

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Sierra Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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 observations, record review and interviews, the facility failed to ensure two (#2 and #3) of five residents reviewed for abuse were kept free from abuse. Specifically, the facility failed to protect Resident #3 and Resident #2 from physical abuse by Resident #1. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was received from the nursing home administrator (NHA) on 7/14/26 at 9:20 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. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not limited: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors and/or any other individual. II. Incident of physical abuse by Resident #1 towards Resident #3 and Resident #2 on 6/20/26A. Facility investigation On 6/20/26 a resident reported to the nurse that Resident #3 was on the floor. Resident #3 reported to the nurse she had been involved in a verbal altercation with Resident #1, due to her observing Resident #1 throwing water on Resident #2 (see incident below) which caused Resident #2 to cry. Resident #3 said she told Resident #1 to stop the behavior at which point Resident #1 became upset, cursed at her and pushed her, causing her to fall and land on her buttock. Resident #3 was assessed by facility staff and assisted back to her wheelchair. Resident #3 and Resident #1 were separated for safety. The facility substantiated physical abuse based on witness statements and video surveillance. During the investigation of the incident between Resident #1 and Resident #3 on 6/20/26, it was discovered Resident #1 had also thrown water on Resident #2 (see above). Resident #2 was found to be wet from a liquid being spilled on him by Resident #1. There were no injuries noted. The facility substantiated the allegation based on witness statements and video surveillance. B. Resident #1 (assailant) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included Parkinson's disease (progressive neurological disorder), dementia and mild neurocognitive disorder (decrease in mental function). The 7/7/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. He required set up/clean up assistance with walking, eating, and toilet hygiene. He was independent with transfers. The MDS did not indicate that the resident had behaviors. 2. Record review The psychosocial care plan, initiated 3/31/26, documented Resident #1 was at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills. The resident had poor impulse control related to dementia. Resident #1 had (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	facility for a long period of time and she got along with staff and peers with ease. The SSD said Resident #3 was willing to involve herself if she knew something was wrong. The SSD said she did not identify any changes in behaviors for Resident #1, Resident #2 or Resident #3 following the incidents on 6/20/26. Licensed practical nurse (LPN) #1 was interviewed on 7/13/26 at 3:22 p.m. LPN #1 said if abuse was suspected, observed or reported, she would notify the supervisor after ensuring residents' safety. LPN #1 said Resident #1 liked to wander the halls, participate in activities and drink coffee. LPN #1 said she had not observed Resident #1 have any concerning aggressive behaviors, as he was easily redirectable if needed. LPN #1 said Resident #2 liked to watch television in the common area and would socialize with his peers. She said she had not noted any behaviors from Resident #2. LPN #1 said Resident #3 could be forgetful but she had not noted any agitation or aggressive behaviors for the resident. The NHA was interviewed again on 7/13/26 at 3:47 p.m. The NHA said abuse was any allegation involving, physical, verbal, mental, or misappropriation of property of a resident. The NHA said if any type of abuse was suspected or observed, the staff should alert the supervisor, or himself, as he was the abuse coordinator. He said once notifications were made, the facility immediately ensured resident safety and began an investigation into the situation. The NHA said the facility wanted to promote the safety and well-being of the residents. The NHA said in the situation of Resident #3 being pushed by Resident #1, Resident #1 was separated and placed on frequent checks to promote safety for all residents. He said while the facility was investigating how Resident #3 was found on the floor, it was discovered that Resident #1 had also thrown water on Resident #2. The NHA said the facility reviewed video surveillance along with obtaining witness statements of other residents and were able to determine that Resident #1 had first thrown water on Resident #2 and then pushed Resident #3 after she intervened. The NHA said after a resident-to-resident incident occurred, social services would do a follow up visit to evaluate how residents were doing and follow up with those concerns if needed, such as latent fear or trauma from the incident. He said the SSD would notify the IDT if additional assessments might be needed, such as nursing assessments or even third party psychosocial evaluations. The NHA said based on the follow-up, it helped determine resident cares moving forward. The director of nursing (DON) was interviewed on 7/13/26 at 4:08 p.m. The DON said staff should first separate the residents involved in a resident-to-resident incident to promote safety of the residents. She said staff should then notify their supervisor and the NHA. The DON said residents should be assessed for injuries. The DON said a resident pushing another resident or throwing water on another resident would be considered abuse.		