STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065168	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Heights Rehabilitation and Nursing LLC	1795 Monterey Rd 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 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 record review and interviews, the facility failed to ensure one (#1) of four residents were kept free from abuse out of six sample residents. Specifically, the facility failed to ensure Resident #1 was kept free from physical abuse by Resident #2 Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, dated 4/11/25, was provided by the nursing home administrator (NHA) on 11/5/25 at 11:22 a.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.II. Incident of physical abuse towards Resident #1 by Resident #2 on 9/9/25.A. Facility investigationThe 9/9/25 facility investigation was provided by the NHA on 11/4/25 at 12:19 p.m.The investigation, documented at 4:45 p.m., revealed Resident #2 had accused his roommate, Resident #1, of stealing from him and would not allow Resident #1 to enter the room. Resident #2 had blocked the door with his body, called Resident #1 a thief and pushed him. The investigation documented both residents had cognitive impairments. Resident #1 was interviewed by the assistant director of nursing (ADON) and said he did not feel safe when asked if he was safe here. He said Resident #2 had treated him in an upsetting manner. He said Resident #2 had punched and kicked during this interaction and he tried to kick him out of the room the day before. Resident #2 was interviewed by the ADON. Resident #2 said Resident #1 started the fight and they were mad at each other. He said they both had hands on each other. The investigation documented the incident was substantiated. The investigation documented Resident #2 was then moved to a private room, placed on alert charting for the next 72 hours. He was also placed on 15-minute checks. B. Resident #1 (victim)1. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the November 2025 computerized physician order (CPO) diagnoses included vascular dementia.The 6/17/25 minimum data set (MDS) assessment revealed the resident had moderately impaired cognitive status with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #1 required a walker and supervision to touching assistance for activities of daily living (ADL).The MDS assessment documented the resident did not have verbal or physical behaviors directed at others. C. Resident #2 (assailant)1. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included unspecified dementia with agitation, restlessness and agitation, altered mental status and communication deficits. The 9/17/25 MDS assessment revealed the resident had severely impaired cognitive status with a BIMS score of five out of 15. He was independent with activities of daily living (ADL).The MDS assessment revealed the resident did not have any behaviors or wandering tendencies. 2. Record reviewThe mood/behavior care plan, initiated 1/22/25 and revised 11/3/25, documented Resident #2 would become physically (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	aggressive when agitated by other residents, he was at risk for increased confusion and frustration with the diagnosis and placement. He had a history of telling other residents to get out of his way and he did not want them there. He verbalized not being happy in the facility and would wander into other resident's rooms. Interventions included redirecting the resident when he became agitated, placing the resident on one-to-one for safety, offering food and drink when he became agitated and 15-minute checks for elopement risk and behaviors.The cognitive care plan, initiated 12/27/24 and revised 3/31/25, documented Resident #2 was at risk of increased confusion and frustration with his diagnosis and placement. Interventions included, offering food or drink, change of environment when he became frustrated and to redirect when he became agitated. The elopement care plan, initiated 1/24/25 and revised 11/3/25, documented Resident #2 was an elopement risk/wanderer related to being disoriented to place, history of attempting to leave the facility unattended with impaired safety awareness. Resident #2 was on 15-minute checks for elopement risk and behaviors. Pertinent interventions included identifying patterns of wandering and completing an elopement/wander risk assessment quarterly and as needed. Review of the electronic medical record (EMR) revealed the resident had been admitted to the secured unit.The progress note, dated 8/13/25, documented Resident #2 became agitated and aggressive towards another resident. He was put on one-to-one observation for behaviors. The 9/9/25 Room Change Notification form indicated Resident #2 was moved to a private room for the health and safety of him and other residents. III. Staff interviewsCertified nurse aide (CNA) #2 was interviewed 11/4/25 at 1:18 p.m. CNA #2 said she got information regarding the residents when she did a walk through of the unit with the staff going off shift. She said she was not aware of where to look for specific information regarding triggers for resident behaviors. She said she asked the nurse if she had questions. CNA #1 was interviewed 11/4/25 at 1:27 p.m. CNA #1 said she worked on Resident #2's unit. He said he was usually worked another hall and was not aware of any specific behavior triggers which would cause Resident #2 to act aggressively. He said the 15-minute checks were to monitor the resident's location because he wandered. CNA #1 said he was not aware of the incident on 9/9/25. The director of nursing (DON) was interviewed 11/5/25 at 10:11 a.m. The DON said when Resident #2 was moved off the secured unit he was placed with a roommate. The DON said the roommate had verbalized concerns with Resident #2, so the interdisciplinary team (IDT) decided to move Resident #2 to another room, with Resident #1, before there were any incidents. The DON said staff could look at the Kardex (staff directive tool) for information about triggers, behaviors and interventions. The DON said that care plans should include resident specific triggers and interventions for mood and behavior. The DON said knowing this information assisted staff on what to look for especially if they were new to the resident. She said if a resident had a change in behavior this is discussed in the morning IDT meeting and the care plans were updated with the new behavior and interventions. The DON said the staff were notified verbally of changes and this information was expected to get passed on from shift to shift. CNA #3 was interviewed 11/5/25 at 11:09 a.m. CNA #3 said she checked on Resident #2 because he punched someone and to monitor his location because he wandered up and down the halls. She said she did not know what triggers Resident #2 to become upset with other residents. She said Resident #2 liked to walk the hallways and sometimes needed redirection to his room because he would get lost.