STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Rehabilitation and Nursing, LLC	1340 E Fillmore St Colorado Springs, CO 80907

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#5) of eight residents reviewed for abuse out of 12 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #5 from verbal abuse by Resident #15.Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy and procedure, dated 4/11/25, was provided by the regional clinical resource on 12/4/25 at 5:21 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility will implement policies and procedures to prevent and prohibit all types of abuse and achieve the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.II. Facility investigationThe facility investigation, dated 12/3/25 was provided by the nursing home administrator (NHA) and the regional clinical resource on 12/4/25 at 8:57 a.m. The investigation revealed the following:On 10/1/25 at 11:00 a.m. Resident #15 initiated verbal aggression towards Resident #5. A statement from the business office manager, dated 12/3/25 at 6:57 p.m., revealed on the day of the incident (10/1/25) she heard Resident #15 in a threatening manner in the dining room. When the business office manager entered the dining area, she heard Resident #15 threatening to hurt Resident #5. Resident #15 initially raised his fist, then proceeded to grab a dining room chair to hit Resident #5 with it. The assistant director of nursing (ADON) intervened and grabbed the chair from Resident #15. Resident #15 then continued to be verbally abusive to the facility staff who tried to speak with him.A statement from another staff member, dated 12/3/25 at 7:46 p.m., revealed the staff member was in another area of the facility on 10/1/25 and heard Resident #15 shouting at Resident #5 in the dining room. Resident #15 was cursing at Resident #5 when the staff member heard a loud noise. When the staff member entered the dining room Resident #15 still appeared agitated and one of the dining room chairs was on the floor. All residents, including Resident #5, were taken out of the dining room so the staff could deescalate and calm Resident #15 down.Resident #5 was interviewed on 12/3/25 and did not recall the incident that occurred on 10/1/25. Resident #5 said he ate in his room because he felt like it, and said he felt safe in the facility.The facility substantiated the abuse allegation.III. Resident #15 (assailant)A. Resident statusResident #15, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included bipolar disorder, anxiety disorder and schizoaffective disorder.The 9/10/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent for most activities of daily living (ADL).The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.B. Record reviewThe schizoaffective diagnosis care plan, initiated 10/25/24 and revised 12/4/25 (during the survey) revealed Resident #15 had potential to be verbally aggressive due to his diagnosis of schizoaffective disorder. Resident #15's trigger was identified as being when someone new was seated at his table in the dining room. Pertinent interventions included administering medications as ordered and analyzing key times, places, circumstances, triggers, and what de-escalated Resident #15's behaviors. On 12/4/25, an intervention was added to the care plan to have no other residents seated at Resident #15's table besides his friend whenever possible; if another resident was seated at the table, staff would speak to the other resident.The behavior care plan, revised 10/25/24, revealed Resident #15 had the potential to be physically aggressive. Pertinent interventions included assessing and anticipating the resident's needs, assessing and addressing contributing sensory deficits and administering medications as ordered.A progress note, dated 8/26/25 at 2:55 p.m., revealed while in the dining room, a staff member approached Resident #15 and asked him if he would mind turning the common area television volume down, as he had the remote. Resident #15 became rageful, screamed at the top of his lungs and raised his fists at the staff member and threatened to knock her out. Resident #15 said the remote was his, and he would kill anyone who touched it. The staff member attempted to speak with Resident #15 and de-escalate his behavior but was unsuccessful. Another staff member approached Resident #15 and asked if she could help, and Resident #15 cursed at her and attempted to lunge at her from his wheelchair. Staff members called the NHA and had Resident #15 speak to him, and Resident #15 went outside after the conversation without further issues.A progress note, dated

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 an environment free from risk of accidents and hazards for one (#7) of three residents reviewed for accident hazards out of 12 sample residents.Specifically, the facility failed to ensure the safe and appropriate use of mechanical lifts when working with Resident #7.Findings include:I. Facility policy and procedureThe Safe Resident Handling/Transfers policy and procedure, dated 4/11/25, was received from the regional clinical resource on 12/4/25 at 5:21 p.m. It read in pertinent part, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur.II. Resident #7A. Resident statusResident #7, age less than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body), generalized muscle weakness and cerebral infarction (stroke).The 10/24/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) assessment score of three out of 15. The resident was dependent on staff for most activities of daily living (ADL). The resident was dependent on staff for most transfer activities.B. Facility investigationThe facility investigation, dated 12/3/25 at 6:20 p.m. was received from the regional clinical resource on 12/4/25 at 8:57 a.m. The investigation revealed that on 10/17/25 Resident #7 was being transferred from his wheelchair to his bed after dinner using a Hoyer lift (mechanical lift). The investigation documented the staff using the manual Hoyer lift did not extend the lift's legs fully, so the lift began to tip and was partially caught by one of the staff members. Resident #7 landed on the floor on his back, and did not sustain any injuries. Radiograph (Xray) results, dated 10/20/25, revealed Resident #7 received radiographs of his right hip which did not show any evidence of fractures or breaks.The investigation included Hoyer lift competencies for four licensed practical nurses (LPN), one rehabilitation nurse aide, and 11 certified nurse aides (CNA) with dates ranging from 11/7/25 to 12/3/25. -However, not all nursing staff competencies were included. Additionally, the staff competencies were assessed starting three weeks after the incident on 10/17/25.Additional documentation was provided by the regional clinical resource on 12/4/25 at 5:35 p.m., including an in-service on mechanical lift use and safety that was conducted on 10/18/25. -However, only one-third of the nursing staff signed off that they had participated in the in-service.C. ObservationsAn initial tour of the facility was conducted on 12/3/25 at 10:45 a.m. Three electric Hoyer lifts were stored in the back hallway of the facility along the wall with several items of furniture or other appliances between them. The lifts and the appliances were pushed together so the lifts were not easily accessible.On 12/3/25 at 4:40 p.m. CNA #3 and CNA #4 performed hand hygiene, donned gloves and entered Resident #7's room with the manual Hoyer lift. The CNAs provided incontinence care for Resident #7 and positioned a Hoyer lift sling under the resident while he laid in bed. CNA #3 maneuvered the Hoyer lift arm over the resident and attached the loops of the sling to the lift while CNA #4 adjusted Resident #7's bed to better position the resident for the transfer. CNA #3 pumped the lever arm of the Hoyer lift to raise Resident #7 from his bed while CNA #4 lowered Resident #7's bed so the resident had enough clearance to swing from the bed to his wheelchair. CNA #3 then released the pump on the lift and Resident #7 was lowered into his wheelchair.A second tour of the facility was conducted on 12/4/25 at 7:40 a.m. The three electric Hoyer lifts were in the same position as they were on the initial observation of the back hallway, and remained pushed between furniture and appliances. D. Record reviewThe ADL care plan, revised 11/25/24, revealed Resident #7 had an ADL self-care performance deficit. Pertinent interventions included Resident #7 required a Hoyer lift for all transfers.A progress note, dated 10/17/25 at 6:58 p.m., revealed Resident #7 was being transferred from his wheelchair to his bed after dinner. Once suspended, the Hoyer lift tipped and was partially caught by the registered nurse (RN) assisting with the transfer. Resident #7 landed on his back on the floor and was witnessed to not hit his head. Resident #7 complained of head pain and stated his head did hit the floor, but did not complain of any other pain. Resident #7 was lifted from the floor to his bed and assessed, with no injury or redness to his skin noted. The assistant director of nursing (ADON), the director of nursing (DON), the hospice provider and the resident's representative were all