STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065217	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canon Lodge Care Center	905 Harding Ave Canon City, CO 81212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#8) of three residents reviewed for abuse out of 28 sample residents were free from abuse.Specifically, the facility failed to protect Resident #8 from physical abuse by Resident #22.Findings include:I. Facility policy and procedureThe Abuse Prevention policy, reviewed on 5/6/25, was received from the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It revealed in pertinent part, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as verbally aggressive behavior, physically aggressive behavior, sexually aggressive behavior, taking, touching, or rummaging through other's property, wandering into others' rooms/space, residents with a history of self-injurious behaviors, residents with communication disorders or who speak a different language, and residents that require extensive nursing care and/or are totally dependent on staff for the provision of care.II. Physical abuse of Resident #8 by Resident #22 on 7/1/25A. Facility investigationThe facility investigation was provided by the NHA on 8/12/25 at 9:03 a.m.The investigation documented that on 7/1/25 at 7:56 a.m., in the main dining room, certified nurse aide (CNA) #1 asked Resident #22 if she could move him in order to make room for Resident #8 to get to a table in the dining room. When Resident #22 was moved, he turned himself around in his wheelchair and placed both hands on Resident #8 chest, pushing him backwards. Resident #8 left the dining room and went to his room. Staff assessed Resident #8 for injuries and none were observed. Resident #22 was placed on one-to-one monitoring following the event while an investigation was being completed. CNA #1's eyewitness statement, dated 7/1/25, documented that CNA #1 had asked Resident #22 if she could move him to allow Resident #8 access to a table in the dining room. Resident #22 told CNA #2 sure go ahead and try while laughing. CNA #2 moved Resident #2 to the side and when she went to move Resident #8, Resident #22 had turned around towards Resident #8 and put both hands on Resident #8's chest, slamming him backwards in his wheelchair. Resident #8's wheelchair rolled backwards and Resident #8 was heard yelling no and took off out of the dining room.CNA #1 said Resident #22 hollered Do not be moving me! CNA #1 informed Resident #22 she had asked his permission prior to moving him and that no one had touched him other than her. Resident #22 responded that if anyone touched him, he would make them regret it.CNA #1 said she found Resident #8 in his room and he had two hand prints on his chest. Resident #8 returned to the dining room but was shaking and scanning the dining room for Resident #22. Resident #22 was taken to a table in the corner of the dining room away from Resident #8.The social services director (SSD) attempted to interview Resident #8 but he had no response and left the room. Resident #22 was interviewed by social services and he had no recollection of the event. The facility completed staff, resident and family representative interviews and no other abuse concerns were identified. The police, the physicians, the ombudsman and the family representatives were all informed of the incident. Resident #22 remained on-one-to one monitoring for 72-hours until the interdisciplinary team (IDT) met and concluded one-to-one monitoring was no longer needed as Resident #22 had not exhibited any other behaviors.The facility substantiated the abuse allegation as it was witnessed by staff. B. Resident #8 (victim)1. Resident statusResident #8, age greater than 65 was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included neurocognitive disorder (decline in cognitive function, including memory, thinking, and reasoning), dementia and rhabdomyolysis (damaged muscle tissue breakdown).The 6/16/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of two out of 15. The resident had unclear speech, was sometimes understood and sometimes understood others. The MDS assessment indicated the resident had no behaviors.2. Record reviewThe comprehensive care plan, initiated 6/16/25, documented Resident #8 had a behavior problem of wandering, trying to look out windows and not being aware of others' personal space related to frontal temporal lobe dementia. The goal was that Resident #8 would not experience behaviors that were harmful to himself or others. Interventions included administering