STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065169	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Heights Nursing and Rehabilitation	1601 Constitution Rd Pueblo, CO 81001

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being for one (#1) of three residents reviewed for psychosocial well-being out of seven sample residents.Resident #1 was admitted to the facility on [DATE] with a history of attempted suicide by two self-inflicted gun shots to her head in 2025.When the resident admitted to the facility on [DATE], the hospital discharge orders included a physician's order for suicide precautions at the facility. However, record review revealed the facility failed to implement suicide precautions for Resident #1 and failed to implement a suicidal ideation care plan upon her admission. On 3/4/26 the staff observed Resident #1 throwing things in her room and she told the nurse she wanted to cut herself and die. The nurse practitioner (NP) evaluated Resident #1 and made a recommendation for Resident #1 to be placed on one-to-one supervision for safety and remove any potential threats from Resident #1's room. However, the facility failed to follow the NP's recommendation for one-to-one supervision and remove any potential threats from Resident #1's room (see observations below). On 3/4/26 the facility made a referral to the behavioral health crisis team to have Resident #1 evaluated at the facility.The behavioral health service crisis team evaluated the resident on 3/5/26 and made a safety plan with the resident that included coping skills. However, during the survey, staff were interviewed and were not aware of the safety plan and what interventions should be in place to keep Resident #1 safe from self-harm.On 3/6/26 Resident #1 was found by staff in the morning attempting to wrap cords from her room around her neck. In the evening of the same day, she was observed by the nurse wrapping the telephone and call light system cords around her neck and trying to stab herself in the leg with a pen. However, the facility again failed to implement any person-centered safety measures related to the resident's suicidal attempts.On 3/12/26 Resident #1 continued to make statements of wanting to hurt herself. The resident said she was digging through her nose, with her finger, to scratch her brain to end her life. Resident #1 was evaluated in the facility by a psychologist that day. The psychologist recommended restricting the resident's access to all cords, utensils and sharps. However, observations during the survey revealed Resident #1 continued to have access to pens and cords and the staff were not aware of the recommended safety intervention. The facility failed to update the resident's care plan to include the psychologist's recommendations. Due to Resident #1's ongoing safety concerns and suicide attempt history, the NP evaluated the resident and placed an order for one-to-one supervision again on 3/25/26.However, the NP's order for one-on-one supervision was not initiated. On 3/28/26 Resident #1 was observed by staff to have cutlery and broken glassware from the kitchen in her room and she was throwing plates and cutlery and ripped up personal belongings. On 4/8/26, during the survey, several easily accessible electronic cords were observed in Resident #1's room. Resident #1 was observed unattended sitting in her wheelchair at the nurses' desk. A nearby medication cart had risk items (pens) on the top of the carts and within Resident #1's reach. Specifically, the facility failed to:-Implement physician's orders for safety interventions due to suicide attempts and suicidal (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ideations for Resident #1; and,-Educate staff on Resident #1's safety interventions. Findings include:I. Findings of Immediate Jeopardy Resident #1 was admitted with a history of two self-inflicted gunshot wounds to her head. Upon admission, the facility failed to assess the resident's risk of suicide. Throughout the resident's admission, she made several statements of wanting to hurt and kill herself. Additionally, the resident was found stabbing herself, scraping her skin off and attempting to wrap a cord around her neck. The NP recommended placing the resident on one-to-one supervision on 3/4/26 and again on 3/25/26, however the facility failed to implement the intervention. The facility failed to develop a person-centered care plan with safety interventions for Resident #1 and educate the staff on the interventions. A. Situation of immediate jeopardyThe facility failed to provide the appropriate level of support and supervision for Resident #1, who had a history of self-harm and had voiced an active threat to harm herself.B. Imposition of immediate jeopardyOn 4/9/26 at 4:50 p.m. the nursing home administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failure to ensure Resident #1 was kept safe after making suicidal ideations.C. Facility plan to remove immediate jeopardyOn 4/10/26 at 8:26 a.m., the NHA provided a plan to remove the immediate jeopardy situation. The plan read: 1. Immediate action On 4/8/26, Resident #1 was placed on 30-minute safety checks by a caregiver until she was discharged to a local acute care center for acute psychiatric care. The staff members that were assigned to complete Resident #1's safety checks were educated by the staff development coordinator on 4/9/26 regarding the resident's risks and recent attempts at suicide utilizing sharp objects, cords and tubing. All cords were secured to the walls leaving nothing loose or free to be unsecured. Resident #1 would not return to the facility. Resident #1's physician and family member were informed of the discharge to the hospital for placement in a mental health facility for ongoing suicide attempts and current attempts to harm herself. The staff assigned to care for Resident #1 were educated by the SSD and the DON on identified resident's specific needs, and the care plan was updated. 2. Identification of others An audit was completed on 4/10/26 by the social services coordinator and the social services consultant to identify if any other resident had current or historical suicidal attempts or thoughts of harming self. From that audit, a total of eight other residents were identified. Of those eight residents, only one resident required the implementation of a safety plan. The residents identified were assessed by the social services director (SSD), the social services consultant, and the director of nursing (DON). Interventions were put into place to keep the identified residents safe. The interventions associated with the one resident's safety plan to ensure the resident's safety included having the resident meet weekly with our psychologist and quarterly with our psychiatrist unless the resident required more frequent visits. If the resident's condition worsened, the plan included for the staff to remain with the resident continuously, notifying the registered nurse (RN)/provider immediately, increasing the resident's observation to one-on-one supervision, removing all potential hazards and initiating emergency psychiatric intervention. 3. Systemic changesOn 4/10/26 the following was completed:The interdisciplinary team (IDT) was educated by the clinical resource team that when an admission referral was received and the admitting resident had current suicidal ideation, the facility must review the referral with the clinical resource team and the medical director to make sure that the facility could meet that resident's specific personal safety needs. The IDT was educated by the clinical resource team on implementing a safety care plan and then updating each care plan to reflect the changes in the residents' needs as applicable. The IDT and all nursing staff were educated by the DON and the SSD on how to review all new admission orders thoroughly, within 72 hours, to ensure all orders have been captured and implemented. The DON educated all nursing staff on following physician's orders, and if they have questions or concerns about any order, they must notify the provider and document the reasons for the concern. All staff were educated by the DON and the SSD on suicidal ideation monitoring and prevention. All staff were educated that if at any time they see or hear of any resident attempting or voicing suicidal or self-harming ideations, they must notify the NHA, the DON and/or the SSD immediately. The staff were educated by the DON and the SSD on (continued on next page)

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She said she was unhappy because she had to go outside to the same area where other residents went to smoke. Resident #1 said she had made previous attempts to end her life and said she thought about killing herself or asking the physician for assisted suicide. Resident #1 said her thoughts of ending her life were triggered by her need to rely on others for help with her activities of daily living (ADL). Resident #1 said she had asked staff for work to do in the facility and thought she would be helpful to check on residents that could not speak for themselves, but she said she had not heard anything back from staff.C. Record review1. Care planThe [NAME]-Brown Safety Plan (standardized safety tool), created on 1/4/26 and updated on 3/12/26 was provided by the corporate resource nurse on 4/8/26 at 3:25 p.m. The corporate resource nurse said the safety plan was created by the psychiatrist provider. The safety plan included the following pertinent safety steps: Step one warning signs: not feeling supported by your brother, feeling lonely and isolating yourself, an increase in depressed mood, an increase in crying, not feeling safe or happy where you are, and an increase in pain. Step two internal coping strategies: things I can do to take my mind off my problems without contacting another person: music, reading, spending time with a dog, listening to western music, riding an exercise bike in therapy. Step three people and social settings that provide distraction: providing a list of names and telephone numbers, places: being outdoors in the sun 10 to 15 minutes a day. Step four people whom I can ask for help during a crisis: listing of names and contact information. Step five professions or agencies I can contact during a crisis: listing of names and agencies and contact information. Step six making the environment safer (plan for lethal means safety): patient does not have access to guns; patient lives in a 24/7 nursing and rehabilitation facility since 2/27/26, patient likes the staff and facility, patient has some chronic suicide ideations, resident has no plan to kill herself, she gets lonely, is in pain, and would like more support from her family, brother reports family tries to visit patient daily. Staff at the facility report they will restrict access to all cords, utensils, and sharps. They administer medications and check on the patient and give support. They will have the patient see the facility psychiatrist. The patient was encouraged to do a care plan with staff and family at the nursing home.-However, the safety plan was not implemented into Resident #1's comprehensive care plan (see record review below) and staff were not aware of the safety care plan (see interviews below).The cognitive impairment baseline care plan, initiated 2/27/26, revealed Resident #1 was alert, cognitively impaired and forgetful related to a traumatic brain injury. However, there were no interventions identified for this care area.The psychotropic medication baseline care plan, initiated 2/27/26, identified Resident #1 was prescribed a psychotropic medication (Seroquel) and had no adverse effects. The care plan identified the facility nurse completed a medication reconciliation with the resident and/or representative upon admission. The safety risk baseline care plan, initiated 2/27/26, identified Resident #1 had a history of falls three weeks prior to admission. There were no interventions identified for this care area.-Review of Resident #1's baseline care plan, did not reveal any person-centered safety interventions related to the resident's history of suicide attempts or as ordered by the hospital physician upon discharge (see record review below).The comprehensive care plan, initiated 3/3/26, revealed Resident #1 reported she had traumatic incidents in her past. The care plan documented Resident #1 had always dealt with depression and anxiety and had attempted suicide by shooting herself in the head. The care plan documented Resident #1 exhibited increased (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	triggers around discussing suicidal ideations, depression and had increased triggers at night time. Pertinent interventions included avoiding sudden movements, loud voices, or rushed care, crisis services through health solutions, encouraging participation in individualized activities based on the resident's interests, such as art or painting, crafts, gardening, and science, staff was to introduce themselves each time and explain what they were doing for her before care, monitoring the resident's responses to ensure the animal interaction provided comfort and reduced anxiety (initiated 3/5/26), contacting health solutions crisis and providing active listening (initiated 3/23/26).On 4/8/26 at 2:11 p.m. the clinical resource nurse provided a revision to Resident #1's comprehensive care plan. The revisions identified Resident #1 had traumatic incidents in her past. The care plan documented the resident's triggers included major life changes, such as changes in the environment, feeling lonely and feeling unsupported by her brother. Updated interventions included encouraging Resident #1 to utilize internal coping skills, such as music of choice, reading, spending time with animals if available, riding the exercise bike in therapy and following up with the pain management clinic as needed, showering twice a week per preference and going outside daily as weather permitted.The major depressive disorder with psychotic features care plan, initiated 3/3/26, revealed Resident #1 had complex behaviorial and emotional symptoms that included withdrawl, yelling, cursing, depressive statements and chronic expressions of suicidal ideation. The care plan documented the resident had a history of self-harm. The care plan identified that Resident #1 experienced delusional thoughts and believing her children or grandchildren had been kidnapped. The care plan revealed the beliefs lead to intense panic, fear and emotional distress where Resident #1 may become increasingly agitated, verbally escalated and difficult to redirect. Pertinent interventions included offering consistent staff interaction daily at preferred times, providing brief, simple reassurance, coordinating with activities staff for structured but low-stimulation programs, scheduling regular family calls/visits when possible, providing small group activities to reduce overwhelmness, teaching simple grounding exercises, validating feeling without validating delusion (initiated 3/3/26), immediately reporting suicidal ideation statements or behavior changes to the nurse and the mental health provider, mainting a safe environment and removing harmful items if risk increased, conducting frequent emotional status checks and documenting mood and statements and redirecting Resident #1 to another activity or topic when agitation began. The care plan documented Resident #1 was receiving behavioral health services and loved the rodeo and talking about her grandchildren (initiated 3/6/26).2. Progress notes and assessmentsThe 2/27/26 hospital discharge summary revealed the physician's orders for discharge included suicidal precautions, continuing home Seroquel 150 milligrams (mg) nightly and sertraline (antidepressant) 100 mg daily. The resident was discharged to a skilled nursing facility.The 3/3/26 nurse progress note, documented at 6:20 a.m., revealed Resident #1 was frantic during the previous night. The progress note documented Resident #1 was yelling at staff and throwing things in her room. The nurse documented the physician was notified and staff would continue to monitor Resident #1. The 3/3/26 physician progress note, documented at 8:00 a.m., revealed the physician evaluated Resident #1 and documented Resident #1 had a history of a gunshot wound to her head that required a right-sided craniotomy. Resident #1 had left-sided paralysis. The physician documented Resident #1 had no acute distress, had recurrent major depressive disorder with behaviors and was stable with a good affect. The physician gave a new order for trazodone (antidepressant), increased the Seroquel to 150 mg extended release at bedtime and ordered hydroxyzine (antihistamine) every eight hours as needed for 14 days.The 3/4/26 nurse progress note documented at 7:22 a.m. (late entry) the NP was notified that Resident #1 made statements of wanting to cut herself and wanting to die. The note revealed the psychiatrist was notified for a psychiatrist evaluation. The note revealed a certified nurse aide (CNA) and the DON were alerted that Resident #1 needed one-on-one supervision for safety due to Resident #1's history of attempted suicide. -There was no documentation of the psychiatrist's response to the notification.The 3/4/26 nurse progress note, documented at 7:27 a.m., revealed Resident #1 was crying, throwing things in her room, spilling fluids and knocking over her table. The (continued on next page)

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	suicidal ideation and was referred for concerns of depression, tearfulness, anxiety, worry, confusion, delusions, high risk behavior, suicidal ideation and history of suicide attempt. The assessment revealed Resident #1 reported two previous suicide attempts by gunshot to the head and the last attempt at suicide was last summer (2025). The resident had daily thoughts of wishing to be dead. The assessment revealed Resident #1 told the psychologist she had daily suicidal ideations but denied having a plan. Resident #1 told the psychologist if she were to kill herself, it would be by gunshot, hanging herself or stabbing an object into her head. The psychologist recommended to the facility to schedule visits with the resident's grandchildren, keeping her room close to the nurses' station for monitoring, encouraging family to visit, engaging her in activities with others, capitalizing on her strengths in teaching, reaching out to emergency services if intent or plan was vocalized and and utilizing redirection, calming techniques and distraction when agitated. The assessment revealed Resident #1 was included in formulating a treatment plan that included adressing anxiety, behavior-conduct problems, confusion, delusions/hallucinations, hopelessness, marital/family problems, nervous/worried, sleep disturbance, tearfulness, worthlessness, agressive behavior and suicidal thoughts. Additional recommendations by the psychologist included developing and implementing a behavior plan to reduce the resident's affective and/or cognitive symptoms and providing individual therapy to reduce the resident's affective and/or cognitive symptoms. The assessment revealed the psychologist reviewed the plan with the facility's SSD and the facility was monitoring Resident #1 with a plan in place.-However, review of Resident #1's care plan did not reveal person-centered safety interventions (see care plan above) and the staff were not aware of the safety interventions (see staff interviews below).The 3/6/26 SSD progress note, documented at 9:44 a.m., revealed the SSD was notified regarding Resident #1's concerning behaviors of attempting to wrap items around her neck. The SSD documented mental health services were contacted regarding the behavior concerns and crisis services were notified. The 3/6/26 SSD progress note, documented at 11:07 a.m., revealed mental health services spoke with Resident #1 at the facility. The progress note revealed Resident #1 declined any thoughts or attempts of suicide ideation and stated she wanted her family to visit more. The 3/6/26 SSD progress note, documented at 11:10 a.m., revealed mental health services gave Resident #1 a crisis number and the SSD reminded Resident #1 of the safety plan which included communicating with staff about wants and needs regarding her care.The 3/6/26 nurse progress note, documented at 6:03 p.m., revealed Resident #1 had major behaviors during the shift. The progress note revealed that at the beginning of the shift, Resident #1 was wrapping the telephone cord and call light cord around her neck and needed constant supervision. The progress note revealed the crisis center was called and two women came to the facility to speak with Resident #1. The progress note revealed Resident #1 was then calm and cooperative until dinner time. At dinner time, Resident #1 began to have behaviors, where she entered the dining room hollering that she was in prison and tried to pull her hair. The nurse progress note documented Resident #1 then started to stab her leg with a pen from the front lobby. The nurse progress note documented Resident #1 was not redirected and was kicking chairs and cursing. The progress note revealed Resident #1 exhibited unsafe behaviors and the charge nurse was notified to assist with Resident #1. The progress note revealed staff would continue to monitor Resident #1. -However, the 3/4/26 NP progress note documented the nurse had removed all threats from the resident's room (see NP progress note above).The 3/7/26 at 3:31 a.m. nurse progress note (which was documented as a late entry) documented that on 3/6/26 at 6:15 p.m., Resident #1 left the facility by ambulance for a mental health evaluation. The resident was evaluated in the emergency department and did not meet criteria for an emergency M1 hold (an involuntary, 72-hour emergency mental health hold). Resident #1 returned to the facility on 3/7/26 at 3:21 p.m. Resident #1 was diagnosed at the emergency department with a urinary tract infection and had a physician's orders for antibiotics. The note documented the resident's Seroquel was increased to 50 mg in the morning for anxiety. -Review of Resident #1's EMR did not reveal the facility reviewed the resident's care plan after the 3/4/26 incident to ensure the effecti