STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View Rehabilitation and Nursing LLC	2438 E Fountain Blvd 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 residents received adequate supervision and intervention to prevent physical abuse for one (#4) of four residents reviewed for abuse out of nine sample residents. Specifically the facility failed to protect Resident #4 from physical abuse by Resident #3. 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 1/28/26 at 1:04 p.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, 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. Prevention of Abuse, Neglect and Exploitation the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property 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 assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.II. Incident of physical abuse of Resident #4 by Resident #3 on 12/1/25The facility's investigation, dated 12/2/25, was provided by the NHA on 1/28/26 at 9:58 a.m. The investigation revealed the following: Resident #3 and Resident #4 were seated at a table in the dining room together. During mealtime Resident #4 reached out and took Resident #3's dessert. Resident #3 slammed his hands on the table and then hit Resident #4 in the chest while calling Resident #4 names. Resident #3 and Resident #4 were separated immediately with no injuries, and the police were notified. The facility initiated their investigation. One of five staff members interviewed witnessed the incident. On 12/1/25 at 1:00 p.m. certified nursing aide (CNA) #3 saw Resident #4 take Resident #3's dessert. Resident #3 slammed his hands on the table and then hit Resident #4's chest, and was calling him names. -Staff interviews (see below) during the survey revealed facility staff were aware of Resident #4's behavior of frequently grabbing out for desserts. Facility staff were also aware that Resident #3 was territorial about his belongings and had a history of becoming aggressive. The facility investigation identified both Resident #3 and Resident #4 had severe cognitive impairment with behaviors. The facilities investigation concluded the physical abuse was substantiated. B. Resident #4 (victim) 1. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), the diagnoses included cognitive social or emotional deficit following cerebral infarction, mood disorder due to known physiological condition with depressive features, generalized muscle weakness, and contractures to the left and right lower (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Fountain View Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2438 E Fountain Blvd 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	legs.The 1/22/26 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. He required maximum assistance with all activities of daily living (ADL). The MDS assessment indicated the resident did not display behaviors. 2. Record ReviewThe comprehensive care plan, initiated on 1/7/25, revealed Resident #4 exhibited impaired cognitive function/ impaired thought process related to a history of cerebrovascular accident (CVA) with residual cognitive social and emotional deficit. The interventions included using the resident's preferred name, identifying yourself at each interaction, facing the resident when speaking and making eye contact, reducing any distractions- turn off the television (TV), radio, close door etc. The care plan documented the resident understood consistent, simple, directive sentences. Additional interventions included providing the resident with necessary cues- stop and return if agitated and cueing the resident.The IDT progress note dated 12/9/25 revealed Resident #4 was involved in a resident-to-resident altercation on 12/1/25 during the lunch meal. He grabbed his tablemate's dessert and his tablemate (Resident #3) then slammed his hands on the table and hit him in his chest and began calling him names. Resident #3 and Resident #4 were immediately separated. Resident #4 was assessed for injuries and none were noted. Resident #4 was offered an alternate seating arrangement away from Resident #3 moving forward to prevent further altercations.Social services will follow up.C. Resident #3 (assailant)1. Resident statusResident #3, greater than 65, was admitted on [DATE]. According to the January 2026 CPO, the diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The 12/18/25 MDS assessment revealed the resident was cognitively impaired with a BIMS score of five out of 15. He required substantial assistance with all ADLs.2. Record Review The comprehensive care plan, revised on 8/20/24, revealed Resident #3 has impaired cognitive function related to dementia diagnosis. The care plan documented the resident presented with confusion and forgetfulness. The care plan documented the resident needed redirection and cueing. The care plan documented the resident lacked orientation resulting in delusional thought processes at times redirectable. Pertinent interventions, revised on 8/20/25 included, use Resident #3's preferred name, identifying yourself at each interaction, facing the resident when speaking and making eye contact, reducing any distractions (turn off TV, radio, close the door). The care plan documented the resident understood consistent, simple, directive sentences. Additional interventions included providing the resident with necessary cues stop and return if agitated.The comprehensive care plan, revised on 11/6/24, revealed Resident #3 had a suspected history of trauma related to chronic homeless lifestyle, per family, that may contribute to problematic behaviors such as possessiveness of space, lack of trust and reactive responses. Resident #4 appeared stable, content, and adjusted. Resident #4 does have impaired cognition resulting in delusional thought processes at times. Facility staff will observe for any triggers and anticipate Resident #3's needs as indicated. Pertinent interventions revised on 8/20/24 included assessing Resident #3's need for additional services and therapeutic support or specialists from the community,along with offering referrals periodically and as needed. III. Staff interviewsCNA #1 was interviewed on 1/28/26 at 9:15 a.m. CNA #1 said Resident #4 was non-compliant, and would grunt, make noises, or ball up his fists. CNA #1 said Resident #4 got agitated during care and had a history of smacking and punching staff. CNA #1 said these behaviors were documented and reported to the nurse on duty. CNA #1 said during mealtimes Resident #4 should be sat with specific residents who did not exhibit aggressive behaviors. CNA #2 was interviewed on 1/28/26 at 9:28 a.m. CNA #2 said Resident #3 had a history of sundowning by packing his belongings into his suitcase and trying to leave the facility. CNA #2 said Resident #3 had been aggressive towards staff when he did not want to get up in the morning or take a shower. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Fountain View Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2438 E Fountain Blvd 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	CNA #2 said Resident #3 was territorial over his belongingsLicensed practical nurse (LPN) #2 was interviewed on 1/28/26 at 9:47 a.m. LPN #2 said Resident #3 did not like loud environments She said when Resident #3 was in the dining room, he would become aggressive if someone took his food LPN #2 said Resident #3 was known to shout at other residents he was upset with. She said Resident #3 had a history of making verbal threats of hurting other residents, however Resident #3 was wheelchair bound and unable to get to another resident if they were far away. LPN #2 said if Resident #3 was close enough to another resident, he would try to hit, grab, or swing. She said Resident #3 was aggressive toward staff in the morning when waking him up. LPN #2 said both Resident #3 and Resident #4 had dementia and did not recall the event. She said on 12/1/25, Resident #3 hit Resident #4 when he took his desert. LPN #2 said Resident #4 liked sweets and that is why he would reach for desserts of other residents. The NHA was interviewed on 1/28/26 at 12:13 p.m. The NHA said Resident #4's plan of care did not document Resident #4's history of reaching for other resident deserts in the dining room. She said Resident #4 should not have been seated next to Resident #3, especially since Resident #3 had a history of territorial behaviors.