STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065242	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookshire Post Acute	4660 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to take steps to protect one (#1) of three residents from physical abuse out of six sample residents reviewed for abuse. Specifically, the facility failed to protect Resident #1 from physical abuse by Resident #2 on 10/15/25.Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy and procedure, revised 2001, was provided by the nursing home administrator (NHA) on 1/6/26 at 5:58 p.m. It read in pertinent part, The administrator is responsible for determining what actions are needed for the protection of residents. The individual conducting the investigation at a minimum observes the alleged victim including their interactions with staff and other residents and documents the investigation completely and thoroughly. The follow-up investigation report will provide sufficient information to describe the results of the investigation and indicate any corrective actions taken if the allegation was verified. II. Incident of physical abuse of Resident #1 by Resident #2 on 10/15/25 A. Facility investigation The 10/15/25 investigation revealed the nurse was called by a certified nurse aide (CNA) who was pointing at Resident #1's head. The nurse noticed Resident #1 was bleeding from an open skin wound on his top scalp. The dimension of the wound was about 0.4 inches (in) in length. Resident #1 said someone hit him with a cup. Resident #2, who was alert and oriented times two to three, verbalized not knowing how it happened but admitted having an altercation with Resident #1 who at the time was in the hallway and Resident #1 was found bleeding from his head. Resident #2 said everything went so fast. The registered nurse (RN) was notified, an assessment was done, vital signs were taken and neurological checks were initiated for Resident #1, per the facility's protocol. Resident #1 was treated with first aid and administered as needed Tylenol for pain management per the physician's recommendation. Resident #1 was taken to the director of nursing's (DON) office to be separated from Resident #2 and interviewed by the DON about the incident. Frequent checks were initiated. Resident #2 was then interviewed by the DON for more information on the incident. Frequent visual checks were initiated for Resident #2. The facility's conclusion revealed the facility and the staff acted quickly, appropriately and effectively to minimize the interaction between Resident #1 and Resident #2 who both resided in the secure unit. Camera footage was reviewed and revealed the incident had happened surprisingly, out of nowhere, with both male residents taking a part in escalating the situation. There did not appear to be any preconceived or knowing intent but more so a reaction. The occurrence did not result in serious bodily injury and both residents were able to enjoy lunch calmly shortly thereafter. Both residents were diagnosed with dementia and could not recall the event shortly afterward. -Review of the 10/15/25 investigation revealed there was no documentation to indicate there was immediate education to staff to keep Resident #1 safe and other residents safe while the investigation was in process. -Review of the 10/15/25 investigation revealed there was no root cause determined for why the incident occurred. B. Video (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	footage of the 10/15/25 incident between Resident #1 and Resident #2The video footage of the 10/15/25 incident between Resident #1 and Resident #2 was reviewed on 1/6/26 at 4:10 p.m. with the NHA, DON and the regional nurse consultant. The video footage revealed Resident #2 was walking up and down the secured unit with a commercial grade plastic polypropylene reusable coffee mug in his hand. Resident #1 was sitting in a chair next to the door leading to the main facility. When Resident #2 walked back towards where Resident #1 was sitting, Resident #2 walked into Resident #1's personal space. Resident #1 put his right foot out and tripped Resident #2. Resident #2 did not fall, but walked back towards Resident #1 and hit the top of Resident #1's head with his coffee cup and then Resident #2 walked away. Resident #1 stood up and walked out of the camera view. Resident #1 was visibly upset based on his facial expressions. III. Resident #1 - victim A. Resident status Resident #1, age [AGE], was admitted on [DATE] and discharged on 10/17/25. According to the January 2026 computerized physician orders (CPO), diagnoses included vascular dementia, cognitive communication deficit, anxiety disorder and failure to thrive. According to the 10/9/25 admission assessment, the resident was alert and oriented times one to two and was able to make some needs known verbally. B. Record review The 10/15/25 nurse note revealed Resident #1 sustained a minor injury on the top of his scalp following a possible confrontation with Resident #2. A voicemail was left for the physician and the DON was notified. Resident #1 was stable after first aid was administered. Resident #1 reported no sign of pain at the time of the documentation and the facility would continue to monitor for any change in condition. The 10/16/25 nurse note revealed Resident #1 was being monitored for his scalp wound. Resident #1 did not complain of pain and no pharmacological treatment was given. Resident #1 slept through the night. The resident would continue to be monitored for any change in condition. The 10/16/25 physician note revealed Resident #1 was seen in his room. He was sitting on the side of the bed. Resident #1 was awake, alert and very hard of hearing. He appeared confused at baseline. As per staff, he had an altercation with another resident (Resident #2) where the other resident hit Resident #1 on the left side of his scalp. The residents were separated to avoid any further conflict. Resident #1 had his belongings in a bag and had been sitting with his belongings and not wanting to go back to his room. The resident was currently independent and ambulatory. Resident #1 did not know why he was in the facility. He was in the secure unit because he was prone to leaving the facility. He was currently stable with no acute distress and the facility would continue to monitor him closely. The 10/17/25 discharge summary revealed Resident #1 was discharged to another nursing facility in a city the resident preferred to live in. The summary revealed the resident constantly verbalized the desire to discharge to his preferred city and was wandering around the unit constantly. The skin condition revealed he had an abrasion on the top of his scalp on the left side related to an encounter with another resident. There was no evidence of bleeding. Resident #1 reported tenderness with palpation. -A review of Resident #1's electronic medical record (EMR) revealed there were no new interventions in place to protect him from Resident #2 following the incident on 10/15/25. -A review of Resident #1's EMR revealed there was no documentation Resident #1 was monitored after the incident for any indication Resident #1's baseline changed.IV. Resident #2 - assailant A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the January 2026 CPO, diagnoses included dementia with behavior disturbance, bipolar disorder, cognitive communication deficit and unspecified mood disorder. According to the 10/14/25 minimum data set (MDS) assessment, the resident was cognitively impaired with a brief interview mental status (BIMS) score of eight out of 15. He was independent with oral hygiene, toileting and dressing. He required set up assistance with eating, showering and personal hygiene. The 10/14/25 MDS assessment revealed his cognitive patterns include inattention and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain assessment and notified the physician, family, the NHA and the police. LPN #1 said she also wrote a progress note. LPN #1 said the nurse initiated the intervention and sometimes it was a one-on-one for the assailant. LPN #1 said if there was a resident-to-resident altercation, she was told about it during shift change in a verbal report. She said she was familiar with Resident #2 and he was in resident to resident altercations.The NHA, the DON and the regional nurse consultant were interviewed together on 1/6/26 at 3:55 p.m. The NHA said he was the abuse coordinator. The NHA said if there was an incident of abuse, staff should first ensure the residents were safe and separate the residents. The NHA said the nurse should immediately notify the DON or unit manager and then the DON or unit manager should inform the NHA. The NHA said risk management was started by the unit nurse, the DON or the assistant director of nursing (ADON). The NHA said a progress note, skin assessment and pain assessment should be completed. The NHA said the family and physician were notified. The NHA said the interdisciplinary team (IDT) was responsible for implementing and determining the interventions. The regional nurse consultant said interventions were documented as a progress note. The DON said interventions were communicated to staff by physician's orders or verbal report or both. The DON said both the assailant and the victim were monitored post-incident by frequent checks and check-ins to see if the residents wanted to talk about the incident. The DON said social services talked with the assailant and the resident as well. The DON said the nurse did the check-in out in the dining area when administering medications or during an assessment. The NHA said the nurse should monitor for non-verbal queues.The DON said the monitoring should be for 72 hours. The DON said the monitoring should be documented as a progress note. The regional nurse consultant said the point of the monitoring was to see if the resident was continuing to do their day to day activities or if they were breaking away from their normal routine. The NHA said interventions were evaluated 72 hours by the IDT. The NHA said the intervention to keep the victim safe was Resident #1 spent time with the DON and the ADON in their office and had lunch with them. The NHA said after lunch they wanted to try to see how Resident #1 would do in the unit. The DON said Resident #1 forgot about the incident and he knew his head hurt. The NHA said Resident #2 spent most of his time in his room except for meals and staff were always in the dining area during meal time. The NHA said Resident #1 did not want to be in his room and he wanted to be in the common area. The NHA said if Resident #2 came out of his room, the intervention to keep Resident #1 safe was the staff was extra vigilant to ensure Resident #1 and Resident #2 did not interact. The NHA said the education to keep the residents safe and what the immediate interventions were was verbally and through shift to shift report. The DON said the nurse could read progress notes as well to determine what interventions were put into place. The NHA, the DON and the regional nurse consultant were interviewed together again on 1/6/26 at 5:30 p.m. The NHA said there should have been documentation to educate the staff on what safety interventions were in place to keep Resident #1 and Resident #2 safe. The NHA said there should have been new behavior interventions for Resident #2. The NHA said the IDT did discuss the incident but it was not documented. The DON said there should have been monitoring for Resident #1 after the incident. The NHA said the root cause of the 10/15/25 incident was not documented because the video footage showed what caused the altercation.