

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065034 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/08/2025 |
| NAME OF PROVIDER OR SUPPLIER Amberwood Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 4686 E Asbury Cir Denver, CO 80222 | |

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. (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

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065034 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/08/2025 |
| NAME OF PROVIDER OR SUPPLIER Amberwood Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 4686 E Asbury Cir Denver, CO 80222 | |
| 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect residents from physical abuse for two (#2 and #3) of five residents reviewed for abuse out of five sample residents. Specifically, the facility failed to protect Resident #2 and Resident #3 from physical abuse by Resident #1. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation policy, revised April 2021, was provided by the director of nursing (DON) on 10/15/25 at 10:45 a.m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to, facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors and/or any other individual. The facility will develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents, neglect of residents and/or theft, exploitation or misappropriation of resident property. The facility will establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. The facility will provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. The facility will identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. The facility will investigate and report any allegations within timeframes required by federal requirements and protect residents from any further harm during investigations. II. Facility investigation of physical abuse towards Resident #2 and Resident #3 by Resident #1 on 7/30/25 The facility investigation, dated 7/30/25, revealed that on 7/30/25, an incident occurred between Resident #1, Resident #2 and Resident #3. Resident #1 entered the room shared by Resident #2 and Resident #3. Resident #2 was upset Resident #1 entered their room and began throwing pieces of pineapple at Resident #1. Resident #1 became upset with Resident #2 and left the room, knocking a glass jar of pickles off Resident #2's dresser as he left the room to go outside and smoke. Upon returning to his room, Resident #1 discovered that his laptop had been shattered. Resident #1 returned to Resident #2 and Resident #3's room and asked Resident #2 if she broke his laptop. Resident #2 refused to respond to Resident #1's question, which angered Resident #1. Resident #1 then proceeded to remove the armrest from his wheelchair and threw it at Resident #2. The wheelchair armrest struck Resident #2 in the chest and then hit Resident #3 in the leg. The incident was not witnessed by staff, but staff responded when they heard the altercation. The residents were separated and assessed for injuries and no injuries were noted to any of the residents. The nursing home administrator (NHA), the DON and social services were notified and the police were called. The investigation documented that all three residents were interviewed by the facility following the incident. The interviews were as follows: Resident #3 said Resident #1 came into her and Resident #2's room and Resident #2 began throwing pineapple at Resident #1. Resident #3 said Resident #1 left the room and knocked over a jar of pickles on his way out. She said Resident #1 later came back to their room to ask Resident #2 if she broke his laptop and when Resident #2 did not answer him, he took the armrest off his wheelchair and threw it at Resident #2. Resident #3 said the armrest hit Resident #2 in the chest and then bounced off and hit her (Resident #3) in the leg. Resident #3 said she was not a part of the argument between Resident #1 and Resident #2, but she got caught in the middle of it. She said she did not want to be involved in the drama between Resident #1 and Resident #2. Resident #2 said she was upset because she found out Resident #1 took her vaporizer device. She said when Resident #1 came into her and Resident #3's room, she (Resident #2) threw pineapple at him which made Resident #1 mad so he left the room and knocked a jar of pickles off her dresser when he left. Resident #2 said Resident #1 later came back to the room and asked her if she broke his laptop. She said when she did not answer Resident #1, he got mad and threw his wheelchair armrest at her. Resident #2 said the armrest hit her and then hit Resident #3. She said the incident got out of hand and if she got mad at Resident #1 again, she would talk to staff about it instead of getting in another incident. Resident #1 said he took Resident #2's vaporizer device and she got mad at him and threw pineapple at him when he walked into Resident #2 and</p> | | |