| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065168 | A. Building<br>B. Wing | 02/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Falcon Heights Rehabilitation and Nursing LLC | 1795 Monterey Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were kept free from physical abuse for two (#11 and #7) of eight residents reviewed for abuse out of 11 sample residents.Specifically, the facility failed to: -Protect Resident #7 from physical abuse by Resident #9; and,-Protect Resident #11 from physical abuse by Resident #10.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 2/25/26 at 2:41 p.m. It read in pertinent part, It is the policy of this facility to protect the health of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. The facility will develop and implement written policies and procedures that:-Prohibit and prevent abuse of residents;-Establish policies and procedures to investigate abuse allegations; and,-Include training for staff on activities that constitute abuse and abuse prevention. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide necessary care and services for each resident admitted to the facility:-An assessment of the individual's functional and mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission; and,-The facility will make individual determinations in consideration of current staffing patterns, staff qualifications, competency and knowledge, and clinical resources, and physical environment. The facility will implement policies and procedures to prevent and prohibit all types of abuse by: -Identifying, correcting, and intervening in situations in which abuse is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and ensuring that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms;-The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;-Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and-Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.II. Incident of physical abuse of Resident #7 by Resident #9 on 2/7/26A. Facility investigationThe 2/7/26 facility investigation revealed that an altercation occurred between Resident #7 and Resident #9 in the dining room. The investigation revealed the altercation was witnessed and reported by another resident. The investigation documented that the witness told staff that she witnessed Resident #9 hit Resident #7 on the chest and on the shoulder. The investigation revealed staff immediately separated Resident #7 and Resident #9 and placed Resicent #9 on a one-on-one for constant supervision for the safety of all residents.The investigation revealed Resident #7 had expressive aphasia, which severely limited her ability to speak and prevented her from verbally reporting the incident to staff. The investigation revealed Resident #7 had a behavior of agitating other residents by pointing and muttering.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #9 had a history of behavioral outbursts during psychotic episodes. The investigation revealed Resident #9 told staff she did not recall the altercation with Resident #7.The investigation substantiated the incident of physical abuse. B. Resident #7 (victim) 1. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included schizoaffective disorder (a mental health condition) and depression.The 2/4/25 minimum data set (MDS) assessment revealed Resident #7 had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. Resident #7 required supervision or touching assistance from staff for bed mobility, transfers, dressing, and walking.The assessment revealed Resident #7 had verbal behavioral symptoms toward others for one to three days during the assessment look-back period.2. Record review The mood and behavior care plan, initiated 11/27/24, revealed Resident #7 had been an aggressor and recipient of physical aggression. Pertinent interventions included administering medications as ordered (initiated 3/1/25), separating the resident from Resident #9 (initiated 2/9/26), and monitoring Resident #7 closely while in the dining room during meal times and activities (initiated 2/13/26).The 2/7/26 nurse progress note revealed the nurse heard a resident say Resident #7 had been hit several times in the chest and on the shoulder by Resident #9. The progress note revealed that Resident #7 was unable to verbalize what occurred. The nurse documented that she completed an assessment of Resident #7 and no injuries were present. The 2/9/26 interdisciplinary team (IDT) progress note revealed that the cause of the altercation between Resident #7 and Resident #9 was that Resident #7 was impulsive, that she had finished her activity in the dining room and was waiting for her dinner. The IDT progress note revealed the IDT recommended that a nurse be close to the dining room during meal times and activities. C. Resident #9 (assailant) 1. Resident statusResident #9, age less than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included stroke, left-sided paralysis, bipolar disorder (a mental health condition), depression, and anxiety. The 2/3/26 MDS assessment revealed Resident #9 had moderate cognitive impairment with a BIMS score of 10 out of 15. Resident #9 was independent with bed mobility, required supervision or touching assistance from staff for transfers, was non-ambulatory and used a manual wheelchair independently after being set up by staff. The assessment indicated Resident #9 had no physical or verbal behaviors directed at others during the assessment look-back period. 2. Record reviewThe mood and behavioral care plan, initiated 11/5/25, identified that Resident #9 had a history of taking items from staff, swinging at staff, and throwing objects at other residents.Pertinent interventions included administering medications as ordered (initiated 11/5/25), monitoring behavioral events (initiated 11/5/25), and providing care one-on-one to monitor for physical aggression toward other residents (initiated 2/12/26). The 2/7/26 nurse progress note revealed that Resident #9 was involved in an altercation with another resident (Resident #7) in the dining room. The nurse's progress note revealed she completed an assessment on Resident #9 and found no injuries. The nurse's progress note documented Resident #9 told her Resident #7 had scratched her and she did not know why. The progress note revealed Resident #9 was placed on a one-on-one with staff for monitoring and the safety of other residents. The 2/9/26 IDT progress note revealed that the cause of the altercation between Resident #7 and Resident #9 was Resident #9 was impulsive, had a history of aggression towards others, was bipolar, and had a borderline personality disorder with a recent change to medications. The IDT initiated a new safety intervention to place Resident #9 on one-on-one supervision, and recommended a referral to behavioral health services and a physician review of her prescribed medications.III. Incident of physical abuse of Resident #11 by Resident #10 on 2/14/26A. Facility investigationThe 2/14/26 facility investigation revealed that a physical altercation occurred between Resident #10 and<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #11 while they were on a supervised smoking break. The investigation documented Resident #10 was agitated and objected to Resident #11 placing his legs in proximity to him. The investigation documented Resident #10 stood up from his wheelchair and attempted to swing at Resident #11 and Resident #11 placed his foot against Resident #11's chest to create distance from Resident #10. The investigation documented Resident #10 responded by pulling himself closer, grabbing Resident #11 by the shirt and punching Resident #11 in the face near his right eye. The investigation documented the staff member supervising the smoke break intervened and separated the two residents immediately. The investigation documented Resident #10 and Resident #11 were assisted to their rooms and assessed by the nurse. The investigation revealed the facility implemented a new safety protocol and required two staff members to supervise the smoking area when five or more resident smokers were present. Staff were educated to ensure Resident #10 and Resident #11 were kept separate from each other in the facility and while on smoking breaks. Additionally, staff were educated to intervene if there was an escalation of behaviors between Resident #10 and Resident #11.The facility investigation revealed Resident #11 had a history of physical and verbal aggression towards others, was known to be impulsive and had a tendency to engage in confrontations with residents and staff. Resident #10 had a history of physical aggression towards other residents and being combative with staff. Resident #10 was monitored by staff for impulsive behaviors.The investigation revealed after the altercation on 2/14/26, Resident #10 was placed on one-on-one supervision for close supervision to prevent physical aggression toward other residents. The investigation documented Resident #11 told staff that Resident #10 hit him and pointed to his right eye. The investigation documented Resident #10 told staff he did what he needed to do when Resident #11's legs were touching him. The investigation substantiated the incident of physical abuse. B. Resident #11 (victim)1. Resident statusResident #11, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included a history of traumatic brain injury, depression, anxiety, Parkinson's disease, dementia and schizophrenia (a mental health condition). The 12/18/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of six out of 15. Resident #11 required supervision or touching assistance for bed mobility, transfers, toileting, and walking. Resident #11 used a manual wheelchair and required set-up assistance from staff. The assessment documented Resident #11 had verbal behaviors directed at others for one to three days during the assessment look-back period.2. Record reviewThe verbal aggression care plan, initiated 11/16/17, revealed Resident #11 was verbally aggressive at times due to dementia, depression and anxiety. The care plan identified triggers for verbal aggression, which were from others staring at him and having to wait for his cigarettes on smoking breaks.The cognitive communication care plan, initiated 8/7/2020, revealed Resident #11 had difficulty understanding others due to his history of traumatic brain injury, dementia and schizophrenia. Pertinent interventions included monitoring Resident #11 for his position in groups to promote communication with others and providing adequate time for the resident to respond to others.The 2/14/26 nurse progress note revealed Resident #11 was the recipient of physical aggression by Resident #10 in the smoking area. The nurse completed an assessment and found a 0.5 centimeter (cm) by 0.5 cm red area on the right side of his face and redness on the right cheek and right jaw. The progress note revealed Resident #11 denied pain from the altercation. The progress note revealed Resident #11 did not know what happened and reported to the nurse that Resident #10 just kept hitting him. The 2/15/26 IDT progress note revealed the cause of the altercation between Resident #11 and Resident #10 was due to a misunderstanding of personal space. The IDT initiated new interventions to require a second staff member to supervise smoking breaks if the smoking group exceeded five residents. C. Resident #10 (assailant)1. Resident<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | statusResident #10, age greater than 65, was admitted on [DATE] and transferred to another facility on 2/23/26. According to the February 2026 CPO, diagnoses included mood disorder, depression, anxiety and personality disorder.The 12/2/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The assessment revealed Resident #10 required set-up assistance from staff for bed mobility and standing, and supervision from staff for bed mobility and transfers. Resident #10 was independent with using a manual wheelchair. The assessment documented Resident #10 had no physical or verbal behaviors towards others during the assessment look-back period. 2. Record reviewThe anxiety care plan, initiated 4/21/15, revealed Resident #10 had anxiety with verbal aggression towards others. Pertinent interventions included reviewing quarterly for possible dose reduction of medications (initiated 1/3/16) and offering diversion activities when aggressive behaviors were present (initiated 9/28/17).The physical aggression care plan, initiated 2/10/25, revealed Resident #10 had a history of physical aggression towards other residents. Pertinent interventions included administering medications as ordered, anticipating and meeting resident needs, assisting with coping and interacting skills, providing opportunities for positive interactions with staff and residents, explaining all procedures, and discussing unacceptable behavior, monitoring behavior episodes, intervening to protect other residents (initiated 2/10/25) and monitoring one-to-one for physical aggression (initiated 2/16/26).The 2/14/26 at 1:30 p.m. nurse progress note revealed Resident #10 had been in an altercation with Resident #11 outside in the smoking area. A staff member supervising the smoking break observed Resident #10 grab Resident #11 by the shirt and punch him multiple times. The nurses documented Resident #10 told her Resident #11 had swung his leg towards his chest. The progress note revealed the nurse completed an assessment and documented Resident #10 had no injuries from the altercation.The 2/16/26 IDT progress note revealed the cause of the altercation between Resident #11 and Resident #10 was due to a misunderstanding of personal space in close physical proximity to each other. The IDT initiated new interventions and placed Resident #10 on one-to-one monitoring when outside of his room.IV. Staff interviewsThe NHA, the operations director and the director of nursing (DON) were interviewed together on 2/25/26 at 4:45 p.m. The NHA said the altercation between Resident #7 and Resident #9 occurred in the dining room while residents were waiting for their dinner. The operations director said a staff member reported she observed Resident #9 punch Resident #7 on the chest and shoulder. The operations director said after the altercation, staff responded immediately by separating the residents. The operations director said the nurse assessed both residents and neither resident had injuries. The NHA said Resident #9 was placed on one-on-one supervision for prevention of additional altercations. The NHA said resident #9 would remain on one-on-one supervision until the IDT reviewed behaviors and determined that less monitoring was appropriate. The DON said there were no additional altercations between Resident #7 and Resident #9. The DON said Resident #9 had occasional verbal aggression with staff during care that resolved when staff redirected or re-approached Resident #9. The NHA said the altercation between Resident #10 and Resident #11 occurred outside in the smoking area. The operations director said the altercation was observed by a staff member supervising the smoking break and said the altercation occurred quickly, and the staff member was unable to intervene in time to prevent Resident #10 from hitting Resident #11. The operations director said after the altercation, Resident #10 and Resident #11 were separated, assessed by the nurse and had no injuries. The operations director said Resident #10 was placed on one-to-one supervision for resident safety. The operations director said that in response to the altercation, the facility initiated a policy change to require two staff members to monitor smoking breaks when the smoking group exceeded five residents. The NHA said Resident #10 agreed to a referral to another long-term<br><br>(continued on next page) |

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