STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Post Acute, The	3131 S Federal Blvd Denver, CO 80236

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 - Some	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** 47350 Based on record review and interviews, the facility failed to ensure four (#1, #2, #3 and #4) of four residents reviewed for abuse out of four sample residents were free from abuse. Specifically the facility failed to: -Prevent verbal and physical abuse between Resident #2 and Resident #4. -Protect Resident #1 from physical abuse by Resident #2; and, -Protect Resident #3 from physical abuse by Resident #4. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy and procedure, revised 2025, was provided by the nursing home administrator (NHA) on 5/8/25 at 11:33 a.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation policy and procedure, revised September 2022, was provided by the NHA on 5/8/25 at 11:33 a.m. It read in pertinent part, Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. II. Incident of verbal and physical abuse between Resident #2 and Resident #4 on 1/31/25 A. Facility investigation (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 - Some	The 1/31/25 physical abuse investigation documented a witnessed resident-to-resident verbal and physical altercation between Resident #2 and Resident #4. Resident #2 and Resident #4 were in the smoking area during a supervised smoking session. Resident #2 walked up to Resident #4, who was standing with his back against the wall, and yelled at him. Resident #4 then called Resident #2 an expletive. Resident #2 attempted to push Resident #4, which caused Resident #2 to fall to the ground. Resident #2 then stood up and attempted to slap Resident #4. The staff separated the two residents. The two residents were assessed and no injuries were identified. The investigation indicated both residents were started on psychosocial visits and denied fear. Both of the residents were being followed by behavioral health services (BHS), and their behaviors related to agitation were being addressed. Resident #4 was suspended from smoking during the investigation. The facility unsubstantiated the allegation of physical abuse at the conclusion of the investigation due to no bodily harm noted during the investigation. -However, physical abuse occurred when Resident #2 pushed Resident #4 against the wall and verbal abuse occurred when Resident #4 called Resident #2 an expletive. B. Resident #2 (assailant and victim) 1. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included epilepsy (seizure disorder), chronic obstructive pulmonary disease (COPD) and dementia. The 4/18/25 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. He was independent with eating, toileting, personal hygiene, transfers and bed mobility. The assessment did not indicate the resident exhibited physical or verbal behaviors towards others. 2. Resident interview Resident #2 was interviewed on 5/8/25 at 9:32 a.m. The resident exhibited speech that was difficult to understand. Resident #2 said he did not remember the incident in the dining room. He said there was a resident that had been ramming him with his walker and yelling expletives at him. He said I told him to stop that. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavior care plan, initiated 4/7/25, documented Resident #2 had a history of being verbally aggressive to staff and residents due to ineffective coping skills and poor impulse control. Interventions included administering medications as ordered, analyzing triggers and what de-escalated his behavior, providing positive feedback for good behavior, redirecting by staff away from tasks for staff and resident safety and offering supervised opportunities for him to participate in cleaning tasks. -However, the behavior care plan was not initiated until after a second resident-to-resident incident occurred on 4/5/25 (see 4/5/25 incident below). The 1/26/25 nursing progress note documented Resident #2 was heard shouting in the dining room and hitting the dining room door. He was agitated and shouting that he was being mistreated by everyone on the staff. He was unable to provide details. He said staff were changing his medications and taking medications away from him. The 1/31/25 nursing progress note documented the director of nursing (DON) interviewed the Resident #2 regarding the resident's fall/incident. Resident #2 denied onset of pain and denied feeling threatened or fearful. -However, the nursing progress note documentation did not reveal what occurred during the resident-to-resident altercation that occurred on 1/31/25 with Resident #4. The 2/1/25 at 6:00 p.m. nursing progress note documented Resident #2 was on follow-up for a resident-to-resident altercation on 1/31/25. Resident #2 was observed not to be aggressive towards staff or other residents. The 2/1/25 at 9:52 p.m. nursing progress note documented Resident #2 was on monitoring after a resident-to-resident altercation. The resident appeared angry and agitated but took his medications. The resident was in his room. The 2/2/25 nursing progress note documented Resident #2 continued to be agitated and angry when approached for assessment. He denied pain or discomfort. The 2/3/25 nursing progress note documented Resident #2 was on a 72-hour assessment after a resident-to-resident altercation. The resident was in his room and had no complaints. He was upset over not being allowed to leave when he wanted. A comprehensive review of Resident #2's electronic medical record (EMR) did not reveal documentation of any interdisciplinary team (IDT) notes after the 1/31/25 resident-to-resident altercation with Resident #4. C. Resident #4 (assailant and victim) 1. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included stroke, COPD and dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/7/25 MDS assessment revealed the resident had severe cognitive impairment with deficits in short and long term memory. He had moderate impairment for daily decision making with poor decision making and required cues and supervision per staff assessment. He was independent with eating, toileting, bed mobility, personal hygiene and transfers. The assessment did not indicate the resident exhibited physical or verbal behaviors towards others. 2. Record review The behavior care plan, initiated 11/2/21 and revised 2/25/25, documented Resident #4 had a history of behaviors related to a traumatic brain injury (TBI), anxiety disorder and dementia. He could be physically aggressive towards staff during supervised smoking when times were late or missed and had been involved in resident-to-resident altercations. Interventions included behavioral monitoring (5/19/21), providing opportunity for positive interaction (5/19/21), encouraging to express feelings appropriately, (5/19/21), explaining procedures before starting (5/19/21), discussing behaviors if being reasonable (5/19/21), providing a program of activities (4/27/22), referring to behavioral health service for psychological interventions to decrease physical altercations (1/22/24), moving to a private room to prevent further occurrences (3/14/24) and laboratory work (labs) for a physically aggressive episode (3/18/25). The smoking care plan, initiated 3/14/25 and revised 3/17/25, documented Resident #4 required supervision during smoking due to his cognitive impairment. Interventions included assessing ability to smoke safely, explaining smoking policy, smoking apron and supervising while resident was smoking. -However, the smoking care plan was not initiated until 3/14/25. Review of Resident #4's EMR revealed there was no progress note of the incident that occurred on 1/31/25 with Resident #2. The 2/1/25 at 6:00 p.m. nursing progress note documented Resident #4 was on follow-up for a resident-to-resident altercation from 1/31/25. Resident #4 was ambulating in hallways without complaints or visible injury. The 2/1/25 at 9:49 p.m. nursing progress note documented Resident #4 was on monitoring after a resident-to-resident altercation. Resident #4 denied pain or discomfort or injury. The 2/3/25 at 12:56 a.m. nursing progress note documented Resident #4 continued to be monitored after a post-altercation with another resident (Resident #2). No complaints or behaviors were identified. III. Incident of physical abuse between Resident #2 and Resident #1 on 4/5/25 A. Facility investigation The 4/5/25 physical abuse investigation documented a witnessed resident-to-resident physical altercation between Resident #2 and Resident #1. The staff observed the two residents arguing after Resident #1 closed a window in the dining room. Resident #2 slapped Resident #1, which caused Resident #1 to lose his balance and fall to the ground. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff separated the two residents and Resident #1 was assessed head-to-toe by a registered nurse (RN). Redness to Resident #1's eye was observed but no other injuries were identified. The investigation indicated Resident #2 and Resident #1 lived on different hallways but both residents would have staff monitoring during meals and when in close proximity to each other. The facility substantiated the allegation of physical abuse at the conclusion of their internal investigation. B. Resident #2 (assailant) 1. Record review The 4/6/25 at 3:51 a.m. nursing progress note documented a resident-to-resident physical altercation between Resident #2 and Resident #1 occurred on 4/5/25 at 7:30 p.m. Resident #2 initiated the physical aggression and got into an argument with Resident #1 and then slapped Resident #1 and pushed him to the ground after Resident #1 closed the window in the dining area. Resident #1 was assessed head-to-toe by a RN and had redness to his right eye. No other injuries were noted. The physician was notified. Resident #1 denied pain. A review of Resident #2's May 2025 medication administration record (MAR) revealed a physician's order for behavior monitoring for antipsychotic medications with the target behaviors of afraid, angry, agitated, mood changes, noisy, restless, withdrawn, crying and combative to check each shift and document in the nursing progress notes every shift, ordered 3/28/25. -However, behaviors were documented as did not occur for each shift for 4/5/25. C. Resident #1 (victim) 1. Resident status Resident #1, age 75, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included dementia and traumatic brain injury (TBI). The 4/11/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with eating, toileting, personal hygiene, bed mobility and transfers. The assessment did not indicate the resident exhibited physical or verbal behaviors towards others. 2. Resident interview Resident #1 was interviewed on 5/7/25 at 1:05 p.m. Resident #1 said Resident #2 liked to sit in the dining room next to the windows and liked them open. He said he had said something to Resident #2 about bums having beards since Resident #2 had a beard. He said Resident #2 got mad at him and hit him in the face with his fist. He said he did not remember any difficulty with his eye afterwards. He said he had never had an issue with Resident #2 before. He said he avoided Resident #2 because he did not like him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review The behavior care plan, initiated 1/2/19 and revised 4/25/25, documented Resident #1 was extremely impulsive, was difficult to direct and was verbally aggressive towards other residents due to a TBI and dementia. Interventions included redirecting the resident away from situations with verbal aggression (9/17/24), reminding him to speak kindly and be careful of word choice (9/19/24), administering medication as ordered (8/21/24), anticipating needs (1/2/19), assisting the resident to develop more appropriate coping (1/2/19), encouraging him to express feelings appropriately (1/2/19), explaining procedures (1/2/19), praising progress improvement (1/2/19) and providing him with an activities program (1/2/19). -A review of Resident #1's comprehensive care plan did not reveal any new personalized interventions after the 4/5/25 altercation with Resident #2 to prevent further abuse (see facility abuse investigation above). The 4/6/25 at 12:09 a.m. nursing progress note, documented on 4/5/25 at 6:30 p.m., revealed a certified nurse aide (CNA) brought to the attention of the RN that there was an altercation between two residents. Resident #1 had received physical aggression from Resident #2. Resident #1 had reported he closed the window because it was cold and Resident #2 was upset because he closed the window and they got into an argument. The CNA said Resident #2 slapped Resident #1 on the right cheek and pushed him to the ground before staff could get there and separate them. Resident #1 was assessed and had redness noted to his right eye. No other injuries were noted. The DON, the NHA and the physician were notified. IV. Incident of physical abuse between Resident #4 and Resident #3 on 3/17/25 A. Facility investigation The 3/17/25 physical abuse investigation documented a witnessed resident-to-resident physical altercation between Resident #4 and Resident #3. Resident #4 became upset during supervised smoking time and began cursing and yelling at the social services assistant (SSA) and pushed the smoking cart over. The SSA stepped back to call for staff assistance. Resident #3 was looking at Resident #4 and Resident #4 began yelling at her, flipping her off and calling her expletives. Resident #4 then walked over to Resident #3 yelled at her and hit her hand which was resting on her wheelchair. The two residents were separated. Resident #3 was assessed by a RN for injuries and no injuries were identified. Staff stayed with Resident #4 until the resident's representative could sit with him until he laid down for a nap. The investigation indicated Resident #4's representative would provide a vaporizer (vape) pen for him for when his cigarettes ran low and the IDT was to monitor Resident's #$'s smoking materials to ensure he did not run out. The facility substantiated the allegation of physical abuse at the conclusion of the investigation. B. Resident #4 (assailant) 1. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's behavior care plan revealed the facility updated the care plan with an intervention to obtain labs for a physically aggressive episode (3/18/25). The 3/17/25 nursing progress note documented that Resident #4 was involved in an altercation with another resident (Resident #3). Resident #4 was witnessed hitting Resident #3 on her left arm during smoking time, after being informed he was out of cigarettes. Resident #4 was escorted back to his room. The DON, the physician and the resident's representative were notified. The 3/18/25 at 8:48 a.m. behavior progress note documented Resident #4 was informed of the removal of his smoking privileges following the resident-to-resident altercation with Resident #3. Resident #4 became extremely angry and began yelling and cursing. An attempt was made to speak with him regarding alternative methods with the resident's urge to smoke. Resident #4 threw his coffee at the progress note writer's face and the resident punched the writer twice on the right side of his neck and face. The family representative was notified and spoke with the resident for a few minutes and calmed him down. Resident #4 asked the family representative if he could smoke and was told not right now. Resident #4 then threw the cell phone down the hallway, went to his room, got under the sheets and went to sleep. The family representative arrived and sat with the resident until he had calmed. The 3/18/25 at 5:48 p.m. behavior progress note documented no further behaviors were noted after Resident #4 became angry with the staff earlier. The resident allowed blood to be drawn for lab tests. A review of Resident #4's May 2025 CPO documented a physician's order for behavior monitoring for target behaviors of aggression, impulsivity and yelling out. Staff were to check each shift and document in the nursing progress notes every shift, ordered 4/18/23. -However, review of Resident #4's MAR documented behaviors did not occur on 3/17/25. C. Resident #3 (victim) 1. Resident status Resident #3, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 CPO, diagnoses included COPD, diabetes mellitus, morbid obesity, stroke and schizoaffective disorder. The 3/5/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent with transfers, substantial/maximal assistance with toileting, personal hygiene, bed mobility and required set up assistance for eating. The assessment did not indicate the resident exhibited physical or verbal behaviors towards others. 2. Resident interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 was interviewed on 5/7/25 at 1:45 p.m. Resident #3 said Resident #4 was in the smoking area and flipped over the cart (on 3/17/25). She said she yelled for someone to call the police and Resident #4 came over and hit her on the arm and it hurt. She said she had had no further interactions with him and avoided him. She said nothing seemed to happen to correct the situation because Resident #4 was back out smoking in the smoking area the next day. She said the social worker seemed to be very afraid of him when he did not have any more cigarettes. She said she could not enjoy her smoke breaks when Resident #4 was out there. 3. Record review The psychosocial behavior care plan, initiated 2/27/25 and revised 3/10/25, documented Resident #3 had a history of making false allegations and using vulgar language against other residents and staff and became agitated when other residents were sitting at the same table. Interventions included providing diversional activities (2/27/25), anticipating needs (2/27/25), being aware of surroundings when pushing her wheelchair through doorways (2/27/25), documenting and recording behavioral episodes and responding to call light timely (2/27/25), establishing a rapport with the resident (2/27/25), providing cares in pairs (2/27/25) and following through on all allegations to ensure safety (2/27/25). -A review of Resident #3's comprehensive care plan did not reveal new interventions after the 3/17/25 altercation with Resident #4 to prevent further abuse (see facility abuse investigation above). -A review of Resident #3's EMR did not reveal nursing progress note documentation of the resident-to-resident altercation with Resident #4 on 3/17/25 or the RN assessment performed after the incident. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/8/25 at 9:05 a.m. LPN #1 said Resident #4 was pleasant but could become easily agitated if things did not go his way. She said issues around smoking were triggers for his behaviors, especially if he ran out of cigarettes. She said he would try to get cigarettes from other residents and they would not give him one. She said Resident #4 had a tendency to try to take things that were not his. She said the smoking area was supervised and two staff people should be out there at all times. She said Resident #2 was impulsive and reactionary in the moment and was sorry for his behavior afterwards. RN #1 was interviewed on 5/8/25 at 9:20 a.m. RN #1 said when resident-to-resident physical altercations occurred, staff first separated residents to ensure their safety and then notified the DON and the NHA. She said she was not aware of any special interventions for Resident #2 or Resident #4 for their behaviors around their recent resident-to-resident altercations. She said frequent behavioral monitoring was only done in certain situations, such as when someone was having suicidal ideation. She said she was not aware of any special behavior monitoring for residents involved in resident-to-resident physical altercations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 was interviewed on 5/8/25 at 9:55 a.m. CNA #1 said Resident #4 was independent. She said he just liked to go to his room and be left alone. She said she was not aware of any recent behaviors or resident-to-resident altercations involving Resident #4. She said she was not aware of any special interventions for his behaviors. She said when residents became aggressive with one another, staff separated and redirected them. The medical records director (MRD) was interviewed on 5/8/25 at 10:05 a.m. The MRD said she was part of the staff assigned to the resident smoking sessions supervision, which was assigned rotationally amongst the managers and other staff. She said she was at the smoking cart (on 1/31/25) and had her back to the residents. She said she heard raised voices and Resident #2 was on the ground and angry. She said Resident #4 was apologetic. She said she tried to help Resident #2 off the ground and he resisted so she went to get other staff to assist. She said there were usually 10 to 12 people during a smoking session, which was manageable since there was a routine and everyone knew the routine. She said she now kept an eye out for Resident #2 and Resident #4 but did not know if there were any special interventions for those two residents when they were in the smoking area. The NHA and the clinical resource director (CRD) were interviewed on 5/8/25 at 10:51 a.m. The NHA said if alleged resident-to-resident abuse occurred, the facility would obtain witness statements and begin with an initial investigation and immediately report it. He said if the allegation proved to be false, the facility would unsubstantiate it. He said if actual abuse occurred, the residents involved were separated so their safety was ensured. He said RN assessments were conducted to determine if any injury occurred. The NHA said any alleged abuse was reported to the NHA, the DON and the social services director (SSD). He said the facility would conduct a formal investigation that included interviews and a chart review. He said there was an IDT review to put in place the appropriate interventions and determine long-term interventions. He said the interventions were then care planned. He said there was no formal IDT documentation in the chart. He said the IDT review of an incident was done during the morning meeting and the IDT note with interventions was kept on a spreadsheet. He said each resident-to-resident altercation should be placed in the care plan and interventions that were identified for each resident should be care planned. The NHA said Resident #2 believed he worked at the facility and was very protective and particular about how the building was kept. He said in the 4/5/25 altercation between Resident #2 and Resident #1, Resident #2 had sat down in the dining room by the window and had opened the window. He said Resident #1 went to shut the window after Resident #2 had opened it. He said Resident #2 became very angry and he slapped Resident #1, which caused Resident #1 to trip over his walker and fall to the ground. The NHA said the incident was witnessed by staff. He said there was a scheduled appointment for Resident #2 with behavioral health services (BHS) and they had been involved with his behavioral management. He said Resident #2 and Resident #1 did not interact much and they lived on separate hallways. He said the altercation should be documented in the care plans with the appropriate identified interventions and documented in the nursing progress notes. He said there should also be a 72-hour follow-up behavioral documentation after a resident-to-resident altercation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA said the resident-to-resident physical altercation between Resident #4 and Resident #3 on 3/17/25 happened during a smoking session. He said the SSA was supervising the smoking session. He said Resident #4 was smoking to the side of the smoking area and started yelling at the SSA. The NHA said Resident #4 pushed the smoking cart and the SSA fell to the concrete. He said Resident #3 was looking at Resident #4 and Resident #4 walked towards Resident #3 and yelled at her. He said Resident #4 flipped Resident #3 off and swatted at her arm. He said the staff separated them. He said in the smoking area, the amount of staff present during smoking times depended on how many residents were out there smoking. He said for five to six residents there was one staff member. He said for eight to ten residents there should be at least two staff members. The NHA said there was a resident-to-resident altercation between Resident #2 and Resident #4 in the smoking area on 1/31/25. He said Resident #4 was leaning against the building and Resident #2 was in the courtyard. He said Resident #2 walked up to Resident #4 and pushed Resident #4 on the chest which caused Resident #2 to fall backwards onto the ground. He said the incident was verified based on camera footage. The NHA said the altercation should be care planned and documented. The NHA said the facility would be looking at how to document the IDT reviews of resident-to-resident physical altercations going forward, with emphasis on ensuring documentation was completed on the root cause of the incident and ensuring interventions were put into place after each altercation and updated on the residents' care plans. The CRD said the facility would be doing an audit of their care plans and looking into their process for behavior tracking and documentation.