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	01/07/2026

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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(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 protect three (#3, #5 and #7) out of three residents from physical abuse out of 11 sample residents. Specifically, the facility failed to:-Protect Resident #3 from physical abuse by Resident #6; -Protect Resident #5 from physical abuse by Resident #6; and, -Protect Resident #7 from physical abuse by Resident #5.Findings include: I. Facility policy and procedure The Abuse policy, dated 5/3/23, was provided by the nursing home administrator (NHA) on 1/6/25 at approximately 5:00 p.m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's medical symptoms. II. Incidents of physical abuse by Resident #6 toward Resident #3 on 12/12/25 and 12/14/25 A. Facility investigations The facility investigation, dated 12/12/25, documented Resident #3 was backing through the doorway in her wheelchair when Resident #7 guided her chair through the doorway, then Resident #6 proceeded to hit her (Resident #3) with an open hand on her upper back. The investigation documented the residents were separated. The investigation documented there were no physical or psychosocial injuries noted. The investigation documented Resident #6 was put on 15-minute checks for 24 hours following this event, and his behavioral care plan was updated to include his supervision when he was in the smoking area. The facility investigation substantiated abuse. The investigation documented as of 12/12/25 Resident #6 had five other documented instances of physical aggression in the past year. The facility investigation, dated 12/14/25, documented Resident #3 was backing through the doorway in her wheelchair when Resident #7 guided her chair through the doorway, then Resident #6 proceeded to hit her (Resident #3) in the head. The investigation documented a small bump was found on Resident #3's head. There were no other physical or psychosocial injuries noted. The investigation documented Resident #6 was once again put on 15-minute checks for 24 hours following this event. The facility investigation substantiated abuse. B. Resident #3 (victim) 1. Resident status Resident #3, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician's orders (CPO), diagnoses include chronic obstructive pulmonary disease and peripheral vascular disease. According to the 11/26/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. 2. Resident interview Resident #3 was interviewed on 1/6/26 at 1:14 p.m. Resident #3 said she had two recent incidents with Resident #6. Resident #3 said she had no pre-existing relationship or arguments with Resident #6. She said both times he hit her for no apparent reason. She said during both of the incidents she was in the common areas and the staff were able to separate them quickly. She said she said she still felt nervous when he (Resident #6) was in the same room as her. C. Resident #6 (assailant) 1. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the January (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	2026 CPO, diagnoses include schizophrenia (mental illness), nicotine dependence and unspecified head injury. According to the 11/6/25 MDS assessment the resident had short and long and short term memory problems and severe cognitive impairment per staff assessment. 2. Resident interview and observations Resident #6 was interviewed on 1/6/26 at 12:05 p.m. Resident #6 said he got along great with everyone in the facility and he could not recall any altercations with other residents. On 1/7/26 at 9:13 a.m. Resident #6 was yelling derogatory comments at staff because he wanted a cigarette. The staff were able to calm the resident down by redirecting him and giving him a cigarette. 3. Record review Resident #6's behavior care plan, initiated, 2/24/25, revealed the resident had the potential to display physical aggression and has a history for several peer to peer altercations. Pertinent interventions included administering medications as ordered, anticipating the residents needs, intervening when the resident becomes agitated and engaging in calm conversation, withdrawing if the response to this is aggressive and attempting to approach again later. The care plan indicated the resident was also placed on 15-minute checks and made a supervised smoker in response to an altercation on 12/12/25. III. Incident of physical abuse by Resident #5 towards Resident #7 on 12/22/25 A. Facility investigation The facility investigation, dated 12/22/25, documented Resident #5 got into a verbal altercation with her roommate, Resident #7. Resident #7 was allegedly wearing Resident #5's shirt. Resident #5 took notice of this and attempted to remove the shirt from Resident #7. Resident #5 was unsuccessful at removing this shirt and proceeded to throw juice in Resident #7's face. This was witnessed by Resident #5 and Resident #7's roommate of both residents, who called for help after the incident occurred. The investigation documented no physical injuries or psychosocial harm were sustained to Resident #7. Resident #7 was noted to be incapable of dressing herself,and would have been unable to put on Resident #5's shirt without assistance. The investigation documented Resident #5 was put on 15-minute checks for 24 hours and was moved to another room following the incident.The investigation documented Resident #5 and Resident #7 were interviewed during the facility investigation. Resident #5 said Resident #7 previously took another one of her shirts and ruined it and she did not want it to keep happening. Resident #7 said Resident #5 accused Resident #7 of wearing her shirt. Resident #7 said Resident #5 hit her chin and poured juice on her. B. Resident #5 (assailant) 1. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses include heart failure, opioid abuse, and bipolar disorder. According to the 12/4/25 MDS assessment the resident was cognitively intact with a BIMS score of 14 out of 15. 2. Resident interview and observation Resident #5 was interviewed on 1/7/26 at 9:01 a.m. Resident #5 said she threw kool-aid on previous roommate's face (Resident #3) because she took her shirt. Resident #5 said she was upset about being moved to another room following this incident with Resident #3. On 1/6/26 at 11:15 a.m. Resident #5 was observed getting agitated with staff over cigarettes. Staff was able to calm Resident #5 by telling her she would get more tomorrow.3. Record review Resident #5's Preadmission Screening and Resident Review (PASSR), effective 8/8/24, recommended individual therapy for Resident #5's mental illness. Resident #5's behavior care plan, initiated on 4/15/25 and revised 10/6/25, revealed the resident had the potential to display verbally aggressive behaviors, often involving cigarettes and money. Pertinent interventions included de-escalating the resident by redirection and reassurance, intervening before agitation escalates, engaging calmly in conversation, and calmly walking away if aggressive response is received, and monitoring interactions between resident and roommate, separating them if altercations arise. Resident #5's nurse progress notes, dated 10/5/25 at 6:00 p.m., documented Resident #5 was verbally aggressive towards her roommate (Resident #7). Resident #5 said she hoped Resident #7 would choke on her own blood. Resident #5 also made hostile and profane (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remarks to staff members at this time. C. Resident #7 (victim) 1. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses included brain tumor, obesity and repeated falls. According to the 12/4/25 MDS assessment the resident had moderate cognitive impairments with a BIMS score of 10 out of 15. 2. Record review Resident #7 nursing care plan, initiated on 8/27/25, said Resident #7 required assistance with dressing herself. IV. Incident of physical abuse between Resident #5 and Resident #6 on 1/2/26 A. Facility investigation The facility investigation, dated 1/2/26, documented Resident #6 was going to bed at around 10:30 p.m., when she accidentally bumped into Resident #5 with her wheelchair while wheeling backwards. Resident #5 proceeded to hit resident #6 in the head. Resident #7 then hit Resident #5 back in retaliation. The investigation documented both residents being put on 15 minute checks for 24 hours. The nursing assessment after the incident revealed neither resident sustained any physical injuries and did not appear afraid. Resident #5 and Resident #6 were both interviewed as a part of the facility investigation. Resident #5 denied hitting Resident #6 in retaliation. Resident #6 did not recall hitting nor being hit on 1/2/26. B. Resident #5 (victim) 1. Resident interview Resident #5 was interviewed on 1/7/26 at 9:01 a.m. Resident #5 said she has had two incidents with Resident #6, one of them being recent. Resident #5 said during the most recent incident she accidentally bumped into Resident #6 and he hit her in the face. Resident #5 denied hitting him back. She said the staff did not separate the residents and laughed at her when she was hit. She said she felt helpless since the staff did little to address the incident and she did not feel like there was anything she could do to prevent it from happening again. VII. Staff interviews Licenced practical nurse (LPN) #2 was interviewed on 1/6/26 at 2:54 p.m. LPN #2 said physical abuse occurred if there was physical contact made. LPN #2 said all staff received training on combatting abuse and she felt confident in their CNA's ability to manage behaviors. Certified nurse aide(CNA) #1 was interviewed on 1/6/26 at 2:56 p.m. CNA #1 said any kind of unwanted hitting or touching was generally considered abuse. CNA #1 said she she worked with Resident #5 and Resident #6 often and she paid close attention to them. CNA #1 said if it seemed like either of them were getting agitated she would try to de-escalate them and talk them down. She said if this was ineffective she would then try to give them space to calm down. CNA #1 said these strategies generally proved effective at preventing any incidents. LPN #1 was interviewed on 1/6/26 at 3:05 p.m. LPN #1 said abuse could occur in many forms. She said she was unsure exactly what line needed to be crossed for it to constitute abuse. LPN #1 said she did not see any abuse in the facility. She said if a resident was getting agitated she would try to calm them down and de-escate them, as well as continue to monitor them frequently. The maintenance director was interviewed on 1/7/26 at 9:50 a.m. The maintenance director said he was a CNA. He said the facility generally responded to physical abuse by keeping relevant residents separated and moving them to separate floors. The maintenance director said clothing was generally labeled and distributed by room. The maintenance director said CNA's should be double checking labels to ensure the resident was getting their correct clothing if they were assisting a resident in getting dressed. LPN #4 was interviewed on 1/7/26 at 10:01 a.m. LPN #4 said any hitting or nonconsensual touching was generally considered abuse. LPN #4 said if she were to witness any abuse she would do her best to separate the residents and then immediately report it to administration members for full investigation. The nursing home administrator (NHA) was interviewed on 1/7/26 at 12:01 p.m. The NHA said the facility was working really hard to prevent Resident #6's behaviors. She said there were some medication changes. She said they were trying to be cautious with the medication changes, so it did not make things worse. She said she thought some other residents would antagonize him by bumping into him. The NHA said she thought the cause of the incident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between Resident #5 and Resident #7 was a simple clothing mix-up, although she was unsure if the shirt was actually labeled for Resident #5. The NHA said she thought the situation was solved since they moved Resident #5 to a different room.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#9) of three residents reviewed for accident hazards received adequate supervision out of 11 sample residents. Specifically, the facility failed to assess, educate, and initiate care plan interventions for Resident #9.Findings include: I. Facility policy and procedure The Fall Management policy, 2/29/24, was provided by the nursing home administrator (NHA) on 1/6/26 at 4:14 p.m. It read in pertinent part, A fall reduction program will be established and maintained, to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. Research has shown that a structured fall reduction program can substantially reduce the rate of falls and related injuries in nursing facilities; however, falls may likely occur. Identifying risk factors, followed by timely and appropriate interventions, is the key to a successful program. Risk factors that are internal to the resident include the resident's physical health and functional status. External risk factors include medication side effects, the use of appliances, and environmental conditions. Each resident will be reevaluated quarterly, annually and when a significant change occurs. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Please note interventions are to be re-evaluated when a resident falls for efficacy. 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 IDT (interdisciplinary team) Risk Management to ensure complete and appropriate interventions have been implemented; review that a care plan has been initiated and provide revisions to the plan of care as necessary after falls. The facility will review all falls daily (Monday through Friday) during the morning quality assurance process improvement (QAPI) meeting. II. Record review Review of facility training documentation revealed two in-service trainings on fall prevention on 7/31/25 and 10/8/25. The reports documented 100 percent of staff completed both trainings. III. Resident #9 A. Resident status Resident #9, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician's orders (CPO), pertinent diagnoses included bipolar disorder, underweight, muscle weakness, fatigue and reduced mobility. The 10/26/25 minimum data set (MDS) assessment revealed the resident was not cognitively intact, with a brief interview for mental status (BIMS) score of six out of 15. The MDS assessment documented Resident #9 needed set-up assistance with his activities of daily living. The MDS assessment indicated the resident had sustained a fall. B. Record review Review of Resident #9's comprehensive care plan, dated 11/4/25, revealed no care plan focus or fall interventions. Multiple nursing progress notes documented on 10/19/25 revealed Resident #9 had gone to the hospital after he had fallen while out in the community. The notes documented Resident #9 had broken his elbow, reported bodily pain and had abrasions (cuts or scrapes) on his knees and palms. The IDT risk management note, dated 10/20/25, said Resident #9 had lost his balance and fallen on 10/19/25 while out in the community. The physician's follow-up note, from 10/21/25, revealed Resident #9 had sustained a left radial fracture and left knee pain as a result of his fall on 10/19/25. The physician's note documented that Resident #9 had significant difficulties ambulating (walking) since the fall. Review of the 10/24/25 nursing fall risk assessment revealed Resident #9 was a high fall risk. No nursing fall risk assessments have been completed since then. Review of occupational therapy notes from 10/21/25 to 11/25/25 revealed Resident #9 was on fall risk precautions. Review of Resident #9's electronic medical record (EMR) did not reveal the facility assessed the resident's ability to safely leave the facility independently or provide the resident with education on safety in the community. C. Observations On 1/7/26 at 8:50 a.m. Resident #9 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was walking in the hallway. He used one hand to push a front-wheeled walker at an angle and used his other hand to prevent his pants from falling. Halfway down the hallway, he stopped and adjusted his pants from falling using a rubber glove to tie two belt loops together. D. Resident #9 interview Resident #9 was interviewed on 1/7/26 at 8:55 a.m. Resident #9 said he had been using a walker for mobility since his fall in October 2025. He said he continues to have pain in his left arm and left leg as a result of the fall. He said he used a walker for mobility because he was afraid he might fall again. He said he went out into the community alone daily. E. Staff interviews Licensed practical nurse (LPN) #2 and LPN #3 were interviewed on 1/6/26 at 11:30 a.m. LPN #3 said she was Resident #9's nurse for the day. LPN #3 and LPN #2 said they did not have any residents at risk of falls currently. LPN #3 said if a resident fell, the interdisciplinary team would decide if the resident was a fall risk and developed a care plan for falls accordingly. The physician was interviewed on 1/6/26 at 2:00 p.m. The physician said Resident #9 had diagnoses of reduced mobility and muscle weakness, which could contribute to being a fall risk. The physician said that having a fall in the past six months was predictive of a resident falling again. The physician said Resident #9 had many factors to consider when determining his fall risk status, including his age. The physician said these factors could indicate Resident #9 was at risk of falls. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 1/6/26 at 2:00 p.m. The NHA said Resident #9 left the facility every day and walked around the community. The NHA said sometimes he visited his family member, who lived nearby. The DON said Resident #9 fell in the community while on his daily outing. The DON said Resident #9 did not have a fall risk care plan and the facility would only write care plans for factors that could be controlled within the facility. The physical therapist (PT) was interviewed on 1/7/26 at 11:16 a.m. The PT said he considered Resident #9 a fall risk based on the occupational therapist's assessment of Resident #9 (see record review) and the fall on 10/19/25. The PT said Resident #9 preferred to use a front wheel walker. The PT said ideally the resident would be using a four-wheeled walker, because it would provide Resident #9 with more stability as he was walking around the community.