STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065273	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Post Acute	6270 W 38th Ave Wheat Ridge, CO 80033

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 observations, record review and interviews, the facility failed to ensure one (#3) of four residents were kept free from physical abuse out of six sample residents.Specifically, the facility failed to protect Resident #3 from physical abuse by Resident #4.Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 10/9/25 at 10:05 a.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support protecting residents from abuse, neglect, exploitation or misappropriation of property by anyone; developing and implementing policies and protocols to prevent and identify abuse or mistreatment of residents neglect of residents and/or theft, exploitation or misappropriation of resident property; provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management and handling verbally or physically aggressive resident behavior; implementing measures to address factors that may lead to abusive situations; identifying and investigating all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property and protecting residents from any further harm during investigations.II. Incident of physical abuse between Resident #3 and Resident #4 on 6/21/25A. Facility investigationThe facility's abuse investigation, dated 6/21/25, documented that at approximately 8:15 p.m. Resident #3 and Resident #4 were in the smoking patio area when a verbal altercation occurred. Resident #3 told Resident #4 to smell his feet and called him names. Resident #3 then moved his electric wheelchair toward Resident #4 in an aggressive manner. Resident #4 flicked a lit cigarette at Resident #3 and spit at Resident #3, grabbed Resident #3's arm and dug his fingernails into his skin, and struck Resident #3 in the face, which caused Resident #3's glasses to fall to the ground.Resident #3 left the patio and notified staff. Staff ensured both residents were kept apart and remained on opposite sides of the hallway for the rest of the evening. The facility initiated 15-minute checks for both residents. A registered nurse (RN) assessed Resident #3 after the incident and documented minor scratches on the resident's arm and a small burn on his chest. Resident #3 denied pain. The RN offered wound treatment and Resident #3 declined. Resident #3 declined to discuss the incident further but appeared angry and frustrated. A physician's assistant offered counseling and therapy and Resident #3 declined.Resident #4 was interviewed after the incident and he said that Resident #3 made inappropriate comments and moved his wheelchair toward him. Resident #4 said he reacted by striking Resident #3 in the face.The investigation documented that staff and residents were interviewed and they did (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	not report any ongoing safety concerns. Documentation confirmed that physical contact occurred and that treatment was offered and declined. The interventions implemented after the incident for both residents included continued 15-minute checks, behavior monitoring and review of the residents' care plans. Resident #3's care plan directed staff to provide redirection, offer preferred activities and monitor mood and behavior. Resident #4's care plan directed staff to maintain a calm environment, encourage expression of feelings and documented behavioral episodes with triggers. The investigation documented that the facility substantiated that the allegation of resident-to-resident physical abuse occurred.B. Resident #3 - victim1. Resident statusResident #3, age less than 65, was initially admitted on [DATE], readmitted [DATE] and discharged [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included paraplegia, depression and anxiety. The 9/2/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required substantial assistance with toileting, bathing, and moderate assistance with dressing. The MDS assessment did not indicate that the resident had any behaviors.2. Resident #3 interviewResident #3 was interviewed on 10/8/25 at 5:43 p.m. Resident #3 said that on the day of the incident (6/21/25) he was in the smoking area in his wheelchair when Resident #4 made verbal and racial remarks toward him, including comments about him being crippled. He said that when he moved his wheelchair toward Resident #4, his intention was not aggressive but to respond to what was being said. He said there were no staff members present during the altercation and that his roommate ran inside to get help. Resident #3 said that before staff arrived, Resident #4 hit him twice in the face which caused his glasses to fall and break. He said Resident #4 also flicked a lit cigarette that caused a burn between his chest and stomach. He said the cigarette landed on his stomach and he did not feel it immediately because he was paraplegic and had limited sensation. He said he later noticed burn marks on his chest and stomach area. He said he declined an assessment at the time but continued to have a visible mark afterward. Resident #3 said the situation ended once staff arrived. 3. Record review The behavioral care plan, initiated 2/7/25 and revised 9/23/25, documented that Resident #3 had diagnoses of depression and anxiety and exhibited verbal aggression toward others. The care plan described a history of racist or derogatory comments, unfounded accusations and easy agitation. Resident #3 sometimes made jokes or comments that he found humorous but that could irritate others and that he could speed in his electric wheelchair when agitated. Pertinent interventions included redirecting the resident to a quiet area, encouraging the use of games on his cell phone, offering arts and crafts supplies, providing brain teaser puzzles, offering preferred music or television, offering snacks or drinks, and encouraging calm expression of feelings. Additional interventions included observing and documenting behavioral episodes, notifying the physician and responsible party of aggression or significant changes, obtaining a psychological consultation if indicated, and educating staff to provide care in pairs for safety when the resident exhibited aggressive behavior.The 6/21/25 nurse progress note revealed that Resident #3 had a verbal altercation with another resident in the smoking area and the other resident became physical with Resident #3. The 6/26/25 nurse progress note documented that a skin assessment was completed at the time of the incident on 6/21/25 and no burns or open sores were observed. The note revealed that the other resident flicked a lit cigarette at him, but no burn was noted during the assessment. The note documented that the resident was scratched by the other resident, but there was no bleeding or skin tear observed.A subsequent nurse progress note dated 6/26/25 at 6:17 p.m. revealed that Resident #3 reported an open area on his chest that appeared to be a cigarette burn. The note documented that there were no signs or symptoms of infection and that wound care orders were received. The note further (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that the open area was not present during the initial assessment on 6/21/25 and that the physician was notified.C. Resident #4 - assailant1. Resident statusResident #4, age less than 65, was admitted on [DATE]. According to the October CPO, diagnoses included dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.The 8/21/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with completing his activities of daily living (ADL).The MDS assessment did not indicate that the resident had any behaviors.2. Resident #4's interviewResident #4 was interviewed on 10/8/25 at 11:08 a.m. Resident #4 said his stay at the facility had been all right. He said he usually got along with the other residents and talked with them without any problems. He said he often went to the smoking area and did not have a preference whether other residents were present or not. He said he became angry and had a fight with Resident #3 in June 2025 and he did not know what was wrong with Resident #3. He said he had never had disagreements with any other residents. He said the police investigated the incident and that he now had to go to court. He said it helped him calm down when other residents did not talk to him when he felt frustrated. He said he did not want to discuss the incident further.3. Record reviewThe behavioral care plan, initiated 12/4/24 and revised on 7/3/25, documented that Resident #4 could become angry if he perceived that he was being disrespected or teased. It documented that he could become verbally or physically abusive toward others if provoked. Pertinent interventions included observing and documenting changes in behavior, including frequency and potential triggers, encouraging the resident to verbalize feelings, redirecting to a quiet area if agitated, encouraging physical activity, offering preferred activities, music, television programs, snacks or drinks and encouraging calm expression of feelings. Additional interventions included maintaining a calm and slow approach, obtaining a psychological consultation as indicated, notifying the physician and responsible party of episodes of aggression and documenting all behavioral episodes.The 6/21/25 nurse progress note documented that Resident #4 was involved in a physical altercation with another resident (Resident #3) in the smoking area. The note indicated that a verbal disagreement occurred and escalated when Resident #4 scratched, spit, and struck the other resident in the face, knocking the resident's glasses off. Staff separated the residents and placed both residents on frequent checks.The 6/25/25 nurse progress note documented that the frequent checks were discontinued.III. Additional resident interviewResident #6 was interviewed on 10/9/25 at 8:43 am. Resident #6 said he used a vaporizing device in the smoking area that evening on 6/21/25 and Resident #3 joked with Resident #4 to come smell his fee. Resident #6 said Resident #4 responded to Resident #3 to smell his own feet and Resident #4 approached and got in Resident #3's face. Resident #6 said he left the smoking area to get help. Resident #6 said he informed RN #1 and RN #1 immediately ran into the smoking area and Resident #6 went to his room. Resident #6 said he did not see Resident #4 throwing a lit cigarette at Resident #3 or punching him, but he said Resident #3 told him that Resident #4 punched him and flicked a lit cigarette at him when Resident #6 left to get help. Resident #6 said the facility did not obtain a witness statement from him or talk to him afterward. IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 10/8/25 at 12:55 p.m. LPN #1 said he had worked at the facility for three years, first as an agency staff member and more recently as a full-time employee. He said he worked on the hall where Resident #4 resided, and that Resident #3 lived in a different area of the facility. He said there was an assigned team responsible for supervising residents who required supervision. He said the facility kept residents' cigarettes and lighters secured. LPN #1 said staff reviewed the electronic treatment administration record (eTAR) and psychological monitoring documentation for residents who required closer (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation. He said he had not seen Resident #4 display aggression or assault anyone and that he was shocked when he heard about the incident that occurred on 6/21/25 between Resident #3 and Resident #4. He said he watched for body language, nonverbal cues, agitation and anything out of the ordinary to recognize early signs that a resident was becoming agitated or aggressive so he could intervene appropriately.LPN #1 said that if one resident became physically aggressive toward another resident, he would speak to them in a calm tone, remain neutral, step between the residents if there was physical contact, separate them and call for assistance. He said he stayed with the residents until help arrived and then notified the abuse coordinator, the NHA and the director of nursing (DON). He said he had not been aware of Resident #4's previous aggressive incidents before the 6/21/25 event and that the behavior was unexpected. He said he would review the resident's care plan for behavioral interventions in place and that following an incident, staff typically increased monitoring until the resident returned to baseline.Certified nurse aide (CNA) #1 was interviewed on 10/8/25 at 2:07 p.m. CNA #1 said residents who were not independent had designated times for supervised smoking and that staff kept the residents' cigarettes and lighters. She said she heard about the altercation between Resident #3 and Resident #4 from the charge nurse, who instructed staff to increase observation and monitoring of Resident #4, watch for any signs of verbal or physical aggression toward other residents and ensure that other residents were kept safe. CNA #1 said if Resident #4 became upset, the interventions were to talk to him, de-escalate the situation and notify the charge nurse if his behaviors were out of control. She said she made sure other residents were safe and kept away from Resident #4. CNA #1 said she was usually informed by the charge nurse when increased monitoring was needed for a specific resident. She said she also reviewed the Kardex (tool utilized for providing consistent care for residents) for interventions and documented her observations and interactions immediately.CNA #1 said Resident #3 occasionally made comments to staff, such as calling them lazy or using profane language when his medications were given late, but that he was redirected verbally and would apologize afterward. She said it was not typical for Resident #4 to be physically aggressive because he was very social, joked with others and often helped the activities director with setting-up activities. CNA #1 said she recognized early signs of aggression by closely monitoring changes in tone of voice, yelling, or screaming and that she would run to investigate and de-escalate the situation. She said she stayed with the residents involved to ensure safety and obtained assistance as needed. She said she reported information to the abuse coordinator and that after an incident and staff ensured resident safety. RN #1 was interviewed on 10/9/25 at 11:23 a.m. RN #1 said she could not recall who came to get her to assist the residents in the smoking area on the day of the incident between Resident #3 and Resident #4. She said Resident #3 had been talking about his showers and mentioned that his feet were smelly, then asked Resident #4 to smell his feet. She said Resident #3 also said Can you help a brother out and smell my feet, which offended Resident #4. RN #1 said Resident #4 began yelling at Resident #3. RN #1 said that during her assessment and observation immediately after the incident, there were no burn marks noted on Resident #3's chest or stomach area and no burn marks observed on his shirt. She said that a day or two later, burn marks consistent with a cigarette burn appeared on Resident #3's chest. She said the area was round, approximately 1 centimeter (cm) by 1 cm in size, irritated and raw. RN #1 said it was possible she did not see burn marks initially because the injury was fresh and had not yet fully developed.The social services director (SSD) was interviewed on 10/9/25 at 11:52 a.m. The SSD said she had not been at the facility on the day of the incident between Resident #3 and Resident #4, but she said she would normally begin the investigation when such an event occurred. She said her responsibilities included separating the residents, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contacting the police if the incident involved physical abuse, notifying the ombudsman and the (interdisciplinary team (IDT) and documenting the occurrence.The SSD said that to ensure the victim was monitored for emotional trauma, staff made sure the resident was in a safe location, spoke with the resident, offered behavioral health services, provided ombudsman contact information, and offered a room change if needed. She said the facility did whatever was necessary to prevent the situation from escalating.The SSD said that once interventions were in place, the residents' care plans were updated and staff were educated regarding behavioral interventions. She said the facility monitored whether the aggressor's behavior improved or worsened after new interventions were implemented. She said nurses completed behavior monitoring and checked the eTAR and electronic medication administration record (eMAR) for any behaviors noted during their shifts. She said if psychotropic medications were prescribed, the facility completed psychopharmacological monitoring and gradual dose reduction (GDR) reviews.The SSD said she coordinated with nursing leadership, including the DON and the assistant director of nursing (ADON), to ensure that behavioral interventions and supervision changes were implemented and documented. She said she reviewed the records to verify that behavioral monitoring and physician orders were entered and followed.The social services assistant (SSA) was interviewed on 10/9/25 at 12:16 p.m. The SSA said she did not remember the details of the incident that occurred on 6/21/25 between Resident #3 and Resident #4 and she could not recall when she was first notified. She said she remembered obtaining statements from both residents. The SSA said she did not recall that the victim developed burn marks on his chest or stomach.The SSA said that if she identified a resident with cigarette burns or observed an altercation, she would separate the residents, redirect them and contact the police and the ombudsman. She said she would offer or provide medical attention for the victim, notify the nurse if emergency services were needed, and escort the assailant to his room or another area of the building to ensure the safety of all residents.The DON was interviewed on 10/9/25 at 1:16 p.m. The DON said she ensured that all staff understood and followed behavior management interventions in the residents' care plans. She said the staff completed crisis prevention intervention (CPI) training annually and they provided additional education when the residents argued. She said staff were reminded to separate the residents and report the incident to management.The DON said she monitored staff compliance with behavior-related documentation and interventions by educating staff, reviewing the Kardex for interventions, confirming that nurses checked the care plans, and ensuring that behavior tracking was completed. She said she reviewed the behavior monitoring dashboard each morning and reminded staff to complete documentation if it was missing. The NHA was interviewed again on 10/9/25 at 1:00 p.m. The NHA said the facility was in the process of upgrading their cameras and that the camera in the smoking area was not functioning on 6/21/25. He said his expectation for staff during abuse incidents was to intervene, de-escalate verbal or physical behavior, notify the NHA, and for the DON to initiate risk management, place the resident on behavior tracking, interview witnesses, implement interventions and update the care plan. He said they would also notify the ombudsman. He said if 15-minute checks were initiated, then nursing staff would follow up to ensure they monitored the residents. He said the facility ensured the accuracy of an occurrence by considering every perspective, interviewing witnesses as soon as possible, obtaining multiple points of view and requiring the SSD to investigate thoroughly.The NHA was interviewed a second time on 10/9/25 at 2:31 p.m. The NHA said the nurse progress note documented that RN #1 completed a head to toe assessment on 6/21/25 and did not observe burn marks at that time. He said the facility did not believe the chest burn came from the 6/21/25 incident although he initially had said the chest burn was caused during the incident on 6/21/25.