

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/17/2025
NAME OF PROVIDER OR SUPPLIER  Crestmoor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  895 S Monaco Pkwy Denver, CO 80224	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to investigate allegations of abuse for one (#1) of five residents reviewed for abuse out of seven sample residents.</p> <p>Specifically, the facility failed to complete a thorough and timely investigation after Resident #1 made abuse allegations that staff and other residents were trying to harm her.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse policy, revised 2/29/24, was received from the nursing home administrator (NHA) on 6/17/25 at 12:46 p.m. It documented in pertinent part,</p> <p>The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends or any other individuals.</p> <p>If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Reporting can be completed verbally or in writing.</p> <p>In addition to an investigation by the police department, the facility conducts an internal investigation. While the investigation is ongoing, the alleged assailant has interventions implemented to help ensure the safety of the alleged victim as well as other residents. The investigation includes interviewing any staff members, residents or family members who may have knowledge of the incident.</p> <p>II. Allegation of abuse</p> <p>A. Facility investigation</p> <p>The 4/17/25 alleged physical or verbal abuse occurrence packet was provided by the NHA on 6/17/25. The packet revealed Resident #1 was interviewed on 4/17/25 and said her granddaughter hired a certified nurse aide (CNA) to try to kill her. Resident #1 stated she felt safe at the facility because she was at the NHA's office all day yesterday (4/16/25) and she was feeling better.</p> <p>(continued on next page)</p>

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>The packet documented that eight additional residents were interviewed on 4/18/25 with no additional information.</p> <p>A family member, who was not listed in Resident #1's electronic medical record (EMR) was interviewed on 4/18/25 with no additional information.</p> <p>-However, the family member who was interviewed was not involved in the incident (see interviews below).</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 4/18/25. The interview revealed LPN #1 reported Resident #1's son had reported Resident #1 was afraid of someone hurting her and that was why she left the facility (see progress notes below).</p> <p>Registered nurse (RN) #2 was interviewed on 4/18/25. The interview revealed that RN #2 interviewed Resident #1 and Resident #1 reported her granddaughter hired a CNA to try and kill her. RN #2's interview revealed that Resident #1 had a history of accusing her granddaughter and other family members of trying to poison her for her money.</p> <p>B. Resident #1</p> <p>1. Resident status</p> <p>Resident #1, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included dementia, delusional disorders and insomnia (sleeping disorder).</p> <p>The 5/30/25 minimum data set (MDS) assessment documented Resident #1 had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out 15. She was independent with all activities of daily living (ADL).</p> <p>The MDS assessment indicated Resident #1 did not exhibit physical or verbal behavioral symptoms directed toward others.</p> <p>2. Resident's family member interview</p> <p>Resident #1's son was interviewed over the phone on 6/17/25 at 3:25 p.m. The resident's son said he got a call from the pharmacist at the grocery store across from the facility on 4/14/25 in the evening. He said Resident #1 was fearful of a staff member and was saying how the staff member was rough with her and would push her. The son said he talked to the nurse at the facility and then was able to bring her back. He said at first Resident #1 refused to go back to the facility but he was able to bring her back. He said he stayed with her at the facility for a little while before having to leave to go to work. He said no staff from the facility had reached out to him about the incident after it occurred.</p> <p>3. Record review</p> <p>(continued on next page)</p>		

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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>The 4/14/25 nursing progress note documented by LPN #1 revealed that Resident #1 was socializing with other residents. When the time came to give Resident #1 her medication, Resident #1 could not be found. The resident's son came to the facility stating that Resident #1 said three other residents were trying to kill her. Resident #1 was calling her son from her cellphone. Resident #1 was found across the street from the facility at a grocery store. Resident #1's son was able to talk Resident #1 into coming back to the facility. Resident #1 entered the facility crying and upset, still stating that other residents were trying to kill her. Resident #1's son was going to stay in the facility overnight. The RN supervisor, the NHA and resident's representative were notified. 15-minute checks were started on Resident #1.</p> <p>A second 4/14/25 nursing progress note documented by RN #1 revealed that Resident #1 was assessed by the RN on the floor, the resident had no bruises or skin tears and Resident #1 was started on 15-minute checks. Resident #1 was in a stable condition and presently relaxed in her room with her son. The unit manager was notified and a report was given to the night supervisor.</p> <p>III. Staff interviews</p> <p>Regional clinical resource (RCR) #1, RCR #2 and the director of nursing (DON) were interviewed together on 6/17/25 at 1:52 p.m. RCR #1 said another RCR came to the facility on 4/17/25 to check in with other care areas. RCR #1 said the RCR identified the nursing progress note from 4/14/25 and initiated an investigation for Resident #1's allegations.</p> <p>RCR #2 said during the investigation, it was determined by the social services director (SSD) that Resident #1 was fearful of a staff member and not fearful of any residents.</p> <p>LPN #1 was interviewed on 6/17/25 at 2:20 p.m. LPN #1 said she was the nurse taking care of Resident #1 on the evening of 4/14/25. She said Resident #1 was outside in the courtyard with other residents during the evening of 4/14/25. LPN #1 said she saw the residents come back inside and she saw that Resident #1 was with them. She said she told Resident #1 it was time for her medications and LPN #1 went to get the medications. She said when she came back with the medications a few minutes later, Resident #1 was no longer there. She said she started to look around and asked the other residents where she had gone. She said the residents did not know where Resident #1 was and they started to look around. LPN #1 said she looked in rooms and could not find Resident #1.</p> <p>LPN #1 said she told other staff she could not find Resident #1 and one staff member told LPN #1 that Resident #1 sometimes used the bathroom in room [ROOM NUMBER]. LPN #1 said she looked in room [ROOM NUMBER] and could not find Resident #1. LPN #1 said the staff at the facility looked in all the rooms and bathrooms. She said after about 15 minutes of knowing Resident #1 was gone, Resident #1's son called the facility and talked to LPN #1. LPN #1 said the son called from the grocery store across the street and said he was with Resident #1. He said Resident #1 had said she was scared of three other residents at the facility and that they were trying to poison and kill her. He said she was very fearful and did not want to come back to the facility. After a few minutes, LPN #1 said the son convinced Resident #1 to go back to the facility and he brought her back. LPN #1 said she immediately called and reported the incident to the NHA and the unit nurse manager (RN #2). LPN #1 said the NHA and RN #2 had instructed her to do 15-minute checks on Resident #1 and assess her. LPN #1 said Resident #1 was very fearful and upset when she initially came back to the facility but calmed down back to her baseline after about an hour.</p> <p>(continued on next page)</p>		

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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>The SSD was interviewed on 6/17/25 at 2:58 p.m. The SSD said she was employed at the facility during the incident on 4/14/25. She said she was not there the evening of 4/14/25 or the next day, on 4/15/25. She said the process with any abuse allegations was to start an investigation right away. She said she typically helped with interviews. She said in this incident, the NHA had told her he wanted to run it through his bosses to see if it was necessary to do an investigation. She said there should have been no reason for delays in starting the investigation into Resident #1's allegations.</p> <p>The pharmacist was interviewed over the phone on 6/17/25 at 4:20 p.m. The pharmacist said she worked as a pharmacist at the grocery store pharmacy across the street from the facility. She said she had a good friend who she worked with at the facility and she referred community members needing assistance to the facility. The pharmacist said she knew Resident #1 from working with her and the facility. She said Resident #1 had a history of having delusions of people poisoning her food. She said she was not at the pharmacy on the evening of 4/14/25 but she had received a call from another pharmacist who was working and a pharmacy technician. She said the staff at the pharmacy had informed her that Resident #1 was at the pharmacy looking for the pharmacist. She said the technician said Resident #1 was very upset and scared. She said she tried talking to Resident #1 on the phone and could not completely understand what Resident #1 was saying. She said she called the resident's son and he said he was going to pick her up. The pharmacist said no staff from the facility had reached out to her about the incident that occurred.</p> <p>The DON and RCR #1 were interviewed together on 6/17/25 at 4:45 p.m. The DON said when there were abuse allegations involving a resident, the NHA was expected to be notified right away. The DON said the DON, the resident's representative and the physician were all expected to be notified as soon as possible. She said if a staff member called with abuse allegations during hours in which the DON or the NHA were not at the facility, the DON or the NHA would guide the staff on how to initially start the investigation.</p>		