STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065297	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Care Center	1660 Allison St Lakewood, CO 80214

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 - 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 record review and interviews, the facility failed to ensure two (#1 and #3) of four residents were free from abuse out of four sample residents.Resident #2 was admitted on [DATE] with diagnoses of dementia, transient ischemic attack (TIA- a temporary blockage of blood flow to the brain), hypertension, repeated falls and dysphagia.Resident #1 was admitted on [DATE] with diagnoses of hemiparesis (weakness on one side of the body) affecting left side , cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing), dementia (loss of cognitive function), systolic heart failure (ineffective blood pumping), type two diabetes (abnormal glucose control), displaced fracture of the wrist and hypertension (high blood pressure). Resident #2 and Resident #1 were roommates who resided on the secured unit. On 8/21/25 Resident #2 pushed Resident #1 causing her to fall to the floor where she sustained a right wrist fracture, an abrasion and bump to the head. Resident #3 was admitted on [DATE] with a diagnosis of depression and anxiety disorder.Resident #4 was admitted on [DATE] with a diagnosis of Alzheimer's disease. Resident #4 had documented presence of wandering behaviors with dissociative staring and entering other residents' rooms. On 8/21/25 Resident #3 filed a grievance form where she reported Resident #4's staring made her uncomfortable. Resident #3 was moved to the first floor as a resolution to the grievance. However, on 9/9/25 Resident #4 was moved to the first floor, across from Resident #3. Resident #3 said Resident #4 had made additional inappropriate comments and had touched her inappropriately. She said having Resident #4 reside across the hallway made her fearful and she was self-isolating in her room.The facility had implemented a stop sign on Resident #3's door to prevent other residents from entering her room. However, this was not installed until the time of the survey. The facility failed to prevent Resident #3 from self-isolating due to Resident #4 sexually inappropriate behaviors towards her. Specifically, the facility failed to:-Protect Resident #1 from physical abuse by Resident #2; and,-Protect Resident #3 from sexual abuse by Resident #4. Findings include: I. Facility policy and procedure (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 - Actual harm Residents Affected - Few	The Abuse policy, dated 5/3/23, was received from the nursing home administrator (NHA) on 10/14/25 at 9:52 a.m. It revealed in pertinent part The facility 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. Providing a safe environment for the resident is one of the most basic and essential duties of our facility. Employees have a unique position of trust with vulnerable residents.This facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, friends, or other individuals. Identification of abuse shall be the responsibility of every employee. 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 were 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. Willful means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm. II. Incident of physical abuse between Resident #1 and Resident #2 on 8/21/25 A. Facility investigation The 8/21/25 facility investigation was provided by the NHA on 10/14/25 at 2:15 p.m. The investigation documented Resident #1 and Resident #2 were having a conversation in their room alone. Resident #2 then came out of the room to get a staff member. Certified nurse aide (CNA) #4 was told by Resident #2 that Resident #1 was on the floor. Resident #2 took CNA #4 to the room where Resident #1 was on the floor. Resident #2 said Resident #1 was turning around and she (Resident #2) pushed her and she (Resident #1) lost her balance and fell. Resident #1 said Resident #2 had pushed her. CNA #4 was interviewed. She said she was completing her rounds when Resident #2 came to her and told her I accidentally pushed her. CNA #4 said Resident #2 took her to the residents' room where she found Resident #1 on the floor face down in front of the bathroom door. CNA #4 said she asked Resident #2 what happened and Resident #2 responded she was sorry. CNA #4 then got the nurse on duty. Resident #1 was assessed by facility staff and required transfer to higher level of care for assessment due to a head injury and complaints of right wrist and pinky finger pain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The residents were separated after the event and the interventions completed post-event were a room change and medication review. The facility's internal investigation concluded, based on the state manual, the abuse allegation was unsubstantiated due to no actual allegation of abuse by either resident. -However, physical abuse occurred when Resident #2 pushed Resident #1 causing her to lose her balance and fall, resulting in a fracture of the wrist for Resident #1. B. Resident #1 (victim) 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included hemiparesis affecting the left side, cerebral infarction, dysphagia, dementia, systolic heart failure, type two diabetes, displaced fracture of the wrist and hypertension. The 8/26/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of four out of 15. She required maximum staff assistance with dressing, personal hygiene, supervision/touch assistance with toileting, bed mobility and transfers. 2. Record review The cognitive impairment care plan, dated 10/23/25, revealed Resident #1 had cognitive impairment related to dementia with agitation. The care plan documented Resident #1 was severely cognitively impaired and was able to follow consistent simple, directive sentences with cues. Interventions included if the resident became agitated, stop and return, monitoring/documenting any changes in function specifically in decision making, memory recall, general awareness, difficulty understanding others, level of consciousness and mental status. The 8/21/25 after visit summary from the hospital revealed Resident #1 was seen post a fall and had a closed head injury, abrasion to the lip and a closed displaced fracture of the right wrist. The emergency department note revealed the resident was involved in an altercation with another resident at her facility. The resident stated she turned around and fell backwards striking her head and chin. The resident was given a volar splint (a device that immobilizes and supports the hand and wrist, extending from the palm to the mid-forearm). A computed tomography (CT) scan (medical imaging procedure that uses Xrays to create detailed cross-sectional images of the body's internal organs and tissues) was completed due to the trauma and hematoma. The CT scan results were unremarkable. The August 2025 CPO documented a physician's order on 8/22/25 for Tylenol (medication to reduce pain/fever) 325 milligrams (mg) two tablets two times a day for wrist fracture and bruises for seven days. A psychosocial/social services note, dated 8/21/25 at 5:22 p.m., revealed the memory care director checked in with Resident #1. The resident was calm and pleasant and she walked with the resident to the dining room for dinner. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 8/22/25 at 5:40 a.m., documented Resident #1 was on observation post an unwitnessed fall with a bruise to the face area, neurological assessment was at baseline and per the hospital discharge note, she had a right wrist closed displaced fracture supported by an ace wrap for stability. Resident #1 was educated on keeping the ace wrap in place. A physician's progress note, dated 8/22/25 at 11:39 a.m., revealed Resident #1 was seen after an altercation with another resident (Resident #2) and had an abrasion to the lip/chin and a closed displaced fracture of the right wrist. Per facility staff, the resident was found lying on the ground with a bump on her head and a cut to her lip. She was sent to the hospital for further evaluation. Per the emergency room note, the resident's CT scan was un-remarkable for injury and the Xray was positive for a closed displaced fracture of the right wrist. Resident #1 was discharged with a volar splint. The resident was to follow up with osteopathic medicine. C. Resident #2 (assailant) 1. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the October 2025 CPO, diagnoses included dementia, transient ischemic attack, hypertension, repeated falls and dysphagia. The 9/1/25 MDS assessment revealed the resident had severe cognitive impairment with short and long term memory issues per staff assessment. She required maximum staff assistance with toileting, moderate staff assistance with dressing and personal hygiene. The assessment documented she was independent with bed mobility, transfers and ambulation 2. Record review The cognitive care plan, dated 12/19/23, revealed Resident #2 had impaired cognitive function and impaired thought processes related to dementia with behavioral disturbances. Pertinent interventions included offering ideas to Resident #2 to explore and practice new coping skills while in the facility, engaging Resident #2 in mindfulness activity, offering the resident to go on a walk and giving her space and time to express her emotions. A psychosocial/social services note, dated 8/21/25 at 4:14 p.m., revealed the memory care director met with Resident #2. The memory care director noted that Resident #2 said she had a busy day helping set up a new guest room. Resident #2's demeanor was pleasant and calm. A physician's progress note, dated 8/22/25 at 11:39 a.m., revealed Resident #2 was seen for a physical occurrence Resident #2 had with another resident (Resident #1) on 8/21/25. Resident #2 was unable to provide accurate information on the incident. Facility staff reported Resident #2 said she had punched the other resident because they had pushed her. No injuries were noted to Resident #2. The other resident (Resident #1) was sent to the hospital as a result of the injury for further evaluation. -However, review of the facility's investigation did not reveal documentation regarding a punch. D. Staff interviews (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA #1 was interviewed on 10/14/25 at 2:59 p.m. CNA #1 said most residents that resided on the memory care unit had behaviors that the staff had to monitor. CNA #1 said Resident #1 and Resident #2 used to be roommates before they had an altercation. CNA #1 she had observed Resident #1 tell Resident #2 this is my house and needed to be redirected to her room after being moved rooms after the altercation. CNA #1 said she utilized the name plates outside the residents' doors to redirect residents frequently. Licensed practical nurse (LPN) #1 was interviewed on 10/14/25 3:12 p.m. LPN #1 said Resident #2 could be aggressive at times, but she was redirectable. LPN #1 said she was aware of the altercation that occurred between both residents, where Resident #2 pushed Resident #1 who then fell and fractured her wrist and hit her head. LPN #1 said Resident #1 struggled to keep the brace on her wrist. LPN #1 said Resident #1 and Resident #2 were roommates prior to the altercation, but moved rooms after it occurred. She said both residents still conversed with each other during her shifts. LPN #1 said both residents seemed to be at baseline after the altercation. The director of nursing (DON) was interviewed on 10/14/25 at 4:22 p.m. The DON said in the event of an abuse situation, she expected nursing staff to ensure residents were safe and then start an investigation by notifying the NHA about abuse or suspected abuse. She said once the NHA was aware, an investigation was started. She said the investigation included a resident assessment, resident interviews, staff interviews and the residents were monitored for non-verbal behaviors that may occur in a resident post an incident. The DON said she was not aware of any behaviors Resident #1 had prior to the altercation. The DON said Resident #1 returned to her baseline after the altercation. The DON said Resident #2 had behaviors that included wandering and walking fast in the hallway with a focus on her walking. The DON said Resident #1 and Resident #2 were roommates and friends prior to the occurrence on 8/21/25. The social services assistant (SSA) was interviewed on 10/14/25 at 4:59 p.m. The SSA said when she came into the facility every morning, she reviewed behavior charting/alerts from the previous days along with checking in with staff for any concerns. The SSA said she completed activities on the memory care unit. The SSA said Resident #1 participated in activities frequently and she was very social with other residents. The SSA said the resident did not exhibit any aggressive behaviors towards other residents or staff. The SSA said Resident #2 was an active participant in activities and was very social with other residents and offered to help them during activities. The SSA said after the altercation in August 2025, Resident #2 did not remember the altercation at first then became very apologetic with Resident #1 because she had pushed her and caused her to fall. The SSA said both residents had gotten along with each other until the day of the occurrence and post the occurrence they returned to their baseline. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA was interviewed on 10/14/25 at 5:30 p.m. The NHA said all staff were to complete abuse training on hire, annually and they reviewed abuse training during monthly staff meetings as well. The NHA said staff were to follow the abuse policy when abuse was observed or suspected. The NHA said the process was to ensure resident safety, then she was to be contacted and then the investigation would start. The NHA said the investigation process included resident assessments, such as skin checks, and resident/staff interviews. She said interventions, such as keeping residents separated and frequent monitoring, were initiated if indicated. The NHA said she was notified on 8/21/25 right after the altercation between Resident #1 and Resident #2 occurred. The NHA said Resident #1 had an abrasion to her temple while being assessed. The NHA said she asked the resident in the moment what occurred. Resident #1 said she fell because Resident #2 pushed her and said that they were talking and not arguing. The NHA said Resident #1 was unable to recall the topic of conversation. The NHA said Resident #2 was upset, tearful and remorseful and said she did not mean to push her. The NHA said Resident #2 told the NHA that Resident #1 and she were talking, not arguing. The NHA said Resident #2 could not recall the topic of conversation. The NHA said Resident #2 told her she knew she should not have put her hands on Resident #1. The NHA said other staff members assisted in collecting resident and staff interviews and the police and adult protective services were notified. The NHA said the facility unsubstantiated the abuse allegation based on the state occurrence manual and did not review federal guidelines. III. Incident of sexual abuse by Resident #4 towards Resident #3 A. Resident #3 (victim) 1. Resident status Resident #3, age [AGE], was admitted on [DATE]. According to the October 2025 CPO, diagnoses included cauda equina syndrome (compression of nerves at the end of the spinal cord), depression, anxiety disorder and iron deficiency anemia. The 8/4/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident used a walker mobility device. Resident #3 was independent with most activities of daily living (ADL) and she required stand-by assistance from staff with showers and shower transfers. 2. Resident interview and observation (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #3 was interviewed on 10/14/25 at 9:00 a.m. Resident #3 said she was involved in a resident-to-resident altercation, but she did not want the facility informed she reported it due to fear of retaliation. Resident #3 said Resident #4 lived in the room directly across the hall from her, previously touched her inappropriately and told her I'd like to (explicit language) you. Resident #3 said the incidents of inappropriate sexual touching occurred when both residents previously lived on the second floor. She said no further incidents had occurred since Resident #4 moved to the first floor. Resident #3 said Resident #4 wandered into other residents' rooms all the time and the staff would frequently attempt to redirect him. Resident #3 said she no longer felt comfortable eating her meals in the cafeteria because Resident #4 ate his meals there. Resident #3 said being around Resident #4 made her uncomfortable and she feared he may attempt raping her. Resident #3 said she previously reported the inappropriate touching to staff and nothing was done, so she feared the repercussions of reporting it again. Resident #3 was interviewed again on 10/14/25 at 10:37 a.m. Resident #3 said Resident #4 grabbed her on her buttocks over her clothes. Resident #3 said Resident #4 attempted to get his hand inside of her pants and she slapped his hand away. Resident #3 said she could not remember exactly when the incidents occurred, however they happened when both residents lived on the second floor. Resident #3 said the incidents were not observed by staff. Resident #3 said she filed a grievance form about Resident #4 touching her one and a half to two months ago, but it was not followed up on. Resident #3 said she was fearful of retaliation and getting kicked out with nowhere to go. Resident #3 said she did not want to move out of her current room because she felt safe. Resident #3 was intermittently tearful throughout the conversation. -An interview with the NHA (see below) revealed no grievance form was found documenting Resident #4 inappropriately touched Resident #3. Resident #3 was interviewed a third time on 10/14/25 at 1:21 p.m. Resident #3 said the NHA spoke with her earlier that day (10/14/25) and told her Resident #4 would be moved to a different room. Resident #3 said she felt a bit more comfortable with the stop sign barrier and Resident #4's room move. Resident #3 said she planned on attending the Bingo activity that evening. 3. Observations On 10/14/25 at 12:20 p.m. Resident #3 was in her bedroom. An unidentified CNA delivered Resident #3's lunch tray to her in her room. On 10/14/25 at 12:27 p.m. an unidentified maintenance staff member placed a stop sign on Resident #3's door with velcro. The velcro strips were secured to the door frame with screws. 4. Record review Review of Resident #3's electronic medical record (EMR) revealed she was moved to the first floor from her previous room on the second floor on 8/21/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A facility grievance form, dated 8/21/25, was provided by the NHA on 10/14/25 at 4:18 p.m. It documented Resident #3 reported to the social services director (SSD) that a resident (Resident #4) was making her feel uncomfortable. It documented Resident #3 stated the resident would stand in front of her doorway and always stare in. It documented Resident #3 stated Resident #4 would sometimes stare at her in the dining room. The grievance form documented the follow-up action taken was moving Resident #3 to a room located on the first floor. It documented Resident #3 was agreeable and thought it would be the better option for her. -However, on 9/9/25 the facility moved Resident #4 to the first floor across from Resident #3's room. The behavior care plan, initiated 10/14/25 (during the survey), revealed Resident #3 had a behavior problem related to unspecified depression and unspecified anxiety disorder. It documented Resident #3 could often become emotional and tearful due to her past while living in the community. It documented Resident #3 had a history of manipulating situations and had a history of ingratiating herself into other residents' care without being asked. Interventions included administering medications as ordered, anticipating and meeting the resident's needs, intervening as necessary to protect the rights and safety of others, rewarding the resident for appropriate behavior by offering a snack reward as indicated. The wellbeing care plan, initiated 10/14/25 (during the survey), revealed Resident #3 chose to be highly involved in daily care decisions regarding suggested or recommended interventions and had specific preferences related to room changes and safety. Interventions included honoring individual choices and preferences as able within the parameters of the facility, providing the resident with choices and preferences, reviewing potential alternative choices with the resident, and a stop sign barrier to the doorway. -Review of Resident #3's progress notes revealed no documentation regarding her reported grievance, her room move, or the conversation she had with facility administration before Resident #4's room change (see NHA interview below). C. Resident #4 (assailant) 1. Resident status Resident #4, age less than 65, was admitted [DATE]. According to the October 2025 CPO, diagnoses included Alzheimer's disease (a cognitive and memory disorder) with early onset, dementia without behavioral/psychotic/mood disturbance and anxiety, anxiety disorder, major depressive disorder and personal history of malignant neoplasm (cancer) of the prostate. The 7/25/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of five out of 15. He had fluctuating inattentive and disorganized thinking behaviors. He required partial assistance with bed mobility and transfers, and stand by assistance with locomotion. He did not have any wandering behaviors present during the assessment lookback period and used a wander/elopement alarm restraint daily. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Observations During a continuous observation of Resident #4 on 10/14/25, beginning at 10:57 a.m. and ending at 11:09 a.m., the following was observed: At 10:57 a.m. Resident #4 walked to his room from the admissions office. Resident #4 was ambulating independently with standby assistance from an unidentified CNA. Resident #4 and the unidentified CNA walked into the resident's room, located directly across the hallway from Resident #3's room. The CNA partially closed Resident #4's door. At 10:59 a.m. Resident #3 was seen standing in the hallway corridor in front of the first floor elevator bay, talking with an activities staff member and another resident. At 10:59 a.m. Resident #4 and the unidentified CNA exited his room and started walking down the hallway towards an open sitting area at the other end of the hallway. The unidentified CNA walked approximately two to three feet in front of Resident #4. Resident #3 was positioned with her back facing Resident #4 as he walked past her in the hallway. Resident #4 walked behind Resident #3, passing within one foot of her. Resident #4, smiling while walking, stopped and looked at the activities staff member, Resident #3 and another resident. The unidentified CNA encouraged Resident #4 to continue following her down the hallway towards an open sitting area at the end of the hallway. Once inside the sitting area, the unidentified CNA encouraged Resident #4 to sit on a couch in the sitting area and told him to wait there and she would be back. A television in the sitting area was not turned on, and no other staff were present to engage Resident #4. At 11:02 a.m. Resident #4 stood up from the couch and ambulated out of the sitting area. The same unidentified CNA saw Resident #4 and told him to go back to the sitting area and wait for her. Resident #4 looked and smiled at the unidentified CNA, but did not respond. The unidentified CNA left to continue assisting another resident. Resident #4 was standing in the hallway looking around. At 11:04 a.m. an unidentified staff member approached Resident #4 and engaged with him. The same staff member then started talking to Resident #3. Resident #3 and the staff member began walking down the hallway towards the front lobby. Resident #4 followed them down the hallway, walking approximately one to two feet behind and to the right of Resident #3. Resident #3 and the staff member stopped at the admission's office and continued talking. Resident #4 moved to the staff member's left side. Once finished talking, Resident #3 started walking back down the hallway in the direction of her room. At 11:06 a.m. an unidentified admissions staff member asked Resident #4 if he wanted to sit in her office. The unidentified admissions staff member said she had a snack for him approximately two to three times. The unidentified admissions staff member asked Resident #4 if he wanted to watch a movie. At 11:09 a.m. Resident #4 sat down on the couch in the admissions office. The unidentified admissions staff member handed him an opened snack bag. The staff member opened a small can of soda and placed it on the table in front of Resident #4. 3. Record review (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #4's EMR revealed he was moved to the first floor from his previous room on the second floor on 9/9/25. The Elopement/Wandering care plan, initiated 4/30/25 and revised 10/14/25 (during the survey), documented Resident #4 was an elopement risk/wanderer related to Alzheimer's disease with early onset. It documented Resident #4 had a history of following other staff out of the door. It documented Resident #4 also had a history of going into other residents' rooms without being invited. Pertinent interventions included distracting the resident from wandering by offering pleasant diversions/structured activities/food/conversation/television/books (initiated 4/30/25), monitoring location and documenting wandering behavior/attempted diversional interventions in a behavior log (initiated 4/30/25), checking placement of wander guard every shift (initiated 4/30/25) and offering a snack/drink or engaging in conversation (initiated 10/14/25). The behavior care plan, initiated 10/14/25 (during the survey), documented Resident #4 exhibited occasional inappropriate sexual behaviors, including making sexually explicit comments, such as I want to (explicit language). It documented the resident's comments were not directed toward a specific resident but may cause discomfort to others. It documented the resident had a history of self-stimulation and touching himself inappropriately. It documented Resident #4 may stare at others for a while due to word-finding difficulties and communication challenges and the behavior could make other residents uncomfortable or lead to misinterpretation. Pertinent interventions included administering medications as ordered, anticipating and meeting the resident's needs, intervening as necessary to protect the rights and safety of others and redirecting the resident into conversation when he displayed inappropriate behaviors or as needed. A nursing progress note, dated 10/6/25 at 2:36 p.m., documented Resident #4 was on frequent checks due to his wandering into other residents' rooms. It documented Resident #4 could become confrontational with staff and may not be easily redirected. It documented Resident #4 wandered into the nurses' station, took objects off the medication cart and the staff were redirecting. A behavior note, dated 10/5/25 at 12:32 a.m., documented Resident #4 was yelled at after wandering into two different residents' rooms. It documented the female residents wanted their room doors closed to keep Resident #4 out. It documented Resident #4 also went to the front door and dining room door and pushed on the handles, setting off the alarms. D. Staff interviews The NHA, the DON, the regional clinical resource and the clinical nurse resource were interviewed together on 10/14/25 at 11:20 a.m. The NHA said Resident #4 stood in other residents' doorways. The NHA said the facility used stop sign barriers, which had been effective in redirecting Resident #4. The DON said facility staff had previously been made aware of Resident #4's behaviors and were advised to frequently check on him. The NHA and the DON said Resident #4 sometimes dissociated when he could not find his words, which presented as him staring. The NHA and the DON said they were aware that Resident #3 had previously reported Resident #4's staring made her uncomfortable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065297	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Care Center	1660 Allison St Lakewood, CO 80214

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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 - Actual harm Residents Affected - Few	The NHA said she had a discussion regarding Resident #4's room change, with Resident #3, to assess her comfort with the move before Resident #4 moved downstairs. The NHA said Resident #3 declined an offer to move back upstairs. The NHA said a stop sign barrier was offered and Resident #3 agreed to one because she could call out for help if needed. The NHA and the DON said they did not know that Resident #3 reported she was inappropriately touched by another resident. The NHA said Resident #4 was moved directly across the hall from Resident #3 because it was the only open male room at the time. The NHA said Resident #4 was moved downstairs due to his functional status and facility staff's concern with him potentially bumping into other residents upstairs. The NHA, the DON, the regional clinical resource and the clinical nurse resource said they would initiate an investigation into Resident #3's allegation of inappropriate touching from Resident #4. CNA #2 was interviewed on 10/14/25 at 2:35 p.m. CNA #2 said abuse should be immediately reported to the nurse, then the nurse would notify the DON. CNA #2 said she was not aware of Resident #3 having any behaviors. CNA #2 said Resident #3 moved downstairs due to her discomfort of being around Resident #4. CNA #2 said Resident #4 exhibited sexual behaviors, but he was redirectable. CNA #2 said she had not personally observed or been told of Resident #4 inappropriately touching another resident. CNA #2 said Resident #3 went upstairs for some activities, however, Resident #3 did seem to be isolating herself. CNA #2 said Resident #3 would come out of her room for drinks, but ate her meals in her room. CNA #2 said Resident #3 began isolating in her room when Resident #4 moved downstairs. CNA #2 said Resident #3 told her she wanted to eat meals in her room because she felt more comfortable and safer. The clinical nurse resource was interviewed on 10/14/25 at 2:45 p.m. The clinical nurse resource said no staff had reported hearing of, or seeing, Resident #4 inappropriately touching other residents. The clinical nurse resource said one nurse reported Resident #4's staring made Resident #3 uncomfortable. The clinical nurse resource said other female residents in the facility denied being inappropriately