STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065266	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Alzheimer's Center of Excellence	1600 S Potomac St Aurora, CO 80012

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 two (#9 and #12) of six residents reviewed for abuse out of 12 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #9 and Resident #12 from physical abuse by Resident #8.Findings include:I. Facility policy and procedureThe Abuse-Prevention policy, reviewed on 5/6/25, was provided by the nursing home administrator (NHA) on 3/4/26 at 6:58 p.m. It read in pertinent part, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as verbally aggressive behavior, physically aggressive behavior, and wandering into other's rooms/space.II. Incident of physical abuse by Resident #8 towards Resident #9 on 2/24/26A. Facility investigationThe facility's investigation documented an incident occurred on 2/24/26 at 11:25 a.m. between Resident #8 and Resident #9. Registered nurse (RN) #1 reported Resident #8 was standing at the entrance door of the unit, pushing on the doors in an attempt to open them. Resident #9 walked to the exit doors at the same time and, unprovoked, Resident #8 pushed Resident #9 forcefully against the exit doors. Resident #9 attempted to walk away and Resident #8 followed her to a nearby room. Upon seeing that, RN #1 moved quickly toward both residents to intervene. RN #1 saw Resident #8 continuing to hit Resident #9's back and arms as Resident #8 followed Resident #9 to a room. RN #1 intervened and called for assistance. An unidentified certified nurse aide (CNA) who was in a nearby room arrived to help. Resident #8 attempted to hit the CNA, however the CNA ducked and Resident #8 hit the wall. The social worker also arrived to provide additional support. Staff assured both residents were separated and safe.Resident #8 denied the incident occurred. She was put on one-on-one supervision immediately after the incident and moved to another unit on 2/27/26 where there was more space for her to walk and other residents were less likely to invade her personal space. Resident #8's medications were reviewed and changes were made.Resident #9 had no change in her mood or behavior and did not sustain an injury. She was not fearful and was unable to recall the incident and denied it occurred. Both residents continued their regular daily routines.The facility substantiated the physical abuse.B. Resident #8 (assailant)1. Resident statusResident #8, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included dementia (gradual decline in mental abilities), depression, insomnia and other encephalopathy (a condition where the brain is not working normally because of illness or injury in the body).The 2/13/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. She was able to walk independently at least 150 feet. The MDS behavior assessment was not documented. 2. ObservationsDuring a continuous observation on 3/4/26, beginning at 12:30 p.m. and ending at 4:00 p.m., the following was observed:At 12:38 p.m. Resident #8 was eating lunch in her room. She had a visitor at that time.At 1:10 p.m. Resident #8 was sitting in her room with the visitor. No concerning behavior was observed.At 3:30 p.m. Resident #8 was sitting in the activity room alongside other (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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