STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065297	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Care Center	1660 Allison 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** 19262 Based on record review and interviews, the facility failed to prevent physical abuse for one (#274) of three residents reviewed for abuse out of 39 sample residents. Specifically, the facility failed to protect Resident #274 from physical abuse by Resident #276. Findings include: I. Facility policy and procedure The Abuse policy, dated 5/3/23, was provided by the nursing home administrator (NHA) on 3/10/25 at 11:47 a.m. The policy revealed the facility did not condone resident abuse and would 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. Residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraints not required to treat the resident's symptoms. Physical abuse was defined as abuse that resulted in bodily harm with intent. It included hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. (continued on next page)

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	The facility assessed each potential resident prior to admission. This assessment included a behavior history. Persons with a significant history or high risk of violent behavior were carefully screened and assessed for appropriateness of admission. If a resident experienced a behavior change resulting in aggression toward other residents, the community would implement interventions for protection of the alleged assailant and other residents. The facility would conduct further assessment and arrange for appropriate psychiatric evaluation for further screening. The resident's care plan would be revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization , would then be implemented. When another resident jeopardized the safety of one resident, alternative placement might be considered for that resident. If a cognitively intact resident willfully and knowingly abused another resident, the abused resident and the responsible party might file criminal charges against that resident. II. Incident of physical abuse between Resident #274 and Resident #276 on 5/25/24 The facility's incident report for physical aggression, dated 5/25/24 at 11:10 p.m., revealed Resident #276 hit Resident #274 multiple times in the head. Resident #274 was in a one-to-one altercation with her roommate, Resident #276. At 11:05 p.m. a certified nurse aide (CNA) overheard the altercations and quickly let nursing staff know. The CNA separated the residents and placed Resident #276 in an adjacent room. Resident #274 said Resident #276 hit her several times in the head. The altercation was related to the television sound being too loud with its level of sound on nine. Resident #274 received a skin tear to the left forearm above the wrist that measured two millimeters (mm). The skin tear was cleaned, dressed and an ice pack was placed on the area. A second nurse sat with Resident #274 to help calm her down. The residents were placed on 15-minute checks. The NHA and the director of nursing (DON) were notified and the altercation was placed on the 24-hour report. Staff would continue to monitor and the report would be passed on to the next shift. Registered nurse (RN) #2's statement regarding the incident revealed Resident #274 said that her roommate, Resident #276, hit her several times in the head and scratched her, related to the television sound being too loud. Resident #274 was oriented to person, place and time. Both residents' families, physicians were notified and the incident was reported to the State Agency. A typed statement by RN #2, dated 5/25/24 at 11:05 p.m., revealed Resident #274 told RN #2 that Resident #276 asked her to turn the (expletive) television down. Resident #276 was in her wheelchair, stood up next to Resident #274's bed and started throwing things off her table. Resident #274 said Resident #276 hit her in the face and left arm. She said Resident #276 hit her in the head about seven or eight times. RN #2's typed statement further revealed that the social services director (SSD) spoke with Resident #274 on 5/29/24 (not timed) about recapping what happened the night of the altercation. Resident #274 reported that she was watching television when Resident #276 said could you please turn the (expletive) television sound down. Resident #274 told Resident #276 she would not turn the television down because she would not be able to hear the television. Resident #274 said a few minutes later, she observed Resident #276 standing behind the curtain in the room and then Resident #276 started walking towards her. Resident #274 said her initial thought was that Resident #276 was walking to the bathroom. However, Resident #274 said that Resident #276 became very upset and came over to her and hit her what felt like seven or eight times. Resident #274 said she was unable to remember how or where she was hit, other than it felt like punches. Resident #274 reported that she tried to hold or push Resident #276 with one hand, but was unable to do so. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2's statement additionally revealed Resident #274 reported that during the chaos, Resident #276 knocked items off Resident #274's table and wanted to punch the television. Resident #274 told Resident #276 if she punched the television, she would need to pay the gentleman that let Resident #274 borrow his television. Resident #274 said shortly after this, a nurse and a CNA came into the room. Resident #274 seemed to remember a nurse sat with her for about an hour to help her calm down. Resident #274 said she did not see Resident #276 after the altercation. Resident #274 said she was taken to another room until the next morning and later moved to a room on the first floor. Resident #274 said she did not feel angry or have any symptoms of depression. Resident #274 said she was not afraid at the time of the interview. A second typed statement by RN #2, dated 5/25/24 at 11:40 p.m., revealed Resident #276 told RN #2 that she told Resident #274 to turn the television sound down several times because she was unable to sleep. Resident #276 said she got up in her wheelchair and smacked Resident #274 to make her turn the television down and she would do it again. She said Resident #274 was an awful roommate. RN #2's typed statement further revealed the SSD spoke with Resident #276 to follow up and gather more information. Resident #276 said she did not remember much of the event because it occurred a couple of days ago. However, Resident #276 said she had written Resident #274 a letter of apology and Resident #274 had declined the letter. Resident #276 said Resident #247 told the SSD that she would not like the letter. Resident #276 said Resident #274 was annoying and drove her off the rail (to behave in a way that was unacceptable). Resident #276 said she remembered going to the bathroom that night and asking Resident #274 to turn the television sound down. Resident #276 said she did not recall Resident #274's response, but she did remember sitting on Resident #274's bed uninvited. Resident #276 said she knew her roommate was likely irritated by this act and she asked Resident #274 to turn the television off again. Resident #276 said she did not remember the response by Resident #274. Resident #276 said she did not recall her motions but shortly after Resident #274's response, Resident #276 said she hit Resident #274 about three times or so. The SSD asked Resident #276 if she could explain a little more in detail of why she thought her roommate was awful or annoying. Resident #276 said that Resident #274 would not keep the sound on her television down. Resident #276 reported said she liked the fact that Resident #274 did not use her toilet or sink and often-needed assistance from staff. Resident #276 said the television was the reason she became angry. RN #2's typed statement revealed once the SSD left the room, Resident #276 presented remorsefully, apologized several times and reported that she would take a nap since she had already eaten lunch. A typed statement by CNA #5, dated 5/30/25 (not timed), revealed Resident #274 and Resident #276 were yelling at each other when she entered the room to turn the light off. CNA #5 said she went to go get the nurse to help deescalate the residents and when she left the room, she heard Resident #274 say Resident #276 was hitting her. CNA #5 said she ran down the hall, entered the room and saw Resident #276 hitting Resident #274. Resident #274 had her arm up to guard her face. At the time of the altercation, the only injury was a small skin tear on Resident #274's left wrist. CNA #5 helped the nurses move Resident #274 to a different room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A third typed statement by RN #2, dated 5/30/25 (not timed), revealed the incident between Resident #274 and Resident #276 happened around 11:00 p.m. (on 5/24/25). RN #2 said CNA #5 came out of the residents' room to tell her that Resident #276 was yelling at Resident #274 regarding the television. Resident #274's television was not at all loud at this time. RN #2 said CNA #5 ran out of the residents' room and requested her assistance again. RN #2 went into the room where Resident #274 was in bed and Resident #276 was sitting in her wheelchair near the sink. RN #2 said she asked what happened and Resident #276 yelled that she had asked Resident #274 to turn the television volume down and she would not, so she (Resident #276) hit her (Resident #274). The residents were separated immediately and a second nurse sat with Resident #274 for over an hour to ensure she was safe. III. Resident #274 - victim A. Resident status Resident #274, age greater than 65, was admitted on [DATE] and discharged to the hospital on 2/14/25. According to the February 2025 computerized physician's orders (CPO), diagnoses included anxiety, rheumatoid arthritis, moderate protein calorie malnutrition, emphysema, chronic pain, chronic obstructive pulmonary disease, heart failure and spinal instabilities. The 1/27/25 minimum data set (MDS) assessment documented the resident had intact cognitive ability with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required substantial/maximal staff assistance for upper body dressing, lower body dressing and putting on or taking off footwear. The assessment indicated the resident had no behaviors. B. Record review A care plan, initiated 5/13/24, revealed Resident #274 met the criteria for a major mental illness (MMI) with a primary diagnosis of generalized anxiety disorder and an additional diagnosis of recurrent major depression disorder. The resident denied any symptoms of depression but did endorse (support) feeling anxious over time. The resident had anxiety attacks and usually retreated to her room and calmed herself down if she felt anxious. The interventions included allowing the resident time to answer questions and to verbalize her feelings, perceptions, and fears as needed. Staff were to encourage the resident to participate in activities of daily living (ADL) and activities of interest on a daily basis. The resident preferred to watch television, read and conduct word puzzles. Staff were to notify the resident's representative/family/caregiver of any changes in the resident psychosocial status. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, initiated 4/9/24 and revised 5/31/24, for mood, revealed the resident had depression symptoms related to the diagnosis of depressive episodes with anxiety disorder. The resident could isolate herself at times. The resident preferred to do her own independent leisure and liked watching hallmark movies. The interventions included staff to monitor any changes in decrease of activities with her own independent leisure. Staff were to monitor/document/report as needed any sign or symptoms of depression, including, hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, and/or tearfulness. Staff were to monitor/record/report to her physician as needed any risk for harming others, including increased anger, labile mood or agitation, feeling threatened by others or thoughts of harming someone and/or possession of weapons or objects that could be used as weapons. A nurse progress note, dated 5/26/24 at 5:53 a.m. and written by RN #2, revealed Resident #274 was alert and oriented times two to three. Resident #274 was able to make her needs known to staff. The resident had a one-to-one altercation with her roommate at 11:05 p.m. The altercation was overheard by a CNA, who let nursing staff know quickly. The CNA separated the residents and Resident #274 was moved to an adjacent room. Resident #274 said that Resident #276 hit her several times in the head and scratched her related to the loudness of the television. The television was set at level nine. Resident #274 had a skin tear to the left forearm above the wrist that measured two mm. The skin tear was cleaned, dressed and an ice pack was placed on the area. A second nurse sat with the resident to calm her down. The resident was placed on 15-minute checks and the NHA and the DON were notified. The event was placed on the 24-hour report. The staff would continue to monitor the residents and the event would be passed on to the next shift. A nurse note, dated 5/26/24 at 4:35 p.m., revealed Resident #274 continued to be monitored for being the recipient of a physical altercation. The resident denied any pain or discomfort. The resident denied feeling fearful. A nurse note, dated 5/27/24 at 11:25 p.m. and written by a licensed practical nurse (LPN,) revealed Resident #274 continued to be monitored for an altercation. The resident was pleasant, calm and stayed in her room. No further altercations were noted. The resident had bruises and a skin tear to the left forearm with an intact dressing. The resident had a bruise to the left jaw, shoulder and neck. The resident complained of pain to her left arm and scheduled Tramadol was administered with positive effect. The resident remained on 15-minute checks. The resident rested in bed with her eyes closed. A physician's note, dated 5/29/24 at 3:12 p.m., revealed Resident #274 was seen for an annual physical assessment and a follow-up assessment following an assault by her roommate. The resident was alert/oriented to person, place and time. The resident's mental status was at baseline (normal). The resident said she had some left forearm pain/bruising and left shoulder discomfort. The resident said her left jaw area was also sore following the altercation over the weekend. The resident was positive for facial swelling and had surrounding bruising with mild tenderness/pain on the left lower jaw area. The resident had mild pain and bruising on the left forearm and left shoulder area. The facility staff said the resident had done well since being moved out of her old room where the altercation occurred. IV. Resident #276 - assailant A. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #276, age greater than 65, was admitted on [DATE] and passed away on 10/14/24. According to the October 2024 CPO, diagnoses included schizoaffective disorder, vascular dementia with mood disturbance, memory deficit following a cerebrovascular disease (stroke) and stage 4 chronic kidney disease. The 7/15/24 MDS assessment documented the resident had intact cognition with a BIMS score of 14 out of 15. The resident required setup or clean-up staff assistance) for upper body dressing. The resident required substantial/maximal staff assistance for lower body dressing and putting on or taking off footwear. The assessment indicated the resident had no behaviors. B. Record review A care plan, initiated 10/25/23 and revised on 10/20/24, for impaired cognitive function or impaired thought process related to vascular dementia with mood disturbance and memory deficit following cerebrovascular disease. Interventions included for staff to reduce any distractions, such as turning off the television or radio and closing the entrance door. The resident understood consistent, simple, directive sentences. Staff were to provide the resident with necessary cues and to stop/return if agitated. Staff were to monitor/document/report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and/or mental status. A care plan, initiated 5/28/24 (following the altercation with Resident #274) and revised 10/20/24, revealed Resident #276 had a history with the potential to be physically aggressive towards other residents, including her roommate which could be related to poor impulse, depression and anger. The resident had a related diagnosis of schizoaffective disorder and vascular dementia with mood disturbance. Intervention included for staff to analyze the times of day, places, circumstances, triggers and what deescalated the resident's behavior and document. The resident had identified a loud environment as a potential trigger and staff were to redirect the resident to a quiet area when agitated. The resident had triggers for physical aggression, which included her roommate using the toilet and having the television on at night. Staff were to modify the resident's environment by reducing the noise, dimming the lights, keeping the blinds open, placing familiar objects in the room and keeping the entrance door open. When the resident became agitated, the staff were to intervene before the agitation escalated, guide the resident away from the source of distress and engage the resident calm in conversation. If the resident's response was aggressive, staff were to ensure the resident and other residents' safety, walk calmly away, and approach later. The resident's behaviors were de-escalated by offering her a room change or providing a safe space to talk and air her emotions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note, dated 5/26/24 at 5:45 p.m. and written by RN #2, revealed Resident #276 was alert and oriented times one to three. The resident was able to make her needs known. The resident had a one-to-one altercation with her roommate at 11:05 p.m. Resident #276 was the instigator. Resident #276 was screaming at her roommate to turn the (expletive) television sound down several times. The resident got out of bed into her wheelchair and rolled to Resident #274's side of the room, stood up and swatted Resident #274 on the head. Resident #274 was hit on the head several times and received a small skin tear on the left forearm above the wrist measuring two mm. The skin tear was cleaned and dressed. The residents were separated. Resident #276 was moved to another room and placed on 15-minute checks. Resident #276 said she would hit Resident #274 again even after being told it was assault/battery and that she could not hit people. Resident #276 said she would go to jail. Statements were taken from both residents and were placed on the 24-hour report. The NHA and the DON were notified. The nurse would continue to observe and would pass on the information to the next shift. A nurse progress note, dated 5/27/24 at 1:03 p.m., revealed Resident #276 was alert and oriented times two to three. The resident continued to be followed up on related to a one-to-one altercation. The resident was at her baseline and expressed remorse when she was reoriented to the reason for 15-minute checks, but she was unable to reliably assess veracity (accuracy) of it. A nurse note, dated 5/28/24 at 1:18 p.m., revealed Resident #276 was alert and oriented times two to three. The resident continued to blame her roommate for the one-to-one aggression and for the incident. The resident had no signs of remorse. The resident was isolated in her room except for lunch and dinner. A psychosocial/social services note, dated 5/28/24 at 2:30 p.m. and written by the SSD, revealed Resident #276 said in the past that she preferred to continue her therapy visits with her psychiatrist. However, given the most recent event with her roommate, a mental health services facility had been contacted and would contact the SSD in two business days. A nurse progress note, dated 5/29/24 10:49 a.m. and written by the DON, revealed she spoke with a nurse practitioner (NP) to follow up on Resident #276's incident and increase in agitated behaviors. In the past six months, the resident had a gradual dose reduction of Duloxetine (medication for the treatment of anxiety and depression) from 90 milligrams (mg) in February 2024 to 60 mg. In April 2024, the medication was reduced to 30 mg. The NP ordered the medication to be increased back to 60 mg. Because the dose provided the most stability for the resident's behaviors. Behavioral health services were to meet with the resident and review her medications. The DON would follow up with the NP after the follow up by a behavioral health services consultation with their recommendations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's psychological follow up, dated 5/29/24 at 2:00 p.m., revealed the chief complaint was agitation. Resident #276 was irritable and had a blunted (reduced or flat) affect. She was alert/oriented to time, place, person and situation. The resident was verbal and could communicate with staff effectively. There was no clear indication of significant cognitive impairment. The resident's memory, complex attention, concentration and language all appeared predominately intact. At approximately 11:00 p.m. (on 5/25/24), Resident #276 became agitated and irritable and assaulted her roommate, who was watching television, according to the DON. At first, the resident was cursing because she wanted to turn off the television, but when the roommate did not comply, she assaulted her. The resident expressed regret for her actions. The facility staff reported the resident's affect and behavior were baseline with ongoing agitation and aggression. Previously experienced symptoms appeared to be exacerbated as above, despite medications and/or behavioral interventions from staff. This encounter was completed in person and the physician assessed Resident #276's safety and deemed the current risk to be moderate. A safety plan was not required. A nurse practitioner (NP) progress note, dated 5/30/24 at 7:20 p.m. (written as a late entry), revealed the nursing staff reported that Resident #276 got into a physical altercation with her roommate last night (5/25/24). The nurse reported that Resident #276 initiated the altercation. The resident expressed remorse and stated that Resident #274 did not deserve the altercation and Resident #276 did not know why she lashed (suddenly tried to hit) out like that. Resident #274 had switched rooms. The resident was now being administered Duloxetine HCL 30 mg capsules with delayed release particles and was administered two capsules (60 mg) orally one time a day related to schizoaffective disorder. V. Staff interviews The SSD was interviewed on 3/13/25 at 10:50 a.m. The SSD said she was not in the facility when the event between Resident #274 and Resident #276 occurred. She said she followed up on the investigation of the event. She reviewed her typed statement and agreed to its content. The SSD said she spoke with Resident #274 on 5/29/24 about recapping a little of what happened the night of the altercation. She said Resident #274 reported that she was watching television when Resident #276 asked her to turn the television sound down. She said Resident #274 told Resident 276 she would not turn the television down because she would not be able to hear the television. The SSD said Resident #274 told her that a few minutes later, she observed Resident #276 standing behind the curtain in the room and then Resident #276 started walking towards her. She said Resident #274 said her initial thought was that Resident #276 was walking to the bathroom. However, the SSD said Resident #274 said that Resident #276 became very upset and came over to her and hit her what felt like seven to eight times. The SSD said Resident #274 was unable to remember how or where she was hit, other than it felt like punches. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said Resident #274 reported that she tried to hold or push Resident #276 with one hand, but was unable to do so. She said Resident #274 told her that during the chaos, Resident #276 knocked items off Resident #274's table and wanted to punch the television. She said Resident #274 told her she informed Resident #276 if she punched the television, she would need to pay the gentleman that let Resident #274 borrow his television. The SSD said Resident #274 reported that shortly after this time, a nurse and a CNA came and she seemed to remember that a nurse sat with her for about an hour to help her calm down. She said Resident #274 told her she did not see Resident #276 after the altercation. The SSD said Resident #274 was taken to another room until the next morning and later moved to a room on the first floor. Resident #274 said she did not feel angry or had any symptoms of depression. Resident #274 said she was not afraid at the time of the interview. The NHA was interviewed on 3/13/24 at 11:04 a.m. The NHA said she was not in the facility at the time of the altercation. She said she was called by a RN at approximately 11:00 p.m. (on 5/25/24). She said the residents had been separated and Resident #274 was now in a different room. The NHA said both residents were placed on 15-minute checks. She said to her knowledge, both residents were not afraid of each other. She said this was their first altercation to her knowledge. The NHA said the altercation took place in the residents' room on the second floor and Resident #274 was then moved to a room on the first floor. She said the residents did not have any further altercations and neither of the residents had any altercations with other residents. The NHA said Resident #276 was very remorseful of the altercation about the television and wrote a letter of apology to Resident #274, but Resident #274 did not accept the letter. The NHA said this was the first aggressive behavior by Resident #276. The DON was interviewed on 3/13/25 at 11:40 a.m. The DON said she was not in the facility at the time of the event. She said she was called by a RN and was first told there was a verbal disagreement between the two residents related to the sound volume of the television. She said she was told Resident #276 was yelling and made contact with Resident #274's arm that produced a skin tear. The DON said Resident #274 did develop bruising on the left side of the face and on the arm. She said both residents were separated and it was concluded that this was a reportable event to the state electronic portal system. The DON said she came into the facility the next day (5/26/24) and the residents were in separate rooms. She said the residents had shared a room and both were in separate rooms on the second floor. She said Resident #274 said she was okay to move to a first floor room and Resident #276 went back to her original room on the second floor. The DON said this was the first altercation between these two residents. She said neither of them had any previous altercations with other residents. The DON said she talked to both residents the next day after the altercation and neither of them were afraid. Resident #276 wrote a letter of apology to resident #274, but she would not accept the letter.