

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                                                 |
| F 0600<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure three (#15, #9, and #11) of five residents were free from abuse out of 15 sample residents. Specifically, the facility failed to:-Protect Resident #15 from sexual abuse by Resident #5;-Protect Resident #9 from sexual abuse by Resident #14; and,-Protect Resident #11 from physical abuse by Resident #12. Findings include:I. Facility policy and procedureThe Abuse, Neglect, and Exploitation policy, revised 7/16/26, was provided by the nursing home administrator (NHA) on 7/21/26 at 10:56 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. The facility will develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents. Employees will be educated on abuse during initial orientation and throughout the year during in-service training and as needed. The facility will establish a safe environment that supports a resident's consensual sexual relationship and establish policies and protocols for preventing sexual abuse.II. Incident of sexual abuse of Resident #15 by Resident #5 on 2/23/26A. Facility investigationThe facility's investigation of the incident of sexual abuse of Resident #15 by Resident #5 on 2/23/26 was provided by the NHA on 7/20/26 at 12:57 p.m. The investigation documented that on 2/27/26, Resident #15 reported to a staff member that two to three days prior, a resident (Resident #5) lying in his wheelchair near the bird cage beckoned her to come to him. When she did, Resident #5 grabbed her breast. The facility investigation documented that Resident #15 said she told Resident #5 she was aware of his behavior and he should stop. Resident #15 reported Resident #5 had grabbed her breast, on approximately 2/23/26 and said she was not afraid of Resident #5 because he was in a wheelchair and could not move without assistance. The investigation revealed Resident #15 had no previous behavior incidents at the facility. Resident #5 was identified as an alleged assailant in two previous incidents at the facility on 8/15/25 and 10/13/25 and was placed on one-to-one care for supervision and behavior monitoring. The investigation indicated the facility substantiated the sexual abuse.B. Resident #15 (victim)A. Resident status Resident #15, age greater than 65, was admitted to the facility on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included diabetes mellitus, difficulty walking, anxiety, and depression. The 7/14/26 minimum data set (MDS) assessment revealed Resident #15 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision/touching assistance from staff for shower transfers and walking, and set up assistance for bed mobility. The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Resident interviewResident #15 was interviewed on 7/16/26 at 2:15 p.m. Resident (continued on next page)</p> |                                                                                           |                                                 |

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<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                                                 |
| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>#15 said she remembered the incident with Resident #5 on 2/23/26. Resident #15 said Resident #5 reached out and grabbed her breast. Resident #15 said she was unsure if anyone witnessed the incident and said she did not initially report the incident because she was not afraid of Resident #5. Resident #15 said she had seen Resident #5 in the facility occasionally, and on the day Resident #5 grabbed her breast (2/23/26), staff had not intervened to direct her away from him. Resident #15 said she was not upset after the incident and she was not afraid of Resident #5 or any other resident in the facility. Resident #15 said she would report any future concerns for herself or other residents to the nurse.3. Record reviewA physicians progress note, dated 2/24/26, revealed Resident #15 was evaluated after the sexual abuse was reported and no concerns were identified. -The record review revealed Resident #15 had no care plan focus for the potential for sexual abuse. C. Resident #5 (assailant)1. Resident statusResident #5, age greater than 65, was admitted to the facility on [DATE]. According to the July 2026 CPO, diagnoses included stroke with left-sided paralysis, cognitive communication deficit, history of traumatic brain injury, anxiety, depression, and personality and behavioral disorders. The 3/10/26 MDS assessment revealed Resident #5 was moderately cognitively impaired with a BIMS score of 12 out of 15. Resident #5 used a wheelchair for mobility and was dependent on staff assistance for his activities of daily living (ADL).The MDS assessment indicated the resident had physical behavioral symptoms directed at others for one to three days during the assessment look-back period. 2. Record reviewThe behavior care plan, revised 6/29/25, revealed Resident #5 had inappropriate physical contact with female staff and/or female residents. Pertinent interventions included administering medications as ordered, monitoring medications for effectiveness, monitoring with one-to-one supervision for 72 hours after incidents until the interdisciplinary team (IDT) determined if behavior was appropriate to discontinue one-to-one monitoring, anticipating and meeting Resident #5's needs, discussing inappropriate behavior with Resident #5, intervening as necessary to protect others for inappropriate touching, positioning Resident #5 with his right side towards the wall so that he could not reach others, and educating staff on appropriate placement of Resident #5 when he was in the common areas (initiated 6/29/25). -There were no revisions made to Resident #5's behavior care plan after the 2/23/26 sexual abuse incident with Resident #15.An IDT progress note, dated 2/27/26, documented Resident #5 was placed on one-to-one supervision while out of bed for an incident of sexual abuse. The IDT documented a referral was made to transfer Resident #5 to another facility.A physician's progress note, dated 2/28/26, documented Resident #5 was evaluated as a follow-up after an incident of sexually inappropriate behavior toward another resident. The progress note revealed Resident #5 had resided at another facility until 6/24/25, when he was transferred for inappropriate sexual behavior toward another resident. The physician documented Resident #5 was scheduled for a facility-initiated discharge to protect other residents. -However, Resident #5's responsible party appealed the discharge plan and Resident #5 remained at the facility. III. Incident of sexual abuse of Resident #9 by Resident #14 on 3/29/26A. Facility investigationThe facility's investigation of the incident of sexual abuse of Resident #9 by Resident #14 on 3/29/26 was provided by the NHA on 7/20/26 at 12:57 p.m. The investigation documented that on 3/29/26 at 6:47 p.m. Resident #9 reported to a staff nurse that she was kissed by Resident #14. When the staff nurse asked Resident #14 about the incident, Resident #14 told the nurse he kissed Resident #9. He said that he would do it again and proceeded to kiss Resident #9 a second time. The facility investigation documented that Resident #14 was not redirectable and was placed on one-to-one for monitoring. After the incident, Resident #9 was assisted to her room by a staff member and was assessed by the nurse. The assessment revealed no concerns. The physician evaluated Resident #9, and no immediate concerns were identified. The (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                 |
| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>facility initiated a referral for a psychosocial evaluation for Resident #9 and began monitoring Resident #9 for post-incident changes in mood or behavior. The facility's investigation revealed Resident #9 had a history of verbal aggression, attention-seeking behaviors, manipulation, making false allegations, and poor impulse control. The investigation revealed Resident #9 had family and power of attorney for a consensual romantic relationship that included hand holding, touching, and kissing, with another resident in the facility (not Resident #14). The investigation documented that Resident #9 told a staff member that she was not getting enough attention from her boyfriend and smiled after Resident #14 kissed her. The investigation revealed Resident #14 had cognitive impairment and had no history of behaviors at the facility. Resident #14 admitted to kissing Resident #9, told a staff member he would kiss her again and proceeded to kiss Resident #9 in front of the staff member. The investigation documented Resident #14 was interviewed by a staff member on 4/1/26, and he did not entirely recall the incident. The facility's investigation included interviews with staff members and other residents, and there were no concerns identified about feeling unsafe from unwanted sexual behaviors. The facility's investigation concluded sexual abuse was not substantiated and that this was an isolated incident due to Resident #9's history of attention-seeking behavior and Resident #14's cognitive impairment, poor impulse control, and diagnosis of dementia. -However, sexual abuse did occur as Resident #9 said that she felt unsafe from Resident #14 and said she did not like Resident #14 kissing her. B. Resident #9 (victim) 1. Resident status Resident #9, age less than 65, was admitted to the facility on [DATE], discharged on 9/7/25, and readmitted on [DATE]. According to the July 2026 CPO, diagnoses included cerebral palsy, quadriplegia, irritability, and anger. The 5/12/26 MDS assessment revealed Resident #9 had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident was dependent on staff for all ADLs. The MDS assessment indicated Resident #9 had verbal behavioral symptoms directed toward others for one to three days during the assessment look-back period. 2. Resident interview Resident #9 was interviewed on 7/22/26 at 8:55 a.m. Resident #9 said she remembered when Resident #14 approached her and kissed her on her lips (on 3/29/26). Resident #9 said she did not ask Resident #14 to kiss her and she was upset that he kissed her a second time on the same day. Resident #9 said she was afraid that Resident #14 was going to try to kiss her, but she had told only her boyfriend (a resident at the facility) about her concerns. Resident #9 said she loved her boyfriend and enjoyed spending time with him. 3. Record review Resident #9's consensual boyfriend care plan, dated 4/8/24, revealed the resident had a boyfriend relationship with another resident who resided in the facility. Resident #9's family and power of attorney agreed and consented to the relationship that included holding hands, touching, and kissing. Interventions included encouraging Resident #9 to express any feelings of discomfort or areas of concern she may have in her consensual boyfriend relationship (initiated 4/8/24). The potential for emotional distress/trauma care plan, dated 3/30/26, identified that Resident #9 may present with behavioral or physical changes after she was kissed by another resident who was not her boyfriend. Interventions included redirecting the triggering resident away from Resident #9 to prevent further contact, educating all staff that Resident #9 had increased vulnerability for unwanted touching from other residents, monitoring non-verbal indicators for emotional distress, and providing activities in a calm, structured environment with trusted staff members nearby (initiated 3/30/26). C. Resident #14 (assailant) 1. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the July 2026 CPO, diagnoses included dementia, depression, unsteady on feet, difficulty walking, and post-traumatic stress disorder. The 7/3/26 MDS assessment revealed Resident #14 had severe cognitive impairment with a BIMS score of six out of 15. Resident #14 used a walker for ambulation. He was independent for all ADLs. The (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           |                                                 |
| F 0600<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>MDS assessment indicated the resident had wandering behavior on one to three days during the assessment look-back period. 2. Record reviewA nurse practitioner's progress note, dated 3/30/26, revealed Resident #14 was evaluated after he was seen kissing another resident (Resident #9) twice and he had a history of similar behaviors. The progress note revealed Resident #14 was placed on one-to-one care for monitoring, and referrals were made to transfer Resident #14 to a facility with a memory care unit and for a behavioral health evaluation. The 3/30/26 social services progress note revealed the IDT noticed Resident #14 had a significant cognitive decline and felt Resident #14 would benefit from being transferred to a memory care unit. A behavior health progress note, dated 3/31/26, documented Resident #14 admitted to kissing Resident #9 previously (approximately one month previously) but denied kissing her on 3/30/26. The progress note revealed Resident #14 would benefit from placement on a secure unit; however, Resident #14's responsible party declined a transfer to another facility. IV. Incident of physical abuse of Resident #11 by Resident #12 on 6/12/26A. Facility investigationThe facility's investigation of the incident of physical abuse of Resident #11 by Resident #12 on 6/12/26 was provided by the NHA on 7/20/26 at 12:57 p.m. The facility's investigation, dated 6/12/26, documented that Resident #12 ran over Resident #11's feet with his wheelchair when they were both outside a staff member's office. The investigation documented Resident #12 told Resident #11 that he would run over his feet if he did not stop talking. The investigation documented Resident #11 stated he was talking to a staff member and Resident #12 rolled over his feet with his wheelchair. The investigation documented Resident #12 said he was rolling forward and not looking where he was going. Resident #12 said that he did not run over Resident #11's toe but had bumped it. Resident #12 said if he had tried to run over Resident #11's feet, he would have yelled. The facility investigation included a witness statement that documented he observed Resident #11 and Resident #12 arguing in front of an office at the facility. The witness said he heard Resident #12 tell Resident #11 to shut up. The witness said at the same time Resident #11 asked Resident #12 to scoot his wheelchair forward so that he did not bump into him. The witness reported he heard Resident #12 tell Resident #11 to shut up or he would run over his feet. The witness reported he then observed Resident #12 intentionally run over Resident #11's feet. The witness reported Resident #11 responded by raising his fist towards Resident #12. The investigation documented the residents were separated at the time of the incident and staff monitored both residents per facility policy. The investigation documented the facility unsubstantiated the incident of physical abuse because both residents had a behavioral response towards each other. -However, physical abuse did occur when Resident #12 intentionally ran over Resident #11's toes. B. Resident #11 (victim) 1. Resident status Resident #11, age less than 65, was admitted on [DATE]. According to the July 2026 CPO, diagnoses included congestive heart failure, malnutrition, dementia, high blood pressure, and cognitive communication deficit. The 7/6/26 MDS assessment revealed Resident #11 had moderate cognitive impairment with a BIMS score of 12 out of 15. Resident #11 required supervision or touching assistance for transfers and showers, and setup assistance for dressing and bed mobility. Resident #11 used a manual wheelchair for mobility. The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms during the assessment look-back period. 2. Resident interview Resident #11 was interviewed on 7/21/26 at 11:15 a.m. Resident #11 said he remembered the altercation he had with Resident #12 on 6/12/26). Resident #11 said Resident #12 yelled at him and told him he was going to run over him with his wheelchair because he was in his way. Resident #11 said he did not provoke or understand why Resident #12 thought it was all right to run over his feet. Resident #11 said Resident #12 was a large person and he had pain in his left foot after the incident. Resident #11 said the facility completed an Xray of his left foot and there was nothing wrong with his left foot. However, Resident (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                 |
| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>#11 said that he continued to have pain in his left foot. Resident #11 said staff separated Resident #12 from him, and he had not had any additional altercations or fear of Resident #12. 3. Record reviewA physician's assistant progress note, dated 6/15/26, documented Resident #11 was evaluated for injury to his first and second toes on his left foot, following a resident-to-resident altercation. The progress note documented Xrays were obtained of the left toes and revealed there were no acute fractures. C. Resident #12 (assailant)1. Resident statusResident #12, age less than 65, was admitted on [DATE]. According to the July 2026 CPO, diagnoses included chronic obstructive lung disease, alcoholic liver disease, morbid obesity, difficulty walking, and lack of coordination. The 5/20/26 MDS assessment revealed Resident #12 was cognitively intact with a BIMS score of 15 out of 15. Resident #12 required substantial to maximum assistance from staff for dressing and transfers. Resident #12 used a manual wheelchair for mobility. The MDS assessment indicated Resident #12 had verbal behavioral symptoms directed toward others for one to three days during the assessment look-back period. 2. Record reviewThe IDT progress note, dated 6/16/26, revealed Resident #12 had poor situational awareness and poor impulse control. The progress note documented the altercation with Resident #11 was witnessed by a staff member and the staff member was unable to intervene to prevent the altercation. The progress note documented the staff member immediately separated the residents and they were assessed by the nurse. Resident #12 had no injuries. A physician's assistant progress note, dated 6/17/26, documented Resident #12 was evaluated for a recent altercation with another resident. The physician documented Resident #12 said he did not intentionally run over Resident #11's feet. The physician's assistant made no recommendations to change Resident #12's behavior care plan.Resident #12's behavior care plan, initiated 12/3/25, revealed Resident #12 had the potential to be verbally and physically aggressive. Pertinent interventions included administering medications as ordered, monitoring for side effects and effectiveness of medications, identifying behavior triggers and effective de-escalation interventions, anticipating and meeting Resident #12's needs, monitoring Resident #12 for signs of Resident #12 posing a danger to himself or to others, assisting Resident #12 with appropriate methods of coping and interacting with others, and discussing inappropriate behaviors (initiated 5/12/26).-There were no revisions made to Resident #12's behavior care plan after the 6/12/26 physical abuse incident with Resident #11.V. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 7/14/26 at 8:17 a.m. LPN #1 said Resident #9 had a boyfriend who sat with her in the common area, and Resident #9 enjoyed holding his hand and spending time with him. LPN #1 said she was aware of the incident of Resident #14 kissing Resident #9. LPN #1 said Resident #14 had recent falls and increased weakness and was not strong enough to wander in the hallways. She said she monitored Resident #9 when she was in the common area and had no observations of Resident #14 approaching Resident #9.Registered nurse (RN) #1 was interviewed on 7/22/26 at 12:35 p.m. RN #1 said he provided care for Resident #15 and had not noticed a change in her mood or behavior after Resident #5 had kissed her. The NHA and the clinical resource nurse were interviewed together on 7/22/26 at 1:25 p.m. The NHA said the incident of sexual abuse between Resident #15 and Resident #5 was not witnessed by a staff member. The NHA said the facility was aware Resident #5 had a history of sexually inappropriate behavior prior to his admission. The NHA said the intervention of positioning Resident #5 out of reach of others was the intervention in place to protect others from Resident #5 grabbing others. The NHA said the facility would review Resident #5's care plan for appropriate and effective interventions.The clinical resource nurse said Resident #9 had a history of attention seeking behavior and calling out to other residents to approach her. The clinical resource nurse said staff were aware that Resident #9 liked to sit in the common area and was dependent on staff to position her. The clinical resource nurse said staff kept (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                 |
| F 0600<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Resident #9 in their line of sight whenever possible. The clinical resource nurse said Resident #14 had made no additional attempts to approach and kiss Resident #9. The clinical resource nurse said Resident #14 was experiencing a change in condition with increased weakness and was unable to ambulate independently. The clinical resource nurse said Resident #14 was evaluated for transfer to a locked memory care unit and his responsible party declined. The clinical resource nurse said the facility would continue to monitor Resident #14 to ensure he did not attempt to kiss any female residents. The NHA said Resident #11 and Resident #12 each had a history of behaviors towards others. The NHA said the facility did not substantiate the occurrence between the two residents on 6/12/26 because after Resident #12 ran over Resident #11's feet, Resident #11 swung at Resident #12's head. The NHA said after the incident, the residents spoke to each other and said they were sorry for the altercation. The NHA said Resident #11 and Resident #12 did not reside on the same hallway and staff were educated to keep the residents apart from each other. RN #1 said he was familiar with Resident #14 and said Resident #14 was unable to propel his wheelchair independently. RN #1 said Resident #14 enjoyed socializing with other residents and staff assisted him to common areas. RN #1 said staff positioned Resident #14 so that he was not physically able to reach out and touch other residents, due to his paralyzed left side. |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision for one (#13) of three residents reviewed for accidents out of 15 sample residents. Specifically, the facility failed to ensure Resident #13 was provided safe transportation in the facility's van. Findings include: Observations, record review, and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation from 7/14/26 to 7/22/26, resulting in the deficiency being cited as past non-compliance with a correction date of 6/10/26. I. Van incident involving Resident #13 on 6/2/26 On 6/2/26 Resident #13 was assisted into the van after an appointment by van driver #1. Resident #13 was not secured properly in the van by van driver #1. When the van braked, Resident #13 slid from his wheelchair and fell onto the floor of the van. Van driver #1 assisted Resident #13 to his wheelchair and returned to the facility. On 6/8/26, Resident #13 reported the 6/2/26 van incident to the nursing home administrator (NHA). Resident #13 complained of swelling and pain in his lower left extremity and embarrassment after falling from his seat in the facility van. An X-ray was ordered of Resident #13's lower extremities and revealed no injuries. The facility's failure to ensure van driver #1 secured Resident #13's wheelchair in the facility's van when he was being transported to and from her appointment placed the resident at serious risk of harm, serious impairment, or death. Resident #13 complained of swelling and pain in his lower left extremity and embarrassment after falling from his seat in the facility van. II. Facility plan of correction The corrective action plan the facility implemented in response to the van incident on 6/2/26 involving Resident #13 was provided by the NHA on 7/20/26 at 12:57 p.m. The correction plan revealed the following: A. Immediate action On 6/8/26, after Resident #13 reported the 6/2/26 van incident to the NHA, Resident #13 was assessed by the facility nurse. The nurse identified no injuries, but Resident #13 complained of lower left leg pain and swelling. On 6/8/26, the physician was contacted and gave an order for a left lower extremity Xray. The Xray was completed and revealed no injuries were present. Van driver #1 was suspended from the facility on 6/8/26, pending an investigation. On 6/8/26, the NHA initiated an investigation that included a root cause analysis and corrective action plan. An inspection of the van, seatbelts, and wheelchair restraints was completed on 6/8/26 by the maintenance supervisor and no defective equipment was identified. B. Identification of others affected On 6/8/26, the facility determined the deficient practice had the potential to affect all residents who used wheelchairs in the facility. A review of other residents was completed to determine if vehicle safety belts were properly applied, and no residents were identified as being improperly restrained in the facility van. C. Systemic changes The facility provided documentation that all staff who could transport residents had completed wheelchair securement training by 6/10/26. The training included correct procedures for securing wheelchairs in vehicles, the use of appropriate restraints and securing devices, how to inspect and ensure all safety equipment was functioning properly before transport, and procedures to follow in case of an emergency or equipment malfunction. D. Monitoring The facility would complete daily monitoring of progress notes and incident reports to identify any concerns with resident safety during transportation in the facility van. The 6/10/26 quality assurance and performance improvement (QAPI) committee reviewed the results of the corrective action plan for staff education and daily monitoring. The QAPI committee determined all staff involved in transporting residents completed the mandatory education and residents were properly restrained in the facility van before operating the vehicle. III. Facility policy and procedure The (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Transporting a Resident, Facility Van policy, revised 6/8/26, was provided by the NHA on 7/21/26 at 10:56 a.m. It read in pertinent part, It is the policy of this facility to provide residents safe, non-emergency transportation to doctor's appointments, activity outings, and other trips the facility deems necessary. The van will be well-maintained and equipped with safety features. Each resident will be secured by a seatbelt while in a seat or in their wheelchair. All wheelchairs will be secured with wheelchair tie-downs.IV. Facility's investigation of Resident #13's fall on 6/2/26Resident #13's fall investigation was provided by the NHA on 7/20/26 at 12:57 p.m. The investigation documented the following:The 6/8/26 incident report documented that Resident #13 was returning to the facility in the transport van. The investigation report documented that van driver #1 secured Resident #13's wheelchair in the facility van. When van driver #1 attempted to apply the vehicle passenger-restraint seat belt, Resident #13 refused and told van driver #1 he did not like the way van driver #1 applied the seat belt. The report read that during the drive back to the facility, van driver #1 applied the van brakes and Resident #13 slid from his wheelchair to the floor in the van. Resident #13 reported the incident to the NHA on 6/8/26. A nurse assessed Resident #13, and no injuries were revealed. On 6/8/26, Resident #13 complained of pain and swelling in his lower left extremity. The physician ordered an Xray of the resident's left leg on 6/8/26 and no injuries were identified. On 6/8/26, the investigation documented the facility provided education and training for applying the five-point vehicular passenger restraints in the facility van. The education included completing a transportation safety checklist and that no transportation would occur if a resident refused to wear the vehicle restraint belt. The educated instructed staff to immediately report any accidents that occurred during the transportation of residents.The facility investigation documented that proper education and demonstrations of how to secure wheelchair residents in the van were not completed prior to the incident. The facility trained all drivers, including a return demonstration, and educated the drivers that all passengers must use a seat belt restraint prior to moving the van. The facility identified the root cause of the incident as gaps in transportation safety, including inconsistent application of passenger restraint belts, and a lack of a standardized process for managing resident refusals to use the passenger seat belt restraint system.The facility investigation identified there was no evidence of facility staff neglect, and van driver #1 was reinstated to his position. V. Resident #13A. Resident statusResident #13, age less than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included end-stage kidney disease, kidney dialysis, right and left below-knee amputations, depression, and anxiety.The 5/29/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #13 used a wheelchair and required set-up, supervision, or touching assistance from staff for repositioning, transferring, toilet hygiene, and dressing. He required supervision or touching assistance for showering and wheelchair mobility. B. Resident interview and observationResident #13 was interviewed on 7/22/26 at 8:40 a.m. Resident #13 was sitting in a wheelchair outside the facility in the outdoor patio area. Resident #13 said he remembered the incident on 6/2/26 in the facility van. Resident #13 said he was very weak from his kidney dialysis when he was loaded into the wheelchair van by van driver #1. Resident #13 said he noticed that van driver #1 secured his wheelchair in the van but did not correctly apply his passenger-restraint seat belt. Resident #13 said van driver #1 appeared unsure of what belts to use for the passenger seat belt restraint system. Resident #13 said van driver #1 tried to use the restraint belt for the seat next to him, instead of the restraint belt for where he was sitting, which created a tangled mess and did not properly reach across his body. Resident #13 said he asked van driver #1 to use the correct belt, and van driver #1 would not listen to him. Resident #13 said he did not have the energy to continue (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>discussing his concern with van driver #1 and trusted that van driver #1 eventually used the correct seat belt restraint. Resident #13 said van driver #1 began driving back to the facility, and along the route, van driver #1 had to brake suddenly, and he (Resident #13) fell forward from his wheelchair and landed on the van floor. Resident #13 said he and van driver #1 were able to reposition him in his wheelchair, and van driver #1 resumed driving to the facility. Resident #13 said when the van returned to the facility, he was upset from the fall and said he was in a hurry to return to his room after the kidney dialysis treatment and waited to report his leg pain because he did not feel well. Resident #13 said van driver #1 asked that he not report the incident to the facility, and Resident #13 said he was okay with that, but said he asked van driver #1 to watch a video or learn somewhere how to use passenger seat belt restraints properly. Resident #13 said when he went for his next dialysis treatment on 6/8/26, he observed van driver #1 appeared to again not understand what seat belts should be used for the passengers in the van. Resident #13 said when he returned to the facility on 6/8/26, he reported the 6/2/26 van incident to the NHA because the van driver had not improved in applying passenger restraint seat belts. Resident #13 said after he reported his concerns to the NHA on 6/8/26, van driver #1 began using the passenger restraint belts properly for himself and other wheelchair passengers on the facility van. Resident #13 said he was unaware the facility developed a behavior care plan that identified that he refused to wear his passenger restraint seat belt (see record review and interviews below). Resident #13 said that made him upset because he always wanted to wear his seat belt and had had years of experience using passenger restraints in transportation vans. Resident #13 said when he did not feel well, he should be able to trust the facility staff to ensure he was properly restrained in the van. Resident #13 said he had pain and swelling in his lower left leg after the fall on 6/2/26. Resident #13 said the facility completed an Xray of his left leg after he reported the van incident and the pain was slowly improving. C. Record review/Resident #13's behavior care plan, initiated 7/8/26, revealed the resident had a tendency to refuse to wear a seat belt in the facility van. Interventions included educating Resident #13 on the necessity of care offered, ensuring the safety of Resident #13, establishing boundaries and limits with Resident #13, monitoring for cognitive factors, emotional, environmental factors with the new behavior, monitoring for signs and/or symptoms of infection, notifying family of new onset finding, providing emotional support regarding new onset of disruptive behavior, providing emotional support regarding new onset of repetitive behaviors, providing verbal feedback regarding behaviors, and using diversion techniques as needed (initiated 7/8/26). A nurse progress note, dated 6/8/26, documented the physician ordered an Xray of Resident #13's left lower extremity. A behavioral health provider progress note, dated 6/11/26 at 8:30 a.m., documented Resident #13 reported the 6/2/26 transportation incident. The progress note revealed Resident #13 did not report the incident to the facility at the time of the incident, and the facility became aware of the incident on 6/8/26. The progress note revealed a nurse assessed Resident #13, and there were no acute changes or injuries noted. The provider documented Resident #13 complained of discomfort in his left lower leg; an Xray was obtained and revealed no acute findings. The provider documented Resident #13 was educated to report safety concerns, incidents, or injuries to facility staff as soon as possible to allow for timely staff assessments and interventions. The IDT progress note, dated 6/11/26 at 9:36 a.m., documented Resident #13 reported that during his transportation to dialysis on 6/2/26, his wheelchair was not secured appropriately in the facility van. The progress note documented Resident #13 did not report the incident to the facility at the time of the event, and the facility became aware of the incident on 6/8/26. The progress note documented Resident #13 was assessed by a nurse on 6/8/26, and no changes or injuries were noted. The progress note revealed Resident #13 complained of discomfort in his lower left extremity, below (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>065175                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Kiowa Hills Rehabilitation and Nursing, LLC                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                           |                                                 |
| F 0689<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | the knee amputation, and the facility obtained an Xray that revealed no acute findings. The progress note revealed the attending physician was notified of the incident and gave no new orders, except for the leg Xray. VI. Staff interviewsThe NHA and the clinical resource nurse were interviewed together on 7/22/26 at 1:25 p.m. The NHA said that on 6/2/26 van driver #1 transported Resident #13 from his kidney dialysis treatment back to the facility. The NHA said Resident #13 refused to wear the van's passenger restraint seat belt. The NHA said when van driver #1 was interviewed, van driver #1 said that he educated Resident #13 about wearing a restraint seat belt, but Resident #13 continued to decline to wear the passenger restraint belt. The NHA said van driver #1 proceeded to travel back to the facility, and when he applied the van brakes, Resident #13 slid forward and fell from his wheelchair. The NHA said Resident #13 was not assessed on 6/2/26, the day of the incident, because Resident #13 did not report the incident or the pain he experienced in his leg until 6/8/26. The NHA said van driver #1 had received education and training in April 2026 on operating/driving the facility van and how to use the passenger seat belt restraint system. The NHA said van driver #1 should have contacted the facility prior to driving with an unrestrained passenger, and van driver #1 should have reported the incident immediately upon his return to the facility. The NHA said when the facility became aware of the incident on 6/8/26, van driver #1 was suspended from working while the facility conducted an incident investigation. The NHA said van driver #1 was re-educated on applying the passenger seat belt restraint system and performed a return demonstration. He said van driver #1 was approved to return to his position as a facility van driver. The clinical resource nurse said during the investigation of the van incident involving Resident #13, the facility identified that Resident #13 refused to wear the van's passenger seat belt restraint and he had previously demonstrated behaviors of releasing his seat belt early, before the van was fully stopped, when the van returned to the facility. The clinical resource nurse said safety education was provided to Resident #13, following the 6/2/26 incident, on the importance of using the passenger seat belt restraint system, and there had been no further concerns. The clinical resource nurse said the facility completed a corrective action plan that included daily monitoring of documentation or incident reports for concerns regarding residents' van transportation. The clinical resource nurse said the facility had had no additional concerns of resident safety during van transportation. |                                                                                           |                                                 |