

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Garden Terrace Alzheimer's Center of Excellence		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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 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 record review and interviews, the facility failed to ensure one (#2) of five residents were free from physical abuse out of eight sample residents. Specifically, the facility failed to protect Resident #2 from physical abuse by Resident #1. Findings include: I. Professional reference According to the Centers for Disease Control And Prevention's (CDC) Abuse of Older Persons (11/7/24), retrieved on 8/3/26 from https://www.cdc.gov/elder-abuse/about/index.html , Older person abuse is an intentional act or failure to act that causes or creates a risk of harm to an older adult. An older adult is someone aged 60 or older. Physical abuse is illness, injury, functional impairment, or death resulting from the intentional use of physical force. Examples include hitting, kicking, or pushing. II. Facility policy and procedure The Abuse, Neglect and Exploitation policy, reviewed 4/1/26, was provided by the nursing home administrator (NHA) on 7/30/26 at 11:22 a.m. via email. 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, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any. Assure that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently. 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; -Taking, touching, or rummaging through other's property; -Wandering into other's rooms/space; and, -Residents with communication disorders or who speak a different language. III. Incident of physical abuse between Resident #1 and Resident #2 on 6/19/26A. Facility investigation The 6/19/26 facility investigation was provided by the NHA on 7/29/26 at 1:00 p.m. The investigation documented Resident #1 and Resident #2 resided on a secured unit. Resident #1 had severe cognitive impairment, impaired communication ability, and unspecified dementia with agitation. Resident #1 was primarily Russian speaking and could become frustrated when others did not understand him. Resident #1 had the potential to become physically aggressive with other residents. Resident #2 had dementia with psychotic features, and per family, he had hallucinations and delusions. Resident #2 was verbally aggressive towards staff, and verbally and physically aggressive to other residents due to his paranoid thoughts and delusions. Resident #2 had a history of climbing out of windows, and his behavior was often unpredictable due to his history of dementia. Resident #2 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065266 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Garden Terrace Alzheimer's Center of Excellence		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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 Note: The nursing home is disputing this citation.	was often hungry and staff were to offer him snacks to prevent him from taking other residents' food while they were eating. On 6/19/26 after most residents had finished eating breakfast, Resident #1 was in the dining room, seated at a table eating. According to the staff, Resident #2 already had breakfast, but walked back into the dining room and attempted to take food off of Resident #1's plate. Resident #1 stood up and with a closed fist, hit Resident #2 on the left side of his face on the cheek area. After Resident #1 punched Resident #2, staff intervened and separated the two residents. After the incident, Resident #2 said that he knew he had been hit on his face, but he could not recall who hit him or why he was hit. Resident #1 was interviewed in Russian via an interpreter, but his response was illogical and he was unable to be interviewed. Resident #2 was moved to another secured unit in the facility on 6/22/26. After the altercation, both residents were placed on one-to-one supervision by staff for close monitoring. B. Resident #1 (assailant) 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included unspecified dementia with unspecified severity with agitation, restlessness and agitation, hypertension (high blood pressure), violent behavior, and difficulty in walking. The 7/1/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident needed staff supervision or touch assistance with eating. The resident required substantial/maximum assistance with oral hygiene, toileting, dressing, and personal hygiene. The resident utilized a wheelchair, and could walk approximately 10 ft. (feet) with supervision or staff assistance. The resident's primary language was Russian. The assessment indicated the resident exhibited physical behavioral symptoms directed towards others, which included hitting, kicking, pushing, scratching, and grabbing; and verbal threatening behavioral symptoms directed toward others, which included threatening others, screaming at others, cursing at others on four to six days per week during the assessment look-back period. 2. Resident #1's representative's interview Resident #1's representative was interviewed on 7/29/26 at 2:30 p.m. The representative said several months ago, Resident #1 was sent to the hospital for several weeks, and the hospital adjusted the resident's medications. The representative said after Resident #1 returned from the hospital stay, a facility physician adjusted Resident #1's medications by gradual dose reductions (GDRs), and that might be the reason Resident #1 had been more aggressive. The representative said he felt the resident was not as violent with the hospital's medication changes. The representative said the previous week (approximately 7/24/26) he spoke with the NHA and requested a different physician to care for Resident #1 because he wanted the medications changed back to the hospital's recommended dosage. (See primary care physicians interviews below). The representative said he would be open to Resident #1 being transferred to a Russian speaking nursing home if the current facility could find one in the area. The representative said Resident #1 knew some English but had become more reliant on speaking Russian. 3. Record review Review of Resident #1's July 2026 CPO revealed a physician's order that staff were to send the resident to the emergency room via 911 for violent behaviors. The progress note, dated 6/19/26, revealed Resident #1 required one-to-one assistance due to a resident-to-resident altercation. Resident #1 came out of his room frequently, peeked around the corner and ambulated up and down the hall with his one-to-one staff person. The progress note, dated 6/20/26, revealed Resident #1 was still on observation for a resident-to-resident altercation. The resident was on one-to-one observation for medication changes. The progress note, dated 6/24/26 revealed Resident #1 was being monitored for increased Depakote (a medication used for mood stabilization). The resident was aggressive before breakfast and later took a long nap. Since napping, the resident had no concerning behaviors observed. The progress note, dated 6/26/26, revealed Resident #1's representative gave permission (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Garden Terrace Alzheimer's Center of Excellence		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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 Note: The nursing home is disputing this citation.	for changes to be made to Resident #1's medication list. Depakote was now at 375 mg (milligrams) TID (three times daily) and Haldol liquid (an antipsychotic medication) was to be used only for severe agitation, as needed once daily for three days. The progress note, dated 6/28/26, revealed Resident #1 was being monitored for an increase in Depakote and Seroquel dosages. The resident had no sedation, drowsiness, nausea, or vomiting on the shift. The progress note, dated 6/29/26 at 10:13 p.m. revealed Resident #1 was being monitored for an increase in Depakote and an increased Risperdal (an antipsychotic medication) dose. The resident had a one-to-one sitter for increased behaviors. On 7/30/26 at 12:39 p.m. the NHA provided notes via email which documented that Resident #1 was reviewed in the facility's psychopharmacology committee meeting on 7/28/26. The committee included the medical director, the unit manager, social services, the pharmacy consultant and primary care physician #2. The note indicate the following changes were recommended for Resident #1's medications: increase Seroquel and add Zolofit back. The resident's Seroquel was increased from 25 mg to 50 mg three times daily (see director of nursing (DON) interview below). C. Resident #2 (victim) 1. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the July 2026 CPO, diagnoses included unspecified dementia, severe with psychotic disturbances, syncope and collapse (faint), difficulty in walking, muscle weakness, unspecified dementia, severe with agitation, restlessness and agitation, delirium, hallucinations, and a history of falling. The 7/1/26 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident was independent with walking, and eating. The resident required supervision with oral hygiene and toileting. The assessment indicated the resident exhibited physical behavioral symptoms directed towards others which might include hitting, kicking, pushing, scratching, and grabbing; and verbal threatening behavioral symptoms directed toward others which might include threatening others, screaming at others, and cursing at others on one to three days per week during the assessment look-back period. 2. Record review The comprehensive care plan, updated 6/21/26, documented Resident #2 had food insecurities due to past trauma and would reach for other people's food when he was hungry. Resident #2 was often hungry. If other residents were eating and Resident #2 was not, staff were to offer him a second plate of fruit or food of choice, or a snack to prevent him from taking others' food while they were eating. The event progress note, dated 6/19/26, documented after the altercation between Resident #1 and Resident #2, revealed there were no marks or injury noted on Resident #2's face. The 6/19/26 skin assessment, documented after the altercation between Resident #1 and Resident #2, revealed there were no marks or injury noted on Resident #2's face. The progress note, dated 6/22/26, revealed Resident #2 was moved to a different secured unit within the facility. IV. Staff interviews The NHA was interviewed on 7/29/26 at 2:00 p.m. The NHA said Resident #1 had been sent to the hospital a few months prior and had his medications adjusted. The NHA said Resident #1 was in the hospital for approximately six weeks before he returned to the facility. The NHA said the resident's representative spoke to her a week ago to request a different physician for Resident #1 because the representative wanted Resident #1's medications to be provided according to the prior hospital's orders. The NHA said four days prior to the survey, the request was completed to change physicians for Resident #1. The NHA said primary care physician #2 met with the facility's management team on 7/28/26 to discuss Resident #1's plan of care. Primary care physician #1 was interviewed on 7/30/26 at 9:05 a.m. Primary care physician #1 said she had been Resident #1's physician for approximately two years. Primary care physician #1 said prior to Resident #1's hospital stay, he was alert, walked around his unit, spoke some English, and even played bingo. Primary care physician #1 said when Resident #1 returned from the hospital, he was in a wheelchair, and primary care physician #1 felt he was sedated at the hospital. Primary (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Garden Terrace Alzheimer's Center of Excellence		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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 Note: The nursing home is disputing this citation.	care physician #1 said when Resident #1 returned from the hospital, he was not aggressive. Primary care physician #1 said she felt if Resident #1 remained in the post-hospital visit condition, he would be appropriate for hospice. Primary care physician #1 said she did a gradual dose reduction (GDRs) of medications over several months and for a while, Resident #1 had done well with the adjustments, and started to walk again. Primary care physician #1 said recently Resident #1 needed his medications increased again due to ongoing aggressive behaviors when staff provided care for him. Primary care physician #1 said she had increased Resident #1's Depakote after the 6/19/26 incident with Resident #2. Primary care physician #1 said she was concerned that Resident #1 hit a visitor on 7/12/26, because if Resident #1 hit another vulnerable resident, it could be dangerous. Primary care physician #1 said she became aware of the resident's representative's request to transfer Resident #1 to a different physician just a few days ago. Primary care physician #1 said the representative was upset with the GDRs that had happened with the resident's medications. Primary care physician #2 was interviewed on 7/30/26 at 1:25 p.m. Primary care physician #2 said over the past few days he became Resident #1's physician due to a request from the resident's representative. Primary care physician #2 said on 7/28/26 he met with the facility's management team in the psychopharmacology meeting. Primary care physician #2 said Resident #1's medication changes included increased Zoloft, and the resident's Seroquel was increased on 7/30/26. Primary care physician #2 said he was in the facility twice per week and was able to evaluate Resident #1 often. Primary care physician #2 said about every two weeks, Resident #1's medications would be reviewed to determine if the medications were effective. Primary care physician #2 said in the future, there could be other medication changes that that might be effective for Resident #1, if needed. The DON was interviewed on 7/30/26 at 2:00 p.m. The DON said after the 6/19/26 altercation between Resident #1 and Resident #2, Resident #1's Seroquel 25 mg was increased from twice per day to three times per day and his Depakote was changed from 125 mg three times per day to 375 mg three times per day. The DON said in July 2026, Resident #1's Seroquel was increased from 25 mg three times per day to 50 mg three times per day. She said his Depakote was changed from 375 mg three times per day back down to 125 mg three times per day. The DON said the resident's trazodone (medication used for insomnia) had also been increased in July 2026. The NHA was interviewed again on 7/30/26 at 2:30 p.m. The NHA said Resident #2 had no further resident-to-resident incidents after the 6/19/26 incident with Resident #1. The NHA said Resident #1's representative was willing to move Resident #1 to another facility if the facility could find a Russian speaking facility that would meet Resident #1's needs. The NHA said if there was no Russian speaking community, the resident's representative wanted Resident #1 to remain at the current facility. The NHA said this week, on 7/29/26, she requested an outside provider placement company locate a Russian speaking facility.		