

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Englewood Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3575 S Washington St Englewood, CO 80113	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to thoroughly investigate resident-to-resident allegations of physical abuse and staff-to-resident allegations of neglect of care to prevent further instances of abuse and residents from feeling neglected for two (#60 and #18) of four residents out of 40 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Develop a care plan focus for Resident #18, who had a known history of aggressive behaviors towards others and a history of discharge from other facilities due to aggressive behavior; -Gather all pertinent unbiased observations to identify pertinent facts of the events that occurred before, during and immediately following the incident to determine necessary interventions to prevent further abuse. This could include but not limited to observations of the assailant's behavior; words; gestures; facial expression; demeanor; tone and volume of voice; proximity and assailant and victim during the incident; and other applicable details and responses of each resident; -Investigate the extent and medical implications of the assailant's alleged hallucinations to determine if they could occur in other settings including common areas of the facility if the resident fell asleep or experienced similar conditions that occurred during this reported incident on 9/24/24; and, -Complete thorough investigations of the alleged violation of resident-to-resident physical abuse between Resident #18 towards Resident #60 that included sufficient evidence to allow the nursing home administrator (NHA) to determine what actions were necessary to protect the victim, Resident #60, and others residents in the facility from potential abuse by Resident #18 when in common areas of the facility. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse Prevention of and Prohibition Against Policy, revised October 2024, was provided by the NHA on 11/04/24 at 9:00 a.m. It read in pertinent part, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065077
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>All identified events are reported to the administrator immediately.</p> <p>A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse.</p> <p>All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the administrator or his/her designee;</p> <p>An interview will be conducted with staff members (on all shifts) who may have information regarding the alleged incident.</p> <p>Interviews will be conducted with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident.</p> <p>The investigation will include the following:</p> <ul style="list-style-type: none"> -An interview with the person(s) reporting the incident; -An interview with the resident(s); -Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; and, -A review of the resident's medical record, including a review of all circumstances surrounding the incident. <p>At the conclusion of the investigation, the facility will attempt to determine if abuse, neglect, misappropriation of resident property, or exploitation has occurred. The investigation, and the results of the investigation, will be documented.</p> <p>If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves another resident, the facility will continue to assess, monitor and intervene as necessary to maximize resident health and safety.</p> <p>At the conclusion of the investigation, the facility will take action, as necessary, in light of the information gathered, which may include but is not limited to:</p> <ul style="list-style-type: none"> -If the allegation is substantiated, analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property, or exploitation occurred, and determining what changes are needed to prevent further occurrences; and, -Defining how care provision will be changed and/or improved to protect residents receiving services, if appropriate <p>II. Resident to resident allegation of physical abuse towards Resident #60 by Resident #18 on 9/24/24</p> <p>A. Facility investigation</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Description of the incident</p> <p>The facility investigation, dated 9/25/24, revealed that nursing staff found Resident #18 standing over Resident #60 who was in bed. Resident #60 was holding on to Resident #18. The nurse separated the two residents. The responding nurse was not sure of what had occurred at the time of the intervention.</p> <p>A nursing note, in Resident #18's electronic medical record (EMR), dated 9/24/24 at 10:30 p.m. and written by the responding nurse, revealed that the nurse went to Resident #60 and Resident #18's room to answer the call light. Upon entering the room, the nurse observed Resident #60 sitting on the side of his bed holding on to the wrist of Resident #18. The nurse separated the two residents and took Resident #18 to the bathroom.</p> <p>-The nursing note failed to provide an assessment of Resident #18's cognitive status or assess his state of mind other than he was calm and cooperative as he was separated from Resident #60. There was no indication if the resident was assessed for consciousness or other altered state of mind as he was observed standing over Resident #60.</p> <p>2. Witness statements</p> <p>Resident #60 was interviewed by staff just after the incident. Resident #60 said he woke up to find Resident #18 standing over him punching him in the left cheek with a closed fist. Resident #60 said he pushed Resident #18 off of him and held him by the wrist until the nurse was able to remove him.</p> <p>Resident #18 was interviewed by staff just after the incident. Resident #18 said he did not know what was going on and he did not have a problem with his roommate so he must have been hallucinating.</p> <p>A nursing note, dated 9/24/24 at 10:30 p.m., documented that Resident #18 was unable to tell the responding nurse what had occurred and that he did not know why he did that or what he did. Resident #18 said he did not mean it and apologized to Resident #60 several times then said I must have been hallucinating. The residents were moved to separate rooms pending an investigation.</p> <p>-There was no documentation in the investigative report indicating that the investigator asked the responding nurse for detailed information on the exact words of the residents involved or if she had any indication that Resident #18 might have been in an altered state or appeared to have been hallucinating at the time of discovery. There was no indication of which resident turned on the call light or why the call light was turned on in the first place.</p> <p>B. Resident #60 (victim)</p> <p>1. Resident status</p> <p>Resident #60, age [AGE], was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included cognitive communication deficit, generalized muscle weakness and acute respiratory disease.</p> <p>The 10/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident did not display</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD said following the allegation/incident of physical abuse, the IDT implemented interventions for increased monitoring of Resident #18 that included daily visits from social services to assess the resident for risk of aggression and 15-minute checks by nursing staff to ensure he remained calm. She said these interventions remained in place for 72 hours after the incident occurred. She said, in that time, facility staff did not see any evidence of repeated aggression, so the monitoring interventions were considered completed.</p>		