

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Wellsprings Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3636 S Pearl St Englewood, CO 80113	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect one (#1) of three residents from misappropriation of property out of three sample residents. Specifically, the facility failed to protect Resident #1 from misappropriation of property and exploitation by a facility employee. Findings include: I. Facility policy and procedure The Abuse policy and procedure, dated May 2023, was provided by the nursing home administrator (NHA) on 11/5/25 at 4:10 p.m. It revealed in pertinent part, Purpose: 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. Intent: 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. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. Misappropriation of resident property is defined as the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Misappropriation includes, but is not limited to theft, fraud, and financial exploitation. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Reporting can be completed verbally or in writing. II. Incident of misappropriation of property and exploitation of Resident #1 by activity assistant (AA) #1A. Facility investigation The 9/11/25 facility occurrence and investigation revealed that on 9/11/25 at 4:00 p.m., the social services director (SSD) overheard Resident #1 speaking on the phone with someone about having the title of his vehicle signed over to the person on the phone. After some questions to Resident #1, the SSD found out the person speaking with the resident was a facility employee, AA #1. AA #1 begged the SSD not to mention anything to the NHA. Resident #1 stated that he had his friend sign his (Resident #1's) van over to AA #1 because she had been taking him to different places. Additionally, Resident #1 said that in the past, AA #1 took him to the bank, and he withdrew approximately \$1000.00 and gave the money to her to get insurance and pay for the van's registration. The facility performed an immediate assessment of Resident #1, evaluated whether Resident #1 felt safe, took immediate steps to protect the resident, suspended the AA #1's access to the resident and started interventions to prevent further potential abuse, misappropriation of property and exploitation. After additional investigation, the facility found out AA #1 had been abusing Resident #1 financially since May 2025. On 9/11/25, the NHA interviewed AA #1. The NHA asked AA #1 whether she had Resident #1's friend sign his van title over to her. AA #1 first denied it, then said the title was in the friend's name and that the victim had nothing to do with it. The NHA asked her whether the resident had paid for the license and registration and AA #1 responded no. The NHA reported the incident to adult protection services (APS), to the ombudsman and to the police department. The 11/27/23 background screening report documented that the AA #1 had no reportable records found, and she was not substantiated as a perpetrator in an APS case. On 9/12/25, Resident #1 was interviewed and stated that AA #1 told him it would be cheaper for him to get an apartment because she would be his caregiver. The resident said he thought she would have to transport him to his hemodialysis appointments and other places, so he had his personal friend sign the van title over to her. Resident #1 stated that he believed AA #1 had his credit card information, as there were strange charges on it after AA #1 used the card to fill the van with gas. B. Resident #1 1. Resident status Resident #1, age less than 65, was admitted on [DATE] and readmitted [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included chronic pulmonary obstructive diseases (COPD), major depressive disorder, anxiety disorder, type 2 diabetes mellitus and end stage renal disease. The 9/18/15</p>		