unit were observed on [DATE]20 between 8:00 a.m. and 2:35 p.m. During this time, three unknown residents were observed on unit in their wheelchairs going up and down the hallway not engaged by staff. Four other unknown residents were observed sitting in the television room of the unit. The residents were not engaged by staff. Several other unknown residents in the unit were in their bedrooms. The unit had the television on but no residents were observed watching. The residents on the unit did not socialize with other residents or engage in any specialized activities. The 9:30 a.m. daily chronicles, and 9:45 a.m. uptown downtown band activities were conducted, however most of

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F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) the residents stayed on the unit. At 10:30 a.m. to 2:30 p.m. no activities were conducted. Resident #1 was observed during this time sitting in a chair on the wall on the side of the television room just looking around. III. Record review The activity care plan, revised 4/29/19, did not reveal how Resident #1 spent most of her time. According to the care plan, the resident enjoyed sharing stories, reading, social groups, live entertainment, singing in the uptown band, trivia, socializing with peers and staff. The care plan identified Resident #1 had impaired cognitive function and impaired thought process related to [MEDICAL CONDITION] disorder [MEDICAL CONDITION] type, and unspecified dementia without behavioral disturbance. Interventions included: engage the resident in simple structured activities that avoid overly demanding tasks and elopement attempts. Staff invite, encourage, and assist resident with getting to and from all activities of her interest. Review of the progress notes revealed the following: -1/14/2020: Nursing Note Resident#1 often checks the doors, trying to get out of the facility to go home. The nursing note did not show any attempts by staff to avoid elopement attempts or engage in activities. -[DATE]: Nursing Note Resident#1 paces between doors checking to see if they are unlocked so she can get out of the facility to go home. The nursing note did not show any attempts by staff to avoid elopement attempts or engage in activities. -[DATE]: Nursing note Resident #1 accused people of talking about her this shift, told staff member that she was going to kick her in the ass this shift, resident easily redirected. The nursing note did not show any attempts by staff to avoid behavior concerns or engage in activities. -2/20/2020: Nursing note Resident #1 was sitting reading a book and Resident #2 came up to her and insisted that she give it to her. Resident #1 got agitated and stood up and pushed Resident #2 to the floor. The two residents were separated and Resident #1 was taken to a different floor. Resident #1 was unharmed by the incident. The director of nursing(DON), medical doctor (MD), and family were notified. There was no documentation of attempts to engage the residents in activities. -2/22/2020: Nursing note Resident #1 followup for an altercation with another resident: Resident remains on 15 minute checks. No increased agitation noted. Resident #1 was noted sitting next to Resident #2 and having a calm conversation. Resident #1 was observed walking up and down the hall checking doors to see if they were locked. The nursing note did not show any attempts by staff to avoid elopement attempts. There was no documentation of attempts to engage the residents in activities. Activities calendar According to the review of the February 2020, and the March 2020 activity calendar, revealed the residents were scheduled for five to six activities from 9:30 a.m. to 7:30 p.m. daily, primarily the activities conducted were daily chronicles, country cart, and bingo. However most of the activities were from thirty to forty minutes and no activities were conducted in between. IV. Staff interviews Activities assistant (AA) was interviewed on [DATE]20 at 12:15 p.m. She said there was not enough activity staff to conduct all of the activities on every floor all day long. She said it was very hard to work with residents with dementia and had not gone to every room to see if residents wanted to participate in activities. She said there were no specialized activities for the residents in the memory care unit. She said residents would benefit from more activities geared to dementia residents such as music or do one-to-ones with residents. She said it was a team effort and staff on the unit can also do activities. Certified nurse aide (CNA) #1 was interviewed on [DATE]20 at 10:58 a.m. She said she had completed some dementia training for the facility. She said the activities staff do not do enough with the residents to keep them busy and decrease behaviors. She said she felt more training would be helpful for staff to decrease residents physical, mental, and wandering behaviors. Registered nurse (RN) #1 was interviewed on [DATE]20 at 11:05 a.m. She said she sometimes will try to do some activities with a couple of the residents. However she said, not enough activities are offered to the residents. She also said more comprehensive activities would decrease residents from wandering the units and decrease behaviors. Activities director was interviewed on [DATE]20 at 12:25 a.m. He said he had worked at the facility only a couple of months. He said a lot of activities were not conducive to benefit the residents in the memory care unit. He said, he knew dementia was related to behavior care including purposeful and meaningful activities addressing the residents interests, and preferences. He said most of the activities on the schedule were not geared to that, but he was working hard to correct that. The nursing home administrator (NHA) was interviewed on [DATE]20 at 1:45 p.m. She confirmed the residents were not receiving appropriate activities for dementia care on the units from staff. She said, this can be seen in residents not engaging in activities and having behaviors. She also said there was a plan in place to increase meaningful activities for the residents on the units. However she could not show me the plan at that time.