

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Ridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 E 66th Way Commerce City, CO 80022	

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 take steps to protect one (#19 and #256) of eight residents from physical abuse out of 45 sample residents reviewed for abuse.</p> <p>Specifically, the facility failed to prevent Resident #19 from physical abuse by Resident #256.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse: Prevention of and Prohibition Against policy, revised 11/29/23, was provided by the director of nursing (DON) on 7/10/24 at 2:28 p.m. It read in pertinent part,</p> <p>Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>II. Incident of physical abuse between Resident #256 and Resident #19 on 6/13/24</p> <p>A. Facility investigation of the altercation on 6/13/24</p> <p>The witness statement, dated 6/13/24, written by a certified nurse aide (CNA), documented Resident #256 and Resident #19 were sitting at the dining room table. The residents went back and forth talking to each other. They told each other to be quiet. They said do not tell me what to do and I will knock the black out of you. Resident #256 grabbed a hold of Resident #19's hair and would not let go.</p> <p>The 6/13/24 nurse incident note revealed Resident #256 and Resident #19 were sitting at the dining room table. They were talking back and forth telling each other to be quiet. The note documented the residents were saying do not tell me what to do and I will knock the black out of you. The staff went to separate the residents and Resident #256 grabbed Resident #19's hair and did not want to let go. The unit nurse, the therapist and another staff member separated the residents and redirected both residents from one another. The therapist took Resident #256 outside for redirection and distraction. Resident #19 was redirected and removed to an alternate area. The progress note documented no skin changes were noted on either resident. The progress note documented neither resident recalled the</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: 065283	If continuation sheet Page 1 of 3

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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>event and remained at baseline.</p> <p>The facility's conclusion of the internal investigation was Resident #256 pulled Resident #19's hair.</p> <p>The facility's investigation summary revealed Resident #256 was sent to a higher level of care on 6/13/24 for the safety of self and others and for psychosocial safety and stabilization.</p> <p>The facility investigation revealed Resident #256 had four incidents with other residents prior to the incident on 6/13/24.</p> <p>Resident #256 had an incident on 2/23/24, 2/24/24, 4/10/24 and 4/28/24 with other residents The interventions for each incident included to redirect the resident and provide frequent checks.</p> <p>-Resident #256 and Resident #19 had a previous incident on 4/28/24.</p> <p>-Review of Resident #256's comprehensive care plan did not reveal There were not new person-centered interventions after Resident #256 was involved in multiple resident to resident altercations (see care plan below).</p> <p>B. Resident #256 - assailant</p> <p>1. Resident status</p> <p>Resident #256, age greater than 65, was admitted on [DATE] and discharged on 6/13/24 to a local hospital. According to the June 2024 computerized physician orders (CPO), diagnoses included vascular dementia, cognitive communication deficit and muscle weakness.</p> <p>The 4/25/24 minimum data set (MDS) assessment revealed the resident's cognitive status was severely impaired with a brief interview for mental status (BIMS) score of three out of 15.</p> <p>The MDS assessment did not identify the resident displayed behaviors during the assessment period.</p> <p>2. Record review</p> <p>The care plan, dated 2/19/24 and revised 6/20/24, identified the resident had verbal and physical aggression related to her dementia. Resident #256 was agitated when staff attempted to assist her and she responded physically when she became frustrated. Interventions included monitoring the resident and her surroundings to minimize known stressors such as multiple residents too close to the resident (5/23/24) and redirecting as needed(5/10/24).</p> <p>-The care plan did not identify new interventions implemented after the 2/23/24 and 2/24/24 resident to resident altercation incidents.</p> <p>C. Resident #19 - victim</p> <p>1. Resident status</p> <p>Resident #19, age [AGE], was admitted on [DATE]. According to the July 2024 CPO, diagnoses included</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>Alzheimer's disease and dementia.</p> <p>The 5/17/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of one out of 15.</p> <p>The MDS assessment identified the resident displayed verbal behaviors toward others.</p> <p>2. Record review</p> <p>The care plan, revised 7/15/24, identified the resident had a history of being verbally and physically aggressive if others were in her walking path and she could become aggressive if another resident had an object she wanted. Interventions include offering to take her outside (5/17/24) and redirecting her when she yelled at others (6/20/24).</p> <p>V. Staff interviews</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 6/15/24 at 2:12 p.m. He was familiar with Resident #256. LPN #2 said he was not present on 6/13/24 when the altercation took place. He said he was aware Resident #256 and Resident #19 were involved in a resident to resident altercation. He said the residents that resided in the secured unit were confused and often argued among themselves. LPN #2 said he stepped in when arguing occurred, tried to separate the residents when they argued and he tried to distract the residents.</p> <p>The nursing home administrator (NHA) was interviewed on 7/16/24 at 10:57 a.m. The NHA said the 6/13/24 altercation between Resident #265 and Resident #19 was substantiated as physical abuse. He said after the altercation, the facility immediately separated the residents and redirected them. The NHA said the intervention used to prevent the 6/13/24 altercation was to redirect the resident. The NHA said this intervention was not effective.</p>