STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065356	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Colorado Springs	2490 International Cir Colorado Springs, CO 80910

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received adequate supervision and were kept free from elopement for one (#1) of three residents at risk for elopement out of three sample residents. Specifically, the facility failed to provide Resident #1 with the supervision necessary to prevent elopement. Resident #1, who had moderate cognitive impairments and had diagnoses of aphasia and encephalopathy, had a history of wandering and required an escort to his appointment off of the facility's property.On 9/9/25 at approximately 1:00 p.m. Resident #1 was scheduled for pickup by an outside medical transportation company. The resident was taken to his appointment by the transportation driver and escorted into the building. Per the clinic's notes, the resident was seen from 2:17 p.m. to 2:32 p.m., at which time the resident was discharged from the clinic and he subsequently walked away from the clinic. On 9/9/25 at 4:00 p.m. the outside transportation company returned to the clinic to transport Resident #1 back to the facility, but the driver could not find the resident. The transportation company contacted the facility and alerted them they were unable to locate the resident. Facility staff began searching the area for the resident.On 9/9/25 at approximately 6:40 p.m. (four hours after the last known sighting of Resident #1 and 2.5 hours after the resident was identified as missing) the director of nursing (DON) found Resident #1 walking on a sidewalk approximately 3.4 miles away from the clinic where he had attended his appointment.Serious harm to Resident #1 was likely to have occurred during Resident #1's elopement on 9/9/25. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 11/3/25 through 11/4/25, resulting in the deficiency being cited as past noncompliance with a correction date of 9/12/25.I. Situation of serious [NAME] 9/9/25 at approximately 1:00 p.m. Resident #1 was scheduled for pickup by an outside medical transportation company. The resident was taken to his appointment by the transportation driver and escorted into the building. Per the clinic's notes, the resident was seen from 2:17 p. m. to 2:32 p.m., at which time the resident was discharged from the clinic and subsequently walked away from the clinic. On 9/9/25 at 4:00 p.m., the outside transportation company returned to the clinic to transport Resident #1 back to the facility, but the driver could not find the resident. The transportation company contacted the facility and alerted them they were unable to locate the resident. Facility staff began searching the area for the resident.On 9/9/25 at approximately 6:40 p.m. (four hours after the last known sighting of the resident and 2.5 hours after the resident was identified as missing) the director of nursing (DON) found Resident #1 walking on a sidewalk approximately 3.4 miles away from the clinic where he had attended his appointment.II. Facility plan of correctionThe corrective action plan the facility implemented in response to Resident #1's elopement incident on 9/9/25 was provided by the nursing home administrator (NHA) on 11/3/25 at 1:11 p.m. The plan documented the following:A. Immediate action Resident #1 was returned to the facility by the DON on 9/9/25 at approximately 7:00 p.m. Resident #1 was assessed by the nursing staff and was not found to have any injuries. Nursing staff working with the resident that evening were educated by the NHA to closely monitor Resident #1 for his wandering behaviors.B. Identification of other residentsOn 9/9/25 an audit was initiated to identify all residents residing in the facility who were at risk for elopement. Identified residents' care plans were reviewed. Photographs of residents at risk for elopement were updated and their information was placed in the elopement binders at the reception desk. Audits were completed by 9/12/25.Residents with upcoming appointments were reviewed by the interdisciplinary team (IDT) and arrangements were made to have a staff member accompany each resident and ensure their appropriate assistive devices were sent with them to their appointments.C. Systemic changesOn 9/10/25 the elopement binder was updated and accurate based on residents' elopement assessments. On 9/9/25 education on the elopement policy, the elopement binder and the updated procedures for residents' appointments outside the facility was initiated for all staff and added to the orientation education. The education was completed by the DON and the NHA. Education for core staff responsible for patient care was completed on 9/12/25, and all facility staff were educated by 9/19/25.The process and procedures for residents' appointments outside the facility was updated by 9/12/25. The procedures were updated to ensure a staff member or designee accompanied all residents to their appointments, and established a chain of communication with the transportation coordinator, the NHA and the DON. Outside transportation companies were educated on the changes in the facility's processes for appointment transportation. The transportation drivers needed to check in with a facility nurse, who needed to ensure the transportation provider had the appropriate