

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2025
NAME OF PROVIDER OR SUPPLIER  Sundance Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2612 W Cucharas St Colorado Springs, CO 80904	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accidents received adequate supervision out of 14 sample residents. Specifically, the facility failed to ensure Resident #1 was not able to access hazardous chemicals. Resident #1, who was admitted to the facility on [DATE], had a history of dementia and of wandering within the facility. On [DATE] at 1:40 p.m., Resident #1 was able to obtain a bottle of a cleaning chemical that was located in a residential hallway on a maintenance cart that was unsecured and unsupervised. Resident #1 was found by certified nurse aide (CNA) #1 holding the bottle containing a cleaning chemical. Resident #1 was observed to have a blue substance on his lips, which was determined by the facility to be consistent with the contents of the bottle. Resident #1 was reported to have mouth and stomach pain after the incident. He was evaluated by a physician at the facility immediately following the incident and transferred to the hospital where additional evaluation was completed to determine if the resident had an esophageal (tube that runs from the throat to the stomach) injury, airway (breathing) compromise or electrolyte abnormality. Resident #1 was provided intravenous (IV) fluids and the hospital physician determined the resident likely had not ingested the toxic substance. Resident #1 was monitored at the hospital and returned to the nursing facility on [DATE]. The facility determined the product in the bottle was a cleaning product (Gel Pro). The material safety data sheet (MSDS - a document that describes the hazards of a chemical product and provides information on safe handling, storage, disposal and emergency procedures) revealed the product was reserved for industrial and professional use and if swallowed, required immediate medical attention. Ingestion of the product could cause digestive tract burns. Resident #1 experienced pain and required hospital evaluation to confirm he had not ingested a sufficient amount of the chemical to cause further injury. The facility's failure to ensure residents were not able to access hazardous chemicals placed Resident #1 and other residents at serious risk of harm, serious impairment or death if the situation were not corrected immediately. Findings include: Observations, record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE] to [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. I. Situation of serious [NAME] [DATE] at 1:40 p.m., Resident #1 was able to obtain a bottle of a cleaning chemical that was located in a residential hallway on a maintenance cart that was unsecured and unsupervised. Resident #1 was found by CNA #1 holding the bottle containing a cleaning chemical. Resident #1 was observed to have a blue substance on his lips, which was determined by the facility to be consistent with the contents of the bottle. Resident #1 was reported to have mouth and stomach pain after the incident. He was evaluated by a physician at the facility immediately following the incident and transferred to the hospital where additional evaluation was completed to determine if the resident had an esophageal injury, airway compromise or electrolyte abnormality. Resident #1 was provided IV fluids and the hospital physician determined the resident likely had not ingested the toxic substance. Resident #1 was monitored at the hospital and returned to the nursing facility on [DATE]. II. Facility investigation and plan of correction The investigation and performance improvement plan (PIP) the facility implemented in response to the accident on [DATE] involving Resident #1 was provided by the nursing home administrator (NHA) on [DATE] at 1:07 p.m. The plan read as follows: A. Problem statement On [DATE], a cognitively impaired resident (Resident #1) was found ingesting drain cleaner that had been left unattended and unsecured on a maintenance cart. CNA #1 intervened and removed the chemical. The chemical had been left unsecured by the maintenance supervisor during routine work. B. Goal The facility's goal was to eliminate unsafe chemical exposure risks within the facility by implementing a facility wide safety initiative with compliance monitoring and retraining all staff on accident prevention and emergency response protocols. C. Root Cause Analysis A root cause analysis (a problem solving method used to identify the underlying reasons why a problem occurred) was completed and revealed the following: -An unsecured hazardous chemical was left unattended in a resident accessible area; -Staff were unfamiliar with chemical handling/storage policies; -There was a lack of supervision or enforcement of the facility's environmental safety procedures; -The cognitive impairment of the resident was not adequately considered in environmental planning; and, -There was not a current interdisciplinary team (IDT) environmental hazard audit process. D. Immediate Actions Taken CNA #1 immediately removed the chemical and reported the incident to the nurse. The nursing staff contacted a poison control center and reviewed the MSDS. The primary care physician (PCP) assessed the resident and</p>		