STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065163	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eben Ezer Lutheran Care Center	122 Hospital Rd Brush, CO 80723

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 - Some	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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on and observations, record review and interviews, the facility failed to ensure six (#1, #2, #3, #4, #5 and #6) of seven residents out of seven sample residents were kept free from abuse.Specifically, the facility failed to:-Ensure Resident #2, Resident #3 and Resident #5 were kept free from physical abuse from Resident #1; -Ensure Resident #1 and Resident #4 were kept free from abuse towards each other; and,-Ensure Resident #6 was kept free from physical abuse by Resident #7.Findings include:I. Facility policy and procedureThe Abuse policy and procedure, revised 9/13/23, was provided by the nursing home administrator (NHA) on 12/3/25 at 5:58 p.m. It revealed in pertinent part, Each resident will be free from abuse. Abuse can include verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion. It is the policy of this community that all team members monitor residents and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse will be investigated. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes hitting, slapping, pinching and kicking.II. Incidents of physical abuse involving Resident #1A. Incident of physical abuse on 9/22/25 between Resident #1 and Resident #2The facility abuse investigation was provided by the NHA on 12/3/25 at 4:09 p.m. The abuse investigation documented Resident #2 said something to Resident #1 while leaving the dining room. Resident #1 then responded by hitting Resident #2. Resident #2 raised his hand to respond, when Resident #1's daughter yelled, hey at Resident #2, to get him to stop. Staff intervened and Resident #1 and her daughter continued to walk down the hallway. Both residents were separated and assessed with no injuries observed. The incident was witnessed by facility staff and Resident #1's daughter. Resident #2 and Resident #1 were interviewed and unable to recall the incident. The investigation conclusion indicated physical abuse was not substantiated because no injuries were sustained and the assailant had severe cognitive impairment and was unable to understand that her actions could result in a violation of a criminal statute. -However, abuse occurred because Resident #1 willfully struck Resident #2 after he made a comment to her. B. Incident of physical abuse on 10/2/25 between Resident #1 and Resident #2The facility abuse investigation was provided by the NHA on 12/3/25 at 4:09 p.m. The abuse investigation documented the nursing staff witnessed Resident #1 yelling at Resident #2 to give her money back. Resident #1 then hit Resident #2 on the left arm and the head. Both residents were separated and Resident #2 grabbed his walker and walked away. Resident #1 had a history of delusions and believing others were taking her money. Resident #2 was assessed with no injury observed. Resident #2 said he did not get along with Resident #1 but could not recall the incident. The resident was interviewed two days after the incident occurred. The investigation conclusion indicated physical abuse was not substantiated because no injuries were sustained, the assailant had severe cognitive impairment and did not understand her action could result in a violation of a criminal statute. -However, abuse occurred because Resident #1 willfully struck Resident #2 because she thought he stole her money. C. Incident of physical abuse on 10/3/25 between Resident #1 and Resident #3The facility abuse investigation was provided by the NHA on 12/3/25 at 4:09 p.m.The abuse investigation documented Resident #1 did not enjoy the meal which was served at lunch. Resident #1 got up from the table, walked over to Resident #3, picked up Resident #3's arm and hit her on the wrist. The investigation conclusion indicated physical abuse was not substantiated because no injuries were sustained, the assailant had severe cognitive impairment and did not understand her action could result in a violation of a criminal statute. -However, abuse occurred because Resident #1 willfully got up from her chair, walked over to Resident #3, picked up her arm and struck Resident #3 on the wrist. D. Incident of physical abuse on 10/31/25 between Resident #1 and Resident #4 The facility abuse investigation was provided by the NHA on 12/3/25 at 4:09 p. m. The abuse investigation documented Resident #1 entered Resident #4's room to use the bathroom by mistake. Resident #4 grabbed Resident #1's hands and twisted them, telling her that was not her room. Resident #1 pulled her arms away and struck Resident #4. The residents were separated and assessed with no injuries observed. Resident #4 was interviewed and said she did not recall the incident, however said people kept coming into her room. She said she felt they were trying to take her belongings. The investigation conclusion indicated physical abuse was not substantiated because no injuries were sustained, the assailant had severe cognitive impairment and did not understand her action could result in a violation of a criminal statute -However, abuse occurred because Resident #4 willfully grabbed Resident #1's wrist and