STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065380	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Community Living Center at Fitzsimons	1919 Quentin St Aurora, CO 80045

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 - Some	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 observations, record review and interviews, the facility failed to ensure four (#127, #60, #45 and #92) of five residents reviewed for abuse out of 45 sample residents were kept free from abuse. Specifically, the facility failed to: -Prevent resident to resident physical abuse between Resident #127 and Resident #60, who had a known history of physically aggressive behaviors towards other residents and staff who he perceived to be in his personal space and had documented recent physically aggressive behaviors with staff; -Have timely effective interventions to protect Resident #127, who had a history of physical aggression and wandering into other residents' rooms and invading their personal space; and, -Prevent resident-to-resident sexual abuse of Resident #45 by Resident #92 on 5/29/24 and 9/16/24. Findings include: I. Facility policy and procedure The Abuse policy and procedure, revised 2/21/23, was provided by the nursing home administrator (NHA) on 11/21/24 at 1:22 p.m. It revealed in pertinent part, Physical abuse includes, but is not limited to hitting, slapping, punching, biting and kicking. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: aggressive and/or catastrophic reaction of residents; wandering or elopement type behaviors; resistance to care; outbursts or yelling out; and, difficulty in adjusting to new routines or staff. Residents at risk for abusive situations are identified and appropriate care plans are developed. II. Facility investigation of abuse between Resident #60 and Resident #127 on 11/17/24. The 11/17/24 abuse investigation documented an unwitnessed resident-to-resident physical altercation between Resident #60 and Resident #127. The staff observed the two residents on the floor fighting in the television room with one another after lunch. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Community Living Center at Fitzsimons	1919 Quentin St Aurora, CO 80045

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 - Some	The staff separated the two residents and Resident #127 said that Resident #60 had hit Resident #127 on the head with his shoes and Resident #127 hit Resident #60 back. Resident #127 sustained skin tears to his forehead and left hand. The investigation indicated the residents were separated and placed on 15-minute checks. It indicated the on duty nurse did a skin assessment and provided first aid to Resident #127 for his skin tears on his face and left hand. The facility substantiated the allegation of physical abuse at the conclusion of the internal investigation. III. Resident #60 A. Resident status Resident #60, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease (degenerative disease that causes involuntary movements), dementia with Lewy bodies and post traumatic stress disorder (PTSD). The 8/22/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required substantial/maximal assistance with toileting, partial/moderate assistance with personal hygiene, set up assistance with eating and was independent with bed mobility and transfers. The assessment did not indicate the resident exhibited physical behaviors towards others. B. Record review The trauma informed (PTSD) care plan, initiated 11/21/19 and revised 8/23/24, indicated Resident #60 had dementia with behavioral disturbances and had a history of physical altercations with peers and had been moved to three different units. It indicated he was at increased risk for physical altercations related to his increasingly poor impulse control and frustration tolerance. It indicated a trigger was someone invading his space or room. Interventions included administering antipsychotic medication, monitoring for behaviors, notifying the physician for increasing behaviors, monitoring the resident with other peers and intervening if interaction becomes aggressive, avoiding placing with a roommate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Quentin St Aurora, CO 80045	

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 - Some	The physical aggression care plan, initiated 9/22/22 and revised 11/17/24, indicated that Resident #60 had the potential of being physically aggressive towards the staff and other residents. It indicated on 1/25/23 he had a physical altercation with another resident when Resident #60 found the other resident in his bed, on 7/22/23 Resident #60 went into another resident's room had a physical altercation when he thought the other resident was in his house and on 4/22/24 Resident #60 raised his fist and threatened another resident. Interventions included analyzing and documenting what triggers and deescalates behaviors (initiated 9/22/22), providing physical and verbal cues to alleviate anxiety, goals for more pleasant behavior (initiated 9/22/22), monitoring and reporting the resident causing danger to self and others (initiated 9/22/22), redirecting the resident to stay near nurse station and show his room if needed (initiated 11/17/24), reminding the resident to ask for assistance to get peers out of his room, call light with sign to call for assistance when unwanted visitors found in his room, velcro stop sign across his door (initiated 9/22/22), providing a poster with his name redirecting to his room (initiated 7/24/23). Behavior monitoring of 15-minute checks for 72 hours initiated on 1/26/23, 7/24/23 and 11/17/24. -A review of Resident #60's comprehensive care plan did not reveal personalized interventions until 7/24/23, after the second documented physical altercation. The facility daily behavior monitoring, from 10/23/24 to 11/20/24, documented Resident #60 had physically aggressive behaviors including yelling/screaming, kicking/hitting, pushing/grabbing, pinching/scratching, biting on 10/31/24, 11/1/24 and 11/17/24. -However, a review of Resident #60's electronic medical record (EMR) did not reveal if the facility's routine daily behavior monitoring was for physically aggressive behaviors directed at staff or other residents. The 10/16/24 nursing progress notes documented Resident #60 hit a staff member and yelled that he needed a court order before receiving any care. He then hit other staff members and refused care from all staff members. The 10/31/24 nursing progress notes documented Resident #60 was resisting care to take off his wet underwear and was hitting, kicking and biting at staff members. The 11/17/24 nursing progress notes documented Resident #60 had an altercation with another resident and hit him on the face. He was to be monitored every 15-minutes for 72 hours. The house supervisor, the physician and the family were notified. IV. Resident #127 A. Resident status Resident #127, age [AGE], was admitted on [DATE]. According to the November 2024 CPO, diagnoses included type 2 diabetes mellitus and PTSD. The 9/30/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of seven out of 15. He required partial/moderate assistance with personal hygiene and was independent with eating, toileting, bed mobility and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE: 1919 Quentin St Aurora, CO 80045	

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 - Some	The assessment did not indicate the resident exhibited physical behaviors towards others. B. Resident observation and interview On 11/18/24 at 12:01 p.m. Resident #127 was observed with a cut on his left forehead that was covered with steristrips (wound closure strips) and a cut with a bruise on his left hand that was covered with steristrips. Resident #127 was interviewed on 11/18/24 at 3:41 p.m. Resident #127 said on the previous evening a large man reached out and grabbed his hand and hit him in the face. He said the incident made him a little bit afraid and he would defend himself if he had to. He said the police were there to investigate the incident the previous evening. He said he did not remember all the details and did not remember who hit him. C. Record review The wandering care plan, initiated 9/26/24 and revised 10/18/24, indicated Resident #127 wandered in and out of other residents' rooms and significantly intruded on the privacy of others. Interventions included offering pleasant diversion, identifying patterns of wandering and providing structured activities. The physical aggression care plan, initiated 10/22/24 and revised 11/12/24, indicated Resident #127 was at risk for physical aggression due to threatening posture, raising his fists, kicking and pushing staff. Interventions included analyzing circumstances, triggers and what deescalated behavior, observing behaviors with family, providing physical and verbal cues to alleviate anxiety, assisting to set goals for more pleasant behavior, giving choices about care and activities and monitoring for any signs of the resident posing danger to self and others. -A review of Resident #127's comprehensive care plan did not reveal personalized interventions to prevent further abuse from aggression by other residents. The 11/17/24 nursing progress note documented the staff found resident #127 on the floor fighting with another resident. Resident #127 told staff the other resident hit him on the head with his shoes and he hit him back. Resident #127 had a skin tear to the forehead and one on the left hand. The physician, the director of nursing (DON), the police and the NHA were notified. The 11/17/24 nursing progress note documented Resident #127 was on monitoring for a physical altercation with another resident. Steristrips were applied to the left forehead and left hand. V. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Quentin St Aurora, CO 80045	

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 - Some	Certified nurse aide (CNA) #6 was interviewed on 11/21/24 at 9:20 a.m. CNA #6 said Resident #60 and Resident #127 usually got along but on 11/17/24 they were on the ground fighting after lunch. She said Resident #127 was a recent transfer onto the unit due to his wandering. She said Resident #60 did not like anyone in his personal space or his room. She said the staff also kept a big stop sign across Resident #60's room to deter Resident #127 and other residents from going into his room. She said said the stop sign across the door did not stop Resident #127 or other residents from entering the room. She said Resident #127 liked morning activities to keep him busy and he liked conversation with other residents. She said currently both residents were on every 15-minute checks to monitor. Licensed practical nurse (LPN) #1 was interviewed on 11/21/24 at 12:45 p.m. LPN #1 said Resident #60 and Resident #127 were both fighters and Resident #60 could be aggressive. She said both residents were difficult to redirect. She said Resident #60 had other resident-to-resident physical altercations in the past, but she was not sure when or with whom. She said the stop sign across Resident #60's door did not stop Resident #127 or other residents from entering the room. LPN #1 said the only way to keep residents out of rooms was to redirect them away from those rooms. She said both residents were on frequent 15-minute checks for behavior monitoring. She said both residents had been interacting without further aggression since the incident. She said Resident #127 remembered he was in a fight but he did not remember with whom. The NHA was interviewed on 11/21/24 at 5:03 p.m. The NHA said the physical altercation between Resident #60 and Resident #127 happened on 11/17/24. She said it was an unwitnessed altercation and staff was unsure of who initiated the altercation. She said Resident #60 did not remember any details. She said he did have a history of being physically and verbally aggressive with staff and often refused care. She said she was not aware of him becoming physically aggressive with another resident and if he was it was more than a year ago. She said she was not aware Resident #60 did not like other residents in his personal space or room and was not aware that one of the interventions was a stop sign across his door. She said Resident #60 also had a personal history of being a boxer. The NHA said Resident #127 was a recent transfer onto the unit from another facility. She said Resident #127 was upset with being in a new environment and he was unable to smoke. She said those were the only instances of agitation that she was aware of for the resident. She said he was getting better as he was adjusting to his new environment. The NHA said the social worker and the unit manager (UM) were back and were currently still investigating the incident. She said once the investigation was completed and a root cause of the altercation was identified, additional interventions would be put into place. She said proactively, in any resident-to-resident physical altercation, initial interventions would be to separate the residents involved and place them on frequent every 15-minute behavior monitoring to ensure the safety of the residents.VI. Incidents of sexual abuse between Resident #45 and Resident #92 A. Incident on 5/29/24 The facility's abuse investigation, dated 5/29/24, documented the allegation occurred on 5/29/24 at approximately 2:00 a.m. It documented Resident #92 entered Resident #45's room while she was sleeping and began touching her genital area. It documented that the alleged incident lasted approximately five minutes, and Resident #45 did not consent or want the interaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE: 1919 Quentin St Aurora, CO 80045	

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 - Some	The investigation documented the social services director (SSD), the unit manager (UM) and the social services assistant (SSA) interviewed Resident #45 on 5/29/24 at 2:15 p.m. It documented that Resident #92 went into Resident #45's room and woke her up by touching her vaginal area. It documented Resident #45 asked Resident #92 what are you doing? and Resident #92 proceeded to touch her. It documented that Resident #45 said the incident lasted approximately five minutes and that she did not consent to the interaction or want it. Resident #45 was offered to go to the hospital for further evaluation and she agreed. The investigation documented the SSA and the deputy director (DD) interviewed Resident #92 on 5/30/24 at 11:15 a.m. It documented Resident #92 said he went into Resident #45's room, reached down there and then she woke up. Resident #92 said he touched Resident #45 for a couple of minutes and could not hear Resident #45 talk because he was not wearing his hearing aids. Resident #92 said Resident #45 did not move her hands or attempt to move his arm during the incident. He said Resident #45 normally liked when he touched her and that he had not acted differently than he had with her before. He also said he would not stop there again. The investigation included a statement, dated 5/31/24, from certified nurse aide (CNA) #8. CNA #8 said she had not witnessed anything different or concerning about Resident #45 and Resident #92. She said she heard registered nurse (RN) #3 ask Resident #92 why he was sneaking out of that room in the night. The investigation included a progress note, date unspecified, in which RN #3 documented she saw Resident #92 coming out of Resident #45's room and that he got a little nervous when he saw RN #3. RN #3 documented Resident #92 kept hushing her and later asked if she was going to inform Resident #45's roommate of what RN #3 saw. RN #3 documented she would report the incident to the day shift staff for them to notify the social services department. The investigation documented that the police, adult protective services (APS), the resident's families, the ombudsman, the resident's providers and the special victims unit were notified of the alleged incident. The investigation documented the plan of action included moving Resident #92 to a different unit and floor. It also documented Resident #92 was placed on one-to-one observation with 15-minute checks. It also included obtaining orders to send Resident #45 to the emergency room for further evaluation. The investigation documented Resident #45 had a sexual assault nurse examination completed in the emergency room. There was no documentation in the investigation indicating whether the abuse was substantiated or not. -However, sexual abuse occurred due to Resident #92's willful touching of Resident #45's genital area without her consent. B. Incident on 9/16/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE: 1919 Quentin St Aurora, CO 80045	

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 - Some	The investigation report, dated 9/16/24, documented the alleged event occurred on 9/16/24 at 10:00 a.m. It documented the activities director (AD) observed Resident #45 and Resident #92 leaving an activity. The AD observed Resident #92 going up to Resident #45 and touching her breasts. The AD told Resident #92 to stop the inappropriate behavior in a public area and he did. The residents were immediately separated. The police, APS, the ombudsman, the resident's family and the residents' providers were notified of the alleged incident. The investigation documented Resident #45 was interviewed on 9/16/24 at 12:20 p.m. by the SSD, the SSA and the UM. Resident #45 said Resident #92 propelled his wheelchair to her and promptly grabbed her breast with his hand. She said she did not ask him to do this and told him no, not here, after which he stopped. It documented that no changes in Resident #45's behavior were observed. The investigation documented Resident #92 was interviewed on 9/16/24 at 2:00 p.m. by the SSD and the SSA. It documented Resident #92 initially said no when asked if anything unusual occurred after the facility activity, however, he later admitted to touching Resident #45 when he was informed that facility staff knew about the incident. It documented Resident #92 got defensive when informed Resident #45 did not provide consent and that she did not like being intimately touched in public areas. It documented the SSD educated Resident #92 on the definition of consent. The investigation documented the AD was interviewed on 9/16/24 at 1:16 p.m. The AD said she observed Resident #92 roll up to Resident #45 without saying anything and touch her breasts. The AD said she told Resident #92 to keep his hands to himself and he stopped touching Resident #45 after the AD repeated herself a second time. The investigation documented the plan of action included immediately educating Resident #92 about consent, boundaries and inappropriate behaviors in public areas. It also documented Resident #92's intimacy care plan was updated to reflect he would obtain staff assistance to ensure any future intimate encounters were consensual, safe and private. The investigation concluded the abuse was substantiated. VII. Resident #92 - assailant A. Resident status Resident #92, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included major depressive disorder, type 2 diabetes mellitus, dementia, spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord), anxiety disorders and obesity. The 9/9/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. He was dependent on staff for total assistance for oral and toileting hygiene, dressing and all transfers. He needed moderate assistance with bathing and moving from a lying to a sitting position, and was independent with eating and moving left to right in bed. The MDS assessment documented the resident had a hearing aide or other hearing appliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE: 1919 Quentin St Aurora, CO 80045	

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 - Some	B. Record review The behavior care plan, initiated 5/29/24 and revised 9/17/24, revealed Resident #92 had previously had an intimate relationship with a female resident on the second floor. The care plan documented that due to an allegation by the female resident that his sexual behavior toward her in May 2024 was not wanted at the time it occurred, he was moved to the first floor. The care plan indicated Resident #92 had some decline in cognition due to dementia and he might have been experiencing disinhibition of sexual expression as a result. The care plan documented Resident #92 touched the female resident in a nonconsensual sexual manner on 9/16/24. The care plan documented Resident #92 and the female resident had expressed a desire to have intimate encounters at times in a private area and not in the female resident's room. The care plan documented Resident #92 needed reminders of the environment in which he could have consensual intimate encounters that were appropriate and safe such as a private area, not in a public place and away from the female resident's room. Pertinent interventions included discussing Resident #92's behavior with him and explaining or reinforcing what behavior was appropriate if he wished to have an intimate experience with the female resident, such as a private place to meet, obtaining consent from the female resident and honoring her choice if she did not wish to engage in an intimate encounter at any given time (initiated 5/29/24 and revised 9/18/24), staff to address the resident's needs for intimacy and sexual expression in safe and socially appropriate way (initiated 5/31/24) and encouraging the resident to approach social services or nursing staff if he needed assistance locating a safe and private area to engage in an intimate encounter with the female resident (initiated 9/18/24). The cognitive deficit care plan, initiated 9/17/24, documented Resident #92 had a decline in his cognition due to his diagnosis of dementia and he had slight difficulty recalling information at times. He forgot at the moment but might recall it later. He needed staff to provide reminders of information that was important to him. Pertinent interventions included encouraging the resident to seek out staff if he needed information about recent events and appointments. An additional behavior care plan, initiated 9/19/24, documented Resident #92 had used sexual gestures with female staff showing his middle finger and asking if staff wanted some and had tried to hold the hands of staff when they administered him medications or other items. He had been identified as having poor impulse control due to his progression of dementia and needed reminders of the staff's role and to have limits set with sexual behavior. He was able to understand communication from others despite his cognitive deficit. Pertinent interventions included staff were to inform Resident #92 what care was being provided so he knew what to expect, if Resident #92 used sexually-suggestive language or tried to hold staff's hand in an inappropriate manner, staff was to tell the resident in a calm way that staff's role was to address his care needs and request he refrain from using this language or trying to touch staff in a sexual manner (initiated on 11/1/24). Resident #92's sexual intimacy capacity for consent assessment was completed on 5/9/24. The assessment documented the resident showed the ability to answer yes/no questions accurately, was physically able to leave an undesirable situation and verbally or non-verbally able to alert others when needing help. The interaction pattern documented his interactions with resident #45 as friendly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE: 1919 Quentin St Aurora, CO 80045	

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 - Some	-However, the facility failed to complete an updated assessment after it was noted the resident had a decline in cognition due to his diagnosis of dementia. A nurse progress note, dated 5/29/24 at 6:43 a.m., documented Resident #92 was seen coming out of Resident #45's room. Resident #92 got nervous when he saw the nurse and kept hushing her. The note said the nurse would report the incident to the day shift for them to notify social services notification. A nurse progress note, dated 5/29/24 at 4:23 p.m., documented the UM and the director of nursing (DON) discussed the incident with Resident #92. He was notified that they were told he inappropriately touched Resident #45. Resident #92 said it was true and he would not do it again. The social worker, Resident #92's power of attorney and his provider were notified. Fifteen minute checks were started. -A review of Resident #92's electronic medical record (EMR) did not reveal documentation regarding the incident on 9/16/24. VIII. Resident #45 - victim A. Resident status Resident #45, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 CPO, diagnoses included multiple sclerosis (degenerative muscle disease), mild cognitive impairment of unknown origin, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood and morbid obesity. The 9/16/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for assistance with toileting hygiene, transfers, dressing and bathing. She was independent in eating and oral hygiene. B. Resident interview Resident #45 was interviewed on 11/19/24 at 12:30 p.m. Resident #45 said Resident #92 went into her room around 2:00 a.m., the night of the incident and inappropriately touched her genital area. She said she did not feel afraid of Resident #92 and said she told him no and to get out when she caught him. She said a nurse saw Resident #92 leaving her room and the police were notified. Resident #45 said she did not want to press charges because he's a good guy, but she did want Resident #92 to be reprimanded. C. Record review The behavior care plan, initiated 4/21/21 and revised 6/4/24, documented Resident #45 was at risk for financial exploitation due to her previously sending money to men overseas. The care plan also documented she was involved in a three-way relationship with herself and two peers and all had consented to sexual intimacy. Pertinent interventions included discussing Resident #45's behavior with her and explaining or reinforcing why the behavior was inappropriate or unacceptable and educating Resident #45 to yell for help, use her call light and report any non-consensual sexual behavior towards her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Veterans Community Living Center at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Quentin St Aurora, CO 80045	

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 - Some	Resident #45's cognitive decline care plan, initiated 4/23/21 and revised 8/11/21, documented she had impaired cognitive functioning due to her diagnosis of multiple sclerosis and she had difficulty making decisions and some short-term memory issues. Pertinent interventions included communicating with Resident #45 and her guardian regarding the resident's capabilities and needs, cueing, reorienting and supervising as needed and presenting just one thought, idea, question or command to the resident at a time. A sexual intimacy capacity for consent assessment form was completed on 5/9/24. The assessment documented the resident showed the ability to answer yes/no questions accurately, was physically able to leave an undesirable situation and verbally or non-verbally able to alert others when needing help. The interaction pattern documented she had no concerns with her interactions with Resident #92, however, she was having fewer interactions with him because she did not want to upset her other partner/roommate. A second sexual intimacy capacity for consent assessment form was completed on 9/18/24. The assessment documented the resident showed the ability to answer yes/no questions accurately, was physically able to leave an undesirable situation and verbally or non-verbally able to alert others when needing help. The interaction pattern documented her interactions with resident #92 as friendly, and that both residents wished to be friends and have intimate encounters. However, Resident #45 said she wanted parameters in place which included no sexual activity in a public place, no surprises and for her to give consent. An interdisciplinary team (IDT) risk management review note, dated 5/29/24 at 2:00 a.m. documented Resident #45 was inappropriately touched by a male resident. The resident's provider and guardian were notified and physician's orders were obtained to send Resident #45 to the emergency room for evaluation and treatment. It also documented that interventions included placing Resident #45 on another unit for her safety upon return from the emergency room. -Resident #45 had a sexual assault nurse examination completed in the emergency room. She was discharged back to the facility with orders to continue previously ordered antibiotic therapy for a urinary tract infection. -A review of Resident #45's EMR did not include documentation regarding the incident on 9/16/24. IX. Staff interviews The SSD and the SSA were interviewed together on 11/21/24 at 3:05 p.m. The SSD said the situation between Resident #45 and Resident #92 was very complex. She said Resident #92 was moved to a different unit and floor after the incident in May 2024. She said Resident #45 was seen making contact with Resident #92 after the May 2024 incident. The SSD said Resident #45 was not great at setting boundaries for herself and that she encouraged both residents to remain apart, however, they both voiced they still wanted to be friends. The SSD said she was unsure if Resident #92 fully understood the provided education on boundaries and consent. The SSA said Resident #45 was interested in a romantic relationship with Resident #92, however, she was not okay with surprise interactions and him not asking beforehand. He said he was unsure if Resident #92 fully understood the education staff provided on boundaries and consent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Community Living Center at Fitzsimons	1919 Quentin St Aurora, CO 80045

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 - Some	The NHA and the divisional social worker (DSW) were interviewed together on 11/22/24 at 5:02 p.m. The NHA and the DSW both said Resident #45 and Resident #92 considered themselves boyfriend and girlfriend before the incident on 5/29/24 and it was the first time he approached her at night. The DSW said Resident #45 was not cognitively impaired. She said she could be manipulative. She said Resident #92 was less cognitively intact and he was intermittently confused. She said Resident #92 had sexual impulses and poor impulse control due to cognitive decline. She said he was receptive to education regarding consent prior to contact with others. The DSW said that the facility's sexual intimacy capacity for consent assessment form did not need to be signed by residents and was based on the resident's observed body language, the providers' input and the residents' statements. The DSW said the assessments were filled out by the SSD and the unit social worker and were completed quarterly or for a change of condition. She did not specify why a new assessment was not completed for Resident #92 after the incident in May 2024 or when his cognitive decline was observed. The NHA said Resident #92 was moved to a separate unit immediately after the first incident on 5/29/24. She said it was easier for staff to identify when Resident #92 was going to a different unit and help ensure Resident #45's safety. She said it had been more effective having both residents on separate floors and that new staff were alerted to potential issues when oriented to the floor. She said it was ultimately the nurse's responsibility to alert staff of any issues before their shift.