STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065208	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsprings Care Center	3636 S Pearl St Englewood, CO 80113

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42838 Based on observations and interviews, the facility failed to provide a safe, clean, sanitary, and comfortable environment throughout the facility. Specifically, the facility failed to: -Ensure resident rooms were clean, sanitary and odor-free; -Ensure the resident common areas were clean and odor-free; -Ensure residents' bed sheets were changed regularly and when soiled; and, -Ensure residents had hand towels available for use in their rooms. Findings include: I. Facility policy and procedure The Safe and Homelike Environment policy, revised February 2021, was provided by the corporate nurse consultant (CNC) on 2/13/25 at 2:14 p.m. It read in pertinent part, The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. Clean bed and bath linens that are in good condition, and have pleasant natural scents. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a personalized, institutional setting. These characteristics include institutional odors. II. Observations A tour of the facility was conducted on 2/10/25 from 10:56 a.m. to 12:01 p.m. The following was observed: There was a strong overwhelming odor of urine, body odor and smoked cigarettes throughout the building, on the first and second floors. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident rooms #215, #218, #223 and #209 had heavily soiled and black-stained flooring. There were dried liquid spills and crumbs on the floors in the rooms. Resident room [ROOM NUMBER] had a bed with white sheets that were dingy. The bathroom smelled of urine and the floor had a dried sticky substance around the base of the toilet. Resident room [ROOM NUMBER] had a bed with sheets stained with large brown stains. A tour of the first floor was conducted on 2/11/25 from 10:00 a.m. to 12:30 p.m. and again at 2:00 p.m. The following was observed: The second floor had a strong lingering smell of body odor and urine. Some areas of the second floor had a strong odor of feces and smoked cigarettes. Resident room [ROOM NUMBER] had no hamper and there was a pile of dirty clothing on the floor. Resident room [ROOM NUMBER] had no hand towels in the room. Resident room [ROOM NUMBER] had a cable cord that was pulled out of the wall outlet, leaving a hole in the wall. Resident room [ROOM NUMBER] had a stained blanket on the made-up bed and there were no hand towels in the room. Resident room [ROOM NUMBER] had a pungent nauseating odor. The first-floor resident shower rooms had solid linens and trash stored in the room. The trash contained soiled adult incontinent briefs and the room had a strong smell of urine and feces. On 2/12/25 at 9:49 a.m. the second-floor hallways had a strong lingering smell of urine and body odor. On 2/13/25 at 9:20 a.m. the bottom baseboards of the walls in the main dining room were broken and paint was peeling off of them. The heating unit covers were heavily soiled with black dust and debris. There was a large pink stain on the floor at the entrance to the dining room and the rest of the floor was stained and streaked with black marks. On 2/13/25 at 11:05 a.m. resident room [ROOM NUMBER] had heavily stained sheets and pillowcases. Both the sheets and the pillowcases had large dark brown stains on them. The floor was heavily soiled and had dust, debris and crumbs on it. The bookshelf next to the resident's bed had large glops of a pink gooey-looking matter and dried dark brown matter across the front of the shelf. On 2/13/25 at 11:46 a.m., resident room [ROOM NUMBER] had food crumbs on the floor next to the resident's bed and near the closet. A bowl of food was tipped over on the floor at the resident's feet and its contents were spilled out on the floor. Pieces of trash were on the floor, including wrappers, tissues and other unidentifiable items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/25 at 2:20 p.m. the food bowl in resident room [ROOM NUMBER] had been placed on the unoccupied bed in the room, however, the food from the bowl was still on the floor, along with the pieces of trash. III. Resident interviews The resident who resided in room [ROOM NUMBER] was interviewed on 2/11/25 at 10:45 a.m. The resident said he never had clean towels in his bathroom. The resident who resided in room [ROOM NUMBER] was interviewed on 2/11/25 at 2:00 p.m. The resident said her bed sheets did not get changed, even with constant requests. She said the bed sheets were changed once a month if she was lucky. The resident said she cleaned her own room because if she waited for staff to clean her room, it would never get cleaned. The resident who resided in room [ROOM NUMBER] was interviewed on 2/13/25 at 11:46 a.m. The resident said his room used to get cleaned every day, but since the facility hired the new housekeeper a few weeks ago, his room only got cleaned once a week. He said his room had been messy since yesterday (2/12/25). He said his certified nurse aide (CNA) told housekeeping that his room was messy and needed some cleaning. He said the housekeeper came in to clean but she did not do a good job. IV. Staff interviews Housekeeper (HK) #1 was interviewed on 2/12/25 at 9:55 a.m. HK #1 said she was in charge of cleaning the second floor and tried to clean all the residents' rooms every day, however, she said she was not able to keep up with the daily cleaning routine. HK #1 said when she missed a room cleaning, the room that did not get cleaned was the first room on her list for cleaning the next day. HK #1 said, throughout the day, nurses and residents let her know when there were spills or when something was dirty and she would go do a spot-clean. HK #1 said most of the residents left their doors open, so she also was able to peek into rooms and clean them again if she saw one was dirty. The director of nursing (DON) was interviewed on 2/13/25 at approximately 10:00 a.m. The DON said she had ordered more washcloths because residents said they preferred those. She said she would hand them out to residents once the order arrived. Registered nurse (RN) #1 was interviewed on 2/12/25 at 10:10 a.m. RN #1 said the facility stored dirty incontinent briefs in the shower rooms until they were taken to the dumpster. RN #1 said the nursing staff were supposed to take out the trash, including the soiled briefs, at the end of each shift. Licensed practical nurse (LPN) #2 was interviewed on 2/12/25 at 5:25 p.m. LPN #2 said when the nursing staff were unable to manage the odors, she reported smells and odors to the facility's administration so they could get rid of the odors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HK #1 was interviewed a second time on 2/13/25 at 11:30 a.m. HK #1 said she started working at the facility two weeks ago and was still learning. She said she was trying to clean faster so she was able to get to all the residents' rooms on her assignment. HK #1 said she mopped resident rooms daily when she had enough time, however, she said there were times when the residents' rooms were too messy and she was unable to mop the entire floor. HK #1 said the CNAs were supposed to straighten up the residents' rooms and change the residents' bedding. CNA #1 was interviewed on 2/13/25 at 12:10 p.m. CNA #1 said when the residents got their showers, their sheets were to be changed. CNA #1 said if residents did not leave their rooms, it became difficult to change their sheets. CNA #1 said if a resident's bed was wet or soiled, their sheets needed to be changed immediately. The maintenance director (MTD) was interviewed on 2/13/25 at 12:19 p.m. The MTD said he had some repair projects planned. He said he was ordering new baseboards for the dining room and the facility was going to strip and rewax the flooring throughout the facility, including in the residents' rooms. The MTD said the facility used cleaning products and air fresheners to control offensive odors and smells throughout the building and staff was expected to take out the soiled incontinent supplies in the shower rooms on a regular basis. The MTD said there was a book at each nursing station where staff could write up maintenance requests. 50690

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41032 Based on record review and interviews, the facility failed to ensure three (#12, #14 and #23) of five residents reviewed for abuse out of 23 sample residents were kept free from abuse. Specifically, the facility failed to: -Prevent Resident #12 from being sexually abused by Resident #13; -Prevent Resident #14 and Resident #23 from being physically abused by Resident #13; and, -Implement a care plan focus to assess and monitor Resident #13 for inappropriate behavior when he had a known history of violent aggression and other inappropriate behaviors. Findings include: I. Facility policy and procedure The Abuse Policy, revised 5/3/23, was provided by the corporate nurse consultant (CNC) on 2/13/25 at 2:14 p.m. It read in pertinent part, Community 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. This includes, but is not limited, to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Also, verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through use of technology. Sexual abuse is non-consensual sexual contact of any type with a resident. If two residents want to participate in a relationship or intimate acts, the intimacy consent assessment is completed to ensure that the relationship or intimacy can be consented to by both parties. If one of the residents is unable to consent based on assessment, the community will implement interventions to protect the resident who cannot consent. 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. Infrequent arguments or disagreements that occur during the course of normal social interactions would not constitute abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Sexual abuse of Resident #12 by Resident #13 on 2/1/25 A. Facility investigation On 2/1/25 at approximately 3:15 a.m. Resident #12 called nursing staff to her room and told nursing staff that Resident #13 entered her room while she was asleep and touched her vagina. Resident #12 said Resident #13's actions woke her up. Resident #12 said she did not like what happened to her. The investigation report documented the registered nurse (RN) on duty contacted the nursing home administrator (NHA) and reported that Resident #12 pulled the call light and told staff that the new resident who spoke Spanish kept coming into her room and touching her. After the incident was reported to the NHA, Resident #13 was placed on 15-minute checks for the next 24 hours. The following morning, 2/2/25 at approximately 3:54 a.m., the floor nurse observed Resident #13 entering Resident #12's room. The nurses followed Resident #13 and entered Resident #12's room to observe Resident #13 with his hands on the hem of Resident #12's dress. The nurse immediately redirected Resident #13 out of Resident #12's room and back to his room. Later in the morning on 2/2/25, the incident was explained to the director of nursing (DON) and Resident #13 then placed on line-of-sight monitoring and moved to a room on the first floor. Resident #13 was moved to a room on the first floor after nursing staff observed him with his hands on Resident #12 as she slept. -The investigation did not include a statement from the RN on duty on 2/1/25 to who Resident #12 reported her concerns regarding Resident #13 touching her vagina. -The facility investigation did not include statements from the staff on duty who witnessed Resident #13 with his hands on the hem of Resident #12's dress on 2/1/25. B. Resident #13 (assailant) 1. Resident status Resident #13, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses include unspecified dementia, psychotic disturbance, mood disturbance, anxiety and mild cognitive disturbance. The 12/23/24 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 resident was Spanish-speaking only. The resident displayed no aggressive behavior or other inappropriate behavior in the look back assessment review period. 2. Resident interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 was interviewed in Spanish on 2/12/25 at approximately 1:00 p.m. Resident #13 said he was from a Latin American country and just moved to the facility. He said he did not have any friends in the facility and did not have a girlfriend. The resident said it was very difficult for him because he was the only one who spoke Spanish. 3. Record review Review of Resident #13's comprehensive care plan, dated 1/29/25, documented a care plan focus, initiated 2/7/25, for Resident #13's wandering into other residents' rooms. Interventions included behavioral monitoring, discussing inappropriate behavior with the resident and explaining/reinforcing why the behavior was inappropriate and/or unacceptable, intervening as necessary to protect the rights and safety of others, approaching the resident and speaking in a calm manner, diverting the resident's attention and removing the resident from the situation and taking the resident to an alternate location as needed, monitoring behavior episodes and attempting to determine the underlying cause, considering the location, time of day, persons involved and situations and documenting behavior and potential causes. Review of Resident #13's care plan revealed a care plan focus for physical aggression related to dementia and poor impulse control, initiated 2/11/25. This care plan focus revealed the goal was to minimize the resident's risk of harming himself or others. Interventions included analyzing times of day, places, circumstances, triggers, and what de-escalated the resident's behavior and documenting, providing redirection and limit setting, as needed, monitoring/documenting/reporting as needed any signs or symptoms of Resident #12 posing danger to himself and others, when the resident became agitated, staff was to intervene before the agitation escalated, guiding the resident away from the source of distress, engaging the resident calmly in conversation, and if the response was aggressive, staff were to walk calmly away and approach the resident later. -However, the care plan focuses above were not initiated until several days after incidents of resident-to-resident abuse allegations occurred, despite the facility having information at admission that the resident had a history of violent aggressions (see hospital note below). The hospital referral document, dated 10/9/24, revealed Resident #13 had a history of dementia, stroke, and hypertension and was brought to the hospital by law enforcement on a mental health arrest (M1) hold due to confusion and inability to care for himself. The resident was alert and oriented to self and place, but not year and had very limited understanding of the situation. A lot of the resident's history was obtained from the emergency room physician who obtained the history from social work. The hospital referral also documented that in the past, Resident #13 was in a healthcare facility but was removed due to violent behavior. He lacked the capacity for complex medical decision-making and had a court-appointed guardian. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's electronic medical record (EMR) revealed a progress note, dated 2/2/25, that documented a certified nurse aide (CNA) on duty reported observing Resident #13 sneaking down hall and entering Resident #12's room. The CNA on duty followed and observed Resident #13 pulling back Resident #12's privacy curtain and picking up the hem of Resident #12's dress. Resident #12 was sleeping at the time of the incident. When CNA asked Resident #13 what he was doing (via phone translator), the resident started complaining about the swelling in his leg. Resident #13 was removed from Resident #12's room and taken to the activity room. The NHA was notified and instructed the staff to place Resident #13 on one-to-one supervision until he could be moved to another room in the facility. C. Resident #12 (victim) 1. Resident status Resident #12, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses include schizophrenia, anxiety disorder and dementia with behavioral disturbance. The 12/19/24 MDS assessment revealed the resident had moderately impaired cognition with a BIMS score of 11 out of 15. The resident had no behaviors in the seven-day look back assessment review period. 2. Resident interview Resident #12 was interviewed on 2/13/25 at 2:10 p.m. Resident #12 said that a Mexican man came into her room twice and touched her vagina and she said it happened a few days ago. She said she could not remember if he touched her over her clothes or the sheet, or if he touched her bare skin. Resident #12 said the man had woken her from a deep sleep but she was still not fully awake so she had not yelled when it happened. She said he touched her and pushed her and then he stopped. Resident #12 said the staff did not come in to get him, he just stopped. She said she was not worried about anyone else in the facility. Resident #12 said she called and told the nurse she wanted it to stop 3. Record review -Review of Resident #12's EMR failed to reveal a progress note written by the nurse on duty on 2/1/25 and 2/2/25 related to Resident #12's report of being touched by Resident #13. A behavior progress note, written by the NHA (who was not a direct witness to the event between Resident #12 and Resident #13) on 2/1/25 8:23 p.m. documented the NHA attempted to speak with Resident #12, however, the resident did not want to speak with her. The progress note documented the nurse on duty said she had a good rapport with the resident and would try to talk to the resident. When that nurse asked Resident #12 if anything happened during the night, the resident first stated that the night was good, then stated that a male resident entered her room and she did not like him in her room. When asked if Resident #13 touched her, Resident #12 said no, I do not want to talk to you. -There were no further progress notes documented regarding the incident with Resident #13 on 2/1/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #12's EMR failed to reveal documentation related to the incident on 2/2/25 when Resident #13 was witnessed by nursing staff to be in Resident #12's room and touching the hem of her dress (see investigation above). III. Physical abuse of Resident #14 by Resident #13 on 2/8/25 A. Facility investigation An incident report documented an incident of resident-to-resident physical abuse occurring on 2/8/25 at 3:30 p.m., where Resident #13 physically assaulted Resident #14, who was Resident #13's roommate. The incident investigation report documented that Resident #13 hit Resident #14 on his ear. The event was not observed by staff, however, the floor nurse told the facility investigator (the social services director - SSD) that she responded to Resident #14's room after hearing a loud, bang-like noise. When the nurse entered the residents' room, she saw Resident #13 sitting on his bed and Resident #14 with his hand on the right side of his head. Resident #14 told the nurse that Resident #13 just hit him. Resident #14 had redness to the ear but no cuts, bruising, abrasions or lasting pain. The residents were separated and Resident #13 was moved, for a second time, in less than seven days, to a different first floor room on the other side of the building from Resident #14. Resident #13 was interviewed on 2/9/25 by the SSD. Resident #13 admitted to hitting Resident #14 because Resident #14 had annoyed him. -The investigation did not include an interview with Resident #14. B. Resident #13 (assailant) 1. Record review A review of Resident #13's EMR revealed there was no documentation related to the incident with Resident #14 on 2/8/25. C. Resident #14 (victim) 1. Resident status Resident #14, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses include schizophrenia, hypertension and chronic respiratory failure. The 12/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident had no behavior in the seven-day look back assessment review period. 2. Resident interview (continued on next page)

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	065208	A. Building B. Wing	02/13/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #14 was interviewed on 2/13/25 at 2:45 p.m. Resident #14 said his roommate, Resident #13, assaulted him for no reason. Resident #14 said he was sitting on his own side of the room minding his own business and that he and his roommate had not been arguing or even talking when Resident #13 just walked over to him on his side of the room and hit him in the right ear. Resident #14 said his ear hurt initially and was red but had since cleared up. He said he was glad the facility moved his roommate out of the room and gave him a new roommate, who he had no problems with. 3. Record review A progress note, dated 2/8/25, documented that Resident #14 complained of being slapped on the right ear by Resident #13. Resident #14 called the police to report the incident. Resident #14 reported that his ear was hurting after the incident. IV. Physical abuse of Resident #23 by Resident #13 on 2/12/25 A. Facility investigation An incident report documented an incident of resident-to-resident physical abuse occurring on 2/12/25 at 8:00 p.m., where Resident #13 physically assaulted Resident #23. The incident occurred in the common area and was witnessed by staff and residents. The facility investigation documented that Resident #23 accidentally spilled his coffee, but not on any resident. Resident #13, without any warning, walked over to Resident #23 and slapped him on the left side of his face with an open hand. Resident #23 had no physical injury but he expressed fear of Resident #13 due to the nature of his aggression. Several residents who witnessed the incident expressed fear of Resident #13. Resident #13 was taken out of the common area and sent to the hospital for a psychiatric assessment. Due to Resident #13's history of violent behavior, unprovoked physical aggression and allegation of sexual abuse against a female peer, the facility determined they were unable to provide Resident #13 with the level of care needed to keep all residents in the facility safe from future instances of abuse. Resident #23 and the other residents witnessing the incident were placed on psychosocial follow-up for at least a week following the incident. B. Resident #23 (victim) 1. Resident status Resident #23, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses include schizophrenia, dementia without behavioral disturbance, chronic obstructive pulmonary disorder (CPOD) and anxiety. The 12/18/24 MDS assessment revealed the resident had severe cognitive impairments and was unable to participate in the BIMS assessment. The resident was, however, able to recall the current season, the location of his room, staffs' names and faces and knew he was in a facility. The resident did display verbal aggression directed towards others and reflected some aspects of care. (continued on next page)

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	065208	A. Building B. Wing	02/13/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident interview Resident #23 was interviewed on 2/13/25 at 2:30 p.m. Resident #23 said Resident #13 hit him and he was glad they got Resident #13 out of there because he was afraid it would happen again. 3. Record review Review of Resident #23's EMR revealed a progress note, dated 2/12/25, that documented Resident #23 was slapped in the left ear by Resident #13. Per the progress note, Resident #23 spilled coffee on the floor and Resident #13 walked up to him and slapped him. The resident denied pain and had no observed injuries. V. Staff interviews RN #1 was interviewed on 2/12/25 at 12:20 p.m. RN #1 said Resident #13 was not physically aggressive and the facility was only monitoring him for verbal aggressions. RN #1 said the nursing staff were using a translation phone application to communicate with Resident #13. RN #1 said the nursing staff were doing 15-minute checks on Resident #13 after the incident on 2/1/25 and staff were to report any distressing behavior to the NHA and the DON. CNA #3 was interviewed on 2/12/25 at 12:32 p.m. CNA #3 said he was working the first-day Resident #13 arrived at the facility (1/29/25). He said he knew that Resident #13 moved to a new room downstairs but he did not know why. He said the resident was alone most of the day and every time he saw the resident, he looked happy. Licensed practical nurse (LPN) #2 was interviewed on 2/12/25 at 12:33 p.m. LPN #2 said all she knew about Resident #13 was that he only spoke Spanish and he was in a room on the second floor briefly before being transferred to a different room, but she did not know why he changed rooms. -CNA #3 and LPN #2 were not aware of Resident #13's aggressive behaviors or his altercations with other residents, despite Resident #13 having been involved in three abuse incidents within 10 days. LPN #1 was interviewed on 2/12/25 at 12:37 p.m. LPN #1 said she had heard that over the previous weekend (2/8/25), there was an altercation between Resident #13 and Resident #14. She said the nurse on duty called the administrator and Resident #14 called the police. She said Resident #14 accused Resident #13 of slapping/hitting his ear. She said after the altercation, Resident #13 was monitored every 15 minutes for a while. She said every 15 minutes, staff had to visualize Resident #13 and document what he was doing. LPN #1 said she had never seen or heard of Resident #13 doing anything like that before. She said staff learned of the resident behaviors like from the previous nurse's report or by looking at the resident's care plan. CNA #2 was interviewed on 2/12/25 at 12:43 p.m. CNA #2 said he had not seen Resident #13 do anything to another resident but he said he was told that Resident #13 had been verbally aggressive at times. CNA #2 said he had heard there was a possible incident between Resident #13 and Resident #14. He said he had heard that Resident #14 had claimed that Resident #13 hit him in the ear. CNA #2 said residents' aggressive behaviors were documented in the computer and additional behaviors could be added to make the list more resident-specific. (continued on next page)

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	065208	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsprings Care Center	3636 S Pearl St Englewood, CO 80113

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA, the DON and the social services director (SSD) were interviewed together on 2/12/25 at 2:02 p.m The NHA said she was not at the facility at the time of the incident on 2/1/25 when Resident #12 initially reported the incident of Resident #13 touching her inappropriately to the nurse on duty. The NHA said when the nurse called her about the incident, she initially thought Resident #13 had just walked into Resident #12's room, which was why she had only recommended Resident #13 to be placed on frequent checks. The NHA said she did not learn until the next morning (2/2/25), when she arrived at the facility and read the nursing progress note, that Resident #12 had said that Resident #13 touched her vagina. The NHA said she did not have a statement from the nurse on duty at the time of the 2/1/25 and she did not document the conversation she had with the nurse for the investigation but there was a nursing progress note. -However, the progress note was written by the NHA and not the nurse on duty at the time of the incident (see Resident #12's record review above). The NHA said she had checked with the CNA who was on duty that night, but discovered nobody had witnessed the occurrence. The NHA said she, the SSD and the nurse on duty tried to interview Resident #12 the next day (2/2/25) but she did not want to discuss what happened. She said all Resident #12 would say was that she did not like it (Resident #13 touching her) and she wanted it to stop. The NHA said Resident #13 denied the allegation and said he never went into Resident #12's room. The NHA said a nurse witnessed Resident #13 entering Resident #12's room and observing him touching the hem of her dress. She said Resident #13 was redirected out of Resident #12's room immediately. The NHA said no staff witnessed the allegation that Resident #13 touched Resident #12's vagina so she did not substantiate that part of the allegation. The NHA said after Resident #13 was observed with his hand on Resident #12's dress, the facility made a decision to move him to a different unit so he had less opportunity to re-enter her room. The NHA did not think that other female residents were at risk of being victimized but did not further investigate the incident on 2/2/25. The NHA and the SSD said nobody had noticed any inappropriate interactions between Resident #12 and Resident #13 within the few days since Resident #13 arrived at the facility (on 1/29/25). The NHA said Resident #13 primarily only spoke to Spanish-speaking staff and otherwise ate in the dining room and kept to himself. The NHA said she was unaware that Resident #13 had been evicted from another healthcare facility or what was the cause of that eviction prior to his admission to the facility on [DATE]. The NHA and the DON said the facility did not know that Resident #13 had a past history of aggression, but she said even if they did know, they would not have asked the referring hospital for any details of the resident's past history of aggression because they believed the hospital would not provide that kind of information accurately. The NHA and the SSD said they did not believe they needed to monitor Resident #13 for aggressive behaviors because he had not displayed any negative behaviors in his first couple of days in the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said it was the responsibility of the floor nurse on duty, at the time of admission, to read the hospital referral packet and educate the CNAs on the resident's care needs. The DON said the floor nurses should also write the resident's care plan for any relevant care needs. The NHA said Resident #13 had not displayed any physically aggressive behaviors and she did not think the care plan needed any additional interventions. However, after reviewing Resident #13's care plan, the NHA said the care plan could have included more details related to the nature of Resident #13's care needs and behavioral struggles. The NHA, the DON, the SSD and corporate consultant (CC) #1 and CC #2 were interviewed together on 2/12/25 at 6:30 p.m. The team said they would educate the staff about the behavioral history of Resident #13 and provide education on monitoring the resident for potential presenting of negative behavior to prevent Resident #13 from initiating any further display of inappropriate sexual behaviors or aggression toward other residents in the facility. -However, Resident #13 was involved with another incident of physical abuse against Resident #23 on the evening of 2/12/25 (see incident above). The corporate nurse consultant (CNC) was interviewed on 2/13/25 at 9:00 a.m. The CNC said the facility decided to send Resident #13 to the hospital for mental health treatment after he abused a third resident (Resident #23) in the facility. The CNC said after reviewing the initial hospital referral packet and talking with the referring hospital on 2/12/25, they found out that the hospital had more information on the resident and his history of aggressive and abusive behavior. The CNC said, based on that new information, the facility came to the conclusion that this placement was not appropriate for Resident #13 and was not safe for the other residents in the community. She said other residents in the facility had become fearful of Resident #13 and his impulsive and aggressive behavior and the facility did not have the capability to provide the level of behavioral care and oversight that Resident #13 needed to keep him and the existing residents safe. The CNC said leadership was exploring other facility settings with the hospital. Additionally, the CNC said the facility was planning to revamp the admission intake process and educate the referral agents on gathering more extensive and detailed information on a potential resident's history and background.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on interviews and record review, the facility failed to ensure one (#7) of one resident out of 23 sample residents was protected from exploitation and misappropriation of property. Specifically, the facility failed to prevent a staff member from taking $5,060 from Resident #7. Findings include: I. Facility policy and procedure The Staff Acceptance of Gifts, Gratuities and Payments policy, dated 2/2/17, was provided by the corporate nurse consultant (CNC) on 2/13/25 at 2:15 p.m. It read in pertinent part, Staff are not to accept or solicit gifts, including items such as cash, loans, gratuity, service, or promise of future employment. Offered gifts are to be politely and respectfully declined. This policy is not meant to apply when the gift is of nominal value of $5.00 or less. II. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician's orders (CPO), diagnoses included stroke (damage caused by blocked blood vessels in the brain), hemiplegia (weakness on one side of the body), aphasia (difficulty producing speech) and diabetes. The 12/23/24 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. The resident used a manual wheelchair, was dependent on staff for transfers, dressing and bathing and required set-up assistance with eating. B. Resident interview Resident #7 was interviewed on 2/11/25 at 11:40 a.m. Resident #7 said that in November 2024 she received a large influx of money. She said she had to spend the money, so she gave some of the facility staff cash money tips. She said most staff would not take the money, but a few did. She said one of the housekeepers took a large amount of money and wanted more. Resident #7 said she had wanted to help the housekeeper, so she gave her $3,000. She said the housekeeper was not working at the facility anymore. Resident #7 said she did not think other residents gave tips to the staff. III. Facility investigation (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation, undated, documented that when assisting Resident #7 in recertifying eligibility for insurance coverage in January 2025, the nursing home administrator (NHA) found evidence that housekeeper (HK) #2 was receiving money transfers directly to her banking account. HK #2's name was directly listed on Resident #7's banking statement. HK #2 received deposits to her account from Resident #7's account on 11 occasions, from 11/4/24 to 11/13/24, totaling $5,060. The NHA asked Resident #7 how this occurred. Resident #7 told the NHA that she wanted to recognize the staff for their work and she had been giving staff cash. The resident said she withdrew a large sum of money and handed out 500.00 bills to several staff at the facility and spent some on herself. During the investigation, Resident #7 provided a list of staff names that she gave cash and explained how she was providing HK #2 cash money transfers to her account. Resident #7 said HK #2 continued to ask the resident for more money and she felt she wanted to help HK #2 with her financial struggles. The NHA suspended all of the staff that was accused of taking money from Resident #7 during the investigation. The staff who were alleged to have received cash money all denied accepting money from Resident #7. HK #2 denied receiving money until presented with the bank statement evidence. The police were notified of the allegation. HK #2 was terminated. All staff were reminded of the facility policy on accepting gifts from residents (see policy above). IV. Staff interview The NHA was interviewed on 2/12/25 at 10:20 a.m. The NHA said she was not aware of residents giving bonuses or tips to staff, except for the incident that occurred between Resident #7 and a previously employed housekeeper. The NHA said Resident #7 received a large settlement check back in November 2024. The NHA said Resident #7 was educated that the money from the check either had to be spent in a period of time as mandated by her insurance or it would be counted as an asset and it would be claimed by the insurance provider for payment of care. The NHA said the resident opened up a bank account, in November 2024, and then in January 2025, Resident #7 was asked for copies of her bank statements to assist her with her insurance redetermination. The NHA said that was when the facility discovered transactions on Resident #7's bank statements that transferred money to a staff member's account. The NHA said the accused staff members were suspended during the investigation. The NHA said at first Resident #7 had said she gave other employees cash tips, but all the staff she named denied taking money from the resident. The NHA said she investigated further and was unable to prove that claim because there was no evidence and all of the staff denied the claim. The NHA said she was able to substantiate the allegation that HK #2 accepted a large amount of money from the resident because the resident's bank statement showed a direct withdrawal and deposit to HK #2's account. (continued on next page)

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