STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-DENVER	290 S MONACO PKWY DENVER, CO 80224

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 the resident right to be free from abuse, neglect, misappropriation of property, or exploitation for one (#5) of six sample residents. Specifically, the facility failed to ensure Resident #5 was kept free from resident-to-resident physical abuse by Resident #6. Findings include: I. Facility policy The Patient Protection: Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation Prevention policy, dated 2016, was provided by the nursing home administrator (NHA) on 7/1/2020 at 3:00 p.m. It read, in pertinent part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse against patients can be initiated by various people in the center. The center supports and protects patients, family members and staff from harm during an investigation of alleged abuse. Patient protection actions include immediately removing the patient from contact with the alleged abuser during the investigation. II. Physical altercation between Residents #5 and #6 A. Resident #5 status Resident #5, age 85, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 4/17/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a staff assessment for mental status which revealed short and long term memory problems and severely impaired decision making skills. She exhibited inattention and disorganized thinking. She required extensive assistance of one or two staff members with activities of daily living (ADLs) and mobility. B. Resident #6 status Resident #6, age 62, was admitted on [DATE]. According to the July 2019 CPO, [DIAGNOSES REDACTED]. The 4/16/2020 MDS assessment revealed the resident was cognitively impaired with a brief interview for mental status score of four out of 15. She exhibited physical behavioral symptoms and rejection of care. She required supervision of one staff member with mobility and extensive assistance of one staff member with dressing and personal hygiene. C. Resident to resident altercation A nursing progress note dated 6/2/2020 at 10:14 p.m. documented Resident #5 was struck by Resident #6 in the hallway by the nurses' station at 9:45 p.m. Resident #5 developed a bruise on her left hand near her thumb from blocking the hit from Resident #6. The facility investigation revealed Resident #6 was walking in the hallway and approached Resident #5, who was sitting in her wheelchair at the nurses ' station. Resident #6 was observed to raise her arm and hit Resident #5, who deflected the strike with her arms and was struck on the hand instead of the head. The altercation was witnessed by a staff member who was working as a one-to-one for Resident #6 due to past resident to resident abuse incidents. The investigation revealed the staff member was standing a few feet from Resident #6 and could not get to the resident before she struck Resident #5. In response to the 6/2/2020 altercation, the facility separated the residents and moved Resident #6 off of the secure unit on 6/5/2020, with the one-to-one staff member and an alert bracelet to ensure the safety of the other residents on the secure unit. D. Background of past abuse incidents by Resident #6 Review of progress notes for Resident #6 revealed the resident resided on the secure unit in the facility from the date of her admission until 6/3/2020 after the above resident to resident abuse incident. According to the progress notes, the resident had an incident on 11/10/19 where she hit another resident, a one to one was started but was removed after the resident showed no signs of aggression towards others. The resident was noted to be cooperative with care and did not exhibit any behaviors until 12/10/19 when the resident pushed another resident in the dining room. Again, a one to one staff member was assigned and increased behavior monitoring was implemented and the resident ' s behavior returned to normal and no other aggression was exhibited. On 1/28/2020 Resident #6 hit another resident in the dining room. After the event on 1/28/2020, a one to one staff member was implemented permanently with Resident #6 to prevent any further resident to resident abuse events, as the events were noted to be random and unprovoked. Continued review of the resident ' s progress notes revealed the resident did not exhibit any further resident to resident aggression for five months until the event on 6/2/2020. Resident #6 was moved off of the secure unit on 6/3/2020 in response to the resident to resident abuse incident on 6/2/2020. The one to one staff member remained in place. III. Observation On 7/1/2020 at 10:54 a.m. Resident #6 was observed walking up and down the halls with a staff member following close behind her. She was observed to go up and down the halls three times, then she returned to her room and sat down on her bed. At 1:20 p.m. Resident #6 was observed again to be walking up and down the halls with a staff member right next to her and at times holding hands with the staff member. She was observed to stop at her room frequently, sit down on her bed, then immediately stand back up and walk down the hall again. IV. Staff education Review of staff education records revealed all staff was educated related to abuse prevention from 5/7/2020 - 5/29/2020 and again from 6/9/2020 - 6/10/2020. V. Interviews Certified nurses aide (CNA) #1 was interviewed on 7/1/2020 at 1:22 p.m. She stated Resident #6 moved to the unit about a month prior after an incident on the secured unit. She stated the resident walked throughout the unit with her one to one frequently throughout the day. She stated a staff member was with the resident 24 hours a day due to impulsivity and exit seeking. Hospitality aide (HA) #1 was interviewed on 7/1/2020 at 1:56 p.m. She stated she worked as the one to one with Resident #6 most days. She stated the resident liked to walk throughout the unit and was very impulsive. She stated the resident could be resistive to care and was aggressive with staff at times, though had not shown aggression towards any residents since 6/2/2020. HA #2 was interviewed on 7/1/2020 at 2:30 p.m. He stated he worked as the one to one with resident #6 most evening shifts and had for about six months. He stated he was the one to one staff member who witnessed the incident on 6/2/2020 on the secure unit. He stated the resident had not shown any resident to resident aggression for months prior to the incident. He stated the incident was very fast and unprovoked. He stated she had not exhibited any resident to resident aggression since the incident on 6/2/2020 and had been doing well since moving to the new unit. He stated the resident walked up and down the hallways on the unit throughout the day when she was awake and he stayed close to her and kept her away from other residents while she was walking. The director of nursing (DON) and NHA were interviewed on 7/1/2020 at 2:35 p.m. They stated Resident #6 had abused Resident #5 despite a one-to-one staff member with the resident. They stated the resident was moved off of the secure unit, which would distance her from other confused and wandering residents. They stated the one to one remained in place due to the resident ' s impulsivity, exit seeking and occasional aggressive behaviors towards staff members. They stated the resident had not exhibited any other resident-to-resident aggression since 6/2/2020 and had been doing well on the new unit.

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.