STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065272	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Post Acute	1432 Depew St Lakewood, CO 80214

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 observations, record review and interviews, the facility failed to ensure two (#3 and #1) of five residents were kept free from physical abuse out of five sample residents.Resident #3, was admitted on [DATE] with diagnoses of malignant neoplasm of left lung, heart failure, closed nondisplaced intertrochanteric fracture of left femur, unspecified dementia, pulmonary emphysema and post-traumatic stress disorder (PTSD). Resident #4, was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia with psychotic disturbance, cognitive communication deficit, hypertensive chronic kidney disease, and obstructive pulmonary disease.On [DATE] Resident #3 wandered into Resident #4's room. Resident #4 reacted and pushed Resident #3, which caused Resident #3 to fall. Resident #3 sustained a left femur fracture. Specifically, the facility failed to:-Protect Resident #3 from physical abuse by Resident #4; and, -Protect Resident #1 from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy and procedure, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 10:39 a.m. It revealed 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 support the following objectives: 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. 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. Ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates. (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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(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 residents from any further harm during investigations. II. Incident of physical abuse by Resident #4 towards Resident #3 on [DATE] A. Facility investigation The facility investigation, dated [DATE], documented Resident #3 wandered into Resident #4's bedroom. Resident #4 pushed Resident #3, causing him to fall. The investigation documented Resident #3 sustained a fracture of the intertrochanteric femur from the fall. The investigation documented Resident #4 was interviewed on [DATE]. Resident #4 said Resident #3 was walking and not in a wheelchair. The investigation documented both residents were placed on 15-minute checks. The staff reported the incident to the police, the physician and hospice. The staff also completed skin assessments, placed a stop sign on Resident #4's door and changed Resident 3's transfer status. A medication review was completed for Resident #3 and his care plan was updated. The investigation documented Resident #3 was not transferred to the hospital. B. Resident #3 (victim) 1. Resident status Resident #3, age [AGE], was admitted on [DATE] and expired on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included malignant neoplasm of left lung, heart failure, closed nondisplaced intertrochanteric fracture of left femur, unspecified dementia, pulmonary emphysema and post-traumatic stress disorder (PTSD). The [DATE] minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. He required assistance with transfers, personal care and bathing from one person. 2. Resident #3's representative interview Resident #3's representative was interviewed on [DATE] at 1:40 p.m. The representative said after Resident #3's fall (on [DATE]), the hospice nurse mentioned that even if the resident received treatment, his chances of a complete recovery were very low. She said the hospice nurse said it was time to reduce the pain and keep him comfortable. 3. Record review The [DATE] progress note, documented at 5:55 a.m., revealed a staff member heard a scream coming from Resident #4's bedroom. Two staff members went to check on the resident and observed Resident #3 on the floor on his left hip. The staff members asked Resident #4 what happened to Resident #3. Resident #4 admitted he pushed Resident #3 after he (Resident #3) opened his (Resident #4) door and came into his bedroom, causing Resident #3 to fall. The nurse performed a full-body assessment and 72-hour neurological checks and risk management were started. The staff notified the on-call nurse, the NHA, the resident's representative and hospice of the incident. Resident #3 had pain in his hip and sustained a fracture of the left femur. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The comprehensive care plan, revised [DATE], documented Resident #3 required a wheelchair and one-person assistance for mobility. C. Resident #4 (assailant) 1. Resident status Resident #4, age [AGE], was admitted on [DATE]. According to the [DATE] CPO, diagnoses included Alzheimer's disease, dementia with psychotic disturbance, cognitive communication deficit, hypertensive chronic kidney disease and obstructive pulmonary disease. The [DATE] MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. He required assistance with transfers, bathing and personal care from one person. 2. Observations On [DATE] at 10:50 a.m. Resident #4 was in his room and there was a stop sign on his door. At 3:20 p.m. Resident #4 was in his room and there was a stop sign on his door. 3. Record review The behavior care plan, revised [DATE], revealed Resident #4 was at risk for behavioral symptoms (striking out, grabbing others, combative, verbally, or physically abusive and violent behavior) due to his dementia with moderate psychotic disturbance. The care plan documented he preferred his personal space and kept his door closed because he did not like others coming into his room to invade his privacy. Interventions included documenting/recording behavioral episodes, encouraging the resident to verbalize feelings, investigating and reporting all allegations, managing environmental factors to optimize comfort, notifying the physician and the family of episodes of aggression and abusive behaviors, and social services visits and monitoring/documenting physical aggression (hitting, kicking, pushing, grabbing, biting, spitting or throwing objects). The [DATE] progress note, documented at 6:49 a.m., revealed a nurse heard a scream coming from Resident #4's room. On arrival, the nurse noted another resident on the floor. Resident #4 was standing in the entryway of his bathroom. Resident #4 stated that Resident #3 pushed the door to come in, then Resident #4 pushed Resident #3 which caused him to fall. Fifteen-minute checks were started. D. Staff interviews Certified nurse aide (CNA) #2 was interviewed on [DATE] at 3:54 p.m. CNA #2 said Resident #4 rarely left his bedroom and got very upset when somebody entered his room without knocking on the door. CNA #2 said before the incident with Resident #3, the staff tried to prevent other residents from going to Resident #4's bedroom. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 4:19 p.m. LPN #1 said the staff placed a stop sign on Resident #4's door after the incident on [DATE] with Resident #3. LPN #1 said the staff tried to be vigilant with other residents and redirect them when they went close to his room. LPN #1 said Resident #4 liked his personal space. LPN #1 said before the incident on [DATE], the staff had similar interventions implemented and Resident #4 did not have any previous incidents with other residents. LPN #1 said Resident #4's biggest behavioral trigger was when people walked into his bedroom. LPN #1 said after the incident, the staff posted a stop sign on the resident's door and that prevented other residents from entering his room. LPN #1 said Resident #3 was on hospice services when the incident occurred. The director of nursing (DON) was interviewed on [DATE] at 12:06 p.m. The DON said before the incident between Resident #3 and Resident #4, the staff designated a private room at the end of the hall for Resident #4. The DON said before this incident, there were no issues with other residents. The DON said the incident was unwitnessed. The NHA was interviewed on [DATE] at 12:15 p.m. The NHA said before the incident, there was a knock on the door sign posted on Resident #4's door. The NHA said Resident #4 admitted he pushed Resident #3 with the intention to make him leave his room, which caused Resident #3 to lose his balance and fall. III. Incident of physical abuse by Resident #2 towards Resident #1 on [DATE] A. Facility investigation The NHA provided the [DATE] facility investigation on [DATE] at 4:23 p.m. it revealed the altercation occurred on [DATE]. The investigation documented Resident #1 was interviewed on [DATE] by the social services assistant. Resident #1 reported he was just sitting on the couch and Resident #2 he hit him on his right eye. Resident #1 denied being fearful saying he was not scared of anything. The investigation documented Resident #2 was interviewed on [DATE] by the social services assistant. Resident #2 reported he did not know what happened, he just saw him (Resident #1) and hit him. The investigation revealed Resident #5 was the resident who went and notified the staff of the altercation. Resident #5 was interviewed on [DATE]. Resident #5 reported he had seen Resident #2 hit Resident #1. Resident #5 said Resident #1 did not hit back and just walked away. Resident #5 said Resident #1 was just sitting on the couch at the time of the altercation. The investigation documented the facility substantiated the altercation. B. Resident #1 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #1, age less than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included schizoaffective disorder (mood disorder), chronic obstructive pulmonary disorder (ineffective oxygen exchange), hypothyroidism (imbalance of thyroid hormones) and hyperlipidemia (elevated lipids levels in blood). The [DATE] MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. He required supervision assistance with toileting. He required setup assistance with dressing, personal hygiene and eating. He was independent with bed mobility, transfers and ambulation. 2. Observations During a continuous observation on [DATE], beginning at 12:45 p.m. and ending at 1:53 p.m. the following was observed: At 12:45 p.m. Resident #1 was sitting on the couch in the dining room. Resident #1 was making hand movements in circular motion. Resident #1 then went to the patio door, collected an apron and sat outside on a bench waiting for smoking time. Several other residents began to join him on the patio. At 1:18 p.m. Resident #1 returned from his smoking break and sat in a chair in the dining room. At 1:31 p.m. Resident #1 began pacing in the dining room with his hands on his hips or swinging back and forth while pacing. 3. Record review A progress note, dated [DATE] at 9:24 p.m., revealed an unidentified resident went a to nurse and said Resident #2 hit Resident #1. The progress note documented the facility reviewed the video footage and it revealed that Resident #1 was sitting on the dining room couch when Resident #2 approached him and swung at his head. Resident #1 and Resident #2 were separated and went to their rooms. Resident #1 reported that he was hit in the right eye but denied pain and verbalized he was okay. Resident #1 reported he was not afraid of Resident #2. A progress note, dated [DATE] at 12:54 a.m., documented Resident #1 complained of pain to the right side of his face. Resident #1 was administered pain medication. There was no bruising or raised area to the resident's face noted. A physician's note, dated [DATE] at 2:49 p.m., revealed Resident #1 was the victim in an altercation with another resident (Resident #2) who smacked him in the face, causing a small ecchymosis (bruising or discoloration) in their periorbital area/blackeye. The facility reported that Resident #1 was at baseline since the altercation and his black eye was improving/resolving. C. Resident #2 (assailant) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #2, age less than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included schizoaffective disorder, type 2 diabetes (abnormal glucose levels) and gastroesophageal reflux disease (stomach acid flows backward into the esophagus). The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required setup assistance with eating, toileting, dressing and personal hygiene. He was independent with bed mobility transfers and ambulation. The assessment indicated the resident had hallucinations. 2. Observations During a continuous observation on [DATE], beginning at approximately 12:45 p.m. and ending at 1:53 p.m., the following was observed: At approximately 12:45 p.m. Resident #2 came out of his room and sat on the couch in the dining room in between two unidentified residents. A few minutes later, an unidentified staff member approached Resident #2 and asked if they could chat. The unidentified staff member offered a more private location to talk, however Resident #2 refused. The resident reported feeling fine and he was then specifically asked by the staff member about his anxiety and his sleeping patterns. After the visit, Resident #2 had water and returned to his room. Resident #2 was in and out of his room several times during the observation to collect water from the water dispenser in the dining area. At 1:41 p.m. Resident #2 came out of his room and was heard yelling down the hall at an unidentified staff member. Resident #2 threw away a pizza box then went down the hall to talk with staff. 3. Resident #2's interview Resident # 2 was interviewed on [DATE] at 9:53 a.m. Resident #2 reported he felt safe in the facility and he had no issues with other residents who resided in the facility. Resident #2 said he did not want to talk about the altercation between him and Resident #1. 4. Record review The psychosocial behavior care plan, revised on [DATE], revealed Resident #2 was at risk for behavioral symptoms, such as striking out, grabbing others, combativeness, verbally/physically abusive due to delusions, auditory commanding hallucinations and schizoaffective disorder. The care plan documented the goal was for the resident to accept supportive strategies and demonstrate adequate control of his emotions, which would not result in injury to himself or others. Pertinent interventions included providing diversional activities, administering medications, monitoring for side effects of medications, encouraging the resident to verbalize his feelings and observing the resident for potential triggers. A progress note, dated [DATE], revealed an unidentified resident reported to staff that Resident #2 had hit Resident #1. Resident #2 reported he did not know why he hit Resident #1, but he just got really mad. Resident #2 was placed on 15-minute checks and was in his room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note, dated [DATE], documented stat (immediate) labs were ordered for Resident #2. A physician's progress note, dated [DATE] at 2:52 p.m., revealed the visit was for a post-altercation with another resident. Resident #2 did not provide details of the altercation. The note documented, per the facility, Resident #2 slapped another resident (Resident #1) for an unknown reason. Resident #2 denied auditory/visual hallucinations at the time of the visit. E. Staff interviews CNA #1 was interviewed on [DATE] at 2:02 p.m. CNA #1 said she received information about each resident's behaviors during the report at shift change. She said she also got to know the residents to learn about their behaviors. CNA #1 said Resident #2 talked to himself, laughed, wrote down notes and could have outbursts at times. CNA #1 said his aggression was random and hard to know when it would happen. CNA#1 said early signs of Resident #2 having an outburst included if Resident #2 reported he was hearing voices, when he was not focused on any activities or when he was distracted. CNA #1 said staff were to check in with Resident #2 when this occurred and provide a safe space for Resident #2, which was usually his room. CNA #1 said she was aware of Resident #2 having several altercations with other residents. She said the altercations were always with a different resident. CNA #1 said Resident #1 stayed to himself and was not very social with others. CNA #1 said Resident #1 was always noted to be moving his hands/arms and would talk to himself. CNA #1 said Resident #1 enjoyed being outside as it seemed that it comforted him. CNA #1 said Resident #1 did not bother other residents. CNA #1 said the altercation between Resident #1 and Resident #2 came out of nowhere. She said she was not on the unit at the time of the altercation but was told about it on her next shift on the unit. CNA #1 said she did not see any changes to their behaviors post-incident but the staff kept a close eye on them. Registered nurse (RN) #1 was interviewed on [DATE] at 9:47 a.m. RN #1 said Resident #1 kept to himself and did not bother other residents. RN #1 said Resident #2 was often conversing with other residents. RN #1 said Resident #2's triggers for behavioral outbursts occurred when Resident #2 was pacing and when he was responding/talking to himself. RN #1 said Resident #2 had internal stimuli that he responded to. RN #1 said if Resident #2 was aware of hearing the voices he would go into his room where he felt the safest. She said the staff would check on him to help him recognize what was real and what was not. RN #1 said she was aware that Resident #2 had been in several resident-to-resident altercations. RN #1 said the altercation between Resident #1 and Resident #2 happened fast. She said Resident #1 was sitting on the couch when Resident #2 came out of his room, hit him (Resident #1) and then went back to his room. RN #1 said Resident #2 was not remorseful at the time of the altercation but later reported his internal stimuli told him to do it. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The social services director (SSD) and social services assistant #1 were interviewed together on [DATE] at 11:54 a.m. Social services assistant #1 said Resident #1 kept to himself. The SSD said Resident #2 would talk with other residents and partake in smoke breaks. Social services assistant #1 said Resident #2 would become quiet with everyone prior to an event. The SSD said Resident #2 had been receiving mental health services for his physical aggression. The SSD said after every altercation Resident #2 was involved in, the facility would review the altercation and had not found any similarities. The SSD said Resident #2 did not really have triggers that they had been able to identify due to his diagnoses with command hallucination. The SSD said Resident #2 did not always notify the staff that he was having hallucinations. The SSD said if he did notify the staff or the staff noticed the resident was off, the staff were to talk to him to de-escalate him. The SSD said the altercation on [DATE] happened so quickly. The DON was interviewed on [DATE] at 12:06 p.m. The DON said Resident #1 kept to himself and he had a lot of hand movements. The DON said Resident #2 had hallucinations. The DON said Resident #2 was pretty quiet upon admission, but he had opened up more and told staff when he was having hallucinations. The DON said after any altercations, the facility completed a clinical review consisting of a medication review by the consulting pharmacy, physician follow-up, blood work and psychological follow-up and monitoring. The DON said Resident#2 had been in several resident-to- resident altercations since [DATE] and the facility had not been able to identify any patterns. The DON said the facility had all staff complete a crisis prevention intervention training (CPI) to aid interventions. The NHA was interviewed on [DATE] at 12:22 p.m. He said the residents on the Prasada unit were a younger population. The NHA said Resident #2 usually kept to himself, but would interact with staff and other residents. The NHA said the staff had been trying to navigate Resident #2's impulses since his last altercation. The NHA said Resident #2 was receiving mental health services and he had opened up.The NHA said he had begun to be more active in activities. The NHA said Resident #2 did not realize what occurred in the moment when the altercation between Resident #1 and Resident #2 occurred, however, later he recognized something happened and he (Resident #2) was in the wrong.