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	06/24/2025

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that services provided or arranged in accordance with the resident's plan of care were delivered by individuals who have the skills, experience and knowledge to do a particular task or activity for four (#2, #4, #6 and #7) of seven residents out of 11 sample residents. Specifically, the facility failed to: -Ensure Resident #2, Resident #5, Resident #6 and Resident #7's post fall assessments were completed timely by a qualified person and documented in the residents medical record. Findings include: I. Facility policy and procedure The Fall Management policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/24/25 at 4:00 p.m. It read in pertinent part, All fall risk evaluation will be completed within the first 24 hours of admission and a baseline care plan will be initiated for residents to be at risk. If a resident experiences a fall with a head injury, the fall is unwitnessed, or the resident self-reports a fall, neurological checks will be initiated. The facility will review all falls daily during the morning QAPI meeting. Falls review will include the following: review the risk management incident to ensure complete and appropriate parties have been notified regarding the incident, review the interdisciplinary team (IDT) risk management to ensure complete and appropriate interventions have been implemented, review that a care plan has been initiated, and provided revisions to the plan of care as necessary after falls. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included hepatic encephalopathy (brain dysfunction resulting from liver disease), left arm fracture, schizophrenia (mental disorder), type 1 diabetes mellitus, chronic obstructive pulmonary disease (COPD), cirrhosis of the liver (build up of scar tissue on the liver) and alcohol abuse. (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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/25/25 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required staff supervision for showering including tub/shower transferring and was independent with all other activities of daily living (ADL). B. Record review A 5/30/25 nursing progress note documented at 8:19 p.m. revealed Resident #2 reported to licensed practical nurse (LPN) #1 that he had an unwitnessed fall. The note documented Resident #2 was assessed by LPN #1 to have sustained an abrasion to the right eye and the right hand above the 2nd and 3rd fingers. The resident's neurological status was intact. -A review of Resident #2's electronic medical record (EMR) did not reveal documentation of Resident #2 being assessed by a registered nurse (RN). III. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included encephalopathy , aphasia (language disorder affecting the ability to communicate), schizophrenia, anoxic brain damage (oxygen deprivation), acute respiratory failure and category three blindness (severe vision impairment). The 6/8/25 MDS assessment indicated the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was dependent on staff for assistance with all ADL. B. Record review The 5/2/25 fall investigation documented LPN #2 heard Resident #5's wife calling for help. Upon observation, the resident was on the floor between the toilet and the wall. The resident attempted to self transfer from the wheelchair to the toilet and fell. The 5/5/25 (three days after the fall) nursing progress note documented by the director of nursing (DON) revealed was noted on the floor in the bathroom and attempted to transfer himself. Resident #5 was assessed for injuries and range of motion was within normal limits. IV. Resident #6 A. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, schizophrenia, and history of falling. The 4/13/25 MDS assessment indicated the resident was severely cognitively impaired with a BIMS score of 6 out of 15. The resident required moderate staff assistance with bathing, supervision with hygiene and was independent with all other ADL. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review A review of Resident #6's fall investigation and nursing progress notes documented by an LPN on 3/17/25 that Resident #6's roommate pressed the call button. A certified nurse aide (CNA) found the resident sitting on the floor. The resident was alert and oriented and not in distress with stable vital signs. The resident stated she fell asleep while using the bathroom and woke up on the floor. The resident was assessed by an LPN with no abnormal findings, vital signs were stable and the resident was assisted back to bed. Neurological checks were initiated. -A review of Resident #6's EMR and fall investigation did not reveal documentation of Resident #6 being assessed by a RN. V. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included neurofibromatosis (tumor growth on nerve tissues), malignant neoplasm (tumor) of the spinal cord, muscle weakness, need for assistance with personal care and cognitive communication deficit. The 4/17/25 MDS assessment indicated the resident was cognitively intact with a BIMS score of 15 out of 15. The resident needed moderate staff assistance for bathing, set up for eating and moderate staff assistance for all other ADL. B. Record review The 5/2/25 fall investigation review documented it was reported to a LPN at approximately 2:00 p.m. that the resident slipped off the toilet. When the nurse arrived at the resident's bathroom the resident was already sitting up on the toilet seat. The resident was attempting to shift his weight while he was with an occupational therapist. The investigation documented the LPN assessed the resident for pain and vital signs, and notified the DON and physician. -A review of Resident #7's EMR did not reveal documentation of Resident #5 being assessed by a RN. A 6/23/25 progress note (written during the survey) by RN #1 documented she was notified on 3/19/25 at approximately 2:00 p.m. that this resident had a witnessed fall. The resident was assessed and no injuries were noted, the resident denied pain or hitting his head. The resident's vital signs were within normal limits. The DON and physician were notified of the resident's fall. VI. Staff interviews (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quality mentor was interviewed on 6/24/25 at 9:30 a.m. The quality mentor said RN #1 received a report on 5/30/25 from the nurse on duty that Resident #2 had an unwitnessed fall. The quality mentor said RN #1 assessed Resident #2 at 10:00 p.m. when she arrived at the facility for the start of her shift. The quality mentor said RN #1's assessment did not result in different findings than LPN #1's (see above) so RN #1 did not document her assessment. The quality mentor said she provided education to RN #1 that when she assessed a resident the assessment should be documented in the resident's EMR. The quality mentor said RN #1 also failed to document her assessment for Resident #6 and Resident #7's fall because her assessments resulted in the same findings as the LPN's initial assessment. The NHA, the DON and the quality mentor were interviewed together on 6/24/25 at 2:30 p.m. The DON said she assessed Resident #5 after his fall on 5/2/25 but did not document her assessment until 5/5/25. The DON said she completed the assessment and it was in her list of papers and she forgot to enter the assessment timely. The DON said she asked RN #1 to document the results of her assessment of Resident #7 in the resident's EMR during the survey. The NHA said if an RN was not in the facility to assess a resident then the staff should notify the DON. The quality mentor said RN #1 was documenting her assessments by exception. The quality mentor said because RN #1's assessments resulted in the same results, RN #1 chose not to document the assessment but had since been educated on the correct process (see below). VII. Facility follow up The resident assessment education, dated 6/23/25 (during the survey), was provided by the quality mentor on 6/24/25 at 9:30 a.m. The education documented it was provided to LPN #1, RN #1 and the DON on 6/23/25 by the quality mentor. The education documented that upon assessment of fall, a progress note should be written at the time of the fall to ensure that the assessment was documented in the medical record and findings were addressed as necessary. The LPN should also document in the progress notes that an RN completed the assessment. An action plan for falls, dated 6/23/25 (during the survey), was provided by the quality mentor on 6/24/25 at 2:30 p.m. The action plan documented on 6/23/25 it was identified the fall system was not being properly carried out and complete re-education by the DON or other designee with licensed nursing staff would be completed. The education included that anytime a resident fell a post fall assessment was completed by the RN, the LPN should document that the RN completed the assessment and the RN should document the findings in the medical record.