STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065408	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Villa	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)
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 (#1 and #2) of eight residents reviewed for abuse out of eight sample residents were free from abuse. Specifically, the facility failed to ensure Resident #1 and Resident #2 were free from abuse by each other. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised September 2022, was provided by the nursing home administrator (NHA) on 7/7/25 at 11:00 a.m. It read in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator or to other officials according to state law. The individual conducting the investigation as a minimum reviews the documentation and evidence, reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, reviews all events leading up to the alleged incident and documents the investigation completely and thoroughly. The follow up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. II. Physical abuse between Resident #1 and Resident #2 on 5/12/25. A. Facility investigation The facility investigation was provided by the NHA on 7/7/25 at 12:30 p.m. (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 investigation documented the NHA responded to a commotion from staff that occurred in the entrance of the front dining room. When the NHA arrived, the registered nurse (RN) on duty was standing by Resident #2 at the dining room entrance holding his glasses. At this time, Resident #1 was sitting at the table nearest to the dining room entrance. The NHA asked what happened. The staff present, including one certified nurse aide (CNA), one dietary aide and a RN , said that they did not witness the event but there was an event that occurred between Resident #1 and Resident #2. The NHA interviewed both residents following the event. Resident #1 said that he was walking to the dining room for dinner and Resident #2 kicked his shin when he walked by, then grabbed at his shirt and hit his chest. The NHA asked what happened next and Resident #1 said that he acted in self defense and hit Resident #2 to stop Resident #2 from grabbing his shirt. The NHA asked Resident #1 if he remembered if he hit Resident #2 with an open or closed hand. Resident #1 said he did not remember that detail. Resident #2 said he did not fully remember what happened and that Resident #1 came at him. The investigation documented the event was not caught on the facility's camera. The RN present said Resident #1 told her the same things that he communicated to the NHA but he told the RN he slapped Resident #2. B. Resident #1 1. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included dementia, obesity, hypertension (high blood pressure), restlessness and agitation. The 2/22/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was independent with mobility and for meals and needed moderate assistance with hygiene and set up assistance with other activities of daily living (ADL). 2. Record review Resident #1's dementia care plan, initiated 8/7/24, documented he had impaired cognitive function and dementia or impaired thought processes. Pertinent interventions, initiated 8/7/24, included to monitor, document and report to the physician any changes in cognitive function, specifically decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others and mental 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 #1's psychotropic medication care plan, revised 12/16/24, documented he received psychotropic medications due to dementia with behaviors. Pertinent interventions, revised 5/20/25, included to monitor for agitation as evidenced by verbal and physical outbursts and monitor and record occurrences of target behavior symptoms (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others) and document per facility protocol; administer medications as ordered; and monitor and document for side effects and effectiveness. Resident #1's antidepressant medication care plan, revised 12/20/24, documented he received antidepressant medication for dementia with behaviors and insomnia. Pertinent interventions, revised 12/20/24, included to monitor, document and report to the physician as needed ongoing signs and symptoms of depression: sadness, irritation, anger, crying, negative mood and/or comments, not enjoying usual activities, changes in cognition, unrealistic fears, attention seeking, and constant reassurance. A 5/13/25 alert note documented that on 5/12/25 at approximately 5:00 p.m., Resident #2 was in the dining room doorway when Resident #1 entered the dining room and as he was passing by, Resident #2 kicked Resident #1 on his shin, grabbed him and hit him on his chest. Resident #1 hit Resident #2 back in self defense on the left side of the head. A nurse was at the nurses'station and heard the slap and something fall to the ground. The nurse went to check on the commotion and found Resident #2's glasses on the floor and the left arm of the glasses was broken. Resident #2 was assessed. Resident #2 said Resident #1 hit him and broke his glasses. Resident #1 said he hit Resident #2 back in self defense so that Resident #2 would leave him alone. Resident #1 said he hit Resident #2 with a slap on the left side of his face and head. The NHA was notified. C. Resident #2 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included chronic respiratory failure, type 2 diabetes mellitus, Parkinson's disease (disease that causes unwanted movements), cognitive communication deficit and dementia. The 4/11/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. He needed set up assistance for meals and was dependent on staff assistance for his ADLs. 2. Record review Resident #2's behavior care plan, revised 2/4/25, documented he frequently made uninvited sexual advances toward female staff and explicit sexual comments towards female staff. Pertinent interventions included to administer medications as ordered and monitor and document for side effects and effectiveness (initiated 5/28/24) and staff were to assist Resident #2 to an appropriate table in the dining room to prevent collision with other residents (initiated 5/13/25). Resident #2's antipsychotic medication care plan, revised 2/4/25, documented he was on prescribed antipsychotic medications for dementia with behavioral disturbance and to monitor for: uninvited sexual advances towards others; hallucinations; and verbal outbursts (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pertinent interventions, revised 9/3/24, included observing for behavior associated with anti-psychotic medications including delusions, paranoia and hallucinations. Resident #2's Kardex (care plan summary), as of 7/7/25, documented to monitor behavior episodes and attempt to determine the underlying cause, and consider the location, time of day, persons involved and solutions and document the resident's behavior and potential causes. -However, the Kardex failed to list a care planned intervention for staff to assist Resident #2 to an appropriate table in the dining room to prevent collision with other residents (see above). A 5/13/25 nursing note documented that at 5:20 a.m. a CNA reported a bruise above Resident #2's left eye. During the assessment Resident #2 said he got the bruise from the previous day's incident where he was in a fight with another resident. The nurse assessed the site, which was a minor bruise to the left eyelid, and the resident denied having pain. The previous day shift nurse reported Resident #2 was engaged in a physical fight with another resident which broke the left side of Resident #2's eyeglasses. III. Staff interviews CNA #1 was interviewed on 7/7/25 at 2:45 p.m. CNA #1 said she was aware of an incident between Resident #1 and Resident #2, but did not witness the incident. CNA #1 said all residents were monitored for behaviors in the building and she said residents had different interventions based on their behavior. CNA #1 said she could not could not recall any issues between Resident #2 and other residents prior to 5/12/25 and he was easily redirectable. CNA #1 said she could document a resident's behavior in the electronic medical record (EMR) multiple times a day if behaviors occurred. CNA #1 said if a resident had behaviors, she reported them to the nurse and also reported them to the CNA during the shift change so the other staff were aware. CNA #1 said she could find a resident's behaviors in the Kardex and could look up Resident #2's interventions in the Kardex, but she was not sure of Resident #2's exact interventions for his behavior. -However, a review of Resident #2's Kardex on 7/7/25 revealed the 5/13/25 care planned intervention for staff to assist Resident #2 to an appropriate table in the dining room to prevent collision with other residents was not on the resident's Kardex. Licensed practical nurse (LPN) #1 was interviewed on 7/7/25 at 2:52 p.m. LPN #1 said behavior monitoring was generally the same for all residents but if there was a different behavior than the resident's baseline, he would document that in a progress note. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA and the assistant director of nursing (ADON) were interviewed together on 7/7/25 at 4:20 p.m. The NHA said on 5/12/25, the nurse was at the nurses'station and heard something fall on the floor and determined it was Resident #2's glasses. The NHA said the nurse heard what she thought was an open handed slap. The NHA said Resident #1 consistently reported that Resident #2 reached out and kicked him. The NHA said Resident #2 was able to kick and self propel in his wheelchair if motivated. The NHA said Resident #2 reported that he was unable to remember what he did and he said Resident #1 attacked him. The NHA said after the incident, she let staff know that Resident #2 preferred to eat in his room at breakfast but if Resident #1 and Resident #2 were going to be in the dining room, the residents should be separated and not eat at the same table and Resident #2 should be assisted to the dining room because he was wheelchair ambulatory. The NHA said Resident #2's assistance to the dining room was added to his care plan and Kardex so the staff could see it. -However, a review of Resident #2's Kardex revealed the 5/13/25 care planned intervention for staff to assist Resident #2 to an appropriate table in the dining room to prevent collision with other residents was not on the resident's Kardex. The ADON said the CNAs were not able to see a resident's care plan but did use the Kardex. The ADON said Resident #2's Kardex had not been updated with the intervention for staff to assist Resident #2 to an appropriate table in the dining room to prevent collision with other residents. The ADON said she added the intervention to Resident #2's Kardex during the survey.