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	12/09/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who displayed or were diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practical physical, mental, and psychological well-being for one (#4) of four residents reviewed for dementia care out of four sample residents. Specifically, the facility failed to develop and implement effective person-centered dementia management interventions to prevent Resident #4 from wandering into other residents' rooms.Findings include: I. Facility policy and procedure The Dementia Care policy and procedure, revised 9/6/24, was provided by the nursing home administrator (NHA) on 10/28/25 at 12:36 p.m. It read in pertinent part, This facility will provide dementia treatment and services which may include, but is not limited to, ensuring adequate medical care, diagnosis, and supports based on diagnosis, ensuring the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choices, and safety and utilizing individualized, non-pharmacological approaches to care. Residents who display or are diagnosed with dementia will receive the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.Identify, address, and/or obtain necessary services for the dementia care needs of the residents.Develop and implement person-centered care plans that include and support the dementia care needs identified in the comprehensive assessment.Develop individualized interventions related to the resident's symptomology and rate of progression.Review and revise care plans that have not been effective and/or when the resident has a change in condition.Modify the environment to accommodate resident care needs and achieve expected improvements or maintain the expected stable rate of decline.II. Resident #4A. Resident status Resident #4, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included wandering in disease classified elsewhere, psoriasis (a chronic autoimmune skin condition), unspecified dementia, unspecified severity with other behavioral disturbances, and need for assistance with personal care.The 5/28/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired, with a brief interview for mental status (BIMS) score of three out of 15. He required supervision or touch assistance with toileting and personal hygiene, and was independent with eating.The MDS assessment revealed the resident wandered one to three days during the assessment look-back period and exhibited physical behavioral symptoms, such as hitting, kicking, scratching, grabbing, pushing, and sexually abusive behavior toward others.B. ObservationsDuring a continuous observation on 10/27/25, beginning at 12:00 p.m. and ending at 1:34 p.m., the following observations were made:At 12:15 p.m. Resident #4 was observed leaving his room, heading towards the main nurses' station, which was adjacent to the dining room. He diverted to a room close to the nurses' station, room [ROOM NUMBER], which occupied two residents. The resident laid on bed A and covered himself with the other resident's blanket. Certified nurse aide (CNA) #1 and licensed practical nurse (LPN) #1 were at the nurses' station and were not paying attention to where the resident went. The residents who resided in room [ROOM NUMBER] were in the dining room eating lunch. At 12:50 p.m., LPN #1 said Resident #4 was in his room, asleep. However, upon checking the resident's room, LPN #1 noticed Resident #4 was not in his bed. She started searching room by room and eventually found the resident asleep in room [ROOM NUMBER], bed A. At 12:54 p.m., LPN #1 was able to redirect Resident #4 out of room [ROOM NUMBER] to the dining area.At 12:58 p.m., CNA #1 served Resident #4 his lunch meal. The resident sat at the dining table, dozing off. He then got up and attempted to leave the dining area. CNA #1 encouraged him to stay and eat his food.During a second continuous observation on 10/27/25, beginning at 3:40 p.m. and ending at 4:30 p.m., the following observations were made: At 3:40 p.m., Resident #4 was observed laying on bed B in room [ROOM NUMBER]. The staff were not aware where the resident was at that moment. The residents who resided in the room were in the dining room, engaging in bingo activities.At 3:50 p.m., CNA #2 was in the dining room chatting with an activities staff member. LPN #2 was in and out of the nurses' station. At 4:10 p.m. staff did not attempt to find out where Resident #4 was until prompted. CNA #2 started searching room by room, looking for the resident. CNA #2 found the resident asleep in room [ROOM NUMBER], bed B. She woke the resident up and redirected him to the dining room. The resident continued to fall asleep at the dining table. -Though there were activities going on, the staff failed to encourage the resident to participate.C. Record review Resident #4's wandering and elopement care plan, initiated 5/25/23