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	06/11/2026

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 - 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 record review and interviews, the facility failed to ensure residents were kept free from sexual abuse for one (#1) of four residents reviewed for abuse out of five sample residents.Specifically, the facility failed to protect Resident #1 from sexual abuse by a facility employee, housekeeper (HK) #1.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to theonsite investigation on 6/10/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/30/26.I. Incident of sexual abuse on 3/28/26On 3/28/26 a facility employee witnessed HK #1 as he waited for Resident #1 in the hair salon when it was time for the resident's haircut. After Resident #1 sat in the salon chair, HK #1 popped out from behind the salon door, which caused Resident #1 to light up with excitement to see HK #1.Resident #1 told HK #1 he was the love of her life and extended her arm towards him, waving for a hug. HK #1 approached Resident #1 and hugged her as she sat in the salon chair. The employee witness reported that during the hug, Resident #1 also kissed HK #1 on the neck area a few times. HK #1 told the employee witness he knew Resident #1 would have a reaction to seeing him in the hair salon. The employee witness observed HK #1 as he approached Resident #1, complimented her on her new haircut and then leaned toward Resident #1 and hugged and kissed Resident #1 on the lips a few times. After the incident, the employee witness escorted Resident #1 to the memory care unit and reported the incident to the nursing home administrator (NHA).II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #1The corrective action plan the facility implemented in response to the sexual abuse incident involving Resident #1 and HK #1 was received from the NHA on 6/11/26 at 10:21 a.m. The corrective action plan revealed that upon notification of the allegation that occurred on 3/28/26, the facility immediately suspended the assailant (HK #1) and subsequently terminated HK #1's employment. The nurse assessed Resident #1, and no signs or symptoms of trauma or injury were noted. Resident #1 remained at her mood and behavior baseline and had no evidence of physical or emotional injury. Resident #1 was monitored by staff for mood and behavior changes and was referred for behavioral health support. Resident #1 received a sexual assault examination at the hospital, and the examiner revealed there was no evidence of intimate penetration from the examination.B. Identification of other residentsOn 3/30/26, the facility completed an assessment and record review for other residents on the memory care unit that had potential to be affected by the assailant, and no concerns were identified. The facility staff was interviewed, and no additional concerns or allegations of inappropriate physical contact were identified. C. Systemic changesOn 3/30/26, the facility initiated reeducation to staff on abuse prevention, resident rights, professional boundaries, code of conduct expectations, mandatory reporting requirements, and identifying inappropriate staff-resident relationships. The education included expectations regarding therapeutic relationships with residents and appropriate physical contact standards. The education was provided to all facility staff.D. MonitoringThe NHA or designee would complete audits of 24-hour shift reports and check with staff on morning rounds to identify any possible sexual abuse concerns, allegations, or misconduct with any facility resident. The findings of the audits would be reviewed in the quality (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	assurance and performance improvement (QAPI) committee meetings monthly for 90 days. If the QAPI committee identified any trends, corrective action would be initiated. The April 2026 and May 2026 QAPI committee meetings included a review of the audits, and no concerns were identified. There had been no additional incidents of sexual abuse in the facilityThe facility was in substantial compliance on 3/30/26.III. Facility policy and procedureThe Abuse policy and procedure, dated 9/4/25, was provided by the NHA on 6/10/26 at 4:40 p.m. It read in pertinent part, This policy outlines the community's zero-tolerance stance against abuse by anyone, including staff members. Residents have the right to be free from abuse. This includes freedom from sexual abuse. Standards include:-Providing a safe environment for residents is one of the most basic and essential duties of our community;-Employees have a unique position of trust with vulnerable residents;-Residents must not be subjected to abuse by anyone, including community staff; and, -Identification of abuse shall be the responsibility of every employee. Sexual abuse is the non-consensual sexual contact of any type with a resident. When an employee of the community abuses or is suspected of abuse of a resident, the employee is placed on immediate suspension. In the event abuse occurred, appropriate disciplinary action will be carried out.IV. Incident of sexual abuse by HK #1 towards Resident #1 on 3/28/26A. Facility investigationThe 3/28/26 facility investigation revealed a facility employee observed HK #1 participating in intimate, inappropriate touching and kissing on the lips with Resident #1. The investigation revealed the facility employee witnessed HK #1 as he waited for Resident #1 in the hair salon when it was time for the resident's haircut. After Resident #1 sat in the salon chair, HK #1 popped out from behind the salon door, which caused Resident #1 to light up with excitement to see HK #1.The investigation documented that Resident #1 told HK #1 he was the love of her life and extended her arm towards him, waving for a hug. HK #1 approached Resident #1 and hugged her as she sat in the salon chair. The employee witness reported that during the hug, Resident #1 kissed HK #1 on the neck area a few times. HK #1 told the employee witness he knew Resident #1 would have a reaction to seeing him in the hair salon. The investigation revealed the facility witness observed HK #1 as he approached Resident #1, complimented her on her new haircut, and then leaned toward Resident #1 and hugged and kissed Resident #1 on the lips a few times. The investigation revealed that after the incident, the employee witness escorted Resident #1 to the memory care unit and reported the incident to the NHA.The facility investigation included an interview with HK #1. HK #1's statement read that while working at the facility, he had engaged Resident #1 in conversation regarding shared interests. HK #1 reported he bonded with Resident #1 over shared interests and they enjoyed speaking with each other. HK #1 reported that over time, the frequency of their conversations increased during his work hours when he was on the unit where Resident #1 resided. HK #1 stated that within the previous month, his interactions with Resident #1 progressed to hugging when he arrived and left the unit, which he attributed to their friendship. The investigation documented the employee witness assisted Resident #1 from the salon chair, and then HK #1 hugged and kissed Resident #1 on the lips again. The employee witness challenged HK #1 (regarding his behavior), and HK #1 giggled in response. HK #1 told Resident #1 he was leaving, and Resident #1 became sad, kept reaching for him, calling him baby and telling him she loved him. The investigation documented the facility substantiated the incident of sexual abuse. B. Resident 1 (victim)1. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included unspecified dementia and adult failure to thrive. The 5/27/26 minimum data set (MDS) assessment revealed Resident #1 was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. Resident #1 was independent with bed mobility, transfers, and walking. The assessment indicated Resident #1 had no behavioral symptoms directed at others during the assessment look-back period.2. Record reviewThe behavioral care plan, initiated 4/6/26, revealed Resident #1 had behaviors of confusion and teary-eyedness. Resident #1 expressed gratitude verbally and used physical gestures with tactile hand and shoulder rubbing while communicating. The gestures appeared as expressions of (continued on next page)

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