STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065325	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Francis Nursing Center	7550 Assisi Hts Colorado Springs, CO 80919

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 one (#16) of two residents reviewed for abuse out of 46 sample residents was free from abuse. Specially, the facility failed to protect Resident #16 from sexual abuse by Resident #58. Findings include: I. Incident of sexual abuse between Resident #16 and Resident #58 on 11/14/24 A. Facility investigation The facility's investigation documented an incident occurred on 11/14/24 between Resident #16 and Resident #58 in Resident #16's room. Certified nurse aide (CNA) #2 witnessed Resident #58 in Resident #16's room prior to lunch. Resident #58 was patting Resident #16's buttocks with his hand and attempting to kiss her on the mouth. The residents were separated and taken to lunch. CNA #2 alerted registered nurse (RN) #1 of what was witnessed. Resident #16 was interviewed by the unit manager (UM) and stated Resident #58 had come into her room without knocking and uninvited. She said Resident #58 sat and talked with her and then attempted to kiss her while patting her buttocks. Resident #16 told the UM that Resident #58's behavior had made her uncomfortable and she was afraid to tell him no or to stop. Resident #16 told the UM she would like the staff to keep Resident #58 from going into her room. Resident #58 was interviewed by the UM and was asked if he had gone into Resident #16's room uninvited, patted her buttocks and attempted to kiss her. Resident #58 first wanted to know who had reported him for doing this. When he was asked a second time if he had entered the room uninvited, patted Resident #16's buttocks and attempted to kiss her, he said he had done those things. Resident #58 agreed with the UM that he should have obtained permission to engage in these behaviors and then went back to perseverating on who had reported him. The conversation ended with the UM providing education to Resident #58 on consent and he acknowledged understanding. During the investigation conducted by the facility to determine if other residents had been affected, the following events had been reported by staff: (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 11/13/23 by CNA #1 revealed the resident tried to touch and spank a CNA. A progress note dated 11/17/23 by RN #1 revealed the resident tried to grab a CNAs chest. A progress note dated 6/11/24 by RN #2 revealed Resident #58 was being cared for in pairs (two staff at all times during personal care). A statement written by CNA #2 and dated 11/14/24 documented Resident #16 told CNA #2 that Resident #58 made her uncomfortable. The UM statement, dated 11/14/24, revealed Resident #16 had told her she did not want Resident #58 in her room. The written statement documented Resident #16 told the UM she was fearful to tell Resident #58 to leave her room and he made her uncomfortable. The UM's second statement, also dated 11/14/24, revealed she had interviewed Resident #58 and he acknowledged he should have asked permission to go into Resident #16's room. The statement indicated Resident #58 admitted to the UM that he had attempted to kiss Resident #16 and touch her buttocks. On 12/3/24 CNA #3 wrote a statement which revealed Resident #58 had attempted to move the top of her shirt to reveal her undergarment strap. Resident #58 told CNA #3 he would become sexually aroused when he saw those straps and began to ask her personal questions about her intimate relationships. On 12/11/24 CNA #4 wrote a statement which revealed she saw Resident #58 confronting Resident #16 in the hallway asking if she was the reason why he was in trouble. A statement which was undated and written by CNA #6 documented was told by other care staff when she started working at the facility that Resident #58 was handsy. CNA #6 described one incident when she was transferring Resident #58 after toileting and he grabbed her arm and tried to pull her close to him. CNA #6 had to call out to another CNA before Resident #58 would release her. He made several sexually inappropriate remarks and requests to her during the interaction of care and other interactions. CNA #6 stated RN #1 had advised her to not go in his room without another CNA. An undated statement written by the hospice CNA (HCNA) revealed she had been told by staff to not go into Resident #58's room alone without other staff because of the resident's inappropriate sexual behaviors. An undated statement written by CNA #7 revealed a history of Resident #58 making sexually inappropriate comments to CNA #7 and requesting she clean his penis slowly and wife him. The facility substantiated the abuse of Resident #16 by Resident #58 based on staff and resident interviews and observations. B. Resident #16 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16, age [AGE], was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included depression and encephalopathy. The 10/31/24 minimum data set (MDS) assessment documented the resident was moderately cognitively intact with a brief interview of mental status (BIMS) score of eight out of 15. She required staff supervision for bathing and transfers and was independent in ambulation, bed mobility, personal hygiene, dressing, and toileting. The assessment indicated the resident had no behaviors. 2. Record review Resident #16's psychiatric care plan, revised 3/5/25 (during the survey), revealed the resident had a diagnosis of depression and received antidepressant medication. She displayed behaviors of low mood, agitation, hallucinations and delusions. Interventions included attempting non-pharmacological interventions. -However, the care plan failed to document what non-pharmacological interventions should be attempted. Resident #16's trauma care plan, initiated 8/2/24, revealed the resident had a trauma history of being emotionally abused by a religious leader she was providing child care for. The resident revealed the religious leader was discovered to be a pedophile and had attempted murdering his spouse. Interventions included allowing the resident time to express herself, offering reassurance, referring the resident to a psychologist for grief counseling and encouraging her family to visit. -The care plan failed to address the incident when the resident was touched inappropriately by Resident #58 on 11/14/24 or what interventions the facility put in place for her protection and psychosocial well-being following the incident. -Review of the March 2025 CPO failed to reveal a behavior monitoring order to monitor Resident #16's psychosocial well-being after the sexual abuse incident with Resident #58. Progress notes reviewed from 11/14/24 to 3/4/25 revealed the following: Resident #16 and Resident #58 were seen in the dining room talking to each other on 12/24/24, 12/28/24 and 1/5/25 (while on 15-minute checks). Resident #58 was seen on 1/1/25 (while on 15-minute checks) attempting to enter Resident #16's room and had to be redirected by staff as he was not permitted to go into the room. Further review of Resident #16's electronic medical record (EMR) revealed social worker (SW) #1 did not complete a psychosocial assessment with Resident #16 until 12/19/24 (thirty-five days after the sexual abuse incident with Resident #58). -There were no additional social services assessments or visit notes located in Resident #16's EMR between the 11/14/24 to 3/4/25 timeframe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 15-minute check staff documentation revealed Resident #16 was on 15-minute checks from 11/24/24 to 1/7/25. C. Resident #58 (assailant) 1. Resident status Resident #58, age [AGE], was admitted on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia and hydrocephalus. The 1/14/25 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. He required maximum staff assistance with toileting and personal hygiene and required partial staff assistance with showering, dressing, bed mobility, and transfers. The resident was independent in propelling himself in his wheelchair. The assessment indicated the resident had no behaviors direct towards others, behaviors putting others at risk or sexually inappropriate behaviors. -However, Resident #58 had several occasions where he was documented as having inappropriate sexual behaviors, including the sexual abuse incident with Resident #16 on 11/14/24 (see facility investigation above). 2. Resident interview Resident #58 was interviewed on 3/4/35 at 10:30 a.m. Resident #58 said the facility wanted to initiate an involuntary discharge for him based on a report of an interaction between himself and a female resident (Resident #16). He said staff had observed him embracing his friend with his hand on her buttocks. Resident #58 said the facility had given him several discharge notices and communications because his brother had been appealing the facility's decision. He said he felt the facility had made a big deal out of nothing. He said Resident #16 did not tell him to leave her room and when he asked her later if he had offended her, she said no. Resident #58 said he did not recall if he had increased supervision from staff after the incident. He denied any other inappropriate incidents with other residents or staff members. Cross-reference F622 for failure to follow appropriate discharge and transfer requirements. 3. Record review Review of Resident #58's mood and behavior care plan, revised 11/14/24, identified the resident had a diagnosis of major depression and anxiety. He had episodes of inappropriately touching staff sexually and making vulgar sexual comments to staff. He was involved in an incident on 11/14/24 where he made unwanted sexual contact with another resident, causing her to feel uncomfortable and unsafe. Interventions (revised on 10/16/24, prior to the incident) included attempting non-pharmological interventions as able, one-on-one visits, offering to toilet the resident, offering food and drink and administering medications as ordered. -The facility failed to update the care plan with new interventions following the incident with Resident #16 on 11/14/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #58's March 2025 CPO revealed the following physician orders: Clinical staff to perform every 15-minute checks to determine the resident's location and to ensure the safety of the other residents due to this resident's history of sexually inappropriate behavior, ordered on 3/4/25 (during the survey). Behavior monitoring for exhibiting sexual behaviors such as inappropriate touching and inappropriate verbal language of a sexual manner, ordered on 3/4/25 (during the survey). Two CNAs at all times when providing care, ordered on 6/11/24. Review of Resident #58's progress notes from 11/14/24 to 3/4/25 revealed the following: SW #2 did not provide education to Resident #58 on his behavior towards Resident #16 until 12/9/24 (twenty-five days after the sexual abuse incident). A social services quarterly assessment, dated 1/17/25, documented Resident #58 had not had staff reported behaviors within the look back period (period of three months). Social services sent a referral for psychiatry services for Resident #58 on 1/24/25 (two months after the sexual abuse incident with Resident #16). -There were no additional social services assessments or visit notes located in Resident #58's EMR between the 11/14/24 to 3/4/25 timeframe. A psychoactive meeting note, dated 12/19/24, failed to reveal that Resident #58's sexual abuse incident towards Resident #16 had been reviewed or discussed by the facility's interdisciplinary team (IDT). A Risk Management worksheet, dated 12/2/24, documented The resident (Resident #58) has been deemed a danger to the other residents. He has been placed on every 15-minute checks until he is discharged as a means to ensure the safety of the other residents. Review of 15-minute check staff documentation revealed Resident #58 was on 15-minute checks 11/24/24 to 1/7/25. II. Staff interviews RN #3 was interviewed on 3/4/25 at 10:10 a.m. RN #3 said Resident #58 was a two-person assist for staff safety due to his sexually inappropriate behaviors. RN #3 said the change in status for staff assistance for the resident was passed on to her from other staff and not by the management team. RN #3 said the nurses documented the resident's behaviors in the progress notes because he did not have a physician's order to track sexually inappropriate behaviors on the treatment administration records (TAR). RN #3 said the management team did not do a training with the staff on interventions to use with Resident #58 when he displayed sexually inappropriate behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The UM was interviewed on 3/4/25 at 11:00 a.m. The UM said Resident #58 had a history of sexually inappropriate language and touching towards staff when they were alone providing him care. She said the management team instructed the staff to set boundaries for the resident to stop and then tell the nurse or charge nurse what was happening. The UM said the CNAs did not document the resident's behaviors and that was something the nurses were responsible for documenting. CNA #6 was interviewed on 3/4/25 at 3:30 p.m. CNA #6 said the date she gave her written statement was on 11/21/24 (one week after the incident between Resident #16 and Resident #58). She said when she was hired on 9/5/23, she was warned by other staff that Resident #58 would touch staff inappropriately. She said there was an incident when Resident #58 would not let her go but when she called in another staff member and he let her go. She said she was adjusting his wheelchair and he kept trying to get hugs from her despite her telling him she did not give hugs. CNA #6 said during that same incident, he grabbed her breasts and she was told by the nurse to not go into his room without another CNA. CNA #6 said she was currently responsible for staff scheduling and tried to put male CNAs on Resident #58's unit. CNA #7 was interviewed on 3/4/25 at 3:56 p.m. CNA #7 said the CNAs and nurses had advised the prior nursing home administrator (NHA) about Resident #58's sexually inappropriate behaviors. CNA #7 said the prior NHA did not take action on the reports. CNA #7 said she knew Resident #58 was going to escalate and offend another resident but the administration did not handle his behaviors prior to the incident. The vice president of clinical services (VPCS), SW #1, SW #2, and the director of nursing (DON) were interviewed together on 3/4/25 at 5:07 p.m. SW #1 said the facility process regarding a resident with sexually inappropriate behaviors was to bring any incidents to the social services department to begin interviewing residents. SW #1 said the facility would offer to send the victim to the hospital for a rape kit, if applicable, and begin 15-minute checks on the victim and the perpetrator. SW #1 said the social services department acted as the abuse coordinators for the facility, but she said the corporate director of quality and safety (DQS) determined if incidents were reportable. SW #1 said after an investigation, she would update the care plans of the victim and the perpetrator. She said new behavioral interventions would be entered in the residents' care plans. She said care plans were reviewed by each department quarterly. SW #1 said behaviors would be indicated on the perpetrator's MDS assessment if they occurred during the assessment the look-back period. She said social services utilized progress notes, staff interviews, chart review and clinical meetings to collect information on residents in order to accurately complete assessments. She said the 1/14/25 MDS assessment should have reflected Resident #58's behaviors and the 11/14/24 incident. SW #1 said the care plan coinciding with the 1/14/25 MDS assessment should have been reviewed and updated for Resident #58 and Resident #16. SW #1 said she did not know why the MDS assessment, care plan and social services assessments had not been updated or kept accurate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she was not aware of Resident #58's past behavior towards staff until after the 11/14/24 incident with Resident #16, when staff started to come forward and she reviewed his records. She said 15-minute checks were started on both residents for safety after the incident. She said a behavior tracking physician's order would be obtained to monitor sexually inappropriate behaviors on the TARs, but she said she was only able to find a depression behavior tracking order on the TARs for Resident #58. The DON said 15-minute checks were stopped for both Resident #58 and Resident #16 on 1/7/25 because the facility had a meeting with Resident #16 and her family. The DON said Resident #16 did not want to remain on safety checks and asked for Resident #58 to also be removed from safety checks. She acknowledged she had no alternative safety measures put in place to prevent Resident #58 from inappropriately touching another female resident once the 15-minute safety checks were stopped. The VPCS said she believed Resident #58 had the potential to revert to repeating his behaviors if he believed he was no longer being watched. She said she was unaware the 15-minute safety checks had been stopped. She said the facility kept an eye on Resident #58 but staff were not formally documenting it. The VPCS acknowledged the facility needed to put more safeguards in place, including visual checks, to prevent incidents from occurring. The VPCS said the facility failed to keep residents safe by not tracking sexual behaviors, not having specific interventions in place, not moving Resident #58 off of Resident 16's hallway and by not training staff on what to report and how to redirect Resident #58.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to initiate an appropriate facility-initiated discharge for one (#58) of three residents reviewed for appropriate discharge out of 32 sample residents. Specifically, the facility failed to: -Complete an assessment with attempted interventions prior to giving the resident a discharge notice; and, -Ensure there was a documented basis from the physician that the resident's needs could not be met and discharge was necessary. Findings include: I. Resident #58 A. Resident status Resident #58, age [AGE], was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included unspecified dementia and hydrocephalus (build up of liquid on the brain). The 1/14/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required maximum staff assistance with toileting and personal hygiene. He required partial staff assistance with showering, dressing, bed mobility and transfers. The resident was independent in propelling himself in his wheelchair. The MDS assessment indicated the resident did not have an active discharge and had no behaviors. 2. Resident interview Resident #58 was interviewed on 3/4/25 at 10:30 a.m. Resident #58 said the facility wanted to initiate an involuntary discharge for him based on a report of an interaction between him and a female resident that was sexual in nature. Resident #58 said the facility had given him several discharge notices. He said his brother had been appealing the facility's decision to discharge him. He said he felt the facility had made a big deal out of nothing. He said he and the female resident were just friends embracing. Resident #58 said the concern over where he would live was upsetting to him and he spoke with his psychologist about it frequently. He said the facility had not discussed with him ways the facility would help him improve his behavior or how the impending discharge made him feel. 3. Record review (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The mood and behavior care plan, revised 11/14/24, identified Resident #58 had diagnoses of major depression and anxiety. He had episodes of inappropriately touching staff sexually and making vulgar sexual comments to staff. He was involved in an incident on 11/14/24 where he made unwanted sexual contact with another resident, causing her to feel uncomfortable and unsafe. At the time, frequent checks were started on the resident and the female resident for safety but had stopped because the issue had been resolved, and no other issues had come up. Interventions (revised on 10/16/24, prior to the incident) included attempting non-pharmological interventions as able, one-on-one visits, offering to toilet the resident, offering food and drink, administering medications as ordered, monitoring for signs and symptoms of depression and offering reassurance and encouragement. The discharge planning care plan, revised 1/23/25 (after the incident), revealed the resident was to remain in the facility for long term care without any plans to return to the community. Interventions (revised 3/23/23) included providing services according to care plans for long term care to assure optimum well-being, reviewing the resident's discharge potential annually or as needed and if discharging from the facility, assess the resident's future home to determine if his needs could be met. -The facility failed to update the care plan with new interventions following the initiation of an involuntary discharge on [DATE]. -Review of Resident #58's electronic medical record (EMR) did not reveal documentation indicating Resident #58's physician had discussed the resident's discharge or assessed and documented the basis for determining the resident's needs could not be met in the facility and the resident required discharge. A notice of discharge was issued to Resident #58 on 11/18/24. The reason provided in the notice was that Resident #58 had endangered the safety and welfare of other residents as a result of sexually inappropriate behaviors. The notice gave Resident #58 until 12/3/24 (15-days) to discharge from the facility. The social services quarterly assessment, dated 1/17/25, revealed the resident had no active discharge plan and was to remain in the facility for long term care. The assessment included that the resident had no behaviors during the assessment period. -However, the facility had issued a notice of discharge on [DATE]. -Review of Resident #58's EMR did not reveal documentation pertaining to the facility-initiated discharge. Discharge communications were provided by the director of quality and safety (DQS) on 3/3/25 at approximately 11:00 a.m. and revealed the following: The DQS emailed the resident representative on 12/3/24 requesting a meeting to discuss the incident and the resident's discharge. The DQS emailed the resident's representative on 1/8/25 with a behavior contract to be signed by the resident and representative. The contract, dated 1/7/25, outlined the facility's expectations of what would be acceptable behaviors by Resident #58 in order to remain in the facility. (continued on next page)

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