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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065100 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Rock Canyon Respiratory and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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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 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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| <p>F 0600</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 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 investigation The 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 status Resident #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. Observations On 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 other. Resident #6 then reached with his other hand and tried to take a cup the female resident was holding. The female resident pulled away from Resident #6 and told him no and that the cup was hers. Two staff members were standing within a few feet of the residents as this occurred. When the female resident told Resident #6 the cup was hers, a nursing staff member then began redirecting Resident #6 away from the female resident. The staff member assisted Resident #6 into a seat in a separate part of the dining area. At 11:42 a.m. another unidentified resident was assisted by a staff member into the a separate part of the dining area and seated at a table away from Resident #6. The staff member then left the dining area to continue assisting other residents. At 12:04 p.m. Resident #6 stood up from his seat and began pacing in the lower dining area. A staff member entered the lower dining area and redirected Resident #6 back to his seat. Resident #6 began slapping the table and stopped after a few beats. At 12:08 p.m. Resident #6 began slapping his hands on the table again. A nursing staff member delivered Resident #6's meal tray to him and another staff member began to assist the resident with eating. Both staff members left the lower dining area to help continue passing trays shortly thereafter. At 12:42 p.m. Resident #6 finished his meal and was assisted from the dining area into the common area by a nursing staff member. Resident #6 tried several times to take food from trays left unattended from the lunch meal service and was repeatedly redirected by the staff member. C. Resident representative interview Resident #6's representative was interviewed on 10/13/25 at 11:07 a.m. The resident's representative said he knew of an incident in which Resident #6 tried to take food off of someone's plate and the other resident hit him, and said the incident was</p> | | |