

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER Lakewood Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 1625 Simms St Lakewood, CO 80215	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on record review and interviews, the facility failed to ensure four (#2, #3, #6 and #9) of nine residents reviewed for abuse out of 13 sample residents were kept free from abuse.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Protect Resident #2 from physical abuse by Resident #3; -Protect Resident #6 and Resident #3 from physical abuse from each other; and, -Protect Resident #9 from physical abuse by Resident #3. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect, Exploitation and Misappropriation policy and procedure, revised April 2021, was provided by the nursing home administrator (NHA) on 3/24/25 at 2:00 p.m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.</p> <p>The resident abuse program consists of a facility-wide commitment and resource allocation to support protecting residents from abuse by:</p> <ul style="list-style-type: none"> -Developing and implementing policies and protocols to prevent and identify abuse, neglect and exploitation, ensure adequate staffing and oversight to prevent burnout, stressful working situations and high turnover rates; -Conduct employee background checks; -Establishing and maintaining a culture of compassion and caring for all residents; -Providing staff education and training on abuse; -Implementing measures to address factors that lead to abuse; <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Identifying and investigating all possible incidents of abuse;</p> <p>-Protecting residents from further harm during investigations;</p> <p>-Reviewing allegations of abuse during monthly quality assurance and performance improvement (QAPI) meetings; and,</p> <p>-Involving the resident council in monitoring and evaluating the facility's abuse prevention program.</p> <p>II. Facility investigations of abuse incidents</p> <p>A. Incident of physical abuse by Resident #3 towards Resident #2 on 2/13/25</p> <p>The 2/13/25 abuse investigation report was provided by the clinical resource nurse (CRN) on 3/24/25 at 9:50 a.m.</p> <p>It documented there was a witnessed, physical altercation between two residents (Resident #2 and Resident #3). The residents were separated, assessed, placed on frequent checks and their care plans were updated with new interventions. The staff assisted Resident #2 to the Red Rocks unit for an activity. The staff took turns watching Resident #3 on the Columbine (co-ed) unit.</p> <p>Resident #2 sustained an abrasion and bruise to her left eyebrow but declined care.</p> <p>Resident #3 was interviewed by the NHA on 2/13/25 at 2:28 p.m. Resident #3 was unable to answer the NHA's questions appropriately.</p> <p>Resident #2 was interviewed by the NHA on 2/13/25 at 2:47 p.m. Resident #2 made a punching motion and pointed to her face when asked if any of her fellow residents had ever physically harmed her. Resident #2 was unable to appropriately answer the NHA's other questions.</p> <p>Eight additional residents were interviewed and did not have additional information.</p> <p>Housekeeper (HK) #1, who witnessed the altercation, said she was sweeping the dining room and Resident #2 was in a dining room chair. Resident #3 was sitting on a pink sofa chair. Resident #3 stood up and walked over to Resident #2. With a closed fist, Resident #3 hit Resident #2 three times on the eye. HK #1 separated the two residents and Resident #3 tried to hit her. A therapist and certified nurse aide (CNA) responded and the situation was de-escalated. The business office manager (BOM) took Resident #2 up front to the Valentine's Day party and Resident #3 grabbed the broom and started sweeping the hallway.</p> <p>The facility substantiated the incident.</p> <p>B. Incident of physical abuse between Resident #3 and Resident #6 on 2/16/25</p> <p>The 2/16/25 abuse investigation was provided by the CRN on 3/24/25 at 9:50 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>It documented there was a witnessed physical altercation between Resident #3 and Resident #6. The residents were separated and assessed. Resident #6 was assisted to his room and Resident #3 stayed with a CNA in the dining room until he went to bed. The residents's care plans were updated with new interventions. Resident #3 had a new, small abrasion on his elbow upon assessment.</p> <p>Resident #3 was interviewed by the BOM on 2/17/25 at 11:08 a.m. Resident #3 was unable to answer the BOM's questions appropriately.</p> <p>Resident #6 was interviewed by the BOM on 2/17/25 at 11:37 a.m. He answered no when asked if he had recently been upset by an interaction with a fellow resident at the facility, had felt uncomfortable, threatened or fearful by any fellow residents or had been harmed by any fellow residents. He had nothing additional to say.</p> <p>Eight residents were interviewed and had no additional information.</p> <p>CNA #5 made a witness statement on 2/16/25 at 10:56 p.m. CNA #5's witness statement documented that she was in the dining room. She said Resident #3 got up from his nap and came to the dining room. She said she was standing by a table. She said Resident #6 was sitting at another table but got up and began wandering. She said Resident #3 wandered over in the direction of where Resident #6 was wandering. The residents ran into each other and began arguing and yelling. Resident #3 pushed Resident #6 away. Resident #6 then grabbed at Resident #3 and pushed him hard. She said this caused Resident #3 to fall to the floor on his buttocks and tailbone. The nurse and another CNA helped the witness separate the two residents. The assisting CNA helped Resident #6 to his room where he remained for the rest of the night. The witness (CNA #5) stayed with Resident #3 until the nurse assessed him and got him up from the ground. Resident #3 did not hit his head but scraped his elbow on the wall.</p> <p>The facility substantiated the incident.</p> <p>C. Incident of physical abuse by Resident #3 towards Resident #9 on 3/24/25</p> <p>On 3/24/25 at 9:55 a.m. (during the survey), Resident #3 was walking around while pushing a dining room chair in the Columbine unit. Resident #9 walked in front of the chair and sat down in the chair. Resident #3 tried pushing the chair forward and was not able to. Resident #3, with an open palm, slapped Resident #9 on the right side of the head.</p> <p>This incident was reported to licensed practical nurse (LPN) #1 on 3/24/25 at 9:57 a.m. and reported to the NHA on 3/24/25 at 10:02 a.m. LPN #1 separated the two residents and assessed each resident. The NHA said she would start an internal abuse investigation.</p> <p>III. Resident #3 - assailant and victim</p> <p>A. Resident status</p> <p>Resident #3, age 74, was admitted on [DATE]. According to the March 2025 computerized physician's orders (CPO), diagnoses included unspecified dementia with agitation, chronic obstructive pulmonary disease, low back pain and weakness.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the 12/11/24 minimum data set (MDS) assessment the resident had short term and long term memory problems and his cognitive skills for daily decision making were severely impaired through staff assessment. He was dependent on staff for toileting and dressing. He was independent with ambulation.</p> <p>The MDS assessment documented Resident #3 had physical behavior symptoms directed towards others, verbal behavioral symptoms directed toward others and other behavioral symptoms not directed at others every one to three days.</p> <p>B. Record review</p> <p>Resident #3's cognitive impairment care plan, initiated 12/18/24, revealed he had impaired cognitive function related to dementia with behaviors. Interventions included monitoring and reporting changes in cognitive function to his physicians, reviewing medications and using task segmentation to support short term memory deficits.</p> <p>Resident #3's behavior care plan, initiated 12/23/24 and revised 3/21/25, revealed he had the potential to be verbally and physically aggressive related to dementia. Interventions added after the 2/13/25 incident included for staff to provide Resident #3 with meaningful activities, including sweeping with supervision and reading the menus that were posted. Interventions added after the 2/16/25 incident included encouraging Resident #3 to participate in goal oriented tasks, offering snacks and drinks throughout the day and referring Resident #3 to therapy for sensory integration.</p> <p>The skin assessment completed on 2/16/25 documented Resident #3 had a new bruise on his left elbow.</p> <p>The 2/13/25 nursing note documented the nurse was notified that Resident #3 was aggressive towards another resident (Resident #2). Resident #3 was unable to explain what happened. The residents were separated and frequent checks were initiated. Resident #3's representative was notified of the incident.</p> <p>The 2/16/25 nursing note documented that a CNA notified the nurse that Resident #3 and another resident were yelling in each other's faces. Resident #3 pushed the other resident so that resident (Resident #6) retaliated and pushed Resident #3 to the floor. Resident #3 hit his left elbow on the ground. The CNA called the nurse and they separated both residents and the nurse assessed both residents. Resident #3 denied pain and the nurse assisted him to lift himself from the floor. Resident #3 sustained light bruising to his left elbow and a dry dressing was applied on it. The nurse notified the physician, the director of nursing (DON) and the NHA.</p> <p>IV. Resident #2 - victim</p> <p>A. Resident status</p> <p>Resident #2, age 85, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia with behavioral disturbances, chronic kidney disease, mood disorder and chronic pain.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON, the CRN and the NHA were interviewed together on 3/24/25 at 3:30 p.m. The NHA said she verbally educated staff on Resident #3's behavior interventions each time he got new interventions added. She said he was reviewed at monthly psychology pharmaceutical (psych pharm) meetings, weekly at-risk meetings and at the monthly QAPI meetings with the interdisciplinary (IDT) team. She said the facility identified that one of Resident #3's triggers was when he was woken up in the morning. She said the facility implemented interventions to let him sleep as long as he wanted and to wake on his own.</p> <p>The DON said the facility was working with the pharmacist and Resident #3's physician to adjust his medications and get him on the right medication regimen to ensure he maintained his quality of life while keeping his behaviors stable.</p> <p>The NHA said she had sent a referral for Resident #3 to work with a psychiatrist and that Resident #3 had been unable to participate.</p> <p>Resident #3's physician (PHY) was interviewed on 3/25/25 at 11:25 a.m. The PHY said he thought Resident #3's diagnosis was frontal lobe vascular dementia which was consistent with his behaviors and he would update the resident's diagnosis. He said he had been working with Resident #3 to get him on the right medication regimen since he was admitted . He said Resident #3 was gradually getting better with his behaviors. He said the staff that worked with him full-time knew him well and were able to redirect him. The PHY said he received calls from the agency staff regarding Resident #3's behaviors because they did not know him as well.</p> <p>The medical director (MD) was interviewed on 3/25/25 at 11:45 a.m. He said Resident #3 had dementia and would never be cured of his disease. He said just like other diseases, he had exacerbations with his behaviors. He said the staff were working with him to get him on the right medication regimen and the right interventions that worked for him. The MD said the goal was to minimize Resident #3's behaviors without sedating him to the point he had no behaviors.</p> <p>CNA #2 was interviewed on 3/25/25 at 8:35 a.m. CNA #2 said Resident #3 was not having any behaviors so far that morning (3/25/25). She said he refused his shower and they let him refuse because he could get aggressive. She said he got aggressive when other people got in his way or took his food off his plate. She said Resident #9 took food from other resident's plates in the dining room, so they had to keep Resident #3 and Resident #9 separated in the dining room. She said the two residents (Resident #9 and Resident #3) did not get along. CNA #2 said the staff redirected Resident #3 when he got aggressive with snacks, books and reading menus.</p> <p>The DON was interviewed a second time on 3/25/25 at 1:43 p.m. The DON said she felt like the facility was progressing with Resident #3 in the right direction. She said it had been a process to figure out Resident #3's triggers and what he responded well too. She said the facility had been working on getting information from staff and educating the staff regarding Resident #3. She said the staff kept other residents free from harm while residing with Resident #3 by knowing when Resident #3 was up and active, keeping an eye on him, redirecting him with reading material or activities when he was aimlessly wandering, being aware of his stimuli and keeping a close eye on him when he was in the dining room. She said she had not noticed any of the victims of Resident #3's incidents having any changes in their behaviors or mood. The DON said she educated the agency staff about Resident #3's patterns and triggers and also had them review a binder prior to their shift with the facility's policies.</p>		