| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065273 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeside Post Acute | 6270 W 38th Ave<br>Wheat Ridge, CO 80033 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#3) of four residents were kept free from physical abuse out of six sample residents.Specifically, the facility failed to protect Resident #3 from physical abuse by Resident #4.Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 10/9/25 at 10:05 a.m. It 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 support protecting residents from abuse, neglect, exploitation or misappropriation of property by anyone; developing and implementing policies and protocols to prevent and identify abuse or mistreatment of residents neglect of residents and/or theft, exploitation or misappropriation of resident property; 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; implementing measures to address factors that may lead to abusive situations; identifying and investigating all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property and protecting residents from any further harm during investigations.II. Incident of physical abuse between Resident #3 and Resident #4 on 6/21/25A. Facility investigationThe facility's abuse investigation, dated 6/21/25, documented that at approximately 8:15 p.m. Resident #3 and Resident #4 were in the smoking patio area when a verbal altercation occurred. Resident #3 told Resident #4 to smell his feet and called him names. Resident #3 then moved his electric wheelchair toward Resident #4 in an aggressive manner. Resident #4 flicked a lit cigarette at Resident #3 and spit at Resident #3, grabbed Resident #3's arm and dug his fingernails into his skin, and struck Resident #3 in the face, which caused Resident #3's glasses to fall to the ground.Resident #3 left the patio and notified staff. Staff ensured both residents were kept apart and remained on opposite sides of the hallway for the rest of the evening. The facility initiated 15-minute checks for both residents. A registered nurse (RN) assessed Resident #3 after the incident and documented minor scratches on the resident's arm and a small burn on his chest. Resident #3 denied pain. The RN offered wound treatment and Resident #3 declined. Resident #3 declined to discuss the incident further but appeared angry and frustrated. A physician's assistant offered counseling and therapy and Resident #3 declined.Resident #4 was interviewed after the incident and he said that Resident #3 made inappropriate comments and moved his wheelchair toward him. Resident #4 said he reacted by striking Resident #3 in the face.The investigation documented that staff and residents were interviewed and they did not report any ongoing safety concerns. Documentation confirmed that physical contact occurred and that treatment was offered and declined. The interventions implemented after the incident for both residents included continued 15-minute checks, behavior monitoring and review of the residents' care plans. Resident #3's care plan directed staff to provide redirection, offer preferred activities and monitor mood and behavior. Resident #4's care plan directed staff to maintain a calm environment, encourage expression of feelings and documented behavioral episodes with triggers. The investigation documented that the facility substantiated that the allegation of resident-to-resident physical abuse occurred.B. Resident #3 - victim1. Resident statusResident #3, age less than 65, was initially admitted on [DATE], readmitted [DATE] and discharged [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included paraplegia, depression and anxiety. The 9/2/25 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 required substantial assistance with toileting, bathing, and moderate assistance with dressing. The MDS assessment did not indicate that the resident had any behaviors.2. Resident #3 interviewResident #3 was interviewed on 10/8/25 at 5:43 p.m. Resident #3 said that on the day of the incident (6/21/25) he was in the smoking area in his wheelchair when Resident #4 made verbal and racial remarks toward him, including comments about him being crippled. He said that when he moved his wheelchair toward Resident #4, his intention was not aggressive but to respond to what was being said. He said there were no staff members present during the altercation and that his roommate ran inside to get help. Resident #3 said that before staff arrived, Resident #4 hit him twice in the |