STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

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 two (#15 and #42) of five residents out of 30 sample residents were kept free from abuse. Specifically, the facility failed to: -Ensure Resident #15 was kept free from physical abuse by Resident #13; and, -Ensure Resident #42 was kept free from physical abuse by Resident #58. Findings include: I. Incident of physical abuse between Resident #13 and Resident #15 on 1/15/25 A. Facility investigation The 1/15/25 facility abuse investigation, documented at 2:00 p.m., revealed that Resident #13 was ambulating with his front wheel walker when Resident #15, who was seated, reached out and touched or grabbed Resident #13's left wrist. Resident #13 asked Resident #15 to let go. When Resident #15 did not let go, Resident #13 grabbed Resident #15 by the back of his neck, shook him and told him not to touch him. The staffing coordinator (SC) witnessed the incident. The SC immediately separated the residents and reported the incident to the nursing home administrator (NHA). The director of nursing (DON) assessed Resident #15's neck and observed no injury. The investigation documented Resident #15 had severe dementia and would reach out and grab things and people at times. Resident #13 was interviewed by the NHA and the DON following the incident. Resident #13 said, Oh sure, he would say that when told the incident had been reported. When the staff explained that someone else witnessed the incident, Resident #13 said, I was walking by and he grabbed my arm. I don't like that, so I grabbed his neck. The investigation documented the SC provided a written witness statement. The SC said she was coming out of her office when she saw Resident #15 in his doorway and Resident #13 was walking by. She said Resident #15 reached out and grabbed Resident #13's left wrist. She said Resident #13 shouted, Don't touch me and then grabbed Resident #15 by the neck and shook him with his right hand. The SC said she went over and separated them. She said when she separated the residents, Resident #15 struck (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her. The SC said Resident #13 responded, He grabbed me and I don't like that. The investigation documented the facility determined Resident #13 did shake the neck of Resident #15. The intervention included having the activities department and therapy assess different items Resident #15 could hold to help decrease his reaching out, as he was very tactile at that time. Resident #13 was educated to walk away or ask for help in these situations and that grabbing and shaking people was not acceptable. The facility added physical aggression to Resident #13's care plan. The investigation concluded the abuse was substantiated as the action by Resident #13 was willful. B. Resident #15 - victim 1. Resident status Resident #15, age [AGE], was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included dementia, Alzheimer's disease and cognitive communication deficit. The 1/16/25 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory impairment and required substantial assistance with decisions regarding tasks of daily life, per staff assessment. The MDS assessment revealed the resident did not display physical behaviors directed towards others during the assessment period. 2. Record review The behavioral care plan, initiated 8/5/23 and revised 1/27/25, documented Resident #15 had a history of involvement in physical altercations with other residents, both received and initiated. It indicated Resident #15 had impaired cognitive functioning and impaired thought processes related to dementia and struck out if startled and became agitated if overstimulated. Pertinent interventions included monitoring and recording the occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate responses to verbal communication, and violence or aggression toward staff or others and taking the resident to a quieter area and away from other residents if he became agitated due to overstimulation. C. Resident #13 - assailant 1. Resident status Resident #13, age [AGE], was admitted on [DATE]. According to the April 2025 CPO, diagnoses included Parkinson's disease (a disease that causes involuntary movements). The 1/12/25 MDS assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required partial to moderate assistance from one staff member with toileting, dressing and personal hygiene. 2. Record review The behavioral care plan, initiated 8/13/24 and revised 1/21/25, documented the resident had a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history of episodes of declining medications and care despite education. It documented the resident exhibited unprovoked verbally and physically aggressive behavior toward others at times. Pertinent interventions included assisting the resident to develop more appropriate methods of coping and interacting, encouraging the resident to express his needs and feelings appropriately, explaining and reinforcing to the resident why the behavior was inappropriate or unacceptable, intervening as necessary to protect the rights and safety of others, approaching and speaking to the resident in a calm manner, diverting the resident's attention, removing the resident from the situation and taking the resident to an alternate location as needed. II. Incident of physical abuse between Resident #42 and Resident #58 on 12/28/24 A. Facility investigation The 12/28/24 facility abuse investigation, documented at 6:58 p.m., revealed Resident #42 and Resident #58 were in the television common room when they began loudly arguing and yelling at one another. Resident #42 told Resident #58 to shut up and go away. Resident #58 attempted to push Resident #42's wheelchair, but instead pushed the resident directly, causing him to fall from the wheelchair onto the floor. Resident #42 landed on his right side and sustained two small skin tears to his right forearm. Staff immediately separated the residents and returned each resident to their respective room. Resident #42 was assessed by the registered nurse (RN) on duty, who provided first aid treatment to the skin tears that were sustained to the right forearm. Resident #42 later developed bruising to his right hip and buttock area. The facility notified the physician, the family members, the DON, the NHA, the police and the ombudsman. Resident #42 was upset, but reported he was not afraid of Resident #58. Resident #58 said he was trying to push Resident #42's wheelchair away and did not realize his strength. Resident #58 had a history of verbal aggression toward staff when told he could not go home but typically calmed when reminded he was staying at the facility short-term before moving to his son's house. The facility substantiated the physical abuse of Resident #42 by Resident #58, which resulted in two skin tears. B. Resident #42 - victim 1. Resident status Resident #42, age [AGE], was admitted on [DATE]. According to the April 2025 CPO, diagnoses included weakness, abrasion of lower back and cognitive communication deficit. The 12/21/24 MDS revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. The resident required partial to moderate assistance from one staff member with showers. The MDS assessment documented the resident did not display physical behaviors directed towards others during the assessment period. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review The 1/2/25 head-to-toe skin assessment revealed the resident had existing bruises on the right hip and buttock. The assessment also revealed an existing skin tear on the right forearm, which was covered with a dry dressing and showed no signs or symptoms of infection. C. Resident #58 - assailant 1. Resident status Resident #58, age [AGE], was admitted on [DATE] and discharged on 1/4/25. According to the January 2025 CPO, diagnoses included dementia with other behavioral disturbances, multiple sclerosis and hearing loss. The 1/22/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. The resident required substantial assistance with oral hygiene, dressing, transferring, and toileting. The MDS assessment indicated the resident had verbal behaviors directed towards others. III. Staff interviews The DON and the NHA were interviewed on 4/3/25 at 4:15 p.m. The NHA said that as soon as an abuse situation was identified, the staff should separate the residents to ensure their safety. She said the facility staff should immediately notify the NHA and the DON so that the investigation could begin promptly. The DON said Resident #15, who often reached out toward others, grabbed Resident #13's arm as Resident #13 passed by. The DON said Resident #13 asked Resident #15 not to touch him. The DON said when Resident #15 did not respond appropriately, Resident #13 grabbed Resident #15 by the back of his neck. She said Resident #13 later admitted he should not have reacted that way. The NHA said the facility substantiated physical abuse by Resident #13 toward Resident #15. She said Resident #13 was willful in his actions. The NHA said Resident #58 was at the facility for a short respite stay. The DON said Resident #58 and Resident #42 got into a verbal altercation in the common room and Resident #42 told Resident #58 to shut up and go away. The DON said Resident #58 attempted to push Resident #42's wheelchair but instead pushed Resident #42, causing him to slide out of his chair and sustain two skin tears to his right arm. The DON said that Resident #58 admitted to pushing Resident #42 out of his chair. The DON said the incident was substantiated as Resident #58 was willful in his actions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities for one (#24) of three residents out of 30 sample residents. Specifically, the facility failed to provide timely toileting assistance or incontinence care for Resident #24. Findings include: I. Resident #24 A. Resident status Resident #24, age [AGE], was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), cognitive communication deficit and unsteadiness on feet. The 2/27/25 minimum data set (MDS) assessment revealed the resident had severe impairment in making decisions regarding tasks of daily life, per the staff assessment for mental status. He required substantial assistance with oral care, personal hygiene, toileting, bathing, dressing and transferring. B. Observations During a continuous observation on 4/1/25, beginning at 1:08 p.m. and ending at 4:50 p.m., the following was observed: At 1:08 p.m. Resident #24 was lying on the bed in his room, sleeping. At 1:13 p.m. an unidentified staff member entered the resident's room and removed his lunch tray. At 4:16 p.m. two unidentified staff members entered Resident #24's room. The staff members asked if Resident #24 wanted the television turned on and if he preferred the window to be closed. The staff members turned on the television and exited the room. -Staff did not check Resident #24 for incontinence or provide toileting assistance to the resident during the nearly four hour continuous observation. During a continuous observation on 4/2/25, beginning at 8:25 a.m. and ending at 2:10 p.m., the following was observed: At 8:25 a.m. Resident #24 was eating breakfast in the dining room. At 9:00 a.m. the resident was taken from the dining room to the common area to watch television, with a pillow on his lap and his right arm resting on the pillow. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:22 a.m. an unidentified staff member wheeled Resident #24 to the indoor gardening activity. -Resident #24 was not checked for incontinence or offered any toileting assistance prior to being taken to the activity. At 11:54 a.m. an unidentified staff member wheeled Resident #24 to the chapel for lunch. -The resident was not checked for incontinence or offered toileting assistance prior to being taken to lunch. At 12:40 p.m. Resident #24 finished eating lunch and was wheeled to his room by certified nurse aide (CNA) #1 and assisted to bed. -CNA #1 did not check the resident for incontinence or offer toileting assistance after lunch. At 12:45 p.m. Resident #24 was sleeping in bed. At 2:02 p.m. Resident #24's skin was observed with CNA #1. CNA #1 said Resident #24 was soiled with urine and had a bowel movement. CNA #1 provided incontinence care and changed the resident's brief at that time. -Resident #24 went over five hours without being checked for incontinence or being offered toileting assistance. C. Record review The ADL care plan, updated 6/3/24, documented Resident #24 had self-care deficits related to decreased mobility, limited range of motion, a mild right hemiparesis and a cognitive deficit. The resident required supervision and cueing with ADLs. Pertinent interventions included offering and providing assistance with toileting and incontinence care per protocol, conducting routine skin checks per protocol and providing incontinence care promptly after incontinence episodes. According to the CNA task documentation for bladder incontinence, Resident #24 received incontinence care on 4/22/25 at 9:00 a.m. -However, a continuous observation of the resident conducted at that same time revealed the resident was in the common area watching television (see observations above. III. Staff interviews CNA #1 was interviewed on 4/2/25 at 2:02 p.m. CNA #1 said Resident #24 required a pivot transfer. He said he was able to transfer Resident #24 pretty quickly. He said Resident #24 was incontinent and required assistance with incontinence care. He said Resident #24 should be checked every two hours and changed when needed. He confirmed Resident #24 was soiled with urine and a bowel movement when he provided incontinence assistance at 2:02 p.m. after not being checked or changed for over five hours. The director of nursing (DON) was interviewed on 4/3/25 at 4:15 p.m. The DON said facility staff should conduct rounds on residents approximately every two hours. The DON said during these rounds, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident should be checked to determine if they had an episode of incontinence. She said if a resident was found to be incontinent, staff should offer incontinence care to the resident.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to assist residents to obtain routine or emergency dental services, as needed, for one (#12) of one resident reviewed for ancillary services out of 30 sample residents. Specifically, the facility failed to ensure a dental referral was followed upon timely for Resident #12. Findings include: I. Facility policy and procedure The Resident Dental Services policy and procedure, dated December 2016, was provided by the nursing home administrator (NHA) on 4/3/25 at 4:30 p.m. It revealed in pertinent part, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist that comes to the facility monthly, referral to the resident's personal dentist, referral to community dentists, or referral to other health care organizations that provide dental services. Social services representatives will assist residents with appointments, transportation, arrangements, and for reimbursement of dental services under the state plan, if eligible. Direct care staff will assist residents with denture care, including removing, cleaning, and storing dentures. If dentures are damaged or lost, residents will be referred for dental services within three days. If the referral is not made within three days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services and the reason for the delay. II. Resident #12 A. Resident status Resident #12, age [AGE], was admitted on [DATE] and re-admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included bipolar disorder, left hemiplegia (paralysis on one side of the body) following cerebral infarction, major depressive disorder and post-traumatic stress disorder. The 2/20/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required maximum assistance with transfers and bed mobility and moderate assistance for bathing, toileting, dressing and personal hygiene. B. Resident interview Resident #12 was interviewed on 4/1/25 at 9:55 a.m. Resident #12 said she had had pain in her bottom jaw for a long time now. She said she saw the dentist at the facility quite a few months prior and was still waiting for another appointment. She said she had not received any communication from the facility on when her dental appointment would be. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 said she was having pain, but was still able to eat. C. Record review The 4/24/24 dental progress note revealed Resident #12 presented with soreness in the lower jaw. The 11/13/24 dental progress note revealed Resident#12 was seen for treatment due to soreness in the lower jaw and indicated the resident experienced tenderness to the lower ridge. The dentist documented a referral for the resident to have an alveoloplasty (a surgical procedure where the jawbone is reshaped and smoothed, particularly after tooth extraction, to prepare for dentures or dental implants) of her lower ridge (alveolar ridge located just below the bottom teeth). A review of Resident #12's electronic medical record (EMR) did not reveal documentation the facility had followed up on the dental referral from 11/13/24. III. Staff interviews The NHA was interviewed on 4/3/25 at 1:42 p.m. The NHA said the social services department was responsible for the coordination of all ancillary services, including dental care. She said the facility was currently in the process of hiring social services staff. The NHA said she was unable to find documentation that the dental referral had been made for Resident #12, based on the dentist's recommendation from November 2024. She said she would contact the dentist to determine where Resident #12 should be sent for the procedure.