STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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 observations, record review and interviews, the facility failed to ensure one (#7) of eight residents reviewed for abuse out of 13 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #7 from physical abuse by Resident #6. Findings include:I. Facility investigationThe facility investigation, dated 7/11/25, was provided by the DON on 10/14/25 at 12:44 p.m. The investigation revealed the following:On 7/11/25 Resident #6 was attempting to take food from a female resident (Resident #7). The female resident told Resident #6 to stop and Resident #6 hit the female resident. This incident occurred on the secured unit. The residents were separated and Resident #6 was given a new plate of food. Staff sat with Resident #6 until he was done with his meal and calmed down. Resident #7 was assessed and did not have any noted injuries. Neither resident was able to recall the incident.Interviews with facility staff members revealed Resident #6 approached Resident #7 and grabbed some of her food. Resident #7 yelled at Resident #6, and he hit her.A root cause analysis of the incident revealed Resident #6 attempted to take Resident #7's food, Resident #7 told him not to, and Resident #6 hit her as a result. Resident #6 did not have his meal yet and was hungry. The root causes of the incident were determined to be Resident #6's hunger, and Resident #6's dementia not allowing for the cognition that Resident #7's food was not his own.The investigation documented Resident #7 did not have a history of behaviors and did not have a behavior care plan. The investigation indicated Resident #7 had not been involved in any other occurrences.The investigation documented Resident #6 had a history of behaviors, including becoming aggressive, pushing furniture around the dining room and being resistant to care. The resident's care plan included interventions which documented the resident could become physically aggressive and was not easily redirectable.The investigation concluded the incident of physical abuse was found to have happened as it was witnessed. Facility actions included updating Resident #6's plan of care, including adding an intervention which specified when Resident #6 was taken to his seat in the dining room, the staff would immediately provide him with his meal. II. Resident #6 (assailant)A. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, restlessness and agitation, unspecified symptoms and signs involving cognitive functions and awareness, wandering, and anxiety disorder.The 7/21/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired and was unable to complete a brief interview for mental status (BIMS) assessment. The resident was dependent on staff assistance for most activities of daily living (ADL), and required setup or cleanup assistance from staff for eating.The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others during the assessment look-back period.B. ObservationsOn 10/13/25 at 11:37 a.m. Resident #6 approached an unidentified female resident. Resident #6 held her hand, and the residents smiled at each (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	Resident #6's June 2025 treatment administration record (TAR) from 6/1/25 through 6/30/25 revealed an order for behavior monitoring for aggressive behaviors, including hitting and kicking. The TAR documented Resident #6 had episodes of aggressive behavior on 6/9/25, 6/16/25, and 6/17/25.III. Resident #7 (victim)A. Resident statusResident #7, age greater than 85, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included dementia and cognitive communication defects.The 9/24/25 MDS assessment revealed the resident was severely cognitively impaired and could not complete the BIMS assessment. The resident required staff supervision or touching assistance for most ADLs.The MDS assessment documented the resident did not have physical or verbal behaviors directedat others or other behavioral symptoms not directed toward others.B. Record reviewThe cognition care plan, revised 7/15/24, revealed Resident #7 was at risk for impaired cognitive function or impaired thought processes due to cognitive deficits from her dementia diagnosis. Pertinent interventions included staff frequently checking on Resident #7 and anticipating her needs.A progress note, dated 7/11/25 at 2:24 p.m., revealed Resident #7 was sitting at the dining table eating her lunch when another resident (Resident #6) attempted to take her plate from her. Resident #7 refused to let the other resident take her food, and the other resident struck Resident #7 in the head. No injuries were noted on Resident #7's skin assessment. When asked what happened, Resident #7 could not recall the event. Resident #7 denied any pain or injuries. Resident #7's representative, physician and the DON were notified.C. Resident's representative interviewResident #7's representative was interviewed on 10/13/25 at 11:10 a.m. The resident's representative said Resident #7 had not had any issues with any other residents that she was aware of. The representative said Resident #7 did not like when people came up to her and tried to take her items from her, and would yell at people when that occurred.IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 10/14/25 at 9:28 a.m. LPN #1 said Resident #6 wandered the secured unit, so the staff had to keep an eye on him to keep him from going outside. LPN #1 said Resident #6 tried to take food and drinks away from other residents, but the staff were able to redirect him. LPN #1 said Resident #6 was not aggressive, and did not try to hit or kick. LPN #1 said all of the residents in the secured unit had issues with other residents, so the staff just had to redirect the residents whenever issues came up and offer them food, drinks and toileting.Activities assistant (AA) #1 was interviewed on 10/14/25 at 10:00 a.m. AA #1 said Resident #6 wandered and tried to take food and items from other residents, but was able to be directed. AA #1 said the facility staff served Resident #6 first during meals to keep him occupied. AA #1 said the staff sometimes gave Resident #6 an empty bowl before meals just so the resident would be distracted. AA #1 said Resident #6 did not have any aggressive behaviors and never hit or kicked. Certified nurse aide (CNA) #4 was interviewed on 10/14/25 at 11:45 a.m. CNA #4 said Resident #6 tended to wander around the unit and liked to grab food and plates in the dining room. CNA #4 said the nursing staff usually tried to assist him to the dining room and serve him his meal last, so the other residents would have more of a chance to eat before Resident #6 began wandering around and grabbing items. CNA #4 said Resident #6 did not have any aggressive behaviors and was only aggressive if he was provoked. CNA #4 said Resident #6 became mean if he grabbed something from another resident and they did not let the item go or tried to argue back to him. CNA #4 said Resident #6 was easily redirectable with food. CNA #4 said she and the other CNAs knew where everyone needed to be seated in the dining room in order to prevent conflicts, as she knew of another resident who was very protective over his food and would threaten to hit people with his cane.The MDS coordinator (MDSC) was interviewed on 10/14/25 at 2:03 p.m. The MDSC said Resident #6's behaviors fluctuated. The MDSC said Resident #6 would occasionally escalate to hitting or pushing, but was generally calm. The MDSC said Resident #6 occasionally (continued on next page)

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