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 _____	03/11/2020

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 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 protect from and prevent abuse for two (#2 and #3) of three residents reviewed out of five sample residents. Specifically, the facility failed to protect Resident #2 from physical abuse from Resident #1 and failed to protect Resident #3 from physical abuse from Resident #5. Findings include: I. Facility policy The Abuse and neglect prohibition policy and procedure, revised 7/18, was provided by the director of nursing (DON) on 3/11/2020 at 9:30 a.m. It read in pertinent part: -Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resdient's medical symptoms. II. Physical altercation on 12/18/19 between Resident #2 and Resident #1 A. Resident #2 1. Resident status Resident #2, age 64, was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/14/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of 3 out of 15. The resident required two person assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. He required one person physical assistance with locomotion and eating. The MDS identified physical behaviors directed toward other residents one to three days. 2. Record review The comprehensive care plan, last revised 5/6/19, identified the resident was at risk for a psychosocial well-being problem related to his stroke, inability to communicate effectively at times, his being alone with no family and his loss of independence. The goal was for the resident to have no indications of psychosocial well being problems through the next review date. Pertinent approaches included encouraging participation from the resident who depends on others to make his own decisions. B. Resident #1 1. Resident status Resident #1, age under 60, was initially admitted on [DATE], and re-admitted on [DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. The resident required one person assistance with bed mobility, walking and transfers. He required two person physical assistance with transfers, dressing, toilet use and personal hygiene. He required one person physical assistance with locomotion on and off the unit and setup assistance with walking. The MDS identified the resident had physical and verbal behavioral symptoms directed at others one to three days. 2. Record review The comprehensive care plan, last revised 2/25/2020, identified the resident had a history of [REDACTED]. Recently the resident had spontaneously targeted residents and gets angry with no provocation or indication that he is going to hit, swing or push suddenly. The goal was for the resident to not have any altercation with his roommate or other residents through the review period. Pertinent approaches included, offering distraction and redirection as needed and separating the resident from whoever he is upset with. C. Summary of investigation The 2/20/2020 Suspected Abuse Investigation documented the following: Observed Resident #1 with both hands around Resident #2 neck making threats. Conclusion: abuse substantiated, Resident #1 placed on direct observations. The 2/20/2020 Head to Toe Skin Check for Resident #2, completed as part of the physical abuse investigation, documented the following: Neck with redness, right jaw abrasion The 2/20/2020 SBAR (situation, background, assessment, recommendation) for Resident #2, documented the following: Entered the dining room and observed Resident #2 receiving physical aggression from another resident, immediately separated resident and moved to a safe area with a staff member. Noted redness to neck and abrasion of right jaw with small amount of frank blood. Notified NHA and DON. Placed on 15 minute checks. D. Staff interviews The NHA and DON were interviewed on 3/11/2020 at 11:45 a.m. They said both residents were in the dining room, when Resident #1 got up and put both hands around Resident #2 neck. They said Resident #2 was able to push Resident #1 away, and staff immediately separated them. The DON said Resident #2 had abrasions on his neck caused by Resident #1. The NHA said Resident #1 continues on a one to one meaning staff was with him at all times. She said the facility was in the process of finding a more appropriate facility, and until he was discharged he would be a one to one. III. Physical Altercation on 1/10/2020 between Resident #3 and Resident #5 A. Resident #3 1. Resident status Resident #3, age 65, was admitted on [DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. The 1/2/2020 MDS assessment revealed the resident was cognitively intact with a BIMS score of 12 out of 15. The resident required two person assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. She required set-up assistance with locomotion and eating. The resident did not have any behavioral symptoms or rejections of care. 2. Record review The comprehensive care plan, last revised 5/17/18, identified the resident demonstrated self destructive behaviors or physical/verbal behaviors of a history of making false accusations against staff and roommates. The goal was for the resident not to purposely inflict self harm and find a positive release for her anger through the next review. Pertinent approaches included; assess resident's understanding of the situation, allow time for her to express herself and feelings toward the situation. 3. Resident interview Resident #3 was interviewed on 3/11/2020 at 10:42 a.m. She said she had dropped a colored pencil on the floor and Resident #5 became upset with her and hit her on the back of her head. She said she had not seen the resident since the incident, so she is no longer afraid of him. She said she was going to press charges at the time of the incident, but did not want that to follow him around. She said they were in a romantic relationship, and that was the other reason she did not press charges. B. Resident #5 Resident #5, age 66, was admitted on [DATE].The resident discharged from the facility against medical advice (AMA), on 1/10/2020 following the physical altercation between himself and Resident #3. According to the January 2020 CPO, [DIAGNOSES REDACTED]. The 10/22/19 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required set-up assistance with all activities of daily living (ADLs). The resident did not have any behavioral symptoms or rejection of care. 2. Record review The comprehensive care plan, last revised 12/16/19, identified the resident recently had become more unstable and angry with sudden outbursts with yelling, breaking things and throwing things. He was not able to be redirected. The goal was for the resident to appear calmer and allow redirection, if possible through the next review. The approaches were to separate the resident from anyone he has conflict with, and encourage him to talk about why he was upset. C. Summary of investigation The 1/10/2020 Suspect Abuse Investigation documented the following: What happened: Resident #3 claims Resident #5 just hit her in the back of the neck. Summary of interviews/investigation: It is Resident #3 word that Resident #5 hit her, no marks, she called police. She now states she is not afraid of Resident #5 and was just mad. Conclusion: Police called, state reported, no physical injury. Resident #5 states he knuckled her but would not explain what that means. The 1/10/2020 SBAR for Resident #3 documented the following: Resident #3 reported that she and her boyfriend (Resident #5) were sitting in the (name) room, coloring. They started arguing and she threw a colored pencil on the floor. At this time her boyfriend got up and hit her on her neck/posterior head. She reports that this happened this morning. When staff attempted to interview Resident #3 and Resident #5, they both left the facility. Resident #3 then went across the street and called the police. Resident #3 was assessed by the nurse and no bruising, redness, or swelling was

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) noted. D. Staff interviews The DON and NHA were interviewed on 3/11/2020 at 11:45 a.m. The NHA said Resident #3 continued to change her story about the details of the incident, so the facility decided to unsubstantiate the abuse. The DON said at the time of the incident Resident #3 stated Resident #5 had hit her on the neck. The DON said Resident #5 had left the building AMA (against medical advice) and had not returned since the 1/10/2020 incident.