STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065311	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uptown Care Center	745 E 18th Ave Denver, CO 80203

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 51163 Based on observations, record review and interviews, the facility failed to ensure two (#1 and #2) of nine residents reviewed for abuse out of 10 sample residents were kept free from physical abuse. Resident #1 admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis affecting one side of the body) affecting the right dominant side, aphasia (a partial loss of language skills due to brain damage) and nicotine dependence. According to Resident #1's care plan, he had a history of reaching out and grabbing others. Resident #2 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder bipolar type (mental health condition with symptoms of hallucinations and delusions and mood disorder), attention-deficit hyperactivity disorder (ADHD) and cognitive communication deficit. On 2/17/25 Resident #1 and Resident #2 were standing in line waiting to go outside for their smoking break. The residents were standing in a line close to one another. Resident #1 kicked Resident #2 and then, as a result, Resident #2 punched Resident #1 in the face. Both of the residents fell to the ground. Resident #1 sustained a laceration to his face which required him to be sent to the hospital for stitches. Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 3/25/25 at 5:57 p.m. It read in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. (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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Providing a safe environment for the resident is one of the most basic and essential duties of our facility. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. If a resident experiences a behavior change resulting in aggression toward other residents, the facility will implement interventions for protection of the alleged assailant and other residents. The facility conducts further assessment and arranges for appropriate psychiatric evaluation for further screening. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization , can then be implemented. II. Resident-to-resident physical altercation between Resident #2 and Resident #1 on 2/17/25 A. Facility investigation The 2/17/25 facility abuse investigation report was provided by the NHA on 3/24/25 at 3:07 p.m. The investigation documented that on 2/17/25 at 7:41 p.m., Resident #1 and Resident #2 were both waiting in the dining room to go outside to smoke. Resident #1 kicked Resident #2. Staff immediately intervened and as the staff were separating the two residents, Resident #2 hit Resident #1 in the face with a closed hand. This resulted in both residents falling onto the floor. The report documented that both residents were immediately separated and placed on frequent checks. The registered nurse (RN) did a skin assessment for both residents. Both residents sustained injuries. Resident #2 sustained a two centimeter crescent shaped cut on his right hand that potentially was from Resident #2's rings and Resident #1 sustained a two to three centimeter laceration under his left eye, resulting in him being sent to the hospital for stitches. Resident #2 was placed on increased monitoring for safety. The facility investigation documented that the RN on duty went to check on Resident #2 in his room and that Resident #1 continued to try to enter Resident #2's room. Resident #1 was then placed on one-to-one supervision. The investigation documented the interventions that were put in place for Resident #1 included speech therapy to provide treatment to help with his communication skills and he was referred to behavioral health counseling services. The facility implemented increased monitoring for Resident #2. Additionally, Resident #2's behavioral health counselor was notified and his medication regime was reviewed B. Resident #1 1. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included hemiplegia affecting the right dominant side, aphasia and nicotine dependence. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 2/5/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The MDS assessment indicated the resident was independent with all activities of daily living (ADL) and used a manual wheelchair independently. The assessment revealed he had no behavioral symptoms directed toward others. He had exhibited rejection of care for one to three days during the assessment review period. 2. Record review Resident #1's care plan, initiated 11/21/24 and revised 3/13/25, identified the resident had behavior issues related to refusing care and had a history of reaching out and grabbing onto others. Pertinent interventions included behavioral monitoring (initiated 11/21/24), praising the resident's progress in improvement in behavior (initiated 1/2/25), encouraging the resident to communicate verbally with others to ensure personal boundaries as needed (initiated 3/13/25). -The care plan was not updated after the 2/17/25 resident-to-resident altercation to indicate that the resident had a tendency to kick at others who were close. The 2/17/25 nursing note documented that the nurse was called down to the dining room by a certified nurse aide (CNA) because of an altercation between two residents. The note documented that the nurse found Resident #1 in his wheelchair with blood on the left side of his face and a two to three centimeter laceration below his left eye. The 2/17/25 nursing note documented that Resident #1 continually tried to enter Resident #2's room even after being encouraged to return to his own room. The note documented that the nurse had to have a CNA remain in the hallway to prevent Resident #1 from entering Resident #2's room. The note documented that both residents were on 15-minute checks. The 2/17/25 nursing note documented that they received a physician's order to send Resident #1 to the emergency department for evaluation and treatment of the laceration under his left eye. The 2/17/25 after-visit summary from the hospital, documented Resident #1 had a contusion of the face and a facial laceration that needed three sutures. The 2/18/25 nursing note documented that Resident #1 returned from the emergency department with stitches under his left eye and the area had moderate swelling. The note documented the stitches were to be removed on 2/25/25 and the emergency department doctor suggested bactrim ointment (antibiotic) and told the facility that all the testing was clear. C. Resident #2 1. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included schizoaffective disorder bipolar type, attention-deficit hyperactivity disorder and cognitive communication deficit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 1/20/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment documented the resident was independent with all ADLs and walked independently without assistive devices. The assessment revealed the resident had no behavioral symptoms directed towards others and no rejection of care. 2. Resident observation and interview Resident #2 was interviewed on 3/25/25 at 11:18 a.m. Resident #2 said he remembered the incident with Resident #1, which occurred on 2/17/25. He said Resident #1 kicked him and therefore he punched Resident #2 in the face. He said they had since apologized to each other and had not had any further incidents. The resident had large rings on all of his fingers on both hands. 3. Record review Resident #2's care plan, initiated 3/18/24 and revised 3/24/25 (during the survey), documented Resident #2 had auditory and visual hallucinations which could cause him to have paranoia and delusions. The care plan documented that he had a history of impulsiveness and physical altercations. Pertinent interventions included providing a behavioral consult with his mental health providers (initiated 5/29/24), behavioral monitoring (initiated 11/9/24), providing frequent checks (initiated 9/20/24), monitoring the resident's behaviors and attempting to determine underlying cause (initiated 12/24/24) and intervening as necessary when behaviors occurred (initiated 4/26/24). The 2/17/25 nursing note documented Resident #2 was outside smoking when the nurse approached him and asked him what had happened. Resident #2 told the nurse that Resident #1 had kicked him on his left leg so he had punched him. The 2/17/25 nursing follow-up note documented Resident #2 had said Resident #1 had been kicking at him for the past few days, but he had not told anyone about the previous incidents. He told the nurse it was not a big deal at the time. The 2/18/25 nursing note documented Resident #2 remained on 15-minute checks and remained on one-to-one supervision for safety from Resident #1. The 2/20/25 interdisciplinary team (IDT) note documented Resident #2 continued to have delusions. The resident continued to be on one-on-one supervision for continued safety of others. III. Staff interviews CNA #1 was interviewed on 3/35/25 at 3:54 p.m. CNA #1 said the staff were trained on abuse every month through an online portal. She said she had not seen any recent altercations between Resident #1 and Resident #2. She said she always kept an eye on Resident #2 since the altercation with Resident #1. The social services director (SSD) was interviewed on 3/25/25 at 4:45 p.m. The SSD said the social services department was responsible for completing abuse investigations, reporting of the abuse and completing the facility abuse packet. The SSD said the abuse coordinator was the NHA. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The SSD said when abuse happened, the facility investigated to determine the root cause. She said the facility also completed an analysis for any triggers such as hunger, thirst or any environmental stressors. She said a lot of the residents that resided at the facility had major mental illness with behaviors, which caused them not to understand social cues and they were socially inappropriate. The SSD said Resident #1 had a history of reaching out and grabbing other residents. She said the facility continued to monitor and intervene with his behavior. The director of nursing (DON) was interviewed on 3/25/25 at 5:04 p.m. The DON said a resident-to-resident altercation occurred between Resident #1 and Resident #2 on 2/17/25, which was substantiated as abuse. He said the licensed nurses and the CNAs would notify him of any abuse and then he would notify the NHA and the SSD. He said the RN who was working the floor would do a skin assessment after the incident occurred. He said the facility discussed the incident during their IDT meeting. He said it was recommended, after the 2/17/25 incident, that the residents needed to be spread out from each other while they waited to go outside to smoke. The NHA was interviewed on 3/25/25 at 5:30 p.m. The NHA said since the abuse incident between Resident #1 and Resident #2, the facility had moved around the smoking times and asked the residents to wait further away from the smoking door. She said the facility separated the smoking times by floor and each floor was separated by 15 minute intervals.