STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Juniper Village - the Spearly Center	2205 W 29th Ave Denver, CO 80211

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** Based on record review and interviews, the facility failed to ensure two (#65 and #124) of eight residents were kept free from abuse out of 41 sample residents. Specifically, the facility failed to protect Resident #124 from physical abuse by Resident #65 and protect Resident #65 from physical abuse by Resident #124. Findings include: I. Facility policy and procedure The Abuse and Neglect policy, undated, was provided by the nursing home administrator (NHA) on 5/11/26 at 11:45 a.m. It read in pertinent part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Alleged and substantial incidents, complete investigation reports, and if necessary, corrective actions taken, will be reported to the Resident's responsible party, Physician, Ombudsman, State Licensing Authority and Police Department as appropriate. II. Incident of resident-to-resident physical abuse between Resident #65 and Resident #124. A. Facility investigationThe 4/25/26 facility investigation was provided by the NHA on 5/13/26 at 4:56 p.m. The investigation revealed Resident #124 said something to Resident #65 as they were passing each other in the hallway. Resident #65 acted as if she was going to hit Resident #124. Resident #124 then slapped Resident #65's arm away and Resident #65 hit Resident #124 in the back of the head with a closed fist. No injuries were noted. The facility immediately intervened and placed both residents on 15-minute checks. B. Resident #65 (assailant)1. Resident status Resident #65, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included severe unspecified dementia, adult failure to thrive, alcohol abuse, anxiety disorder, depression and insomnia. The 3/30/26 minimum data set (MDS) assessment revealed, the resident had a short-term memory problem. Her cognitive skills for daily decision making were severely impaired. She had inattention and disorganized thinking which fluctuated. She had delusions and wandered one to three days out of the seven-day assessment look-back period. 2. Resident interviewAn attempt was made to interview Resident #65 on 5/11/26 at 10:57 a.m. However, the resident was not interviewable due to her cognitive impairment. 3. Record reviewResident #65's behavior care plan, revised 3/17/26, identified the resident had new disruptive behavior that included going into other residents' rooms and rummaging through their belongings. The care plan documented Resident #65 no longer had a sense of personal ownership. Interventions included ensuring the safety of the resident and others, establishing boundaries and limits with Resident #65, monitoring for environmental factors that may contribute to new behaviors and utilizing diversion techniques as needed. The psychotropic medication care plan, revised 3/26/26, revealed Resident #65 was prescribed psychotropic medications related to her disease process, depression, anxiety secondary to dementia with severe behavioral disturbances. Interventions included monitoring/recording/documenting behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication, violence /aggression towards staff/others, and entering other resident rooms.A behavior note, dated 4/25/26 at 10:37 a.m., revealed Resident #124 said something to Resident #65 when he wheeled past her. Resident #65 acted like she was going to hit Resident #124. Resident #124 slapped Resident #65 on (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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(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	her arm open handed. Resident #65 hit Resident #124 in the back of the head with a closed fist. There were no scratches or bruises on either resident. The physician, the on-call nurse and the residents'families were notified. Both residents were placed on every 15-minute checks and kept separated and safe. Neurological checks were initiated on Resident #124. C. Resident #1241. Resident statusResident #124, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 CPO, diagnoses included Parkinson's disease, dysphagia, cognitive communication deficit, bipolar disorder, hearing loss and post-traumatic stress disorder.The 2/16/26 MDS assessment revealed, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He had inattention, which fluctuated. He wandered one to three days during the assessment look-back period and was able to propel his wheelchair independently. 2. Resident interviewResident #124 was interviewed on 5/14/26 at 10:03 a.m. Resident #124 said Resident #65 punched him in the back of the head. He said he did not know why she hit him. 3. Record reviewResident #124's behavior care plan, initiated 7/1/25, revealed the resident presented with episodic maladaptive behaviors during which he was physically aggressive towards other residents. Interventions included monitoring, documenting and reporting increased distress. A behavior note, dated 4/25/26 at 10:37 a.m., revealed Resident #124 said something to Resident #65 when he wheeled past her. Resident #65 acted like she was going to hit Resident #124. Resident #124 slapped Resident #24 slapped her arm open handed. Resident #65 hit Resident #124 in the back of the head with a closed fist. There were no scratches or bruises on either resident. The physician, the on-call nurse and the residents' families were notified. Both residents were placed on every 15-minute checks and kept separated and safe. Neurological checks were initiated on Resident #124. III. Staff interviewsLicense practical nurse (LPN) #1 was interviewed on 5/13/26 at 1:49 p.m. LPN #1 said she witnessed the altercation between Resident #65 and Resident #124. She said Resident #124 was going to his room and Resident #65 was leaving her room. She said as they were passing each other in the hallway, Resident #65 postured as if she was going to hit Resident #124. She said Resident #124 then pushed Resident #65's arm away and she made a fist and hit him in the back of the head. LPN #1 said Resident #65 had severe dementia with behaviors. She said Resident #65 wandered into other residents' rooms and Resident #124 had behaviors upon admission, but none at the time of the incident. Unit manager #1 was interviewed on 5/13/26 at 1:55 p.m. Unit manager #1 said Resident #65 liked to wander into other residents' rooms and was a high elopement risk. She said Resident #65 had dementia and no awareness of personal space and hit the doors. She said immediately following the incident, both residents were separated and put on 15-minute checks. She said both residents had medication reviews and increases to their medications. She said Resident #65 was very difficult to redirect and was not able to communicate her needs. The director of nursing (DON) was interviewed on 5/13/26 at 3:19 p.m. The DON said staff immediately intervened and separated Resident #65 and Resident #124. He said both residents were then placed on every 15-minute checks and medication reviews were completed for both residents. He said there was no evidence identified to suggest intent to cause harm.