

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

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Allison Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		

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	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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews the facility failed to provide the necessary services to maintain personal hygiene for one (#37) of three residents reviewed for services to maintain highest practicable quality of life out of 39 sample residents. Specifically, the facility failed to ensure Resident #37 consistently received assistance to maintain oral hygiene. Findings include: I. Facility policy and procedure The Supporting Activities of Daily Living policy and procedure, revised March 2018, was received from the nursing home administrator (NHA) on 3/10/25 at 10:46 a.m. It read in pertinent part, Appropriate care and services will be provided for residents who are unable to carry out activities of daily living (ADL) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with oral care. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem. II. Resident #37 A. Resident status Resident #37, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (paralysis on one side of the body), vascular dementia and a history of falling. The 2/19/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. The resident required substantial assistance with most activities of daily living (ADL). The resident required set-up or clean-up assistance for oral hygiene. -However, record review and interviews revealed Resident #27 frequently needed more than set-up/clean-up assistance (see record review and interviews below). B. Resident interview and observations On 3/10/25 at 11:18 a.m. Resident #37 said no one helped her brush her teeth and that she brushed her teeth herself. Resident #37 had visible accumulation of biofilm and debris on her teeth, gums and tongue. On 3/11/25 at 9:55 a.m. Resident #37 had a visible accumulation of biofilm and debris on her teeth and gums. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 11:00 a.m. Resident #37 had a visible accumulation of biofilm and debris on her teeth and gums. C. Record review The ADL care plan, revised 3/2/25, revealed Resident #37 had a self-care performance deficit due to her dementia, hemiparesis and limited mobility. Pertinent interventions included conducting oral inspections frequently and reporting any changes to the nurse. Dental records, dated 6/5/24, revealed Resident #37 was seen for a fluoride treatment, screening and periodontal maintenance. Resident #37 cooperated well with the treatment. Resident #37's oral screening revealed moderate bleeding, moderate plaque, moderate calculus, localized gingival recession, moderate gingival inflammation and poor oral hygiene. Dental records, dated 10/4/24, revealed Resident #37 was seen for a fluoride treatment, screening and periodontal maintenance. Resident #37 cooperated well with the treatment. Resident #37's oral screening revealed heavy bleeding, moderate plaque, moderate calculus, localized gingival recession, moderate gingival inflammation and poor oral hygiene. Dental records, dated 2/14/25, revealed Resident #37 was seen for a fluoride treatment, screening and periodontal maintenance. Resident #37 cooperated well with the treatment. Resident #37's oral screening revealed moderate bleeding, moderate plaque, moderate calculus, localized gingival recession, moderate gingival inflammation and poor oral hygiene. Review of the oral hygiene resident ability task from 2/11/25 through 3/12/25 revealed the following: -No result was marked on 2/11/25 through 2/18/25 and 2/24/25; -Activity did not occur was marked 14 times; -Not applicable was marked seven times; -Setup/clean-up assistance was marked four times; -Supervision/touching assistance was marked one time; -Partial/moderate assistance was marked two times; -Substantial/maximal assistance was marked six times; and, -Dependent was marked seven times. Review of the oral hygiene task from 2/11/25 through 3/12/25 revealed the following: -No oral care was documented as completed on 2/17/25 through 2/20/25, 2/23/25, 2/24/25, 2/27/25 through 3/2/25, 3/9/25, and 3/12/25 through 3/13/25; and, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oral care was marked as completed once on 2/14/25, 2/21/25, 3/5/25, 3/8/25 and 3/11/25. IV. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 3/12/25 at 3:52 p.m. CNA #4 said Resident #37 could brush her teeth by herself but sometimes needed help. CNA #4 said Resident #37 only sometimes brushed her teeth in the mornings but always brushed her teeth before going to sleep. CNA #4 said she recorded when Resident #37 brushed her teeth in her electronic medical record (EMR). CNA #6 was interviewed on 3/13/25 at 9:21 a.m. CNA #6 said Resident #37 needed a lot of help with brushing her teeth. CNA #6 said Resident #37 could sometimes brush her teeth by herself, but could not do so other times, so the CNAs would help her perform the task. CNA #6 said she helped Resident #37 brush her teeth once in the morning and again at night, and marked that she had brushed her teeth in the oral care task in the resident's EMR. Registered nurse (RN) #1 was interviewed on 3/13/25 at 9:45 a.m. RN #1 said Resident #37 could brush her own teeth but needed staff assistance with set-up. RN #1 said Resident #37 needed prompting to brush her teeth as it was not something that she remembered to do. RN #1 said oral hygiene needed to be performed at least once a day, and that had been explained to the CNAs. RN #1 said she did not know of any instances where oral care had been missed. The director of nursing (DON) was interviewed on 3/13/25 at 12:45 p.m. The DON said Resident #37 could brush her teeth by herself but needed encouragement and cueing by the nursing staff. The DON said oral care should be performed at least twice a day and the CNAs would document it once it was completed under the oral hygiene task in the EMR. The DON reviewed Resident #37's oral hygiene task and verified there was missing documentation during both morning and evening shifts. The DON said the nursing staff needed to improve their documentation. The DON said Resident #37 did not have any oral health issues she was aware of. -However, review of the dental records from 6/5/24, 10/4/24 and 2/14/25 revealed the dentist documented the resident had poor oral hygiene (see record review above) and observations revealed Resident #37 had build-up on her teeth (see observations above).		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure three (#279, #30 and #40) of six residents reviewed for accidents out of 39 sample residents remained free from accidents. RESIDENT #279 Resident #279, was admitted on [DATE] with diagnoses of hemiplegia (weakness on one side) after an intracerebral hemorrhage (stroke) and dementia with behaviors. The resident was identified to be at very high risk for falling. On 2/12/25 Resident #279 experienced a fall shortly after admission and the facility implemented a fall care plan with interventions which included ensuring the resident's call light was in reach and encouraging the resident to use the call light. However, the resident had severe cognitive impairments. Resident #279 sustained witnessed falls on 2/14/25 and 2/15/25. The resident was sent to the hospital following the 2/15/25 fall for evaluation of back pain and returned to the facility. The intervention the facility identified for both of these falls was a referral for behavioral health management as the resident was agitated at the time of the falls. The facility did not update the resident's care plan with the behavioral health management referral. The facility failed to identify any further fall interventions until 2/24/25, to include providing prompt response to all requests for assistance as the resident had fluctuating ability to utilize her call light and providing consistent rounding on the resident. However, on 2/26/25 Resident #279 sustained an unwitnessed fall in a common area of the facility which resulted in a right proximal femur fracture (thigh bone close to the hip) that required hospitalization and a right trochanteric fixation nail (TFN) surgical repair of the fracture. The facility failed to identify a root cause of the resident's fall. Upon Resident #279's readmission to the facility on [DATE], the facility failed to implement new fall interventions to prevent further falls for the resident. Due to the facility's failures to implement and document effective and timely person-centered interventions following falls on 2/12/25, 2/14/25 and 2/15/25, Resident #279 sustained a fall on 2/26/25 which resulted in a right femur fracture. RESIDENT #30: Resident #30, was admitted on [DATE] after hospitalization for a right femur fracture that required an IM (intermedullary nail, which is a rod that is inserted into the hollow portion of the femur to stabilize a fracture) hip nailing and was identified as a high fall risk. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/10/24, Resident #30 sustained an unwitnessed fall out of bed. The facility failed to implement new person-centered effective and timely fall interventions after the fall. On 9/20/24, Resident #30 experienced a second unwitnessed fall out of bed which resulted in a fracture around the right femur hardware that required hospitalization and further surgical repair. The facility failed to identify a root cause of the resident's fall. Upon Resident #30's readmission to the facility on [DATE], the facility failed to implement new fall interventions to prevent further falls for the resident. Due to the facility's failures to implement and document timely person-centered interventions following Resident #30's fall on 9/10/24, the resident sustained a fall on 9/20/24 which resulted in a right femur fracture around the hardware from her previous femur fracture. Additionally, Resident #30 sustained five additional witnessed and unwitnessed falls on 10/1/24, 11/16/24, 12/9/24, 2/6/25 and 2/13/25. The facility failed to update the resident's care plan with new person-centered fall interventions following the resident's falls on 10/1/24, 11/16/24, 2/6/25 and 2/13/25. The facility updated the resident's care plan with new fall interventions following the resident's 12/9/24 fall, however, the care plan was not updated until 12/16/24, seven days after the fall. RESIDENT #40: Resident #40, who was admitted on [DATE] with diagnoses of dementia and Alzheimer's disease, was identified as a fall risk. Resident #40 sustained falls on 4/11/24, 10/28/24, 1/10/25 and 1/18/25. The facility failed to update the resident's care plan with new person-centered fall interventions following each of the falls. On 1/21/25 Resident #40 sustained a fifth fall which resulted in a laceration to the resident's head that required transportation to the hospital emergency room to have the laceration glued to close it. According to the resident's progress notes, the facility implemented anti-tip devices on the resident's wheelchair following the fall on 1/21/25, however the resident's care plan was not updated with the intervention and observations during the survey revealed there were no anti-tip devices on the resident's wheelchair. Resident #40 sustained an additional fall on 3/6/25 and two additional falls on 3/9/25. Due to the facility's failures to implement and document timely person-centered interventions following falls on 4/11/24, 10/28/24, 1/10/25 and 1/18/25, Resident #40 sustained a fall on 1/21/25 which required treatment at the hospital for a head laceration. Findings include: I. Facility policy and procedure (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Management policy and procedure, revised 2/29/24, was provided by the nursing home administrator (NHA) on 3/13/25 at 2:20 p.m. It read in pertinent part, The purpose of this fall management policy is to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury. To be effective, a fall reduction program is characterized by four components: fall risk evaluation, care planning and implementation of interventions, ongoing evaluation process quality assurance performance improvement (QAPI), and a commitment by caregivers to make it work. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Interventions are to be re-evaluated when a resident falls for efficacy. II. Resident #279 A. Resident status Resident #279, age 87, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included right femur (thigh bone) fracture and hemiplegia after an intracerebral hemorrhage and dementia with behaviors. The 2/17/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. She was dependent on staff for toileting, required substantial/maximal assistance with personal hygiene, transfers, partial/moderate assistance with bed mobility and required set up assistance with eating. The assessment indicated Resident #279 had two falls without injury and one fall with injury since admission. B. Observations On 3/11/25 at 12:09 p.m. Resident #279 was sitting in a wheelchair at a table in the dining room with another resident. Nursing staff were not present in the dining room or in the nursing station adjacent to the dining room. On 3/12/25 at 9:40 a.m. Resident #279 was sitting with another resident at the table in the dining room. One unidentified dining staff member was in the dining room. Nursing staff were not present in the nursing station adjacent to the dining room. C. Record review (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, initiated 2/12/25 and revised 3/9/25, indicated Resident #279 had impaired physical mobility related to a right femur fracture. Interventions included wheelchair for mobility (initiated 2/12/25), assistance with ambulation as indicated (initiated 2/12/25), transfers by staff (initiated 2/12/25), resident encouragement to use call light (initiated 2/12/25), weight bearing as tolerated to right lower extremity after a TFN (trochanteric fixation nail to fix a proximal femur fracture) (initiated 2/27/25) and physical therapy and occupational therapy (PT/OT) (initiated 3/9/25). The fall care plan, initiated 2/12/25 and revised 3/9/25, indicated Resident #279 was a high fall risk due to impulsive behavior, easily agitated, poor balance and safety awareness, on psychoactive and anticonvulsive medications and had experienced a right femur fracture on 2/26/25. Interventions included anticipating the resident's needs (initiated 2/12/25), assessing the resident for adaptive devices (initiated 2/12/25), ensuring the call light was in reach and encouraging the resident to use the call light (initiated 2/12/25), encouraging adequate lighting and visual aids were in place and assessing for communication needs (initiated 2/12/25), ensuring appropriate footwear when ambulating or mobilizing in wheelchair (initiated 2/12/25), PT evaluation and treat as necessary (initiated 2/12/25), bed in lowest position while in bed (initiated 2/12/25), reviewing past falls and determining cause of falls, recording possible root causes for falls (2/12/25), medication review with consultant pharmacist (initiated 2/24/25), providing prompt response to all requests for assistance as resident had fluctuating ability to utilize call light and providing consistent rounding on resident (initiated 2/24/25). -The interventions initiated on 2/12/25 were not person-centered interventions specific to Resident #279. -Person-centered interventions were not identified after a witnessed fall on 2/14/25 when Resident #279 fell out of bed or after a witnessed fall on 2/15/25 when Resident #279 fell in the hallway without her walker and wheelchair (see below). -The care plan failed to identify and document a root cause with person-centered interventions after Resident #279 experienced an unwitnessed fall on 2/26/25 in a common area which resulted in a right femur fracture that required hospitalization and surgical intervention (see below). The 2/12/25 nursing progress notes documented Resident #279 was admitted at 2:00 p.m. Resident #279 was found on the floor in front of her wheelchair. The resident was assessed without injuries. The 2/12/25 nursing fall risk evaluation documented Resident #279 was a very high fall risk. The 2/13/25 interdisciplinary team (IDT) risk management note documented the root cause of Resident #279's fall was she was new to the facility and was disoriented and confused. Interventions that were put into place were a medical review and therapy services. The 2/14/25 nursing progress notes documented Resident #279 experienced a witnessed fall without head involvement. Resident #279 had attempted to get out of bed unassisted. The resident was assessed without injuries. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 2/14/25 IDT risk management note documented Resident #279 fell from the side of the bed to the floor. The root cause was identified as resident agitation, striking out at staff and lost her balance. Interventions that were put into place were behavioral health management to evaluate and treat. The 2/15/25 at 1:54 p.m. nursing progress notes documented Resident #279 had a fall at 1:00 p.m The ambulance was called at 1:15 p.m. and Resident #279 was transported to the hospital. The 2/15/25 at 9:24 p.m. nursing progress notes documented Resident #279 returned from the hospital. The 2/15/25 IDT risk management note documented a witnessed fall. Resident #279 was walking in the hallway without her walker or a wheelchair. The resident became agitated when staff attempted to assist and lost her balance. The root cause was identified as disorientation and agitation. The resident was transported to the hospital after complaining of back pain. The intervention identified was a referral to behavior health management. -However, personalized interventions for falls and behavioral health referral were not identified on the care plan after the 2/14/25 and 2/15/25 falls (see care plan above). The 2/19/25 behavioral health progress note documented for provider to consider adjusting Resident #279's psychoactive medications and monitor for side effects. The 2/26/25 at 5:15 a.m. nursing progress notes documented Resident #279 had an unwitnessed fall. It documented nursing staff at the nurse's station heard the sound of the couch in the lobby hitting the ground and Resident #279 crying and screaming. Resident #279 was observed on the ground with the couch on top of her. Resident #279 was assessed to have right lower extremity pain. Resident #279 was treated with diclofenac gel (an anti-inflammatory pain medication) and returned to her room. The physician was notified and an x-ray of the resident's right femur and hip were ordered. The 2/26/25 at 8:20 a.m. nursing progress noted documented Resident #279 had a right femoral fracture and was sent to the hospital for further evaluation. The 2/26/25 at 10:30 a.m. behavioral health note documented recommendations for adjusting medications with behavior interventions. Behavior interventions included actively monitoring the resident and surroundings to minimize known stressors, monitoring residents with poor safety awareness, avoid leaving the resident alone or with other residents unless staff were completing frequent, structured checks, maintaining visual supervision when in wheelchair, remaining as close as possible to intervene if necessary, anticipating resident's needs, providing resident with guided choices, if resident became upset, stepping back and engaging in conversation, setting clear boundaries with the resident regarding behavior of concern and remaining calm and neutral and redirecting resident with preferred activity. The 3/3/25 hospital discharge summary documented Resident #279 was admitted on [DATE] with a right femur fracture and orthopedic consult and underwent a right TFN hip nailing on 2/27/25. -However, a comprehensive review of the electronic medical record (EMR) failed to reveal an IDT risk management note of the 2/26/25 incident with a root cause analysis of the fall and interventions that needed to be implemented to prevent further falls. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	D. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/12/25 at 12:30 p.m. CNA #3 said Resident #279 was more calm since her medications were adjusted. She said when Resident #279 was first admitted to the facility, she became upset very easily and would not calm down. She said Resident #279 was very impulsive. She said the agitation and behaviors contributed to Resident #279's falls. She said Resident #279 now spent most of her time sitting in the dining room and staff did not do many activities with her. CNA #3 said she was not aware of any specific fall interventions for Resident #279. Registered nurse (RN) #3 was interviewed on 3/13/25 at 12:20 p.m. RN #3 said Resident #279 had a history of a traumatic brain injury and was independent prior to her admission to the facility. She said when Resident #279 was first admitted to the facility, she would thrash around and was a high fall risk. She said Resident #279 did not like too much stimulation and did not like to be pushed to do anything. She said Resident #279 did like a social environment and did well in the dining room with other people. She said she did not do well with male caregivers and tended to do better with younger female caregivers. She said during the day, staff kept her in the dining area so they could keep an eye on her. RN #3 said she thought Resident #279 had a fall mat and a low bed when she was in bed. The director of nursing (DON) was interviewed on 3/13/25 at 12:26 p.m. The DON said Resident #279 was a relatively new admission to the facility and staff were still getting to know her and what worked for her. She said Resident #279 admitted to the facility with behaviors and would refuse care. She said staff had to give her space or she would scream and accuse staff of harming her. The DON said the fall where Resident #279 experienced the fracture had occurred in the evening in the lobby. She said when staff reviewed the camera footage, Resident #279 had attempted to walk to the therapy room which was next to the lobby. She said Resident #279 was unable to open the door to the therapy room and attempted to walk behind the couch using the couch for balance. She said Resident #279 lost her balance and grabbed onto the couch, which fell on top of her. She said the nursing staff were giving report at the nurses' station at the time, which was in the lobby. She said on the camera footage, the nurses were not in direct line of sight of the resident when the fall occurred. The DON said an intervention that was helpful in alleviating Resident #279's agitation and behaviors which contributed to her falls was calling Resident #279's son. She said too much stimulation and too many staff members attempting to assist the resident increased her agitation. She said Resident #279 did not want male caregivers and there were certain staff members that she preferred. She said one caregiver at a time should approach her. She said the staff also lowered her bed when she was in it. She said Resident #279 enjoyed social interaction with others in the dining room. The DON said staff were not using a fall mat as an intervention because of the tripping hazard. She said she did not know if a special lipped mattress was being used. She said there was an order for behavioral health to see her and talk of adjusting her psychoactive medications. The DON said Resident #279 was working with physical therapy now. -The personalized interventions described by RN #3 and the DON, such as one staff member approaching the resident, avoidance of male caregivers, using preferential female caregivers, keeping the resident in line of sight, calling the resident's son and enjoying social interactions in the dining room, were not included in the care plan. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurse quality mentor (NQM) was interviewed on 3/13/25 at 12:35 p.m. The NQM said the facility was working on an action plan to address recently admitted residents who were a fall risk. -However, documentation of the facility's action plan was not provided during the survey. III. Resident #30 A. Resident status Resident #30, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included Alzheimer's disease, osteoporosis and right femur fracture. The 12/23/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. She was dependent on staff for toileting, personal hygiene, required substantial/maximal assistance with bed mobility, transfer and required set up assistance with eating. The assessment indicated Resident #30 had two or more falls without injury and one fall with injury since admission. B. Observations On 3/12/25 at 9:05 a.m. Resident #30 was sleeping in her bed with the bed in the lowest position with a fall mat at the bedside. On 3/12/25 at 12:00 p.m. Resident #30 was sleeping in her bed with the bed in the lowest position with a fall mat at the bedside. C. Record review The ADL care plan, initiated 8/19/24 and revised 10/6/24, indicated Resident #30 had impaired physical mobility due to a previous history of a right femur fracture with IM hip nailing. Interventions included staff assistance with mobility (initiated 8/19/24), wheelchair for mobility (initiated 8/19/24) and weight bearing as tolerated to the right lower extremity (initiated 10/6/24). The fall care plan, initiated 8/19/24 and revised 12/16/24, indicated Resident #30 was at risk for falls due to poor balance and safety awareness, impulsivity and history of falls. It indicated Resident #30 had a history of crawling out of her bed and wheelchair. Interventions included anticipating the resident's needs (initiated 8/19/24), providing a grab bar in the bathroom with non skid strips (initiated 8/19/24), resident's call light within reach and encouraging use of the call light (initiated 8/19/24), providing prompt response to all requests for assistance (initiated 8/19/24), ensuring adequate lighting and visual aids and assessing for communication needs (initiated 8/19/24), PT evaluation and treatment with wheelchair adjustments as indicated (initiated 8/19/24), bed in lowest position with fall mat when resident was in bed (initiated 8/19/24), reviewing past falls and determining the cause of falls, recording possible root causes and assisting the resident up as resident was an early riser, as she allowed (initiated 8/19/24 and revised 12/16/24), encouraging rest periods when resident exhibited signs of fatigue (initiated 12/16/24), fall mat (initiated 12/16/24) and medication review with consultant pharmacist (initiated 12/16/24). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The interventions initiated on 8/19/24 were not person-centered interventions specific to Resident #30. -Person-centered fall interventions were not identified after the resident's unwitnessed 9/10/24 fall (see below). -The care plan failed to identify and document a root cause with person-centered interventions after Resident #30 experienced an unwitnessed fall on 9/20/24 which resulted in a periprosthetic (a fracture around the previous surgical hardware) right femur fracture that required hospitalization (see below). -The care plan failed to document person-centered interventions for Resident #30's witnessed and unwitnessed falls on 10/1/24, 11/16/24, 12/9/24, 2/6/25 and 2/13/25 (see below). The 9/10/24 nursing progress note documented Resident #30 had an unwitnessed fall. Resident #30 was on the floor by the bed, soiled, during 4:00 a.m. rounds. Resident #30 told the staff she had to go to the bathroom and fell down. Resident #30 was assessed without injury or pain. The 9/10/24 IDT risk management note documented an unwitnessed fall. The root cause was determined to be after Resident #30 had a sudden urge to use the bathroom and fell to the floor when attempting to transfer. Interventions included working with therapy on transfers, dressing, toileting, strengthening and balance and providing a beveled fall mat at the resident's bedside. -However, the interventions identified in the IDT note had already been initiated on 8/19/24 and were not new fall interventions (see care plan above). The 9/11/24 at 11:00 a.m. nursing progress note documented Resident #30 was complaining of severe pain in her right hip. The physician was notified and a right hip x-ray was ordered. The 9/11/24 at 4:00 p.m. nursing progress note documented Resident #30's x-ray was taken and the facility was awaiting results. -However, a review of Resident #30's EMR progress notes failed to reveal documentation of the hip x-ray results. The 9/20/24 nursing progress note documented Resident #30 had an unwitnessed fall. Resident #30 was found on the floor on a blanket by the side of her bed. Resident #30 was complaining of pain in the right hip. The physician was notified and the resident was sent to the hospital for evaluation and treatment. The 9/20/24 hospital progress notes documented Resident #30 had recent right hip surgery and now presented with a significant displaced fracture below the previous right hip hardware. She was admitted for orthopedic consultation. -A comprehensive review of the EMR failed to reveal an IDT risk management note of Resident #30's 9/20/24 fall with a root cause analysis and new person-centered fall interventions that needed to be implemented. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 9/27/24 nursing progress notes documented Resident #30 was readmitted to the facility from the hospital with a right femur fracture. The 10/11/24 IDT risk management progress note documented a witnessed incident on 10/1/24. Resident #30 slid or lowered herself from the edge of the wheelchair to the floor. The root cause was documented as Resident #30 had dementia and poor safety awareness with increased confusion after recent surgery. Interventions documented were a therapy evaluation for wheelchair positioning with the wheelchair seat lowered. -However, the IDT risk management progress note was documented ten days after the incident occurred on 10/1/24. -The facility failed to update the resident's fall care plan with the fall intervention following the 10/1/24 fall (see care plan above). The 11/18/24 IDT risk management progress note documented an unwitnessed incident on 11/16/24. The resident was sitting on the floor at the foot of her roommate's bed with her legs stretched out. The root cause was Resident #30 most likely needed to use the bathroom, was incontinent and was wanting to change. Interventions documented were to provide hygiene and care, environmental rounds for safety, low bed and fall mat in place. -The facility failed to update the resident's fall care plan with the fall interventions following the 11/16/24 fall (see care plan above). -Additionally, the interventions for the low bed and fall mat identified in the IDT note had already been initiated as interventions on 8/19/24 and were not new fall interventions (see care plan above). The 12/16/24 IDT risk management progress note documented an unwitnessed incident on 12/9/24. Resident #30 was seen sitting in the hallway and the roommate alerted staff. The root cause was documented as confusion and disorientation due to dementia and the resident had a history of scooting out of her wheelchair. Interventions documented were physician reviewed medications for possible fall risk and obtained laboratory work (labs). -However, the IDT risk management progress note was documented seven days after the incident occurred on 12/9/24. The 2/7/25 IDT risk management progress note documented a witnessed incident on 2/6/25. Resident #30 raised her legs and tipped her wheelchair backwards and hit her head on the floor. The root cause was poor safety awareness and impulsivity. Resident #30 did not have wheelchair pedals due to self propelling. Interventions documented were therapy working with resident on wheelchair positioning, mobility and core stabilization. -The facility failed to update the resident's fall care plan with the fall interventions following the 2/6/25 fall (see care plan above). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Additionally, the interventions for therapy to work with the resident identified in the IDT note had already been initiated as interventions on 8/19/24 and were not new fall interventions (see care plan above). The 2/17/25 IDT risk management progress note documented a witnessed incident on 2/13/25. Resident #30 was self propelling in her wheelchair and the wheelchair cushion slid off and the resident fell to the floor. The root cause was that the wheelchair cushion was not connected to the wheelchair. The intervention documented was for therapy to do a seating evaluation and connect the wheelchair cushion to the wheelchair with velcro straps. -However, the IDT risk management progress note was documented four days after the incident occurred on 2/13/25. -The facility failed to update the resident's fall care plan with the fall intervention following the 2/13/25 fall (see care plan above). D. Staff interviews CNA #4 was interviewed on 3/12/25 at 1:30 p.m. CNA #4 said Resident #30 would try to get up by herself in the past but did not try to get up by herself now. She said when Resident #30 was in bed, the bed was kept in the lowest position to the floor with a bed mat by the floor. Licensed practical nurse (LPN) #2 and RN #1 were interviewed together on 3/13/25 at 8:45 a.m. LPN #2 said when Resident #30 was first admitted to the facility she had experienced a fall prior to admission with a hip fracture that had been repaired. She said Resident #30 fell shortly after she arrived and fractured the same hip again. She said Resident #30 had poor safety awareness and would often try to transfer herself, usually on the way to the bathroom. RN #1 said Resident #30's most recent falls were not really falls. She said the resident would lower herself off the wheelchair seat onto the floor. She said this had been observed in the dining room. She said this behavior was on Resident #30's care plan. The DON was interviewed on 3/13/25 at 12:26 p.m. The DON said Resident #30's fall with fracture happened in September 2024 and she would have to check the resident's care plan to see what the current fall interventions were. She said the resident would not use the call light and tried to transfer on her own. She said Resident #30 had a low bed and fall mat in place for when she was in bed. She said Resident #30 was care planned for her crawling out of her wheelchair. She said the facility had evaluated her wheelchair to check her seating and her cushion. She said the facility had done a medication review, wheelchair cushion adjustment and the staff would get her up in the afternoon to help prevent this behavior. She said in the instances where the behavior was not observed and it was unclear if she had fallen they would do a risk management assessment and investigate it as a potential fall with a root cause analysis and review interventions that were in place. 50219 IV. Resident #40 A. Resident status (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #40, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included dementia, Alzheimer's disease and osteoporosis. The 1/13/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS assessment score of four out of 15. The resident was dependent on staff for toileting and bathing and required supervision to moderate assistance for most ADLs. B. Resident observations On 3/10/25 at 2:00 p.m. Resident #40 was self-propelling in her wheelchair in the dining room. Resident #40 was wearing non-skid socks and did not have any anti-tip devices applied to her wheelchair. On 3/11/25 at 12:39 p.m. Resident #40 was self-propelling in her wheelchair in the dining room. Resident #40 was wearing non-skid shoes and did not have any anti-tip devices applied to her wheelchair. C. Record review The fall care plan, initiated 5/24/23 and revised 3/10/25 (during the survey), revealed Resident #40 was at risk for falls due to her unsteady gait, cognitive deficits, weakness, impaired safety awareness and history of falls. Interventions implemented on 5/24/23 included anticipating and meeting Resident #40's needs, ensuring her call light was within reach, encouraging the resident to participate in activities that promoted exercise, ensuring adequate lighting, and ensuring she was wearing the appropriate footwear when ambulating in her wheelchair. An intervention to have Resident #40's bed in the lowest position at night, padding to furniture, and personal items within reach was added on 5/24/23 and revised on 1/22/25. On 1/22/25 an intervention was added to request a medication review with the pharmacist as indicated. Interventions implemented on 3/10/25 (during the survey) included having Resident #40's bed in the lowest position and adding padding to her furniture, moving the resident closer to the nurses' station, obtaining bloodwork and urinalysis when indicated, and assisting the resident with repositioning in her wheelchair. -However, the intervention of having the bed in the lowest position was already initiated as an intervention on 5/24/23. -The facility failed to update Resident #40's care plan with person-centered interventions following her falls on 4/11/24, 10/28/24 and 1/10/25 (see below). A fall risk evaluation, dated 8/16/23, revealed Resident #40 was at a high risk for falling. A fall risk evaluation, dated 12/21/23, revealed Resident #40 was not at high risk for falling. 1. Fall incident on 4/11/24 - unwitnessed (continued on next page)		

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility fall report, dated 4/11/24 at 11:48 a.m., revealed Resident #40 was found on the floor between her bed and her wheelchair. Resident #40 said she was changing her incontinence brief and fell . Resident #40 was assessed by two nurses and her cognition was at baseline. Resident #40 had a bruise on her right elbow. Resident #40 was reminded to call for assistance using her call light. The report documented situational factors, including ambulating without assistance. The re[TRUNCATED]		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure three (#44, #59 and #13) of six residents received the care and services necessary to meet their nutrition needs to maintain their highest level of physical well-being out of 39 sample residents. Resident #44 was admitted to the facility for long term care on 9/2/22. It was identified that Resident #44 was at risk for weight loss and nutritional decline due to Alzheimer's disease, previous history of weight loss and hyperthyroidism (increased metabolism due to an overactive thyroid gland). On 10/8/24, Resident #44 weighed 146.5 pounds (lbs). On 12/5/24, Resident #44 weighed 136 lbs, which indicated the resident had lost 10.5 lbs in two months. In December 2024 the facility increased the resident's Med Pass (oral nutritional supplement). The resident was evaluated by speech therapy (ST) and it was recommended to downgrade the resident's diet to pureed on 12/25/24. The resident's comprehensive care plan indicated the resident needed to be weighed weekly to monitor the resident's nutritional status since she was at risk for weight loss. The facility failed to consistently weigh the resident weekly as directed on the care plan. On 1/8/25 the resident weighed 134.8 lbs, which indicated the resident had lost 8 percent (%) (11.7 lbs) in three months, which was considered severe. The facility failed to implement further person centered nutrition interventions after the resident's weight began trending down again on 1/21/25 and the resident lost an additional 5.7% (7.6 lbs) in two months, from 1/21/25 to 3/6/25. Due to the facilities failures to change or implement new nutritional interventions after Resident #44's weight started to trend downward for a second time on 1/21/25 the resident sustained 14.5% (21.3 lbs) weight loss in six months, from 10/8/24 to 3/6/25, which was considered severe. Additionally, Resident #59 was admitted to the facility for long-term care on 10/2/23 with a diagnosis of schizoaffective disorder (mental illness) and vascular dementia. The resident's weight fluctuated and on 11/12/24 he weighed 160 lbs. On 12/10/24, the resident weighed 162.4 lbs. The resident was admitted to the hospital from 12/12/24 to 12/13/24 for an elective knee surgery. The facility failed to reweigh Resident #59 after he was readmitted to the facility. The resident was not weighed until 1/2/25, which indicated he had lost 18 lbs (11%) in one month, from 12/10/24 to 1/2/25, which was considered severe. The facility implemented Juven (protein supplement, Magic cup (frozen nutritional supplement), Boost (oral nutritional supplement) and Liquid protein to combat the resident's weight loss and assist with wound healing. The facility frequently ran out the Magic cup and did not provide an alternative to supplement the resident's calories and nutrition. The resident was admitted to the hospital from 2/13/25 to 2/17/25 for a gastrointestinal bleed. Upon readmission, the resident weighed 144 lbs. The resident lost 8.4 lbs (5.8%) in one month, from 2/19/25 to 3/13/25, which was considered severe. The facility continued to fail to consistently offer the Magic cup or an alternative to provide the resident with additional calories to meet his nutritional needs. Additionally, the facility failed to consistently monitor and document the resident's meal intake to aid in an accurate and thorough nutritional assessment when the resident was experiencing weight loss. Furthermore, the facility failed to consistently monitor and document Resident #13's meal intakes. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Facility policy and procedure The Weight Management policy and procedure, revised 2/29/24, was provided by the nursing home administrator (NHA) on 3/13/25 at 2:20 p.m. It read in pertinent part, Residents identified with weight change will be assessed by the interdisciplinary team (IDT) and further interventions will be implemented to minimize the risk for further weight change where possible and to promote weight stability. Residents identified at risk for weight change will have interventions implemented to minimize the risk for additional weight change included in their plan of care. This may include supplements, registered dietitian (RD) evaluation and assisted dining. Residents with weight variance (loss or gain) are reweighed. Significant/severe weight variance is defined as 5% in one month, 7.5% in three months or 10% in six months. II. Resident #44 A. Resident status Resident #44, age 73, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dysphagia (difficulty swallowing) and hyperthyroidism. The 2/26/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with deficits in long and short term memory, per staff assessment. It indicated that a brief interview for mental status (BIMS) was not attempted because she was rarely to never understood. She was dependent with eating, toileting, personal hygiene, bed mobility and transfers. The assessment documented the resident was 64 inches (five foot, four inches) tall and weighed 130 lbs. The MDS assessment indicated the resident had gained 5% or more in the last month or 10% or more in the last six months. -However, the resident had not gained weight (see record review below). B. Record review The activities of daily living (ADL) care plan, initiated 9/5/22 and revised 9/15/24, indicated Resident #44 had deficits related to Alzheimer's disease and behaviors. Interventions included Resident #44 required cueing by staff for eating (initiated 8/6/22) and was dependent on staff for all care (initiated 12/8/24). (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The nutrition care plan, initiated 9/8/22 and revised 7/26/24, indicated Resident #44 was at nutritional risk due to dementia and previous history of weight loss. Interventions included monitoring weights as ordered (initiated 9/8/22), offering food alternatives of equal nutritional value (initiated 9/8/22), serving the diet as ordered and monitoring intake and recording every meal (initiated 9/8/22), RD to evaluate and make diet recommendations as necessary (initiated 9/8/22), providing and serving supplements as ordered - Med Pass or alternative oral supplement three times a day (initiated 9/15/22), providing a sack lunch for when the resident's husband took the resident out of the facility (initiated 10/31/22), obtaining the resident's weight every Sunday and monitoring for weight loss with Lamictal (initiated 9/28/23). -However, the facility failed to weigh the resident every Sunday as indicated on the care plan (see record review below). A review of the comprehensive care plan failed to include the resident's need for one-on-one assistance for meals after Resident #44 triggered for severe weight loss on 12/12/24 and again triggered for significant weight loss on 2/27/25. Review of Resident #44's electronic medical record (EMR) revealed the resident was prescribed Lamotrigine (medication to treat hyperthyroidism) from 5/5/23 to 10/13/23. -The facility failed to update the resident's care plan when the medication was discontinued. The March 2025 CPO revealed a physician's order for weekly weights for monitoring of weight loss with Lamictal initiation and a history of hyperthyroidism, ordered 5/28/23 and discontinued 12/7/23. -A comprehensive review of the Resident #44's electronic medical record (EMR) did not reveal a current order for a weekly weight for weight loss, although the care plan specified to weigh the resident every Sunday. The resident's weights were documented in the resident's EMR as follows: -On 10/8/24, the resident weighed 146.5 lbs; -On 10/22/24, the resident weighed 144 lbs; -On 10/30/24, the resident weighed 142.5 lbs; -On 11/5/24, the resident weighed 143 lbs; -On 12/5/24, the resident weighed 136 lbs; -On 12/12/24, the resident weighed 126 lbs; -On 12/18/24, the resident weighed 126.8 lbs; -On 12/26/24, the resident weighed 126.6 lbs; -On 1/8/25, the resident weighed 134.8 lbs; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 1/21/25, the resident weighed 132.8 lbs; -On 1/29/25, the resident weighed 130 lbs; -On 2/12/25, the resident weighed 130 lbs; -On 2/19/25, the resident weighed 131.4 lbs; -On 2/27/25, the resident weighed 128.2 lbs; and, -On 3/6/25, the resident weighed 125.2 lbs. -A review of Resident #44's electronic medical record (EMR) revealed the resident was not consistently weighed weekly as directed on the resident's comprehensive care plan (see care plan above). The resident did not have a weekly weight obtained in the month between 11/5/24 to 12/5/24. -A review of Resident #44's EMR revealed the resident did not have a weekly weight obtained between 12/26/24 to 1/8/25, 1/8/25 to 1/21/25 and 1/29/25 to 2/12/25. The resident sustained an 8% weight loss (11.7 lbs), which was considered severed from 10/8/24 to 1/8/25, in three months. The resident sustained a 14.54% (21.3 lbs) weight loss, which was considered severe, from 10/8/24 to 3/6/25 in less than six months. The March 2025 CPO revealed the following diet and nutritional supplementation orders: -Regular diet, pureed texture, regular/thin consistency, ordered 12/25/24; -Med Pass two times a day ordered 9/5/24 and discontinued 12/5/24; and, -Med Pass three times a day for weight loss, may provide alternate oral supplement as needed, ordered 12/5/24. The 12/2/24 quarterly nutrition assessment documented Resident #44 was on a regular diet with regular texture and was receiving Med Pass 120 milliliters (ml) four times a day for weight loss. The note indicated an alternate oral supplement could be provided as needed. It documented the resident's oral intakes were variable and the resident was independent with set-up assistance with eating. The 12/6/24 nutrition progress note documented Resident #44's weight was trending downward. The resident currently weighed 136 lbs, which was down from 146 lbs on 10/8/24. It documented the resident was having a poor acceptance of solids but was drinking fluids well. The resident's weight was discussed with the IDT. The IDT considered interventions that included a referral to ST, trial downgrade in diet texture and increased oral supplementation to three times a day. -However, the 12/2/24 quarterly nutrition assessment documented Resident #44 was receiving Med Pass four times a day. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Allison Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 Allison St Lakewood, CO 80214	
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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 12/12/24 nutrition progress note documented Resident #44 triggered for severe weight loss and was reviewed in the weight meeting. The resident's diet was changed to pureed texture and oral supplementation was increased to three times a day on 12/5/24. -However, the 12/2/24 quarterly nutrition assessment documented Resident #44 was receiving Med Pass four times a day. The 12/19/24 nutrition progress note, documented as follow-up, indicated the resident had no further weight loss over the last week. The staff reported the resident's intake had improved with a pureed diet. She was being evaluated by ST. The 1/23/25 nutrition progress note documented Resident #44's weight was still down but stable and the resident was accepting routine oral supplements. Interventions were to continue with the current plan and monitor. The 2/26/25 quarterly nutrition assessment documented Resident #44 was on a regular diet with regular texture and was independent with meal assistance. Resident #44 was receiving Med Pass three times a day with variable oral intakes. -However, Resident #44 was changed to a regular diet with pureed texture on 12/25/24 and required one-on-one meal assistance. The 2/28/25 nutrition progress note documented Resident #44 triggered for significant weight loss in the past six months. Resident #44 was seen by ST, remained on a pureed diet and continued to receive one-on-one assistance at meals with varied intakes and varied acceptance of Med Pass three times a day. Interventions included adjusting the time of oral supplementation to earlier in day to promote acceptance. -Resident #44's weight began trending down again on 1/21/25 and the facility did not assess the resident until 2/28/25, when she triggered for severe weight loss. The January 2025 medication administration record (MAR) documented Resident #44 was provided 120 ml of Med Pass three times a day. -However, the January 2025 MAR failed to document an alternate oral supplement was provided as indicated on the resident's care plan after Resident #44 did not consume the Med Pass after a meal on 1/1/25, 1/3/25, 1/5/25, 1/9/25, 1/11/25, 1/12/25, 1/17/25 and 1/19/25 (see care plan above). The February 2025 MAR documented Resident #44 was provided 120 ml of Med Pass three times a day. -However, the February 2025 MAR failed to document an alternate oral supplement was provided as indicated on the resident's care plan after Resident #44 did not consume the Med Pass after a meal on 2/1/25, 2/3/25, 2/5/25, 2/9/25, 2/11/25, 2/12/25, 2/17/25 and 2/19/25. The March 2025 MAR (reviewed from 3/1/25 to 3/13/25) documented Resident #44 was provided 120 ml of Med Pass three times a day. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-However, the March 2025 MAR failed to document an alternate oral supplement was provided as indicated on the resident's care plan after Resident #44 did not consume the Med Pass after a meal on 3/9/25. A review of the meal intakes for Resident #44 from 2/10/25 to 3/10/25 revealed the following: -Out of 27 opportunities for breakfast, the resident ate 50% or less three times, 25% or less one time and was not documented three times; -Out of 27 opportunities for lunch, the resident ate 50% or less five times, 25% or less one time and was not documented three times; and, -Out of 27 opportunities for dinner, the resident ate 50% or less two times, 25% or less three times and was not documented ten times. A review of the feeding assistance documentation revealed inconsistent documentation for Resident #44 from 2/17/25 to 3/9/25. The documentation indicated Resident #44 received no help one time, set-up help one time, partial to moderate help two times and substantial or maximal assistance three times. C. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 3/12/25 at 1:30 p.m. CNA #4 said Resident #44 was a good eater and usually ate most of her meals. She said Resident #44 was good with fluid intakes and she liked her supplement beverages. She said Resident #44 would not eat on her own, was dependent with eating and required assistance from staff. The RD was interviewed on 3/13/25 at 8:35 a.m. The RD said the weight team met weekly. She said since Resident #44's dementia was progressing, they had been discussing whether she needed hospice services. She said ST evaluated Resident #44. She said Resident #44's diet had been switched to pureed and that had been easier for her to swallow. She said there had been timing issues on what times Resident #44 was more likely to accept her supplement and they had adjusted the times. The RD said Resident #44's weights had been stable the last three months. She said she did not have any other ideas for nutritional interventions to prevent further weight loss. She said she would continue to evaluate what interventions would be appropriate for Resident #44. She said in the past, Resident #44 had been on Med Pass four times a day. She said there was room for interventions to be tried to help combat the resident's weight loss. She said examples of interventions could include increasing supplements, trying larger portions of items the resident liked, getting feedback from staff and trying snacks. -However, in the last three months Resident #44's weight was trending down and the facility failed to implement new person-centered nutritional interventions to address the resident's severe weight loss. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 3/13/25 at 8:45 a.m. RN #1 said Resident #44's dementia had been progressing. She said she had a period of time when she would not eat for a week or two and would not even open her mouth. She said she thought this was related to the resident's dementia that was progressing. She said Resident #44 had lost weight during that period. She said she was dependent on staff for eating. -However, review of Resident #44's EMR did not reveal documentation regarding Resident #44 refusing to eat for a week or interventions the facility attempted to address the residents' refusals. RN #1 said currently Resident #44 seemed to be eating. She said because of her overall decline staff had been discussing hospice services but was not currently on hospice services. 50219 III. Resident #59 A. Resident status Resident #59, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included schizoaffective disorder, vascular dementia, and gastrointestinal hemorrhage. The 1/7/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent with eating and was dependent on staff for most other ADL. The assessment documented the resident was 65 inches (5 foot, 5 inches) tall and weighed 144 lbs. The assessment documented the resident had experienced a weight loss of 5% or more in the month prior or 10% or more in the six months prior and was not on a physician-prescribed weight-loss regime. The assessment documented the resident did not have any rejections of care. B. Record review The nutrition care plan, initiated 2/28/25, revealed Resident #59 was at risk for nutritional problems due to pressure wounds, weight loss, being bed-bound and inadequate oral intakes. Pertinent interventions included monitoring weights as ordered, providing and serving supplements as ordered, providing and serving his diet as ordered and recording intakes. The March 2025 CPO revealed the following physician's orders: Juven nutritional supplement, mix one packet with eight ounces of water two times a day for wound healing, ordered 2/28/25. Magic cup nutritional supplement, give one four ounce cup twice a day for wound healing, ordered 1/24/25. Boost nutritional supplement, one bottle three times daily for wound healing. Resident may choose what supplement he wants, he has liked Magic Cup in the past, ordered 1/24/25. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Liquid protein supplement, give 30 milliliters (ml) three times a day for wound healing, ordered 1/2/25. Resident #59's weights were documented in the EMR as follows: -On 11/12/24, the resident weighed 160.4 lbs; -On 11/27/24, the resident weighed 161.6 lbs; -On 12/10/24, the resident weighed 162.4 lbs; -On 1/2/25, the resident weighed 144.4 lbs; -On 1/9/25, the resident weighed 146.0 lbs; -On 1/21/25, the resident weighed 145.6 lbs; -On 1/29/25, the resident weighed 144.8 lbs; -On 2/6/25, the resident weighed 146.0 lbs; -On 2/19/25, the resident weighed 144.0 lbs; -On 2/27/25, the resident weighed 135.0 lbs; -On 3/6/25, the resident weighed 135.5 lbs; and, -On 3/13/25, the resident weighed 135.6 lbs. -The resident sustained an 11% (18 lbs) weight loss, from 12/10/24 to 1/2/25, in one month, which was considered severe. -The resident sustained a 5.8% (8.4 lbs) weight loss, from 2/19/25 to 3/13/25, in one month, which was considered severe. A nutrition progress note, dated 10/11/24 at 4:46 p.m., revealed Resident #59 had a significant weight gain. Resident #59 had good food intakes and had off and on issues with edema. A physician progress note, dated 12/16/24 at 11:57 a.m., revealed Resident #59 had a scheduled right total knee replacement on 12/12/24. The nutritional assessment, dated 1/2/25, revealed Resident #59 was at an increased nutritional risk due to a decline in meal intakes since his surgical procedure. Resident #59 had had some refusals for breakfast, ate 50% to 75% for breakfast and lunch and had 76% to 100% intakes for dinner. Interventions put in place included continuing his regular diet, honoring food preferences, offering alternatives and snacks and encouraging intakes. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A nutrition progress note, dated 1/2/25 at 5:16 p.m., revealed Resident #59 had significant weight loss following an elective knee surgery. Resident #59 had an increase in his time spent in bed and poor intakes since his readmission. Resident #59's physician had initiated some routine oral supplements, including Boost three times daily, the week prior with varied acceptance. Resident #59's weight loss was reviewed with the IDT and the RD recommended liquid protein three times daily. -The facility failed to weigh the resident until 1/2/25, 20 days after he was readmitted post-knee surgery to determine a baseline weight. A nutrition progress note, dated 1/9/25, revealed Resident #59's weight had been stable for one week but continued to have concerns with his wounds. The facility staff reported Resident #59 showed some overall improvement but was still eating some lighter meals. The RD recommended the staff continue to offer Resident #59 the oral supplements as ordered and accepted. Resident #59's weight was reviewed with the IDT. A nutrition progress note, dated 1/24/25, revealed Resident #59 had ongoing concerns with inadequate intakes for wound healing. Resident #59's weight had been stable over the last week. Resident #59 had orders for liquid protein three times daily and Boost three times daily. Resident #59 had enjoyed Magic Cup supplements in the past, so the RD recommended the staff offer the supplement at lunch and dinner meals as he would accept. Review of Resident #59's progress notes revealed the resident was not administered the Magic Cup as ordered twice on 1/28/25, once on 1/29/25, once on 2/3/25, twice on 2/5/25, once on 2/7/25, once on 2/10/25, once on 2/11/25, twice on 2/12/25, once on 2/17/25 and twice on 2/19/25. -The progress notes did not reveal any alternative supplement or snack was offered when the Magic Cup was not administered. A physician's progress note, dated 2/18/25 at 11:05 a.m., revealed Resident #59 had undergone a procedure on 2/6/25 to manipulate his knee under anesthesia following his knee replacement. Resident #59 had coffee-ground emesis on 2/14/25 and was rehospitalized. Resident #59 was found to have septicemia likely related to the knee manipulation and was started on a 21-day course of antibiotics. A nutrition progress note, dated 2/20/25, revealed Resident #59 continued to have inadequate oral intakes and his weight remained down significantly but was stable over the month prior. Resident #59 had a recent hospitalization for a gastrointestinal bleed and wound infection and chose to remain in bed. Resident #59 expressed he preferred to eat soups. Resident #59 had variable meal intakes and varied acceptance of oral supplements including Boost three times daily, Magic Cup twice daily, and liquid protein three times daily. The RD encouraged intakes, especially of high protein sources, and recommended the staff continue to offer Resident #59's preferred foods as they were able to. Review of Resident #59's progress notes revealed the resident was not administered the Magic Cup as ordered once on 2/20/25, twice on 2/24/25, twice on 2/25/25, twice on 2/26/25 and twice on 2/27/25. -The progress notes did not reveal any alternative supplement or snack was offered when the Magic Cup was not administered. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A nutrition progress note, dated 2/28/25 at 3:37 p.m., revealed Resident #59 continued to have significant weight loss and pressure wounds. Resident #59 elected to remain in his bed and continued to have varied meal and nutritional supplement intakes. Resident #59 was educated on diet and the facility staff worked to honor his food preferences as they were able to. The RD recommended continued efforts to offer and encourage meals and snacks for Resident #59 and encourage the nutritional supplements. The RD recommended Juven twice daily to help with wound healing. Review of Resident #59's progress notes revealed the resident was not administered the Magic Cup as ordered twice on 3/3/25 and twice on 3/5/25. -The progress notes did not reveal any alternative supplement or snack was offered when the Magic Cup was not administered. A nutrition progress note, dated 3/6/25 at 8:27 p.m., revealed Resident #59 had no further weight loss over the past week and had some improvements with his heel wound despite poor meal intakes, poor acceptance of the Magic Cup and Juven supplements, and varied acceptance of the Boost supplement. The RD's plan was to continue with the interventions as ordered and as Resident #59 would accept. Review of the amount eaten CNA task from 2/17/25 to 3/12/25 revealed the following: -One meal was documented on 2/20/25 at 9:09 a.m. and one meal was documented at 1:11 p.m.; -One meal was documented on 2/27/25 at 9:14 a.m. and one meal was documented at 1:09 p.m.; -One meal was documented on 3/3/25 at 6:54 p.m.; -One meal was documented on 3/5/25 at 7:07 p.m.; -No meals were documented on 3/9/25; -Two meals were documented on 3/10/25 at 1:13 p.m.; and, -One meal was documented on 3/11/25 at 9:25 a.m. and one meal was documented at 1:24 p.m. C. Staff interviews RN #1 was interviewed on 3/13/25 at 9:45 a.m. RN #1 said Resident #59's nutrition was better and he had been eating more recently. RN #1 said Resident #59 went on a self-imposed hunger strike for one week. RN #1 said Resident #59 was on protein supplements, including Magic Cup and Juven. RN #1 said Resident #59 was not picky about what foods he ate when he chose to eat. RN #1 said the facility had issues with running out of the Magic Cup supplement. RN #1 said when the facility ran out of Magic Cup, she would offer Resident #59 a snack or something equivalent. -However, review of Resident #59's progress notes did not reveal any documented alternatives being offered when the Magic Cup was not administered (see record review above). (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD was interviewed on 3/13/25 at 8:45 a.m. The RD said Resident #59 was very particular about what he ate when he first admitted to the facility, so the facility did their best to meet his preferences. The RD said Resident #59 became more willing to try to eat different foods and started overeating a lot, snacking, and taking nutritional supplements on his own. The RD said Resident #59 was doing very well before his elective knee surgery (12/12/24), but since the procedure, he had not been himself. The RD said the facility saw a significant change in Resident #59's eating as far as interest in eating and willingness to eat. The RD said Resident #59 only wanted to eat soups for a period of time. The RD said she had tried implementing different supplements but Resident #59 varied with his acceptance. The RD said she had tried to educate Resident #59 and figure out his food preferences to offer what they could. The RD said it was difficult to maximize Resident #59's nutrition with him controlling his own care. -However, review of the resident's care plan did not reveal documentation indicating the resident was particular with foods or his preferences. The RD said there had been vendor issues with keeping Magic Cup in stock at the facility. The RD said she generally tried to ensure the physician's order for nutritional supplements indicated to offer a different supplement similar in nutritional value if the supplement was out of stock. The RD said she thought the Magic Cup supplement was in stock near the nurse's station so the nursing staff did not have to leave the floor to offer it to the residents. The RD said Resident #59's order did not state they could offer an alternative. The director of nursing (DON) was interviewed on 3/13/25 at 12:45 p.m. The DON said the documentation in Resident #59's amount eaten CNA task was not missing a lot of information. The DON there were some meals missing due to Resident #59 being in the hospital. -However, there were multiple meals not documented when Resident #59 was in the facility (see record review above). IV. Resident #13 A. Resident status Resident #13, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included generalized muscle weakness, dysphagia, Alzheimer's disease, dementia, vitamin D deficiency, prediabetes and severe protein-calorie malnutrition. The 2/21/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. The resident required set-up or clean-up assistance while eating and was dependent on staff for assistance with most other ADL. The MDS assessment documented the resident was 55 inches (4 foot, 7 inches) tall and was 97 lbs. The MDS assessment documented the resident had not experienced any weight loss or weight gain. The assessment documented the resident was prescribed a mechanically altered diet. B. Record review (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The nutrition care plan, initiated 1/20/17 and revised 3/6/25, revealed Resident #13 was a nutrition risk due to her eating habits and preferences, eating less than 50% at meals, and having trouble chewing regular textured foods with altered dental status. Pertinent interventions included monitoring weights as ordered, monitoring intake and recording each meal and offering snacks twice a day and as needed. -However, review of the amount eaten CNA task revealed the facility failed to consistently monitor and document the amount that Resident #13 consumed at meals. Review of the amount eaten CNA task from 2/13/25 to 3/12/25 revealed the following: -Two meals were documented on 2/13/25 at 1:26 p.m.; -One meal was documented as 76% to 100% eaten and one meal was documented as 26% to 50% eaten on 2/14/25 at 1:23 p.m.; -One meal was documented on 2/18/25 at 1:40 p.m.; -No meals were documented on 2/19/25; -Two meals were documented on 2/20/25 at 1:05 p.m.; -Two meals were documented on 2/21/25 at 8:00 a.m. and 12:00 p.m.; -Two meals were documented on 2/23/25 at 9:45 a.m. and 1:10 p.m.; -One meal was documented on 3/1/25 at 9:23 p.m.; -No meals were documented on 3/2/25; -One meal was documented on 3/3/25 at 8:29 p.m.; -One meal was documented on 3/5/25 at 6:29 p.m.; -One meal was documented on 3/6/25 at 7:33 p.m.; -One meal was documented on 3/8/25 at 7:09 p.m.; and, -No meals were documented on 3/9/25. C. Staff interviews CNA #7 was interviewed on 3/12/25 at 3:41 p.m. CNA #7 said she wrote down how much the residents ate and drank at each meal and recorded it in the resident's EMR at the end of her shift. CNA #4 was interviewed on 3/12/25 at 3:52 p.m. CNA #4 said she recorded the percentage eaten of each meal in the resident's EMR. CNA #4 said each CNA was responsible for recording their residents' meal intakes after each meal. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	CNA #6 was interviewed on 3/13/25 at 9:21 a.m. CNA #6 said she marked how much each resident ate of each meal after each meal took place. CNA #6 said any unmarked meals in the EMR could be due to the resident refusing to eat. The RD was interviewed on 3/13/25 at 8:31 a.m. The RD said she and the facility administrators met weekly as a team to discuss the residents' nutrition. The RD said the facility had noted more difficulty in encouraging and redirecting Resident #13 with eating. The RD said Resident #13 disliked being told what to do but could use redirection and refocusing when eating. The RD said she had made an adjustment in interventions the week prior to maximize Resident #13's calorie intake between meals. The RD said she reviewed the CNAs meal intake documentation, but did not rely on them. The RD said she worked with the restorative dining aide. She said she would observe the residents herself prior to the nutrition meetings. The RD said there were missing meals in Resident #13's EMR, but she did not know why they were missing. The DON was interviewed on 3/13/25 at 12:45 p.m. The DON said meal intake percentages were documente[TRUNCATED]		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to use a person-centered approach when determining the use of a grab bar/bed rail for one (#37) of one resident reviewed for grab bars/bed rails out of 39 sample residents. Specifically, for Resident #37, the facility failed to: -Identify alternatives to using grab bars/bed rails prior to installing grab bars/bed rails; and, -Conduct routine assessments and maintenance of the resident's grab bar/bed rail to evaluate the continued safety and/or the continued need for the grab bar/bed rail. Findings include: I. Professional reference The U.S. Food and Drug Administration (FDA) Recommendations for Health Care Providers Using Adult Portable Bed Rails (2/27/23) was retrieved on 3/17/25 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails. It read in pertinent part, Avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. Follow the health care facility's procedures and manufacturer's recommendations and specifications for installing and maintaining bed rails for the particular bed frame and bed rails used. Inspect, evaluate, maintain, and upgrade equipment (beds, mattresses, and bed rails) to identify and remove potential fall and entrapment hazards. II. Facility policy and procedure The Assistive Devices and Equipment policy and procedure, revised January 2020, was provided by the nursing home administrator (NHA) on 3/13/25 at 3:02 p.m. It revealed in pertinent part, Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan. The resident is assessed for lower extremity strength, range of motion, balance and cognitive abilities when determining the safest use of devices and equipment. III. Resident #37 A. Resident status (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Allison Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 Allison St Lakewood, CO 80214	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #37, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), vascular dementia, and a history of falling. The 2/19/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. The resident required substantial assistance with most activities of daily living (ADL). The resident required substantial assistance with transfers. The resident was frequently incontinent of both bowel and bladder. -The MDS assessment documented Resident #37 did not use grab bars/bed rails. B. Resident interview and observations On 3/10/25 at 11:18 a.m. Resident #37 was sitting on her bed. A grab bar/bed rail was attached to the bed frame. Resident #37 shook her head and shrugged her shoulders when asked if she knew what the grab bar was used for. A sign above Resident #37's bed revealed the bar was to be attached at her bedside to maximize the resident's independence and allow the resident to continue with transfers with the least amount of physical assistance. -However, according to the 2/19/25 MDS assessment (see above), the resident required substantial assistance with transfers. C. Record review The ADL care plan, revised 3/2/25, revealed Resident #37 had a self-care deficit due to her dementia, fatigue, impaired balance, limited mobility and right-sided hemiparesis. Pertinent interventions included Resident #37 requiring minimal to no assistance with bed mobility and was able to be independent with the use of a grab bar for assistance, and Resident #37 requiring minimal to no assistance with transfers and was able to be independent with the use of a grab bar for assistance, revised 10/12/24. The fall care plan, revised 3/2/25, revealed Resident #37 was at risk for falls due to confusion, gait and balance problems, history of falls, epilepsy, hemipareses and attempting self-transfers. Pertinent interventions included ensuring the call light was within reach, maintaining a safe environment and physical therapy screening for use of an assistive device. -Review of Resident #37's comprehensive care plan, revised 3/2/25, revealed there was no care plan focus for the resident's grab bar/bed rail. The March 2025 CPO revealed the following physician's order: Bed cane (grab bar/bed rail) in place to improve safety and transfers. Check function and placement each shift, ordered 3/12/25 at 6:00 p.m. during the survey. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physical therapy notes, dated 10/1/24, revealed Resident #37 had decreased right-sided strength and range of motion as well as standing balance deficits. Resident #37 needed moderate assistance to transfer without an assistive device and demonstrated poor safety awareness and technique. Resident #37 was at high risk for falling due to her impairments. The physical therapy plan was to add a bed cane to her bed and to work on transfers to decrease her fall risk. A progress note, dated 10/9/24 at 10:31 a.m., revealed Resident #37 was working with physical therapy on a trial of a bed cane due to repeated falls at her bedside. Resident #37 still required moderate verbal cues and minimal staff assistance with transferring. The goal for Resident #37 was to get her as independent as possible with transfers as she did not call for assistance. A progress note, dated 10/9/24 at 1:14 p.m., revealed Resident #37 had a bed cane placed on her bed. Resident #37 required vocal cueing only ten percent of the time during transfer trials using the bed cane. Signage was placed above Resident #37's bed indicating to keep the bed cane attached to the bed. A progress note, dated 10/16/24 at 1:15 p.m., revealed Resident #37 was working with physical therapy on safe transfers using a grab bar. Resident #37 demonstrated safe transfer strategies with five trials. Resident #37 was also using the grab bar to aid with increased independence with bed mobility. Training for the grab bar was complete. Physical therapy notes, dated 10/17/24, revealed Resident #37 indicated she preferred to transfer without using the bed cane, but her performance improved and assistance decreased when using the bed cane. Resident #37 was able to transfer to and from her bed using the bed cane and contact guard assistance. Resident #37 was discharged from therapy with discharge recommendations including continuing to allow the resident extra time and to use the bed cane for transfers with staff. -However, while there was documentation indicating the resident was working with physical therapy on increasing independence with the use of a bed cane, there was no documentation in the resident's electronic medical record (EMR) to indicate the resident had been assessed for the risk of entrapment related to the bed cane prior to installation of the bed cane. A progress note, dated 3/12/25 at 3:40 p.m., revealed Resident #37 was trying to transfer herself from her wheelchair to her bed when she slid out of her wheelchair. Resident #37 was observed sitting on the floor in front of her bed. When asked if she slid out of her chair when trying to transfer Resident #37 nodded yes. Resident #37's neurological exam was within normal limits, no injuries were noted, and her family was notified. -There was no documentation in Resident #37's EMR to indicate what alternatives were attempted prior to the installation or use of a grab bar/bed rail and how these alternatives failed to meet the resident's assessed needs. -There was no documentation in Resident #37's EMR to indicate the facility was conducting ongoing assessments of the resident's grab bar/bed rail to ensure the continued safety and/or need of the grab bar/bed rail. IV. Staff interviews (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #4 was interviewed on 3/12/25 at 3:52 p.m. CNA #4 said Resident #37 needed help with transferring. CNA #4 said the grab bar on Resident #37's bed used to be used to help her stand up, but she had recently been needing more help with standing and transferring. CNA #4 said sometimes Resident #37 tried to stand up by herself but would then cry out for help. CNA #6 was interviewed on 3/13/25 at 9:21 a.m. CNA #6 said the grab bar on Resident #37's bed was so she could hold the bar while the nursing staff assisted her into bed. CNA #6 said Resident #37 needed help with transfers or she was at risk for falling. Registered nurse (RN) #1 was interviewed on 3/13/25 at 9:45 a.m. RN #1 said the therapy team installed the grab bar a while ago to help Resident #37 transfer with more ease. RN #1 said Resident #37 still needed assistance with transfers from the nursing staff. The director of rehabilitation (DOR) was interviewed on 3/13/25 at 10:53 a.m. The DOR said Resident #37 had sustained a fall on 3/12/25, and he was going to do a physical therapy screening on the resident that day. The DOR said Resident #37 had a bed cane installed to help her with transfers. The DOR said the facility might need to remove Resident #37's bed cane because she might not be able to use it anymore due to her cognition. The DOR said if residents were not using the assistive device they had installed, they needed to remove the device and reintroduce the resident into the physical therapy caseload. The DOR said residents with assistive devices needed to be screened at least quarterly. The DOR said Resident #37 was last assessed for bed cane use in October 2024. Licensed practical nurse (LPN) #2 was interviewed on 3/13/25 at 12:10 p.m. LPN #2 said Resident #37 fell the day prior (3/12/25) when she was trying to transfer by herself. LPN #2 said Resident #37 usually used her call light to ask for help and had a grab bar installed that she used. LPN #2 said Resident #37 had worked with physical therapy to use the grab bar and was cognizant enough to ask for help when transferring. LPN #2 said she did not know if Resident #37 attempted to use the grab bar while transferring when she fell as a CNA found her on the floor. LPN #2 said she wondered if Resident #37 needed another physical therapy evaluation to review her transfer abilities. The director of nursing (DON) was interviewed on 3/13/25 at 12:45 p.m. The DON said Resident #37 fell the day prior (3/12/25) while self-transferring. The DON said Resident #37 did not use her call light effectively and the physical therapy team was going to evaluate her grab bar. The DON said Resident #37 had had her grab bar installed since 10/12/24 and was working with the therapy team when it was initiated. The DON said Resident #37's grab bar should be evaluated quarterly. The DON said Resident #37 was overdue to be evaluated for her grab bar. The DON said Resident #37 was able to use the grab bar and hold onto it during transfers and she thought it was a great intervention that prevented her from falling for a while.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to: -Ensure the staff followed proper infection control procedures for a resident on enhanced barrier precautions (EBP); -Ensure resident rooms were cleaned in a sanitary manner; and, -Ensure medications were handled in a sanitary manner. Findings include: I. Failure to follow EBP A. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 3/20/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status. B. Facility policy and procedure The Enhanced Barrier Precautions policy and procedure, dated December 2024, was received from the nursing home administrator (NHA) on 3/13/25 at 3:02 p.m. It read in pertinent part, Enhanced barrier precautions apply when a resident has a wound or indwelling medical device. EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities. Examples of high-contact resident care activities requiring the use of gown and gloves include changing briefs or assisting with toileting, device care, or prolonged, high-contact with the resident's clothing or skin. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations On 3/10/25 at 11:04 a.m. Resident #281 was lying in bed with her urinary catheter bag clipped to her bed frame. A sign indicating Resident #281 needed EBP was on her door and a set of drawers containing PPE was outside of her room. On 3/12/25 at 10:48 a.m. physical therapist (PT) #1 was working with Resident #281 in her room. Resident #281 was lying in bed and PT #1 was removing Resident #281's pants. PT #1 was wearing gloves but was not wearing a gown. A sign indicating Resident #281 needed EBP was on her door and a set of drawers containing PPE was outside of her room. On 3/13/25 at 9:07 a.m. certified nurse aide (CNA) #6 entered Resident #281's room, donned (put on) a set of gloves, and said she was going to provide incontinence care to the resident and help transfer her to her wheelchair. CNA #6 shut Resident #281's door to provide care (see interview below). A sign indicating Resident #281 needed EBP was on her door and a set of drawers containing PPE was outside of her room. D. Resident interview Resident #281 was interviewed on 3/12/25 at 12:24 p.m. Resident #281 said PT #1 had been helping her with transfers between her wheelchair and her bed that morning. Resident #281 said the staff only wore gloves when they assisted her with incontinence care and transfers. Resident #281 said the staff did not wear a gown when they worked with her. E. Staff interviews CNA #4 was interviewed on 3/12/25 at 3:52 p.m. CNA #4 said EBP was implemented for residents with open areas on their skin or indwelling catheters. CNA #4 said the staff needed to wear a gown and gloves during any transfers or incontinence care when working with residents on EBP. CNA #6 was interviewed on 3/13/25 at 9:21 a.m. CNA #6 said she had helped Resident #281 with incontinence care and putting on her clothes that morning. CNA #6 said she only wore gloves and did not wear a gown. CNA #6 said she had realized she forgot to put on a gown. Registered nurse (RN) #1 was interviewed on 3/13/25 at 9:45 a.m. RN #1 said EBP were implemented for any resident with a wound, catheter, or other indwelling line. RN #1 said EBP meant the nursing staff needed to use a gown, gloves, and perform hand hygiene any time they were in contact with the indwelling line, during wound treatments, transfers, or any other high-contact care. The director of rehabilitation (DOR) was interviewed on 3/13/25 at 10:53 a.m. The DOR said the physical therapy staff needed to wear a gown and gloves when working with residents with urinary catheters in their beds. The DOR said if the physical therapy staff was removing a resident on EBP's clothing they needed to wear a gown and gloves. Licensed practical nurse (LPN) #2 was interviewed on 3/13/25 at 12:10 p.m. LPN #2 said EBP was used for residents with wounds or urinary catheters. LPN #2 said a gown and gloves needed to be worn during care to help prevent contamination of the resident's line or wound with any bacteria on the nursing staff's clothing. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The infection preventionist (IP) was interviewed on 3/13/25 at 12:32 a.m. The IP said any resident with an indwelling line, wound, or MDRO needed to be on EBP. The IP said the staff used a gown and gloves to protect the residents from the introduction of bacteria into their line or wound from the caregiver's clothing or skin. The IP said any direct contact with residents on EBP meant the staff needed to wear a gown and gloves. The director of nursing (DON) was interviewed on 3/13/25 at 1:03 p.m. The DON said the staff needed to wear a gown and gloves for any high-contact care with residents on EBP. The DON said the facility was going to increase their education with the staff on EBP. 47350 II. Failure to clean and sanitize resident rooms appropriately. A. Professional reference The CDC, Environment Cleaning Procedures (3/19/24), was retrieved on 3/20/25 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Clean patient areas (patient zones) before patient toilets. Include identified high touch surface and items in checklists and other job aids to facilitate competing cleaning procedures. Proceed in a systematic manner to avoid missing areas. In a multi bed area, clean each patient zone in the same manner. Mop from cleaner to dirtier areas. B. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy and procedure, revised August 2013, was provided by the NHA on 3/13/25 at 2:20 p.m. It read in pertinent part, Manufacturers' instructions will be followed for proper use of disinfecting products. Perform hand hygiene after removing gloves. C. Manufacturer's recommendations According to the Oxivir One Step manufacturer guidelines, reviewed 2025, was retrieved on 3/20/25 from https://diversey.com/en/product-catalogue/oxivir-1-rtu-100850916-[NAME], Oxivir disinfects viruses and a soft surface sanitizer, both in 30 seconds. It is a one minute bactericidal, fungicidal, tuberculocidal and a ten second non food contact sanitizer. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the M.L.D. Bowl Cleanse manufacturer guidelines, reviewed 2025, was retrieved on 3/20/25 from https://www.spartanchemical.com/products/product/722503/#top, Saturate swab mop with Bowl Cleanse (one to two ounces) while holding the applicator bottle over the bowl. Swab the entire surface area especially under the rim where water outlets are located. Allow M.L.D. Bowl Cleanse to remain wet on the surface at least 10 minutes. D. Observations On 3/13/25 at 8:50 a.m. housekeeper (HK) #1 cleaned room [ROOM NUMBER], where one resident resided in a dual occupancy room. HK #1 donned gloves and sprayed the vanity sink with Oxivir cleaning solution from the housekeeping cart. She then high dusted the room and removed the trash bag. She then sprayed the top of the toilet seat with Oxivir solution. She then removed the trash from the room. She removed her gloves, performed hand hygiene and donned new gloves. She obtained a cleaning cloth from the housekeeping cart, sprayed the cloth with the Oxivir cleaning solution and wiped down the top of the tables on the B side of the room. She disposed of the cloth and obtained a new cloth from the housekeeping cart and wiped the tables and chest of drawers on the A side of the room. She then disposed of the cloth. -HK #1 failed to clean any high touch areas, including door handles, light switches and call light. HK #1 went to the bathroom and obtained a dedicated toilet brush in the bathroom and scrubbed the inside of the toilet bowl. She dipped the toilet brush into the toilet bowl water and scrubbed with the toilet brush on top of the toilet bowl and the toilet lid. -HK #1 failed to spray the external surfaces of the toilet including the toilet tank, handle, underneath the toilet seat or the toilet bowl with the Oxivir solution. She failed to use the toilet bowl disinfectant inside of the toilet. She failed to clean the toilet from clean to dirty and scrubbed with a toilet brush from a dirty area to clean. HK #1 returned to the housekeeping cart to get a mop handle and a mop head. -HK #1 failed to remove her gloves and perform hand hygiene after cleaning the toilet and returning to the housekeeping cart where she touched clean supplies. On 3/13/25 at 9:20 a.m. HK #2 was observed cleaning room [ROOM NUMBER], which two residents resided in. HK #2 performed hand hygiene and donned gloves. She then sprayed Oxivir solution on the room doorhandles, the vanity sink, bedside tables and chest of drawers. She then went into the bathroom, flushed the toilet, sprayed the toilet handle, top of the tank and lid. She then went to the housekeeping cart, sprayed a cloth with the Oxivir solution and wiped the door handles. She then went to the housekeeping cart and obtained a duster and dusted the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HK #2 failed to change gloves and perform hand hygiene after touching the toilet handle and before getting clean supplies from the housekeeping cart. HK #2 obtained a clean cloth from the housekeeping cart and wiped down the bedside tables on the B side of the room. She then returned to the housekeeping cart, disposed of the dirty cloth, sprayed a new cloth and wiped down the A side of the room. She then disposed of the cloth, obtained a new cloth and wiped down the sink and vanity. -HK #2 failed to change gloves and perform hand hygiene after cleaning the B side, before touching the housekeeping cart and cleaning the A side of the room. HK #2 wiped the bathroom starting with the top of the toilet tank, wiped the top of the toilet seat, underneath the toilet seat, top of the toilet bowl and down sides of the toilet bowl. She leaned forward and her lanyard (a loop worn around the neck) with keys fell forward and hit the inside of the toilet bowl. She then returned to the housekeeping cart and disposed of the dirty cloths and obtained the M.L.D. bowl cleaning solution and poured the solution into the toilet bowl. -HK #2 failed to remove gloves and perform hand hygiene after cleaning the bathroom and returning for clean supplies at the housekeeping cart. She failed to keep a frequently handled personal item from coming into contact with a dirty surface. E. Staff interviews HK #2 and the housekeeping supervisor (HKS) were interviewed together on 3/13/25 at 10:00 a.m. HK #2 said after touching anything dirty, hand hygiene should be performed and gloves changed. HK #2 said she should not be wearing a lanyard or wear it in a way if it was not going to come into contact with a dirty surface. The HKS said that the M.L.D. solution should be used inside of the toilet bowl and a toilet brush should not be used to clean anything but the inside of the toilet bowl. The HKS said that high touch areas should be included when cleaning the resident's rooms. The HKS said she would provide further education for all housekeepers. The IP, the DON and the nurse quality mentor (NQM) were interviewed on 3/13/25 at 10:35 a.m. The IP said the housekeepers were included in the monthly all staff hand hygiene education. The IP said when touching anything dirty and before proceeding to anything clean, gloves should be removed and hand hygiene should be performed. The IP said that the use of a toilet brush outside of the toilet bowl was not a sanitary practice. III. Failure to handle medications in a sanitary manner A. Observation On 3/12/25 at 8:05 a.m. licensed practical nurse (LPN) #2 was pouring out Senna (a laxative) tablets in a medication cup in preparation for administration. LPN #2 poured three tablets instead of the two prescribed tablets. LPN #2 picked the third tablet out of the medication cup with her bare hand and placed the tablet back into the stock Senna medication container. (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Staff interviews LPN #2 was interviewed on 3/12/25 at 8:25 a.m. She said medications should not be handled with bare hands and if they were handled they should be discarded in a drug buster (a drug disposal system). She said pills that were handled with bare hands should not be placed in the original container because they were not handled in a sanitary manner. The DON was interviewed on 3/12/25 at 9:25 a.m. She said the nurses should not be handling medications with bare hands because it was not sanitary. She said the medications should be disposed of in a drug buster and not placed back in with the stock supply once they were handled with bare hands. She said she would provide in house education to reinforce this.		