

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Lakeside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6270 W 38th Ave 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to fully investigate and document incidents of sexual abuse involving one (#2) of one resident reviewed out of seven sample residents. Specifically, the facility failed to: -Conduct and document a thorough investigation of an allegation of sexual abuse involving Resident #2 as the victim of sexual abuse by staff members;-Interview the resident's roommate for what he might have heard or seen during the time of the alleged abuse incident;-Pursue the resident's ongoing allegations that staff were rough and abusive towards him during the provision of personal care; and, -Investigate why staff did not stop care when the resident made the allegation of abuse and have other staff take over care. Findings include: I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, was received from the nursing home administrator (NHA) on 3/26/26 at 12:30 p.m. The policy documented in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of property are reported to the local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.II. Allegation of sexual abuse of Resident #2 by a nursing staff member on 2/18/26A. Facility investigationThe facility investigation, dated 2/24/26, documented Resident #2 told the investigator he was yelling for help so he could be changed after having a bowel movement. The nurse on duty, licensed practical nurse (LPN) #1, entered his room and shortly after, certified nurse aide (CNA) #1, entered the room and told the nurse he could assist with changing the resident. The investigation documented the resident refused the CNA #1's offer to get him changed but CNA #1 proceeded to change him anyway. The resident alleged that CNA #1 grabbed his hands and began to wipe his backside and clean him up. The resident said while being wiped and cleaned, CNA #1 then put his fingers into his rectum. He stated that he yelled out telling him to stop but CNA #1 did not stop and continued to wipe his rectum. Resident #2 said CNA #1 finished cleaning him and left the room.The investigation report documented that Resident #2 alleged that during nighttime care interaction, while being assisted with changing, the LPN (LPN #1) on duty inserted his finger into his anus four times. Resident #2's documented statement, dated 2/19/26, revealed the resident said he was yelling for help with incontinence care during the night shift on 2/18/26 when CNA #1 entered his room. The resident said he was not sure what time this occurred. The resident said CNA #1 started to provide care, but LPN #1 entered and told CNA #1 he would take over. -However, LPN #1 and CNA #1's statements contradicted the resident's statement regarding who provided the incontinence care (see staff member's statements below).Resident #2 said he did not want LPN #1 to provide his care and he tried to swat LPN #1 away. He said it was no use because LPN #1 grabbed his hands and turned him aggressively, causing him to hit his head against the wall. LPN #1 continued to provide care. The resident said LPN #1 proceeded to change his brief and while wiping his buttocks, the nurse put his finger into his anus repeatedly four times. LPN #1 finished his care and left the room. The resident said no one checked on him for the rest of the night. The investigation report documented that the resident was distressed and agitated during the investigative interview, which was his normal baseline.-However, this was not (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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #2's demeanor during the interview during the survey on 3/26/26 (see the interview below). During the interview, the resident was very clear about his allegation and was not emotional or exaggerating the initial allegation he made about the staff's behavior, which he described as abusive behavior directed towards himself. In addition, the resident very clearly repeated his initial allegation that it was the LPN not the CNA, who abused him. The investigation documented LPN #1 was off for the next couple of days after the incident, while the investigation occurred and was interviewed by phone by the facility investigator. LPN #1's statement, dated 2/19/26, documented Resident #2 was yelling while CNA #1 was providing incontinence care from a bowel movement. He said the resident was yelling that CNA #1 was touching his anus and that was not what was happening. CNA #1's statement, dated 2/20/26, documented Resident #2 was yelling out to be changed and he and LPN #1 entered the resident's room. CNA #1 said he proceeded to clean Resident #2. During care, the resident said stop putting your finger in my anus. CNA #1 said he told the resident he was not putting his finger in his anus and continued to clean feces off the resident's buttocks and when finished, he left the room. -The facility failed to interview the resident's roommate to see if he saw or heard what occurred. The investigation documented that following the investigation, the facility determined the allegation was unsubstantiated based on the evidence and interviews conducted. There was no evidence or signs of trauma to the resident's rectal area and CNA #1 and LPN #1's interviews both corroborated their stories on what happened during the brief change. The resident also has a cognitive decline and terminal agitation, resulting in false allegations. The facility investigation documented Resident #2's care plan was updated to include a care focus for false allegations and care in pairs to ensure the safety of the resident and accuracy of care and treatment that was provided to the resident. -The facility failed to add a care plan focus to address Resident #2's allegation of rough care or method of incontinence care when a bowel movement occurred to ensure the resident did not feel like staff was being unnecessarily rough or abusive towards him. III. Resident #2A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included bipolar disorder, anxiety, depression, post-traumatic stress disorder and traumatic brain injury. The 3/23/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident had aggressive behavior towards others and experienced delusions. He was dependent on staff for toileting and transfers and bed mobility. The resident used a manual wheelchair and was dependent on staff for mobility. B. Resident interview and observation Resident #2 was interviewed on 3/26/26 at 1:28 p.m. Resident #2 said the care he had been receiving was terrible. He said the staff did not listen to him and were rough with care. He said he felt the staff's approach to his care was abusive. He said the nighttime nurse, LPN #1 was very rough towards him when providing his care. Resident #2 said on the night that he alleged he was abused (2/18/26), he tried to push LPN #1 away but he was weak and did not have enough strength to stop LPN #1 from rolling him over and wiping him. Resident #2 said he had limited mobility in both arms and could not reposition himself in bed without assistance from another person. Resident #2 said LPN #1 had rolled him over onto his side so aggressively his head hit the wall beside his bed. He said once he was on his side, LPN #1 began to wipe him so hard that he felt it was aggressive and abusive. He told LPN #1 to stop but he would not stop. Resident #2 said he did not want LPN #1 to provide his care but LPN #1 still provided his care, despite his request to leadership to prevent LPN #1 from taking care of him. Resident #2 said no one listened to him or believed him. Resident #2 said this was not the only time LPN #1 had been rough towards him. He said a few weeks prior, LPN #1 transferred him to bed in a rough manner, which caused him pain. He said in addition to LPN #1 providing rough care, Resident #2 said there were other staff members who failed to reposition him properly in his wheelchair, which caused him pain and bruising in his arms. Resident #2 said he had asked staff to assist him to sit up straight this morning (3/26/26) for breakfast so he could feed himself but staff did not assist him as he requested. Resident #2 said he had trouble eating when he (continued on next page)</p>		

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