| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on record review and interviews, the facility failed to provide response, action and rationale to residents involved in group grievances. Specifically, the facility failed to effectively address, resolve and follow up with residents who attended food committee and resident council on the outcomes and resolutions of grievances expressed regarding food. Findings include:I. Facility policy and procedureThe Resident and Family Grievances policy and procedure, dated 4/11/25, was received by the nursing home administrator (NHA) on 8/27/25 at 3:52 p.m. It read in pertinent part, It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. The grievance officer is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary. The time frame that a resident may reasonably expect completion of the review of the grievance and a written decision regarding his or her grievance. The grievance officer will take steps to resolve the grievance, and record information about the grievance, and those actions on the grievance form. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the grievance officer. Prompt efforts include acknowledgement of complaint/grievances and actively working toward a resolution of that complaint/grievance. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances, and will share them only with those who have a need to know. The grievance officer, or designee, will keep the resident appropriate apprised of progress towards resolution of the grievances. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the grievance officer will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:-The date the grievance was received;-The steps taken to investigate the grievance;-A summary of the pertinent findings or conclusions regarding the resident's concern (s);-A statement as to whether the grievance was confirmed or not confirmed; -Any corrective action taken or to be taken by the facility as a result of the grievance; -The date the written decision was issued; and, The facility will make prompt efforts to resolve grievances.A. Resident group interviewA group interview was conducted on 8/26/25 at 2:32 p.m. with five residents (#6, #7, #9, #10 and #15), who were identified as alert and oriented through facility and assessment.The residents in the group said they had complained about the food being cold, over cooked and bland in taste. The residents said there was no resolution. The residents said the administration acknowledged the concerns however, did not implement a resolution. The residents said the lunch and dinner orders were not being taken prior to the meal and often the menu did not match what was served. B. Record reviewThe 4/17/25 resident council minutes documented the residents voiced a concern that the certified nurse aides (CNA) were not taking lunch and dinner prior to the meal. The minutes documented the residents voiced a concern that the french fries were not being fully cooked. The follow up section on the form documented the CNAs had been educated. The follow up documentation also documented that the cooks were ensuring the fries reached 180 degrees Fahrenheit (F).-However, it was documented next to the NHA's signature that the action was not sufficient and it was not effective. The 5/15/25 resident council meeting minutes documented the residents voiced a concern that they received the wrong food orders. The residents said they did not know if it was a miscommunication with the CNAs and the kitchen staff. The residents said the menu that was posted was not matching the ticket. The residents said the vegetables were over cooked or raw. The residents said the portion sizes were too small, the fries were not fully cooked and hot food was not hot. The residents said there were not enough snacks. The follow up section on the form documented to ensure the food was hitting the correct temperature of 165 degrees F. It documented for the staff to make sure the meal tickets matched the menu. It documented the CNAs were educated to obtain orders timely. The cooks were educated to ensure the fries were full cooked, that the temperature of the vegetables were correct, portion sizes were correct and to ensure there were enough snacks. -However, it was documented next to the NHA's signature that the action was not sufficient and it was not effective.-Cross reference F803: failure to follow the menus. The 6/19/25 resident council meeting notes documented the residents voiced concerns that the fries were not fully cooked, the hot food was not |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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<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 observations, record review and interviews, the facility failed to ensure two (#1 and #2) of four residents reviewed for abuse out of 16 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #1 and Resident #2 from physical abuse by Resident #3.Findings include:<br><br>I. Facility policy and procedure<br><br>The Abuse Policy, dated 4/11/25, was provided by the nursing home administrator (NHA) on 8/26/25 at 11:10 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, exploitation and misappropriation of resident property.<br><br>Responding immediately and after the investigation to include but not limited to, responding to immediately protect the alleged victim and integrity of the investigation.<br><br>Increased supervision of the alleged victim and residents.<br><br>Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect, such as, aggressive and/or catastrophic reactions of residents, wandering or elopement-type of behaviors.<br><br>If abuse happens: separate the assailant from the victim, isolate the assailant to protect others, assess and treat the victim, and notify the abuse coordinator.”<br><br>II. Incident of physical abuse of Resident #1 by Resident #3 on 6/7/25<br><br>A. Facility investigation<br><br>The facility’s investigation, dated 6/8/25 at 6:25 p.m., was provided by the NHA on 8/26/25 at 12:12 p.m. The investigation revealed the following:<br><br>On 6/7/25 at approximately 6:04 p.m., Resident #3 was observed walking independently down hallway 400. At that time, Resident #1 was positioned at the threshold of her room, standing in the doorway. As Resident #3 approached, Resident #1 began to audibly call out for help. In response, Resident #3 entered Resident #1’s room briefly; however, no physical contact was observed during this initial entry.<br><br>Shortly thereafter, Resident #3 re-entered Resident #1’s room without staff or permission by Resident #1. At this point, staff observed Resident #3 physically grab Resident #1 by the hair. The altercation escalated rapidly, prompting immediate intervention by registered nurse (RN) #1, who was in close proximity and responded without delay. RN #1 successfully separated the residents and removed Resident #3 from Resident #1’s room to prevent further physical aggression.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility investigated an allegation of physical abuse involving Residents #1 and Resident #3 and determined the allegation was substantiated. Resident #3 was observed to frequently respond to external stimuli or episodes of confusion by walking about and making physical contact, such as grabbing staff or other residents. In this incident, Resident #1 reported she did not understand why Resident #3 entered her room and pulled her hair.<br><br>B. Resident #3 (assailant)<br><br>1. Resident status<br><br>Resident #3, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included alcohol induced persisting dementia, bipolar disorder with current episodes of psychotic features, schizoaffective disorder, and panic disorder with paroxysmal anxiety.<br><br>The 6/10/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. The resident was dependent on staff for certain activities of daily living (ADL).<br><br>The MDS assessment documented the resident had physical behaviors directed at others or other behavioral symptoms directed toward others.<br><br>2. Record review<br><br>The mood care plan, revised 6/23/25, revealed Resident #3 was at risk for a mood problem due to her disease process and her diagnoses of depression and dementia with behavioral disturbance. Pertinent interventions included administering medications as ordered, behavioral health consults as needed, assisting the resident with identifying strengths and positive coping skills and providing the resident with a meaningful program of activities.<br><br>The psychotropic medication care plan, revised 3/12/25, revealed Resident #3 was prescribed antidepressant and antipsychotic medications. The plan outlined interventions requiring staff to monitor and record instances of target behaviors and symptoms, which included compulsive verbal statements such as help me, can you help me, or repeated expressions of hunger, uncooperative behavior, verbal expressions of depression, mood changes, agitation, aggression toward others, insomnia, jitteriness, nervousness and restlessness.<br><br>C. Resident #1 (victim)<br><br>1. Resident status<br><br>Resident #1, age [AGE], was admitted on [DATE]. According to the July 2025 CPO, diagnoses included adjustment disorder with mixed anxiety and depressed mood, unspecified dementia, anorexia, hypertension with chronic kidney disease, insomnia, cachexia, obsessive-compulsive behavior and inadequate social skills.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 6/10/25 MDS assessment revealed the resident has moderate cognitive impaired with a BIMS score of nine out of 15. The resident was independent for most ADLs with staff assistance needed for redirection at times.<br><br>The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.<br><br>2. Resident interview<br><br>Resident #1 was interviewed on 8/26/25 at 9:45 a.m. Resident #1 was calm and cooperative. She said she felt safe in the facility and trusted the staff. Resident #1 said she was unable to recall specific details regarding the incident with Resident #3 because it had occurred a long time ago. She said she was not hurt and Resident #3 did not pull her hair.<br><br>-However, the facility’s investigation indicated staff witnessed Resident #3 pulling Resident #1’s hair during the incident (see incident investigation above).<br><br>D. Staff interviews<br><br>Licensed practical nurse (LPN) #1 was interviewed on 8/26/25 at 11:00 a.m. LPN #1 said the facility investigated the incident between Resident #1 and Resident #3 on 6/7/25 and interviewed the staff and the two residents. LPN #1 said she had never experienced any prior incidents involving Resident #3 and Resident #1. She said Resident #3 often reached towards other residents unintentionally, typically mistaking them for staff members. LPN #1 said she was not on duty the night of the reported event, but she said it was highly unusual for Resident #3 to enter another resident’s room, specifically Resident #1’s room, and engage in physical contact, such as pulling her hair.<br><br>RN #1 was interviewed on 8/26/25 at 6:15 p.m. RN #1 said on 6/7/25 she observed Resident #1 walking by the doorway of her room and Resident #3 walking on the same side of the hallway. She said as the residents approached one another, Resident #1 suddenly began shouting “Help, help!” quite loudly. She said the shouting caught her attention immediately. RN #1 said shortly after Resident #1 began shouting, Resident #3 entered Resident #1’s room and appeared to respond to the shouting by moving toward Resident #1 and grabbing her by the hair. She said Resident #1 had some bruising on her right hand; however, she did not witness any specific action or incident that might have caused the bruising.<br><br>RN #1 said she stepped in right away to separate Resident #1 and Resident #3 and prevent the situation from escalating further. She said once they were apart, facility staff assessed Resident #1 for any injuries and none were noted. RN #1 said following the incident, Resident #3 was placed on enhanced supervision to ensure safety and monitor her behavior more closely, per facility policies.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RN #1 said the incident on 6/7/25 was her first time seeing Resident #3 have an issue with another resident, but she said that Resident #3 had more cognitive and behavioral difficulties than other residents within the facility. RN #1 said the staff calmed Resident #3 down, but the best thing was usually to leave her alone for a period of decompression and observation in her room, due to her cognitive decline, behavioral issues and anxiety. RN #1 said Resident #3 could also be troubled at times, but had not had any conflict with any other residents or staff that she was aware of recently. RN #1 said she immediately informed the assistant director of nursing (ADON), the director of nursing (DON), the NHA, the residents’ physician, local law enforcement, and the residents’ representatives about the incident.<br><br>The NHA was interviewed on 8/27/25 at 9:53 a.m. The NHA said the facility substantiated abuse for the incident between Resident #3 and Resident #1 for several reasons. The NHA said Resident #3 had external stimuli that she responded to by going into Resident #1’s room. The NHA said the investigative actions included interviewing staff who responded to the incident, reviewing accounts of nearby residents and assessing both Resident #1 and Resident #3. The NHA said there was no willful infliction or verbal aggression and Resident #3 was not engaging other residents prior to the incident. The NHA said this was supported by the nine residents who were interviewed that were were near Resident #3 and Resident #1 at the time of the incident and did not recall any altercation outside of Resident #1’s room. The NHA said the facility’s investigation revealed, through interviews and observations, that Resident #1 confirmed the hair pulling, but reported no injury or on-going psychosocial distress. He said Resident #3 was unable to provide a clear explanation of the incident or occurrence, due to her cognitive impairment.<br><br>The NHA said that a review of both Resident #1 and Resident #3’s care plans and behavioral histories was conducted and documentation from the incident was evaluated. He said the social services director (SSD) was engaged to monitor and provide support to Resident #1 and monitor any psychosocial effects of the incident. He said during the facility’s interview of Resident #1, she did not report pain or fear during the incident, but appeared focused on discussing the incident repeatedly. He said Resident #1 was cooperative during the interview and expressed appreciation for the staff support. The NHA said there were no noted behavioral changes observed in Resident #1 following the incident. He said she remained calm and continued her usual routine without signs of distress.<br><br>III. Incident of physical abuse of Resident #2 by Resident #3 on 6/8/25<br><br>A. Facility investigation<br><br>The facility’s investigation, dated 6/8/25 at 5:40 p.m., was provided by the NHA on 8/26/25 at 12:22 p. m. The investigation revealed the following:<br><br>Resident #3 exited her room and sat near nurses’ station two. Shortly afterward, Resident #3 approached Resident #2 and grabbed her arm. CNA #1 immediately intervened, separating the residents and escorting Resident #3 back to her room to de-escalate the situation. Resident #3 was placed on one-to-one supervision for close behavioral monitoring. A full medical work up was initiated to assess for any underlying causes contributing to Resident #3’s behavior. Staff were notified and increased awareness and supervision measures were reinforced in shared areas to ensure resident safety.<br><br>Resident #3 and Resident #2 were interviewed, along with the CNA #1, who witnessed the incident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065175 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/27/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St Colorado Springs, CO 80905 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #2 was interviewed and appeared indifferent to the incident, expressing no concerns or distress. Resident #2 said that Resident #3 grabbed her arm. Resident #2 said she was not in pain or fearful of Resident #3. Resident #2 continued with her regular routine without issue.<br><br>Resident #3 was interviewed and unable to provide a clear or coherent explanation of the incident. Due to her cognitive impairment, her responses were disorganized and did not align with the events reported. It was determined that she was not of sound mind and unable to meaningfully participate in the interview.<br><br>CNA #1 was interviewed and said she witnessed Resident #3 approach and grab Resident #2’s arm before promptly intervening.<br><br>The facility concluded the allegation of physical abuse was substantiated due to CNA #1 directly observing Resident #3 grabbing Resident #2’s arm.<br><br>B. Resident #3 (assailant)<br><br>1. Record review<br><br>The care plan, initiated 6/9/25, revealed Resident #3 was involved in two separate interactions on 6/7/25 and 6/8/255 with Resident #1 and Resident #2 where Resident #3 had noted increased agitation. Pertinent interventions included Resident #3 was to have a medical work-up and she was placed on a one-to-one for reevaluation after 72 hours.<br><br>C. Resident #2 (victim)<br><br>1. Resident status<br><br>Resident #2, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (a stroke resulting in paralysis and weakness to one side of the body), intracranial and intraspinal phlebitis and thrombophlebitis (inflammation of brain or spinal veins and the formation of blood clots within them) and thrombocytopenia (an abnormally low number of platelets in the blood, which leads to increased bleeding and bruising).<br><br>The 8/5/25 MDS assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. The resident was dependent on staff for most ADLs.<br><br>2. Resident interview<br><br>Resident #2 was interviewed on 8/27/25 at 12:43 p.m. Resident #2 recalled the altercation from 6/8/25 with Resident #3 and said she was not afraid of her because she (referring to herself) was a fighter. Resident #2 said she had not had any recent altercations with Resident #3.<br><br>3. Record Review<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #2’s comprehensive care plan, revised 6/9/25, revealed Resident #2 was involved in an incident with Resident #3 on 6/8/25. Interventions (initiated 6/9/25) included social services providing a one-to-one two times a week with Resident #2 to monitor for any psychosocial trauma related to the event.<br><br>-However, review of Resident #2’s progress notes failed to reveal documentation to indicate the resident was provided with the one-to-one visits from social services two times a week.<br><br>Psychiatric follow-up progress notes on 7/2/25, 7/14/25, 7/28/25 and 8/11/25 indicated Resident #2 received routine psychological assessments biweekly by the nurse practitioner.<br><br>D. Staff interview<br><br>The NHA was interviewed on 8/27/25 at 9:53 a.m. The NHA said Resident #3 and Resident #2 were both interviewed after the incident on 6/8/25. The NHA said the staff were interviewed following the incident, including CNA #1, who confirmed that Resident #3 approached and grabbed Resident #2’s arm. He said other nearby staff did not witness the incident directly, but reported that Resident #3 appeared restless earlier in the day. The NHA said no other facility residents observed the incident.<br><br>The NHA said the facility’s internal investigation determined that the abuse allegation incident was substantiated. He said CNA #1 directly observed Resident #3 grab Resident #2’s arm. He said no injuries occurred with the incident and skin assessments were performed on Resident #2. He said appropriate interventions, including enhanced supervision and medical work-up were implemented by the facility.<br><br>The NHA said during the interview with Resident #3, she was unable to provide a clear or coherent explanation of the incident. He said due to her cognitive impairment, her responses were determined by the facility to be disorganized and did not align with the events that occurred. The NHA said the facility determined through the interview with Resident #3 that she was not of sound mind and unable to participate in a meaningful interview.<br><br>The NHA said the DON met with Resident #3 and Resident #2 on 6/8/25 about the events that occurred. He said Resident #3 was unable to recall any events due to her cognitive impairment. Resident #2 was unable to communicate the events, due to her aphasia and underlying cognitive impairment. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065175 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/27/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St Colorado Springs, CO 80905 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain proper personal hygiene for one (#11) of three residents reviewed for ADLs out of 16 sample residents.Specifically, the facility failed to ensure Resident #11 was repositioned and provided with incontinence care in a timely manner.Findings include:I. Resident #11A. Resident statusResident #11, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), dementia and muscle weakness.The 8/20/25 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of 11 out of 15. He required dependent assistance with toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene.The assessment documented the resident was always incontinent of bowel and bladder.B. ObservationsDuring a continuous observation on 8/26/25, beginning at 9:23 a.m. and ending at 1:55 p.m., the following was observed:At 9:23 a.m. Resident #11 was lying in bed.At 9:40 a.m. licensed practical nurse (LPN) #1 entered the room and gave Resident #11 his medications.-LPN #1 did not offer to reposition the resident or ask if he needed incontinence care.At 9:58 a.m. certified nurse aide (CNA) #2 entered the room, took Resident #11's breakfast tray and exited the room at 9:59 a.m.-CNA #2 did not offer to reposition the resident or ask if he needed incontinence care.At 11:03 a.m. CNA #2 entered the room and talked to Resident #11 and his roommate and exited the room at 11:04 a.m. -CNA #2 did not offer to reposition the resident or ask if he needed incontinence care.At 12:11 p.m. CNA #2 entered Resident #11's room and was observed talking to the resident saying she would be back with his lunch tray and exited the room at 12:12 p.m.-CNA #2 did not offer to reposition the resident or ask if he needed incontinence care.At 12:41 p.m. CNA #2 delivered Resident #11's lunch tray and exited at 12:42 p.m. -CNA #2 did not offer to reposition the resident or ask if he needed incontinence care.At 1:25 p.m. hospice CNA #1 and hospice CNA #2 entered Resident #11's room. Hospice CNA #1 said they were there to give Resident #11 a bed bath and proceeded to get the resident ready for his bath.At 1:37 p.m. Hospice CNA #1 and hospice CNA #2 cleaned Resident #11's arms and chest with a wash cloth that was rinsed in soapy water and dried him off with towels. Hospice CNA #1 un-taped the resident's dirty brief and cleaned Resident #11's perineal area (area between the genitals) and dried the area, keeping a towel over Resident #11 when they could. Hospice CNA #1 and hospice CNA #2 rolled Resident #11 to the left, tucking the old brief under him and exposing his bottom. Hospice CNA #1 and hospice CNA #2 placed a new brief on him. The old brief was observed to be saggy and bulky.-Resident #11 was not repositioned or asked if he needed incontinence care for a period of over four hours.C. Resident interviewResident #11 was interviewed on 8/26/25 at 1:07 p.m. Resident #11 said he could not remember if staff changed him today. Resident #11 said staff did not change him every two hours. Resident #11 said staff did not provide incontinence care for him after breakfast (on 8/26/25). Resident #11 said he did not know if he was wet and needed to be changed.D. Record reviewThe ADL care plan, revised 8/26/25 (during the survey), documented Resident #11 had an ADL self-care performance deficit related to AFTT (adult failure to thrive), end-stage congestive heart failure, fatigue, shortness of breath, obesity, bedbound and weakness. Resident #11 was able to verbalize his needs when asked. Resident #11 preferred to remain in bed for the majority of the day due to comfort and energy conservation. Interventions included providing total staff assistance with bed mobility and toileting use.The skin care plan, revised 5/28/25, documented Resident #11 had potential for impairment to his skin integrity. Resident #11 had a history of venous stasis ulcers. Resident #11 preferred to be positioned on his back with his feet elevated on pillows. Interventions included assisting Resident #11 to reposition and/or turn at frequent intervals to provide pressure relief, providing a pressure reducing mattress on his bed, providing total assistance from staff to turn/reposition often as needed or requested and providing incontinence care after each incontinence episode, or per an established toileting plan.The bowel and bladder care plan, revised 5/28/25, documented Resident #11 had both bowel and bladder incontinence. Interventions included checking and changing the resident frequently, on request and as required for incontinence, changing clothing as needed after incontinence episodes and providing total assistance from staff.II. Staff interviewsHospice CNA #1 was interviewed on 8/26/25 at 1:25 p.m. Hospice CNA #1 said that the hospice CNAs came to the facility two days a week on Tuesday and Fridays and gave Resident #11 a bed bath |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#4) of three residents reviewed out of 16 sample residents.Specifically, the facility failed to ensure physician's orders were followed for Resident #4's wound care.Findings include:I. Facility policy and procedureThe Skin Care and Pressure Ulcer policy, dated 4/11/25, was provided by the nursing home administrator (NHA) on 8/26/25 at 3:32 p.m. It read in pertinent part, After completing a thorough assessment/evaluation, the interdisciplinary team (IDT) shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to:-Redistribute pressure (such as repositioning, protecting and/or offloading heels);-Minimize exposure to moisture and keep skin clean, especially of fecal contamination; and-Provide appropriate pressure re-distributing, support surfaces.The goals and preferences of the resident and/or authorized representative will be included in the plan of care.Interventions will be documented in the care plan and communicated to all relevant staff.Compliance with interventions will be documented in the weekly summary charting.II. Resident #4A. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders, diagnoses included chronic venous hypertension (a condition where the veins in the lower legs become damaged, leading to increased blood pressure in the veins) with ulcers and inflammation of bilateral lower extremities, history of chronic kidney disease (CKD), type 2 diabetes, bilateral peripheral venous insufficiency (a condition where the veins in the legs or arms do not function properly, leading to blood pooling and damage), chronic tobacco and methamphetamine use and homelessness.The 6/26/25 minimum data set (MDS) assessment revealed that Resident #4 had minimal cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required partial/moderate assistance to roll left and right and partial/moderate assistance to move from sitting to standing. The assessment indicated the resident had three venous and/or arterial ulcers (open wounds that develop on the lower legs due to problems with blood circulation) upon admission.B. ObservationsOn 8/26/25 at 10:53 a.m. Resident #4's wound care was observed with licensed practical nurse (LPN) #2. The resident's legs and ankles were lying on the bed flat without a pillow or other form of support to elevate the resident's heels and ankles off of the bed surface.The resident's dorsal side of her right foot was covered with a bordered gauze dressing (an absorptive dressing consisting of three layers). LPN #2 removed the border gauze dressing which revealed a non-woven fluffy/fibrous looking material, approximately four inches by four inches in size.The resident's right dorsal foot wound was an irregular shape about the size of a closed fist and the wound bed was uneven, pink and red. LPN #2 cleansed the right dorsal foot wound, applied skin prep (a topical solution or wipe used to prepare the skin around wounds for the application of dressings or other medical devices), placed xeroform gauze (a petrolatum-impregnated gauze with an added ingredient called bismuth tribromophenate that helps promote healing by keeping wounds moist and non-adherent, thus facilitating easier dressing changes) and covered the wound with a signed and dated bordered gauze dressing.LPN proceeded to perform the wound care for Resident #4's right medial (inner) ankle. The resident's right medial ankle was not covered with a bordered gauze dressing (see physician's orders below). Resident #4's right medial ankle wound had a saturated non-woven dressing material over it which had mostly molded itself to the resident's ankle. LPN #2 sprayed the dressing, which was stuck to the resident's wound, with a wound cleanser multiple times and let it sit to make the material softer. Once the dressing was softer, LPN #2 peeled the dressing off in pieces, due to the dressing becoming more slimy when exposed to the wound cleanser spray. There was no xeroform gauze beneath the adhered dressing removed by LPN #2 (see physician's orders below). LPN #2 cleansed the right medial ankle wound. Once cleansed, the wound bed was pink and red. LPN #2 applied skin prep, placed xeroform gauze and covered the wound with a signed and dated bordered gauze dressing.LPN #2 proceeded to perform the wound care for Resident #4's left medial ankle wound, had a bordered gauze dressing on it that was slightly saturated |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observations, record review and interviews the facility failed to ensure recipes were followed to meet the residents' nutritional needs.Specifically, the facility failed to follow the correct portion sizes to ensure adequate nutrition was provided to the residents. Findings include:I. Facility policy and procedureThe Food Preparation Guidelines policy and procedure, dated 4/11/25, was provided by the nursing home administrator (NHA) on 8/27/25 at 3:52 p.m. It read in pertinent part, It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. The cook, or designee, shall prepare menu items following the facility's written menus and standardized recipes.II. ObservationsDuring a continuous observation during the dinner meal on 8/26/25, beginning at 4:00 p.m. and ending at 6:00 p.m., the following was observed: At approximately 5:00 p.m. the dietary manager (DM) prepared and served a plate for a resident who was prescribed a pureed diet. The plate consisted of pureed barley soup and a pureed hamburger patty. -However, the menu extensions indicated the residents prescribed a pureed diet should have received pureed Italian grinder sub and pureed potato salad (see menu extensions below).At 5:15 p.m. an unidentified dietary aide (DA) began plating the resident's meals. for dinner. The unidentified DA placed half of the baked Italian sub sandwich on the plate and put a bowl of the barley vegetable soup on the plate. The unidentified (DA) then handed it to the staff and staff began handing out the food to the residents in the dining room.-However, the menu extensions indicated the residents were to receive two half sandwiches (see menu extensions below).III. Record reviewThe menu extensions were provided by the NHA on 8/27/25 at 3:52 p.m. The menu extensions revealed the residents who were prescribed a regular diet should have received two halves of a baked Italian sub sandwich, #8 scoop (half cup) of potato salad, 6 ounces (oz) (two third cup) of soup, 9 oz beverage of choice and a three inch by two inch brownie.-However, observation revealed the residents were served half of the baked Italian sub sandwich, instead two halves as indicated on the menu extensions (see observations above).The menu extension revealed the residents who were prescribed a pureed diet should have received #6 scoop (two third cups) of pureed Italian grinder sub, #8 scoop (half cup) of pureed potato salad with no raw vegetables, #6 scoop (two third cup) of pureed homemade soup of the day, 8 oz beverage of choice and a three inch by two inch pureed brownie.-However, observation revealed the resident was served pureed soup with a pureed hamburger patty. The resident was not provided with the pureed Italian grinder sub or pureed potato salad. IV. Staff interviewsThe dietary manager (DM) was interviewed on 8/27/25 at 10:50 a.m. The DM said he was responsible for posting the menus for the day. The DM said he used the dining manager RD (registered dietitian) to retrieve his menus for the facility. The DM said the dining manager RD was approved by the RD. The DM said he could not find the recipes in the dining manger RD program. The DM said that he had never used a recipe. The DM said he did not follow a recipe to make dinner on 8/26/25. The DM went over the menu extensions from dinner on 8/26/25. The DM said residents should have gotten two halves of the baked Italian sub sandwich last night for dinner (8/26/25). The DM said the DAs needed more training and were not educated that two halves were supposed to be served. The DM said residents should have been served two halves of the sandwich.The DM said only one resident was prescribed a pureed diet. The DM said the baked italian sub sandwich did not puree well. He said the resident was served the pureed barley soup with a pureed beef patty mixed in. The DM said he did not puree the potato salad because the resident did not like raw vegetables. The DM said the resident also received a pureed chocolate chip cookie and ice cream for dessert.-However, the menu extensions indicated residents on a pureed diet should have received a pureed brownie (see menu extensions above).The DM said when he first started at the facility one of the residents requested chicken strips off the alternative menu. The DM said they were out of chicken strips, so he went and talked to the resident and offered them something else. The DM said he had a stock of everything on the alternative menu so that he does not run out again. The DM said he recently made updated changes to the alternative menu known as the bistro menu. He said he added more options for the residents to choose from. The NHA was interviewed on 8/27/25 at 1:41 p.m. The NHA said the DM and cooks should be following recipes when preparing the meals for the residents. The NHA said there were recipes in the dining manager RD. The NHA said not following the recipes could be concerning for allergies, safety concerns and nutritional values. The NHA said he would make sure to educate the DM on where to find and print out the recipes. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observations, record review and interviews the facility failed to ensure residents consistently receive food prepared by methods that conserve nutritive value, palatable in taste, texture and temperature. Specifically, the facility failed to ensure the residents' food was palatable in taste, texture and temperature. Findings include:I. Facility policy and procedureThe Food Preparation Guidelines, dated 4/11/25, was received by the nursing home administrator (NHA) on 8/26/25 at 3:52 p.m. It read in pertinent part, It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Food shall be prepared by methods that conserve nutritive value, flavor and appearance. This includes but is not limited to: Storing food in a manner to minimize exposure to light and air. Preparing foods as directed. Cooking foods in appropriate amount of water (avoid large volumes). Minimizing holding time prior to meal service. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: Providing meals that are varied in color and texture. Using spices or herbs to season food in accordance with recipes. Serving hot foods/drinks hot and cold foods/drinks cold. Addressing resident complaints about foods/drinks. Honoring resident preferences, as possible, regarding foods and drinks.II. Resident interviewsResident #14 was interviewed on 8/25/25 at 1:14 p.m. Resident #14 said her fries were often cold. Resident #14 said the kitchen served a lot of chicken and she was tired of eating it. Resident #14 said there was not alternative meal options. Resident #14 said she was not given another option for her lunch everyday. Resident #14 said you take what you get and eat it or do not eat.Resident #12 was interviewed on 8/25/25 at 4:25 p.m. Resident #12 said his meal was served cold routinely. He said that the bacon was overcooked, the eggs were watery and the food did not have any flavor. Resident #4 was interviewed on 8/26/25 at 1:50 p.m. Resident #4 said the food was always cold. She said her lunch was cold today.Resident #13 was interviewed on 8/26/25 at 5:30 p.m. Resident #13 said the food was not good. He said the food was served cold, not enough at times and was not flavorful. He said the bread on sandwiches was hard. He said the bread on his Italian sandwich served tonight (8/26/25) was hard and there was not enough meat on the sandwich. He said he only received a half of the sandwich and it was not enough to eat. Cross reference F803: Failure to ensure portion sizes were served according to the menu extensions. Resident #2 was interviewed on 8/27/25 at 12:43 p.m. Resident #2 said the food was horrible. Resident #2 said she had never been offered an alternative meal.Resident #17 was interviewed on 8/27/25 at 2:15 p.m. Resident #17 said he had a difficult time cutting his hot dog because it was overcooked and dry. Resident #17 said he typically ate in his room. Resident #17 said staff sometimes would ask him what he would like off the menu but most of the time it was a mystery. Resident #17 grimaced his face when stating the food temperature is always cold. He said it's a hit or miss asking staff to reheat the food because sometimes they will and sometimes they won't. Resident #17 said the food was always cold. III. Resident group interviewA group interview was conducted on 8/26/25 at 2:32 p.m. with six alert and oriented residents (#10, #15, #7, #6 and #9), per facility and assessment.The residents said the food was always cold. The residents said the pancakes were hard and overcooked, so they could not be cut. The residents said the pancakes were served cold. The residents said the oatmeal was the only food that was always hot. The residents said if they ate their meals in their room that the staff would reheat the food. The group said that staff could not reheat it more than once because there was not enough staff to reheat the food. The group said if they wanted warm food they needed to eat in the dining room.The residents said that the food had been over cooked and sometimes undercooked. The residents said that they reported their concerns in the May 2025 and June 2025 resident council meeting and nothing happened.Resident #6 said the hamburgers were dry and the fries were either burnt or soggy. The residents said the fries were not always cooked all the way.IV. Record reviewThe 4/17/25 resident council minutes documented the residents voiced a concern that the certified nurse aides (CNA) were not taking lunch and dinner prior to the meal. The minutes documented the residents voiced a concern that the french fries were not being fully cooked. The follow up section on the form documented the CNAs had been educated. The follow up documentation also documented that the cooks were ensuring the fries reached 180 degrees Fahrenheit (F)The 5/15/25 resident council meeting minutes documented the residents voiced a concern that they received the wrong food orders. The residents said they did not know if it was a miscommunication with the CNA's and the kitchen staff. The residents said the menu that was posted was not matching the ticket. The residents said the vegetables were over cooked or raw. The residents said the portion sizes were too small, the fries were not fully cooked and hot food was |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065175 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kiowa Hills Rehabilitation and Nursing, LLC | 924 W Kiowa St<br>Colorado Springs, CO 80905 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Based on observations and interviews, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen.Specifically, the facility failed to ensure:-Hand hygiene was conducted appropriately;-Food was held at the correct temperature; and,-Room trays were covered during transportation from the kitchen to the residents' room. Findings include:I. Failure to perform hand hygiene appropriatelyA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 9/4/25. It revealed in pertinent part, Food employees shall clean their hands immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single serve and single use articles. During food preparation, as often as necessary to remove soils and contamination and to prevent cross contamination when changing tasks. -When switching between working with raw food and working with ready to eat food. -Before donning gloves to imitate a task that involves working with food. -After engaging in other activities that contaminate the hands. (Chapter 2-301.14)B. ObservationsDuring a continuous observation during the dinner meal on 8/26/25, beginning at 4:00 p.m. and ending at 5:23 p.m., the following was observed:At 4:05 p.m. cook (CK) #1 was preparing banana pudding while wearing gloves. Without changing gloves, CK #1 then pureed four cups of bananas and added them to the pudding. CK #1 placed a lid on the pudding and placed the pudding in the fridge. At 4:10 p.m. CK #1 took a tray of baked Italian sub sandwiches from the hot warmer box and began cutting the sandwiches in half, using the same gloved hands he used to prepare the pudding. CK #1 placed the sandwiches in a big metal container, using the same gloved hands. CK #1 took out another tray of sub sandwiches from the hot warmer box and began cutting them in half placing them in the same big metal container, using the same gloved hands. She covered the sub sandwiches with parchment paper and placed the metal container back into the hot warmer box. CK #1 then took out another tray of sub sandwiches, cut them up, and placed them in another metal container, using the same gloves hands. CK #1 then covered the second container with parchment paper and placed them back in the hot warmer box.At 4:41 p.m. CK #1 changed her gloves and did not wash her hands. CK #1 opened up a package of cheese, reached into the bread and took out two slices of bread. CK #1 placed one slice of cheese on the bread. The dietary manager (DM) retrieved the deli meat from the refrigerator and sat it down on the counter. Without changing gloves, CK #1 reached into the container of deli meat with the same gloves on and placed the meat on the sandwich. CK #1 got a clean plate and placed the sandwich on the plate and then wrapped the plate with saran wrap.At 4:55 p.m. the two unidentified dietary aides (DA) had gloves on and were taking the food out of the hot warmer box and placing the food on the cart.At 4:58 p.m. one unidentified DA with the same glove hands wheeled the cart out of the main kitchen and down the hallway to the elevator. The unidentified DA pushed the button to get on the elevator and when on the elevator pushed the button again to close the door. The unidentified DA wheeled the cart to the satellite kitchen.At 5:15 p.m. the unidentified DA, with the same gloved hands began taking the temperature of the food and touched the meal tickets. The unidentified DA began preparing plates of food for the residents.At 5:23 p.m. the unidentified DA opened a bag of potato chips. She used the same gloved hands to take potato chips out of the bag and place them on a plate. Without changing gloves, the unidentified DA opened hamburger buns up, grabbed two buns out and placed them on the plate. The unidentified DA then grabbed the hamburger patty out of the metal container with the same gloves hands placed the hamburger on the bun. The unidentified DA did not change out her gloves and continued to plate other residents food.On 8/27/25 at 8:45 a.m. the room trays for the 300 hall were passed out. The cart had four room trays. The plate had a dome cover over the food, however, the oatmeal on the trays were not covered as it was transported down the hallway. C. Staff interviewThe DM was interviewed on 8/27/25 at 10:50 a.m. The DM said the staff should change their gloves between tasks. He said if the CK was handling only buns, they would not need to change their gloves. The DM said the unidentified DA should have changed her gloves after putting her hand in the bag of chips. The DM said the unidentified DA should not have used her hand to get the hamburger patty out of the pan. The DM said the unidentified DA should have used tongs. The DM said he would provide education to the staff on hand hygiene. II. Failure to ensure food was held at the correct temperatureA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 9/4/25. It revealed in pertinent part, Time/Temperature control for safety food, hot and cold holding at 135 |