STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065361	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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 - 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 interviews and record review, the facility failed to ensure two (#2 and #1) of three residents were kept free from abuse out of three sample residents. Specifically, the facility failed to ensure Resident #2 was free from physical abuse by certified nurse aide (CNA) #1. On 1/21/25, CNA #1 entered Resident #2's room to provide care. CNA #1 roughly repositioned Resident #2 with pillows and forcefully pushed Resident #2 toward the wall, causing a loud thud. Resident #2 cried out in pain multiple times, asking CNA #1 to stop being rough with her. The facility failed to initiate an abuse investigation and make a report to the state agency after Resident #2's family reported CNA #1 was rough toward Resident #2 when providing care. The rough care provided by CNA #1 toward Resident #2 caused Resident #2 physical pain and mental anguish as evidenced by her crying out and asking CNA #1 repeatedly to stop and not treat her that way. Additionally, the facility failed to protect Resident #1 from abuse from licensed practical nurse (LPN) #1. Findings include: I. Facility policy and procedure The Abuse Prevention policy and procedure, undated, was provided by the nursing home administrator (NHA) on 3/6/25 at 1:55 p.m. It read in pertinent part, Our residents have the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, corporal punishment and involuntary seclusion. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individuals. The Abuse Investigations policy and procedure, undated, was provided by the NHA on 3/6/25 at 1:55 p.m. It read in pertinent part, All reports of alleged or suspected abuse, neglect, exploitation, misappropriation of resident property, mistreatment of residents and injuries of unknown source shall be promptly and thoroughly investigated by facility management. (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 - Actual harm Residents Affected - Few	Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the administrator, or his/her designee, will investigate the alleged incident. The individuals conducting the investigation will, as a minimum: review the completed documentation forms; review the resident's medical record to determine events leading up to the incident, as well as the resident's cognitive function and medical condition; interview the person (s) reporting the incident; interview any witnesses to the incident; interview the resident (as medical appropriate); interviews the resident's attending physician as needed; interview staff members who have had contact with the resident during the period of the alleged incident; interview the resident's roommate two other residents on their hall, family members, and visitors; if the accused is an employee, interview other residents to whom the accused employee provides care or services; if the accused is another resident, interview residents who have contact with the accused resident; if the accused is a visitor, or family member, interview staff and residents who have contact with them; and review all events leading up to the alleged incident. Employees of this facility who have been accused of resident abuse will be suspended from duty until the results of the investigation have been reviewed by the administrator. The administrator or designee will provide a written report as indicated to the [State Agency] as mandated. II. Resident #2 Resident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on 2/2/25. According to the February 2025 computerized physician orders (CPO), diagnoses included dementia with severe agitation. The 11/14/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. She required partial to moderate assistance with bed mobility, toileting, dressing and personal hygiene and was dependent upon staff for transfers. It indicated the resident did not experience any hallucinations, delusions nor exhibit any behavioral symptoms. A. Resident #2's representative interview The resident's representative was interviewed on 3/4/25 at 4:50 p.m. She said Resident #2 had a recent decline since November 2024 and December 2024. She said her family members felt the facility had broken a lot of trust over the course of her stay at the facility and they were concerned with how staff were treating Resident #2, so they installed a hidden camera in Resident #2's room and recorded the care conferences. She said one of the nurses said during a care conference that Resident #2 would often misbehave and that comment was concerning for the resident's family members. The resident's representative said the facility would constantly complain to the family members that Resident #2 was attempting to get out of bed unassisted. The resident's representative said the camera was placed facing the head of the bed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The resident's representative said, during the second care conference which was held on 1/23/25, the family members expressed several staff members treat her [Resident #2] as a job, not as a human and I find that absolutely deplorable. She said she informed the facility staff that there was a caregiver on the night shift on 1/21/25 that was pretty rough turning the resident, with the resident saying phrases like, don' t touch me like that, you are hurting me and please don' t push my leg. The resident's representative said their family felt they had to be a babysitter to ensure Resident #2 would be well treated and treated with kindness. The resident's representative was interviewed again on 3/5/25 at 3:15 p.m. She said during the care conference on 1/23/25, she showed the facility staff, specifically the director of nursing (DON) a picture of a CNA that was rough with Resident #2. She said she took the picture from the video taken on the night of 1/21/25. She said she asked the DON to ensure that CNA (CNA #1) never cared for Resident #2 again. She said the DON and nurse educator (NE) told her they would identify the CNA and provide her with education. The resident's representative said she did not show the video which was taken on 1/21/25 to the facility staff because they did not want them to know there was a camera set up in Resident #2's room, to ensure Resident #2's protection. The resident's representative was interviewed a third time on 3/6/25 at 11:13 a.m. She said there was a video taken on 1/21/25 at 7:32 p.m. of a care interaction between a CNA and Resident #2. She said the video was one minute and twenty seconds long. The resident's representative described the video, the camera is sitting behind the top of [the resident's] bed looking at her head and body from the top of the bed. We see a CNA enter the frame on the left side with pillows in her hands. She is moving quickly and being quite brusque. She picks up a pillow, folds it in half and begins touching near the end of the bed where [the resident's] legs are. [The resident] says something unclear and then or are you going to touch me again? The CNA says, nope, I' m going to touch you again. The resident's representative continued to describe the video by saying The CNA then roughly pushes something near [the resident's] legs (presumably the pillow but it is not seen) and [the resident] cries out, Ow, I don' t want to be touched like that! It hurts! The CNA picks up another pillow and folds it in half. The CNA says, Well, we need you to stay in bed, so you don' t fall. The CNA forcefully pushed [the resident] over on to her right side, towards the wall, a loud thud is heard and [the resident] screams out in pain Ooooowweee! The resident's representative said the video continued and she said While the CNA is forcefully pushing the pillows under her, [the resident] says I hate it, I don' t want that to happen again. Is that clear?! The CNA moves to the top of the bed and again forcefully pushes [the resident] towards the wall. [The resident] says Oh, that hurts me then rolls back on her back and screams AHHH, Stop it! The CNA pulls on the pillow under [the resident's] head and [the resident] asks Why are you being rough on me? The CNA answers sharply, Because I need you to stay in bed! You then see [the resident] trying to fix her blankets and says, You shouldn' t do that to me, you shouldn' t be here. The CNA is observed pushing the recliner chair directly up against the resident's bed. And the video ends. Cross reference F604 for failure to prevent physical restraints. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	B. Record review The delusion care plan, initiated on 12/30/24, documented Resident #2 was easily confused at baseline and would make delusional statements to staff. The delusions caused different levels of distress. Resident #2 had intermittent periods of agitation where she tried to get out of bed or her wheelchair. The cognition care plan, initiated on 7/19/24, documented Resident #2 was easily confused and experienced impaired decision making, memory loss and disorientation. The interventions included adjusting questioning according to the resident's current cognitive status, communicating with the family and caregivers regarding the resident's capabilities, engaging the resident in simple and structured activities, keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion. The 1/22/25 nursing progress note documented at 5:17 a.m., revealed Resident #2 showed signs of agitation throughout the shift and refused medications at 7:00 p.m., saying Get that out of my face, while waiving her hands back and forth in fighting motions after multiple attempts. Her family arrived at 11:10 p.m. to sit with the resident. The 1/23/25 care conference progress note documented the family had concerns regarding customer service, professionalism or being made uncomfortable by staff. -Review of Resident #2's electronic medical record (EMR) did not reveal any further documentation regarding Resident #2's family concern of rough treatment of the resident by CNA #1. Staffing documentation for the night shift on 1/21/25 was reviewed on 3/5/25 at 3:00 p.m. CNA #1 was documented as the only CNA working the hallway where Resident #2 resided during the incident on 1/21/25 at 7:32 p.m. C. Staff interviews The clinical consultant (CC) and the NHA were interviewed together on 3/5/25 at 3:09 p.m. The CC said there were staff call offs on 1/21/25 on the hallway where Resident #2 resided. He said CNA #1 was a floating CNA and was pulled to work that hallway due to the staff call offs. The NHA confirmed CNA #1 worked on Resident #2's hallway on 1/21/25. The NHA, the DON, social worker (SW) #1, SW #2 and the NE were interviewed together on 3/6/25 at 11:41 a.m. They all said they were not aware they were being recorded during Resident #2's care conferences. SW #1 said she was aware some residents at the facility had cameras in their resident rooms. The DON said Resident #2's family brought up concerns regarding a specific staff member and asked that the staff member not care for Resident #2 any longer. She said she remembered the resident's family showing her a picture of the CNA, but said she did not know who it was. She said she did not look at the staffing schedule, nor personnel file to determine who the CNA was. The DON said she did not conduct an investigation, nor report to the State Agency following Resident #2's family report of rough treatment of facility staff toward Resident #2. The NHA was interviewed on 3/6/25 at 12:10 p.m. The NHA said the word rough reported by Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	#2's family should have triggered an investigation. She said that was considered an allegation of abuse and an investigation should have been initiated and reported to the state agency. She said today (3/6/25) she had started an investigation, suspended CNA #1 and called the police. She said angel rounds had been completed that morning and in the days that followed the 1/21/25 incident between Resident #1 and CNA #1. She said during the angel rounds they asked questions such as if residents were being treated with respect and dignity and if they felt they were harmed by a staff member or resident. She said the residents had not reported any mistreatment by staff. She said the facility staff who attended the care conference on 1/23/25 said they thought the family had more of a customer service complaint, but the word rough was an allegation of abuse and should have been investigated as such. III. Incident of physical abuse by LPN #1 towards Resident #1 A. Facility investigation The facility incident report, dated 4/12/24 at 11:15 p.m., was provided by the NHA on 3/5/25 at 3:25 p.m. The report revealed an allegation of physical abuse involving Resident #1 and LPN #1. LPN #1 was working on the secured unit and did not like that Resident #1 was reaching over to grab items off the nurse's medication cart. LPN #1 grabbed the items and attempted to remove Resident #1 from the area. LPN #1 grabbed Resident #1's arm. CNA #2 observed LPN #1 grab Resident #1's arm to remove the resident from a restricted area. Resident #1 was assessed by registered nurse (RN) #2 and bruising was noted on the resident's bilateral upper extremities in various areas. CNA #2 submitted a form on 4/12/24 that was completed by CNA #2 and dated 4/12/24. The report documented LPN #1 was blocking the entry to the nurse's office to all of the residents on the secured unit. LPN #1 grabbed Resident #1 by her forearm and twisted it, telling Resident #1 to go away while the resident was trying to enter the nurse's station. Resident #1 grabbed some items from the medication cart and threw them at LPN #1. LPN #1 got upset and yelled at Resident #1. LPN #1 did not let the resident go and was yelling at the resident to stop. Resident #1 was getting more aggressive and combative. CNA #2 said she asked LPN # 1 to let the resident go and LPN #1 said no. CNA #2 told LPN #1 that yelling and grabbing Resident #1 would not help the situation. Resident #1 started hitting CNA #2. CNA #2 took Resident #1 away from LPN #1 and Resident #1 calmed down. The investigation documented Resident #1 was cognitively impaired and did not recall the incident. The investigation documented LPN #1 was interviewed on 4/17/24 at 8:31 a.m. LPN #1 said when she arrived on the unit, the nurse's station had residents roaming around it. She said that after escorting the residents out of the nurse's station, she used the medication cart to block the door. LPN #1 said a CNA was assisting her. LPN #1 said Resident #1 was grabbing things off the cart which she was allowing to happen until she was going for the computer on the cart. LPN #1 said that was when she intervened and was attempting to stop Resident #1. LPN #1 said the altercation was short and that she was not even aware that this was an issue until being suspended. Pictures were included in the investigation that was provided by the NHA on 3/5/25. A picture taken on 4/13/24 revealed round bruising to Resident #1's left wrist. A picture taken on 4/15/24 revealed (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	round bruising to the resident's left lower elbow. Another picture taken on 4/15/24 revealed round bruising on the resident's right arm below the elbow. The facility's investigation revealed that, although Resident #1 presented with bruising, she had a history of sundowning behaviors. The facility concluded they were unable to substantiate physical abuse due to the pattern of Resident #1's bruising that was not consistent with twisting. -However, abuse occurred as CNA #2 observed LPN #1 willfully grab Resident #1's arm. The investigation documented, to help prevent a recurrence, LPN #1, an agency employee, was removed from returning to the facility. B. Resident #1 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included mood disorder and dementia. The 1/2/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. She required supervision/touching assistance with eating and toileting. The assessment indicated Resident #1 did not exhibit any physical or verbal behavioral symptoms directed towards others. 2. Record review The mood care plan, initiated 9/14/22, documented Resident #1's short-term memory had continued to decline since she was admitted to the facility. Resident #1 was easily overstimulated and did not do well in loud environments. The care plan documented loud environments caused her agitation and delusions to increase which led to increased exit seeking and striking out at staff. The care plan documented her mood fluctuated from pleasant to angry in a short time. She could verbally and physically strike out during these episodes. Her delusions caused her to become angry and distressed. Interventions included encouraging Resident #1 to participate in activities that may be of interest to her, redirecting the resident if the activity appeared to be overstimulating or triggering to her, ensuring the resident was in a safe place when her anger appeared to be escalating and providing oversight as able to ensure safety. The health status note, dated 4/7/24, documented staff were monitoring Resident #1's arms for redness and irritation. The resident had no redness or irritation noted, lotion was applied and the resident denied itching or pain. The health status note, dated 4/13/24, documented the manager on duty (MOD) was notified by the previous shift's nursing staff during shift change that there was an incident that had happened between Resident #1 and LPN #1. A skin assessment was completed and Resident #1 had bruising to her bilateral upper extremities (BUE), three bruises to her left arm that were 1 centimeter (cm) by 1cm on her wrist, 0.5 cm by 0.5 cm on her lower elbow and 1 cm by 1 cm on her upper elbow. She also had a 0.3 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	cm by 0.3 cm bruise to her right upper elbow. All other skin areas were clean, dry and intact. The health status note, dated 4/13/24, documented the NHA and the DON were notified of the bruising to the resident's right hand and left wrist/forearm. The NHA and the DON advised staff to call the police. The note documented the police were notified and arrived to investigate. The physician note, dated 4/15/24, documented Resident #1 had bruising on her bilateral arms but denied any pain. -A review of Resident #1's EMR did not reveal any documentation that indicated the resident had sustained the bruising prior to the incident on 4/12/24, where LPN #1 grabbed Resident #1's arm. 3. Staff interviews CNA #3 was interviewed on 3/5/25 at 3:56 p.m. CNA #3 said she was not working when the abuse incident happened on 4/12/24. She said she heard that a nurse was rough with a resident CNA #3 said if she saw abuse, it was her duty to report it right away. She said she would report the abuse to the NHA, the DON and the manager on duty (MOD). She said she would fill out an incident sheet. She said the incident binder was located at the nurse's station. She said she had never witnessed resident abuse. RN #1 was interviewed on 3/5/25 at 4:10 p.m. RN #1 said she received abuse and dementia training when she first started. She said residents on the secured unit required more redirection and cuing. RN #1 said de-escalation skills helped and she tried to incorporate calmness on the secured unit. RN #1 said getting the residents outside for fresh air and walking with them helped keep the residents calm. RN #1 said if she saw resident abuse she would ask that staff member to leave immediately. She said she would approach the resident and de-escalate the situation. She said she would report the abuse to the DON. She said she would document what she witnessed in the resident's EMR The DON was interviewed on 3/6/25 at 10:40 a.m. The DON said agency staff received a large packet of training information that contained abuse, reporting and risk management. She said before agency staff worked at the facility, they had to read and acknowledge the information received. The DON said the residents on the secured unit were not able to verbalize their needs and feelings. She said the unit served residents of all different needs. She said the staff on the unit were trained to anticipating the residents' needs. She said the staff made sure the residents had a good quality of life, dignity, care and felt safe. The DON said she was not sure why the abuse investigation from 4/12/24 was unsubstantiated. The NHA was interviewed on 3/6/25 at 10:54 a.m. The NHA said the abuse investigation was unsubstantiated because LPN #1 said she only grabbed Resident #1's hand and the bruising was on her arms. She said the bruises on Resident #1's arm were not fingerprints. She said the bruising looked old and did not (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	look fresh. She said she did not know if LPN #1 was the one who actually caused the injuries on Resident #1's arms. -However, review of Resident #1's EMR did not reveal documentation that the bruising was present prior to the incident on 4/12/24. The NHA said she was not at the facility when the police officer and nurse spoke to Resident #1. She said the police officer thought the injuries were not from the nurse. She said the police officer said the way the bruising displayed did not match up. She said the bruising showed one finger and there would have been more fingerprints on her arm. She said the police officer made the determination to unsubstantiate the findings. -However, abuse occurred due to CNA #2 observing LPN #1 willfully grab Resident #1's arm to move Resident #1 out of the way (see facility investigation above).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were free from physical restraints imposed for staff convenience and not required to treat medical symptoms for one (#2) of three residents reviewed for restraints out of three sample residents. Specifically, the facility failed to ensure Resident #2, who had a history of getting up out of bed unassisted, was kept free from physical restraints. Findings include: I. Facility policy and procedure The Restraint Free Environment policy and procedure, undated, was provided by the nursing home administrator (NHA) on 3/6/25 at 1:55 p.m. It revealed in pertinent part, It is the policy of [the facility] that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Physical restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Discipline means any action taken by the facility for the purpose of punishing or penalizing residents. Convenience refers to any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms. Behavioral interventions should be used and exhausted prior to the application of a physical restraint. II. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on 2/2/25. According to the February 2025 computerized physician orders (CPO), diagnoses included dementia with severe agitation. The 11/14/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. She required partial to (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderate assistance with bed mobility, toileting, dressing and personal hygiene and was dependent upon staff for transfers. The assessment documented Resident #2 did not utilize a physical restraint. B. Resident #2's representative interview The resident's representative was interviewed on 3/4/25 at 4:50 p.m. She said Resident #2 had a recent decline since November 2024 and December 2024. She said her family members felt the facility had broken a lot of trust over the course of her stay at the facility and they were concerned with how staff were treating Resident #2, so they installed a hidden camera in Resident #2's room and recorded the care conferences. She said one of the nurses said during a care conference that Resident #2 would often misbehave and that comment was concerning for the resident's family members. The resident's representative said the facility was constantly complaining to the family members that Resident #2 was attempting to get out of bed unassisted. The resident's representative said the camera was placed facing the head of the bed. The resident's representative said she came to visit Resident #2 multiple times, as well as did her daughter almost every night to assist the resident with eating. She said when she or her daughter would enter the room, they often times found the recliner chair pushed up against the bed, with Resident #2 lying in bed. She said Resident #2 was unable to move the recliner chair out of the way. She said she felt this was the facility staff's way of keeping Resident #2 in her bed. The resident's representative said based on the video and pictures the family took, the recliner chair was pushed up against the resident's bed on 1/21/25 at 7:32 p.m. and on at least two other occasions. She described the pictures as follows: Picture one: The head of the bed was facing the window. The resident's bed was pushed up against the wall on the resident's right side. The recliner chair was pushed directly against the bed. It was approximately two feet from the head of the bed and the chair extended down until approximately one foot from the foot of the bed. Picture two: The bed was positioned in the same way, against the wall on the resident's right side. The chair was pushed directly up against the bed in the same location as picture 1. The resident was laying sideways with her head up against the wall, her knees bent and legs curled up against the back of the recliner. It appeared as though the sheets were tangled up and she was holding them in her hand. The resident's representative was interviewed again on 3/6/25 at 11:13 a.m. She said there was a video taken on 1/21/25 at 7:32 p.m. of a care interaction between a CNA and Resident #2. She said the video was one minute and twenty seconds long. The resident's representative described the video, The camera is sitting behind the top of [the resident's] bed looking at her head and body from the top of the bed. We see a CNA enter the frame on the left side with pillows in her hands. She is moving quickly and being quite brusque. She picks up a pillow, folds it in half and begins touching near the end of the bed where [the resident's] legs are. [The resident] says something unclear and then or are you going to touch me again? The CNA says, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065361	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nope, I' m going to touch you again. She continued to describe the video by saying the CNA then roughly pushes something near [the resident's] legs (presumably the pillow but it is not seen) and [the resident] cries out, Ow, I don' t want to be touched like that! It hurts! The CNA picks up another pillow and folds it in half. The CNA says, Well, we need you to stay in bed, so you don' t fall. The CNA forcefully pushed [the resident] over onto her right side, towards the wall, a loud thud is heard and [the resident] screams out in pain Ooooowwweee! She said the video continued and she said While the CNA is forcefully pushing the pillows under her, [the resident] says I hate it, I don' t want that to happen again. Is that clear?! The CNA moves to the top of the bed and again forcefully pushes [the resident] towards the wall. [The resident] says Oh, that hurts me then rolls back on her back and screams AHHH, Stop it! The CNA pulls on the pillow under [the resident's] head and [the resident] asks Why are you being rough on me? The CNA answers sharply, Because I need you to stay in bed! You then see [the resident] trying to fix her blankets and says, You shouldn' t do that to me, you shouldn' t be here. The CNA is observed pushing the recliner chair directly up against the resident's bed. And the video ends. Cross reference F600: the facility failed to ensure Resident #2 was kept free from physical abuse by a staff member. C. Record review The delusion care plan, initiated on 12/30/24, documented Resident #2 was easily confused at baseline and would make delusional statements to staff. The delusions caused different levels of distress. Resident #2 had intermittent periods of agitation where she tried to get out of bed or her wheelchair. The cognition care plan, initiated on 7/19/24, documented Resident #2 was easily confused and experienced impaired decision making, memory loss and disorientation. The interventions included adjusting according to the resident's current cognitive status, communicating with the family and caregivers regarding the resident's capabilities, engaging the resident in simple and structured activities, keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion. The transfers care plan, initiated on 8/12/24, documented Resident #2 required the use of a mechanical lift for all transfers. The interventions included providing frequent off-loading of the resident when up in the chair, removing the mechanical lift sling when the resident was lying in bed and ensuring two staff member assistance with transfers while using the mechanical lift. The fall risk care plan, initiated on 7/17/24, documented Resident #2 was at risk for falls related to deconditioning, balance problems, unaware of her safety needs and vision and hearing problems. The interventions included anticipating and meeting the resident's needs, putting the bed in the lowest position, encouraging the resident to participate in activities, following the facility protocol, keeping needed items within reach and maintaining a clear pathway without obstacles. The 8/26/24 physician progress note documented Resident #2 had become more impulsive in her room, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	according to staff. The 1/4/25 nursing progress note documented Resident #2 was found on the floor next to her bed, with her head at the foot of the bed. The resident was extremely confused and continued to voice her desire to ambulate independently. The resident was assisted back to bed and did not sustain any injuries, however continued to attempt to rise out of bed. The 1/5/25 interdisciplinary fall progress note documented Resident #2 sustained multiple abrasions from the fall. An abrasion to the left ankle, right great toe, right medial (inner) foot and right medial ankle. The 1/7/25 nurse practitioner progress note documented Resident #2 had moments of impulsivity. The 1/14/25 nursing progress note documented Resident #2 was agitated and anxious. The resident was tangled in her blankets with her gown and brief taken off. III. Staff interviews The NHA, the director of nursing (DON), the social services director (SSD), social worker (SW) #1 and the nurse educator (NE) were interviewed together on 3/6/25 at 11:41 a.m. They all said they were not aware they were being recorded during Resident #2's care conferences. SW #1 said she was aware some residents at the facility had cameras in their resident rooms. They all confirmed Resident #2 had a recliner chair in her room and her bed was positioned up against the wall on the right side. The DON said Resident #2 was impulsive, had hallucinations at times and would attempt to get out of bed without assistance often. She said at times, the facility staff would get Resident #2 up in the chair and place her at the nursing station to be watched, but they could not do that all of the time. The SSD said Resident #2's family was very involved and willing to come in and sit with the resident when she was having episodes of impulsivity, agitation and hallucinations. They all confirmed pushing the recliner chair up against the bed was considered a physical restraint because Resident #2 would not be able to exit the bed while the chair was positioned in that way. The NHA was interviewed on 3/6/25 at 12:10 p.m. The NHA said CNA #1 should never have pushed the recliner chair up against Resident #2's bed. She said in the context of CNA #1 saying We need you to stay in bed so you don' t fall, the recliner chair being pushed up against the bed was considered a physical restraint.