STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Rehabilitation and Nursing, LLC	1340 E Fillmore St Colorado Springs, CO 80907

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 - Some	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: 065225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025

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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to take steps to protect four (#67, #39, #36 and #31) of five residents reviewed for abuse out of 39 sample residents. Specifically, the facility failed to protect Resident #67, Resident #39, Resident #36 and Resident #31 from physical abuse by Resident #17.Findings include: I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy and procedure, revised 4/11/25, was provided by the regional clinical resource (RCR) on 7/21/25 at 10:19 a.m. It read in pertinent part, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include resident-to-resident altercations. It includes physical abuse.II. Incident of physical abuse between Resident #17, Resident #67 and Resident #39 on 6/19/25A. Facility investigationThe 6/19/25 nurse note revealed the nurse was in the nurses' station when a certified nurse aide (CNA) called for help in the hallway. The nurse went to assist and found three residents in a physical altercation. Resident #17 was hitting Resident #39 in the face and then pulled Resident #67's hair. The CNA and the nurse separated all three residents. The CNA told the nurse that Resident #17 took Resident #39's walker. Fifteen minute checks were initiated. Cares and monitoring for the residents were ongoing. The facility's conclusion of the internal investigation was the incident was substantiated. III. Incident of physical abuse between Resident #17 and Resident #36 on 6/22/25A. Facility investigationThe witness statement by the housekeeper, dated 6/23/25, documented the housekeeper was cleaning Resident #36's bathroom in room [ROOM NUMBER]. Resident #36 was standing by her bed and the housekeeper noticed the resident go to the door. Resident #17 entered the room. The housekeeper came out of the restroom and asked Resident #17 to leave because Resident #36 did not like anyone in her room. Resident #17 became verbal and started to push Resident #36. The housekeeper tried to separate the two residents but Resident #17 immediately pushed Resident #36 down. Resident #36 said she was fine. Resident #17 continued to curse at Resident #36 and grabbed Resident #36's sweater cuffs and did not let go. The housekeeper called for help and a CNA immediately came in and tried to separate the two residents. The CNA took Resident #17 out of the room. The nurse came in and checked Resident #36 for any possible injuries and blood. Resident #36 appeared to be okay. The witness statement by CNA #6, dated 6/22/25, documented CNA #6 saw Resident #36 attacked by Resident #17. She heard yelling and hitting. CNA #6 quickly rushed over to see what was going on. Resident #17 was hitting Resident #36 and the housekeeper and CNA #6 immediately tried to separate the residents from each other. Resident #17 did not want to let go until CNA #6 loosened her grip on Resident #36's shirt. CNA #6 took Resident #17 out of the room. The facility's investigation summary revealed a housekeeper was in Resident #36's room and attempted to intervene and de-escalate. Resident #17 pushed Resident #36 to the floor. The housekeeper called for help, and a CNA came to separate the two residents. The facility's conclusion of the internal investigation was the incident was substantiated. IV. Incident of physical abuse between Resident #17 and Resident #31 on 6/23/25A. Facility investigation of the altercation on 6/23/25The victim's statement (Resident #31), dated 6/23/25, documented Resident #31 was sitting on her bed watching television. Resident #17 (assailant) came over and grabbed her arm. Resident #31 said she did not like that. Resident #31 said Resident #17 grabbed her arm so Resident #31 pulled her arm away and Resident #31 slipped off the bed. The 6/23/25 nurse incident note revealed a nurse heard yelling from Resident #31's and Resident #17's room. Resident #31 was on the floor with Resident #17 standing nearby. Resident #31 said Resident #17 pushed her down when she told Resident #17 to get off of her bed. The facility's conclusion of the internal investigation was the incident was substantiated. The facility's investigation summary revealed Resident #17 had one-on-one supervision from a previous incident in the last week. The interventions included continuing one-on-one supervision for at least one month, Resident #17 moved to a new room, a new medication was added to Resident #17's medication regimen and hospice increased nurse visit frequency. The facility's investigation revealed Resident #17 had two incidents with other residents prior to the incident with Resident #31 on 6/23/25 (see incidents above). The investigation revealed Resident #17 had one-on-one supervision from a previous incident. The conclusion of the internal investigation revealed there was a breakdown in the shift change system that led to substantiating the incident. Resident #17 had an incident on 6/19/25 and 6/22/25 with other residents. The intervention for the 6/19/25 incident was a medication review and 15-minute checks. The intervention for the 6/22/25 was one-on-one supervision. -Review of Resident #17 electronic medical

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure three (#47, #9 and #42) of five residents were free from chemical restraints were receiving the least restrictive approach for their needs out of 39 sample residents. Specifically, the facility failed to: -Ensure Resident #47 and Resident #9 behavior care plans included resident specific non-pharmacological care approaches;-Document consistent behaviors for Resident #47 and Resident #9 to justify the continued use of psychotropic medications; -Document resident-specific care approaches, to include medication specific target behaviors and person-centered intervention for Resident #47 and Resident #9's psychotropic medications; and,-Ensure gradual dose reductions (GDR) were attempted for Resident #42's psychotropic medications. Findings include: I. Facility policy and procedure The Use Of Psychotropic Medications policy, revised 4/28/25, was provided by the regional clinical resource (RCR) on 7/24/25 at 5:12 p.m. It read in pertinent part, “It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident’s medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. “A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. “The indications for initiating, maintaining, or discontinuing medications(s), as well as the use of non-pharmacological approaches, will be determined by evaluating the resident’s physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. “Non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. “The resident’s response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident’s medical record. “Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.” II. Resident #47 A. Resident status (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer’s disease, anxiety disorder, depression and cognitive communication deficit. The 7/23/25 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. She required set up assistance with eating, was dependent on staff for oral hygiene, toileting, showering, dressing and personal hygiene. The MDS assessment revealed the resident wandered on one to three days and exhibited physical behavioral symptoms, such as hitting, kicking, and pushing, directed toward others during the assessment look back period. B. Record review Resident #47’s dementia care plan, revised 12/30/24, revealed the resident had potential to be physically aggressive related to dementia. Interventions included analyzing times of day, place, circumstances, triggers and what de-escalated the resident’s behavior and documenting, assessing and addressing the resident for contributing sensory deficits, assessing and anticipating residents needs, monitoring any signs and symptoms of the resident posing a danger to self or others, offering ambulation for resident in hallway and redirecting the resident when she appeared to introduce in others’ space. Resident #47’s elopement care plan, revised 10/25/24, revealed the resident was a risk for wandering and elopement related to Alzheimer’s disease. Resident #47 wandered aimlessly, significantly intruding on the privacy or activities of others. -Review of Resident #47’s dementia and elopement care plans revealed there were no person centered non-pharmacological interventions. Review of Resident #47’s July 2025 CPO revealed the following physician’s orders: Ativan (antianxiety medication) 0.5 milligrams (mg). Take 0.25 mg by mouth at bedtime for anxiety, ordered 1/2/25. Ativan 0.25 mg. Take 0.25 mg by mouth in the afternoon for anxiety, ordered 1/2/25. Olanzapine (antipsychotic medication) 10 mg. Take 5 mg by mouth at bedtime for dementia, ordered 7/7/25. Trazodone (antidepressant medication with an off label use for insomnia) 50 mg. Take two tablets by mouth at bedtime for dementia with insomnia, ordered 12/26/24. Trazodone 50 mg. Take 25 mg by mouth twice a day for dementia and anxiety, ordered 1/8/25. Behavior monitoring - anti-depressants. Withdrawn, loss of appetite, crying, lack of interest, apathy, feeling of helplessness, feelings of worthlessness, suicidal ideations or insomnia. Interventions: document in progress note, ordered 3/4/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior monitoring - anti-anxiety. Document intervention attempted and effectiveness. Target behavior: avoidance and restlessness. Intervention: redirection, one-on-one, activity, low stimulation environment, toileting, offer snack, offer fluid, position change, assess pain or other intervention documented in progress note. Effective yes or no, ordered 3/4/25. -The behavior monitoring physician’s order failed to include Resident #47’s identified behaviors of physical aggression and wandering. -Resident #47’s physician orders did not include behavior monitoring for the resident’s antipsychotic medication. Review of Resident #47’s April 2025 (from 4/1/25 to 4/30/25) medication administration record and treatment administration record (MAR/TAR) revealed there was one incident of anti-depressant behavior documented on 4/9/25. It indicated the resident was withdrawn. -However, there was no documentation to indicate what intervention was offered and if the intervention was effective. The April 2025 MAR/TAR revealed there were two incidents where anti-anxiety behavior was observed for Resident #47 on 4/4/25 and 4/24/25. -However there was no documentation to indicate what behavior was observed, what interventions were offered and if the interventions were effective. -Review of Resident #47’s May 2025 (from 5/1/25 to 5/31/25), June 2025 (from 6/1/25 to 6/30/25) and July 2025 (from 7/1/25 to 7/23/25) MAR/TAR revealed there was no documentation to indicate the had resident exhibited antidepressant, antianxiety or antipsychotic behaviors during the month. -Review of Resident #47’s electronic medical record (EMR) from 4/1/25 to 7/23/25 revealed there was no documentation to indicate the resident exhibited any behaviors, if interventions were offered and if the interventions were effective. III. Resident #9 A. Resident status Resident #9, age [AGE], was admitted on [DATE] . According to the July 2025 CPO, diagnoses included Alzheimer’s disease, rheumatoid arthritis (chronic autoimmune disease attacks the joints), atrial fibrillation (heart beats irregularly and often too fast) and insomnia. The 6/17/25 MDS assessment documented the resident was severely cognitively impaired with a BIMS score of zero out of 15. Resident #9 required set up assistance with eating, partial assistance with oral hygiene and substantial assistance with toileting and personal hygiene. She required a walker and wheelchair. The MDS assessment indicated the resident exhibited verbal behavior directed toward others on one to three days during the assessment look-back period. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review Resident #9’s psychotropic medication care plan, revised 4/18/25, revealed the resident used a psychotropic medication, Risperdal. Interventions included monitoring for effectiveness every shift and monitoring and recording target behavior symptoms including pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards others and documenting, per facility protocol. Resident #9’s antidepressant medication care plan, revised 3/18/25, revealed the resident used an antidepressant medication, Trazodone. -Review of Resident #9’s psychotropic and antidepressant medication care plans revealed there were no person centered non-pharmacological interventions for the resident’s anti-psychotic and antidepressant medication use. Review of Resident #9’s July 2025 CPO revealed the following physician’s orders: Risperidone (antipsychotic medication) 0.25 mg. Take one tablet by mouth two times a day for Alzheimer’s disease, ordered 7/3/25. Trazodone 50 mg. Take 25 mg by mouth at bedtime for depression, ordered 6/15/25. Behavior monitoring - antidepressants. Withdrawn, loss of appetite, crying, lack of interest, apathy, feeling of helplessness, feelings of worthlessness, suicidal ideations, insomnia. Interventions: document in progress note, ordered 5/11/25. Behavior monitoring - antidepressants. Document interventions attempted and effectiveness. Intervention redirection, one-on-one, diversional activity, offering to call family or friend or other. Effective yes or no, ordered 5/11/25. -There was no physician’s order to monitor for behaviors related to Resident #9’s antipsychotic medications. -Review of Resident #9’s April 2025 (from 4/1/25 to 4/30/25), May 2025 (from 5/1/25 to 5/31/25), June 2025 (from 6/1/25 to 6/30/25) and July 2025 (from 7/1/25 to 7/23/25) MAR/TAR revealed there was no documentation to indicate the resident had exhibited antidepressant or antipsychotic behaviors during the month. The 6/20/25 nurse note revealed Resident #9 was awake and yelling at the top of her voice from 10:30 p.m. to 1:00 a.m. No matter what the staff did for the resident, she was not satisfied. -The progress note failed to include what interventions the staff attempted to use to redirect the resident’s behaviors. The 6/27/25 nurse note revealed the resident was up all day in the common areas for meals and was loud to other residents with unspecific meaning. The resident was easily redirected but only for a short time and then repeated again. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The progress note failed to include what interventions the staff attempted to use to redirect the resident’s behaviors. The 7/2/25 nurse note revealed Resident #9 called out for a specific person’s name after breakfast and was very loud and demanding to go see that person. The resident was redirected without difficulty and was quieter after that. -The progress note failed to include what intervention the staff used to effectively redirect the resident’s behaviors. The 7/19/25 morning nurse note revealed Resident #9 continued to call out “Help” and “I can not do this anymore.” The resident was swearing and disrupting other residents. -The progress note failed to include what interventions the staff attempted to use to redirect the resident’s behaviors. IV. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 7/24/25 at 11:36 a.m. CNA #2 said she knew what behaviors to monitor for residents based on their care plans. CNA #2 said she did not document what interventions were used and if the interventions were effective. She said she was familiar with Resident #47 and Resident #9. She said she did not know of any non-pharmacological interventions to use for Resident #47 or Resident #9’s behaviors. Licensed practical nurse (LPN) #3 was interviewed on 7/24/25 at 3:49 p.m. LPN #3 said she would document if she observed a resident’s behavior. She said she did not document if an intervention was used or if the intervention was effective. LPN #3 said was familiar with Resident #47 and Resident #9. She said the behavior Resident #47 had was pacing. She said she did not know what interventions worked Resident #47’s pacing behavior. During the interview, Resident #9 was yelling off and on in the common area in the secured unit. The resident yelled “I get so scared” and “help.” LPN #3 said the behavior Resident #9 had was being loud and wanting help. She said Risperdal, talking calmly and softly and coloring were effective interventions. She said food was not an effective intervention for the resident. The director of nursing (DON) and regional clinical resource (RCR) were interviewed together on 7/23/25 at 3:39 p.m. The RCR said the interdisciplinary team (IDT) determined what behaviors needed to be monitored for residents and social services was responsible for entering the behavior monitoring in the residents’ chart after the IDT discussion. The RCR said the IDT reviewed the incoming notes from the facility or hospital where the resident transferred from and from the 24-hour communication bar in the medical record. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said nursing staff knew what interventions to use for each resident based on the behavior tracking on the residents’ TARs. She said CNAs told the nurses when residents had behaviors. The DON said nursing staff entered a progress note or used the TAR. She said nursing staff should use the TAR and then document a progress note about the behavior. The DON said she knew what interventions worked for residents based on verbal reports from the nursing staff. The DON said if the interventions did not work, she would reach out to the resident’s physician and family. The DON said the residents’ families shared what worked for them. The social services director (SSD) was interviewed on 7/24/25 at 12:34 p.m. The SSD said at admission, she went through the admission paperwork for residents to see if there was any behavior to monitor. She said she knew what interventions to use for a resident because there was an IDT discussion about the behaviors. She said if there was an event where a behavior was exhibited, she worked with the IDT team to find out what triggered the behavior. She said non-pharmacological interventions were used prior to a resident starting a psychotropic medication. She said nursing staff was responsible for documenting if a resident exhibited a behavior, what interventions were used and if the intervention used was effective. She said she was not sure how nursing staff documented residents’ behavior monitoring. The SSD said she was familiar with Resident #9. She said the resident had auditory behaviors because she did not hear well. She said she yelled for her daughter. She said snacks and fluids were interventions that worked for her. -However, according to LPN #3, food was not an effective intervention for Resident #9 (see interview above). The SSD said she was familiar with Resident #47. She said the resident wandered. She said interventions that worked with her were specific redirection like talking to her about her past life, such as where she lived and about her career. The DON and the RCR were interviewed together again on 7/24/25 at 4:27 p.m. The DON said non-pharmacological interventions should be offered when residents’ behaviors were elevated. She said she was familiar with Resident #9 and said she yelled for her daughter. She said interventions that worked for Resident #9 were changing the resident to a different seat at a different table, a one-on-one conversation with the resident, coffee and a snack. -However, according to LPN #3, food was not an effective intervention for Resident #9 (see interview above). The DON and the RCR said the documentation of behavior monitoring, including what interventions to use could use improvement. V. Resident #42 A. Resident status Resident #42, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 CPO, diagnoses included chronic respiratory failure, dementia, bipolar 2 disorder, borderline personality disorder, generalized anxiety disorder and depressive episodes. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/7/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The MDS assessment indicated the resident had delusions. The assessment documented the resident had not had any other behavioral symptoms during the assessment look-back period. The MDS assessment documented a gradual dose reduction (GDR) had been attempted on 9/27/24. The assessment indicated a physician documented a GDR was contraindicated for the resident on 4/28/25. B. Resident interview and observations On 7/21/25 at 10:04 a.m. Resident #42 was talking with her physician in her room. Resident #42 said she did not want to take her Seroquel in the middle of the day because it made her so tired. -The physician’s response was not able to be heard. Resident #42 was interviewed on 7/21/25 at 10:15 a.m. Resident #42 said she had talked with her physician earlier and told them she did not want to be on so many medications because they made her so tired. Resident #42 said her physician told her as long as he was her doctor she had to take all of her medications. Resident #42 said she felt like she was on too many medications. C. Record review The antipsychotic medication care plan, revised 7/14/25, revealed Resident #42 took an antipsychotic medication for her bipolar disorder. Pertinent interventions included administering her medications as ordered and observing for side effects and effectiveness each shift, consulting with the pharmacy and physician to consider dose reduction when clinically appropriate for the resident at least quarterly, and discussing with the physician and family the need for ongoing medication use with the resident. The anxiety care plan, revised 7/12/24, revealed Resident #42 had an anxiety disorder. Pertinent interventions included moving Resident #42 to a calm, safe environment when conflict arose, allowing the resident time to answer questions and verbalize her feelings, and encouraging participation from the resident. The depression care plan, revised 7/14/25, revealed Resident #42 took an antidepressant medication for her depression. Pertinent interventions included administering her medications as ordered and observing for side effects and effectiveness each shift. The bipolar care plan, revised 11/8/24, revealed Resident #42 had bipolar disorder. Pertinent interventions included administering medications as ordered, assisting the resident to develop appropriate methods of coping and interacting, intervening as necessary to protect the rights and safety of others, and observing the resident’s behavioral episodes and attempting to determine their underlying cause. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The cognitive care plan, revised 12/10/24, revealed Resident #42 had impaired cognitive function. Pertinent interventions included administering medications as ordered, cueing and reorienting the resident as needed, approaching the resident in a gentle friendly manner, and reviewing the resident’s medications and recording possible causes of cognitive deficits. Review of Resident #42's July 2025 CPO revealed the following physician's orders: Clonazepam 1 mg oral tablet, give one tablet by mouth at bedtime for bipolar disorder, ordered 9/26/24. Clonazepam 1 mg oral tablet, give one tablet by mouth in the afternoon for bipolar disorder, ordered 9/26/24. Clonazepam 1 mg oral tablet, give one tablet by mouth in the morning for bipolar disorder, ordered 9/26/24. Lamotrigine 200 mg oral tablet, give 200 mg by mouth at bedtime for bipolar disorder, ordered 11/21/24. Lamotrigine 200 mg oral tablet, give 200 mg by mouth in the morning for bipolar disorder, ordered 11/21/24. Melatonin 1mg oral capsule, give 1 mg by mouth at bedtime for insomnia, ordered 1/31/25. Seroquel 25 mg oral tablet, give one tablet by mouth in the afternoon for bipolar disorder, ordered 1/1/25 and discontinued 7/17/25. Seroquel 25 mg oral tablet, give one tablet by mouth in the morning for bipolar disorder, ordered 1/1/25 and discontinued 7/17/25. Seroquel 25 mg oral tablet, give one tablet by mouth in the morning for bipolar disorder, ordered 7/17/25. Seroquel 25 mg oral tablet, give one tablet by mouth in the afternoon at 2:00 p.m. for bipolar disorder, ordered 7/17/25. Seroquel 25 mg oral tablet, give four tablets by mouth at bedtime for bipolar disorder, ordered 1/1/25 and discontinued 7/17/25. Seroquel 25 mg oral tablet, give four tablets by mouth at bedtime for bipolar disorder, ordered 7/17/25. Venlafaxine 150 mg extended release oral tablet, give one tablet by mouth in the morning daily with breakfast for bipolar disorder, ordered 9/26/24. Review of Resident #42's MARs and TARs, from 3/1/25 to 7/24/25, revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2025 (from 3/1/25 to 3/31/25) MAR/TAR revealed there was no documentation to indicate Resident #42 exhibited behaviors during the month. The April 2025 (from 4/1/25 to 4/30/25) MAR/TAR revealed there was no documentation to indicate Resident #42 exhibited behaviors during the month. The May 2025 (from 5/1/25 to 5/31/25) MAR/TAR revealed there was no documentation to indicate Resident #42 exhibited behaviors during the month. The June 2025 (from 6/1/25 to 6/30/25) MAR/TAR revealed there was no documentation to indicate Resident #42 exhibited behaviors during the month. The July 2025 (from 7/1/25 to 7/24/25) MAR/TAR revealed there was no documentation to indicate Resident #42 exhibited behaviors related to anxiety or depression during the month. A psychotropic meeting review form, dated 3/31/25, revealed Resident #42’s psychotropic medications were being reviewed by the medical director, the psychiatrist, the DON, the assistant director of nursing (ADON), the SSD and the NHA. The section on the form that asked if a GDR was contraindicated was marked as not applicable. The committee recommended Resident #42’s Seroquel be increased to 50 mg in the mornings and afternoons and 100 mg in the evenings. The committee further recommended the resident’s venlafaxine be decreased from 150 mg to 75mg. A progress note, dated 4/17/25 at 10:26 a.m., revealed the psychopharmacological medication committee recommended Resident #42’s Seroquel be increased and to decrease her venlafaxine. Resident #42’s physician was aware of the recommendation and was in disagreement with the recommendation. -However, the physician did not document a rationale for why changing Resident #42’s medications would not be recommended. The May 2025 pharmacy medication regiment review revealed Resident #42 was due for a GDR on her psychotropic medications. The pharmacy review documented if a GDR was contraindicated, the pharmacist recommended the physician document it as such in Resident #42’s EMR. A physician’s progress note, dated 5/30/25 at 5:45 p.m., revealed it was contraindicated for Resident #42 to undergo a GDR at that time as the resident was on the lowest effective dose of her medications for adequate symptom management. The note further documented that attempting a GDR at that time would place Resident #42 at high risk for symptoms decompensating to unmanageable levels. A psychotropic meeting review form, dated 6/30/25, revealed Resident #42’s psychotropic medications were being reviewed. The section on the form that asked if a GDR was contraindicated was marked as not applicable. The committee recommended Resident #42’s medications go unchanged and a GDR contraindication was signed by her physician. -However, the physician did not document a rationale for why changing Resident #42’s medications would not be recommended. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatric follow-up note, dated 7/15/25 at 8:00 a.m., revealed Resident #42’s medications were reviewed by her physician. Resident #42 said she would like to GDR her Seroquel, and the physician recommended discussing her medications at the next psychopharmacological medication meeting. -However, according to Resident #42, the physician told her she had to take all of her medications (see resident interview above). D. Staff interviews The DON and the RCR were interviewed together on 7/24/25 at 2:42 p.m. The DON said for psychotropic medications, the nursing staff monitored the residents for side effects and efficacy. The DON said the IDT spoke about residents’ medication regimens during their psychopharmacological medication meetings. The DON said the pharmacy sent the facility recommendations and recommended GDRs and the physician would fill out risk/benefit forms as needed. The DON said Resident #42’s last GDR attempt was on 3/31/25. The DON said the facility attempted to GDR psychotropic medications every three months. The RCR said Resident #42’s venlafaxine was decreased from 150 mg to 75 mg per day on 3/31/25. -However, the decrease of the resident’s venlafaxine was the recommendation made by the psychopharmacological medication committee to the physician on 3/31/25, but the physician disagreed with the recommendation and the resident’s medication was not decreased (see record review above). The DON was interviewed a second time on 7/24/25 at 4:54 p.m. The DON said she found a progress note that documented Resident #42’s physician disagreed with the GDR recommended by the psychopharmacological medication committee on 3/31/25. The DON said Resident #42’s physician did not fill out any documentation to indicate the rationale for not changing the resident’s recommendations.

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	065225	A. Building B. Wing	07/24/2025

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

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	065225	A. Building B. Wing	07/24/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary services to assistance items for one (#49) of two residents reviewed for ADLs out of 39 sample residents. Specifically, the facility failed to ensure Resident #49, who was dependent on staff for care, received her preferred communication device during ADLs. Findings include: I. Resident #49A. Resident statusResident #49, age less than 65, was admitted prior to 2020. According to the July 2025 computerized physician orders (CPO), diagnoses included paraplegia (paralysis of the lower half of the body including the legs and sometimes the abdomen), muscle weakness, dysphagia (difficulty swallowing) and aphasia (difficulty speaking). The 5/8/25 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. She was dependent on staff assistance for toileting hygiene, upper and lower body dressing, rolling, sitting to lying and lying to sitting, chair to bed transfers and toilet transfers. The resident was non ambulatory and was dependent on the use of a manual highback wheelchair.The MDS assessment indicated the resident used communication devices. B. Resident interview and observationsResident #49 was interviewed via her tablet on 7/21/25 at 3:46 p.m. Resident #49 said she used a communication board. She said the staff never gave her the communication board and she said that violated her rights. She said she could use her tablet but the typing took her longer. The resident's communication board was in a basket on top of her dresser and was not within reach for the resident.C. Resident observation During a continuous observation on 4/22/25, beginning at 8:30 a.m. and ending at 12:49 p.m., the following was observed:At 9:10 a.m. certified nurse aide (CNA) #1 entered Resident #49's room to inform her it was her shower day and she would come back later to give her her shower. CNA #1 did not utilize the communication device or offer it to the resident for use. At 9:45 a.m. CNA #1 assisted Resident #49 into the shower room. CNA #1 asked the resident to let her know if the water was too warm during her shower. The resident did not have a communication device in hand to inform CNA #1 if the resident was too warm or too cold. At 9:58 a.m. Resident #49 was assisted back to her room. CNA #1 told the resident she had to obtain the Hoyer lift (mechanical lift) to transfer her back to bed. At 10:02 a.m. CNA #3 entered Resident #49's room to assist CNA #1 with putting Resident #49 in her wheelchair. She was not provided the communication boardAt 10:16 a.m. CNA #1 asked Resident #49 what she wanted to wear. Resident #49 responded by nodding her head. -CNA #1 did not provide Resident #49 with a communication device. At 10:20 a.m. CNA #1 asked Resident #49 which color hair accessories she wanted. Resident nodded her head, CNA #1 picked a color. CNA #1 and asked what color glasses she wanted to wear. The resident nodded her head, CNA #1 picked a pair of glasses. -CNA #1 did not provide Resident #49 with a communication device. At 10:28 a.m. Resident #49 requested her tablet by pointing at it. CNA #1 gave her her tablet. CNA #1 did not offer her the communication board. At 10:57 a.m. all the staff left the room without giving Resident #49 her communication board. At 11:30 a.m. The resident was observed sitting in her wheelchair in her room watching television. Her communication board was observed on top of her dresser. At 12:30 a.m. The resident was sitting in her wheelchair in her room watching television. CNA #1 asked the resident if she needed anything. The resident did not respond. Her communication board was on top of her dresser. D. Record reviewThe care plan dated 10/21/15 identified the resident required substantial/maximal assistance with shower/bathing, and her preferred communication method was her tablet and communication board. Pertinent interventions included the resident requiring a communication board to communicate, ensuring the availability and functioning of adaptive communication equipment, the resident communicated well through email (initiated 10/21/15), evaluating the resident's dexterity/ability to use communication board,writing, use computer or use of sign language as alternate communication to speech (initiated 10/21/15), ensuring her adaptive equipment was provided, present, and functional including wheelchair and communication board (date initiated 9/26/23).II. Staff interviews CNA #3 was interviewed on 7/22/25 at 2:30 p.m. CNA #3 said she did not know how to communicate with Resident #49 and relied on the assistance of other staff. CNA #3 said she had not received any education from the facility about how to communicate with Resident #49. CNA #3 said Resident #49 has had a tablet that she used to play games on but did not use it to communicate with the nursing staff.CNA #1 was interviewed on 7/23/25 at 2:00 p.m. CNA #1 said the resident liked to use her tablet to communicate with the staff. CNA #1 said she only used yes or no questions when communicating with the resident. -However CNA #1 was observed using open ended questions regarding clothing choices

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure activities designed to support the residents' physical, mental and psychosocial well-being were provided for three (#17, #36 and #42) of four residents reviewed for activities out of 39 sample residents. Specifically, the facility failed to to offer and provide personalized activity programs for Resident #17, Resident #36 and Resident #42. Findings include: I. Facility policy and procedure The Activities policy, dated 4/11/25, was provided by the regional clinical regional clinical resource (RCR) on 7/24/25 at 5:12 p.m The policy read in pertinent part, “It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. “Each resident’s interest and needs will be assessed on a routine basis. Activities will be designed with the intent to: -Enhance the resident’s sense of well-being, belonging, and usefulness; -Create opportunities for each resident to have a meaningful life; -Promote or enhance physical activity; -Promote or enhance cognition; -Promote or enhance emotional health; -Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence; -Reflect resident’s interests and age; -Reflect cultural and religious interests of the residents; and, -Reflect choices of the residents. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for: -Residents who exhibit unusual amounts of energy or walking without purpose; (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents who engage in behaviors not conducive with a therapeutic home like environment; -Residents who exhibit behaviors that require a less stimulating environment to discontinue behaviors not welcomed by others sharing their social space; -Residents who go through others’ belongings; -Residents who have withdrawn from previous activity interest/customary routines, and isolates self in room/bed most of the day; -Residents who excessively seek attention from staff and/or peers; -Residents who lack awareness of personal safety; and, -Residents who have delusional and hallucinatory behavior that is stressful to themselves.” II. Resident #17 A. Resident status Resident #17, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer’s disease, chronic obstructive pulmonary disease (a lung condition that makes it hard to breathe) and occlusion and stenosis of unspecified carotid artery (plaque buildup narrows the artery, potentially leading to stroke). The 6/9/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. She required partial assistance with toileting, supervision for oral hygiene and set up assistance with eating. The assessment revealed the resident preferred reading books, newspapers or magazines, listening to music, being around animals such as pets, participating in favorite activities and spending time outdoors. The assessment revealed the resident did not refuse care. B. Resident’s representative interview Resident #17’s representative was interviewed on 7/21/25 at 9:53 a.m. The representative said staff told her activities were offered to Resident #17 but the resident refused. She said she thought the resident would participate in some activities. She said she would engage in watching old television shows. She said she wished the television in the resident’s room worked because it could help with the resident’s behavior. C. Observation (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 7/22/25, beginning at 1:51 p.m. and ending at 3:00 p.m., the following observations were made: The activities calendar in the secured unit revealed pet therapy was scheduled at 2:00 p.m. At 1:51 Resident #17 was in her room with the door closed. At 2:04 p.m. activity assistant (AA) #1 walked into the secured unit with a therapy dog. AA #1 went to multiple residents in the common area to see if they wanted to pet the dog. AA #1 sat down in the common area with residents sitting on both sides of her and across from her. At 2:53 p.m. AA #1 and the therapy dog left the unit. -However, the therapy dog was not directed to go into Resident #17’s room, despite the resident’s interest in dogs (see care plan below). At 3:06 p.m. Resident #17’s room was observed. There was a television above the foot of Resident #17’s bed. The television was not plugged in. There was no television remote in the resident’s room. Certified nurse aide (CNA) #7 was in the room and she said did not know where the remote was for the television. D. Record review Resident #17’s activities care plan, revised 6/12/25, revealed the resident loved dogs and she had two dogs when she lived at home. The resident and the dogs had sat together and birdwatched every afternoon. The care plan goal was for the resident to participate in two to three group activities per week until the next review. Interventions included assisting the resident to group activities if she chose to attend and inviting the resident to participate in activities of interest. A review of Resident #17’s electronic medical record (EMR) revealed the resident did not attend any emotional activities from 6/24/25 to 7/24/25 and she attended seven intellectual activities from 6/24/25 to 7/24/25. -There was no further documentation to indicate the resident had participated in or been offered the opportunity to participate in any other activities during the timeframe. III. Resident #36 A. Resident status Resident #36, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnosis included Alzheimer’s disease, chronic kidney disease stage three, psychotic disturbance, mood disturbance, anxiety and depression. The 6/5/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. She required set up assistance with eating, oral hygiene and was independent with toileting, dressing and personal hygiene. She required substantial assistance with showering. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/17/24 MDS revealed it was somewhat important for the resident to have books, newspapers and magazines to read, to be around animals such as pets, and it was very important to do her favorite activities. B. Observations During a continuous observation on 7/22/25, beginning at 9:09 a.m. and ending at 11:01 a.m., the following observations were made in the facility’s secured unit: At 9:09 a.m. Resident #36 was observed in her room. At 10:07 a.m. AA #1 arrived at the unit. From 10:11 a.m. to 10:40 a.m. AA #1 engaged eight residents in the common area with a ball activity. At 10:14 a.m. an unidentified staff member said Resident #36 and her roommate were going to participate in the ball activity. At 10:15 a.m. Resident #47 interfered with Resident #36 walking towards the activity which caused Resident #36 to walk back to her room. -No staff members attempted to get Resident #36 to participate in the ball activity again. C. Record review Resident #36’s activities care plan, revised 6/8/25, revealed the group activities goal was for the resident to participate in activities two to three times a week. She likes to snack on cookies and chips, magazines with eye-catching pictures, reading a book, or reminiscing with activity staff. She enjoys lotion therapy, aromatherapy, working on simple puzzles, and word searches. She loves animals and really enjoys pet therapy. Her favorite activities are going out on the patio when the weather is warm and reminiscing with select residents and staff. Interventions included offering independent leisure activity materials, offering pet visits when in the building and visit three times a week for 20 to 30 minutes per week. -A review of Resident #17’s EMR revealed the resident did not attend any social activities from 6/24/25 to 7/24/25 and she attended six intellectual activities from 6/24/25 to 7/24/25. -There was no further documentation to indicate the resident had participated in or been offered the opportunity to participate in any other activities during the timeframe. IV. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing home administrator (NHA) was interviewed on 7/23/25 at 3:39 p.m. The NHA said if a resident had it on their care plan that they liked animals and the animal was part of the scheduled pet therapy, the activities staff should try to engage the resident with the pet therapy. He said he did not know when pet therapy was scheduled on 7/22/25 or why the pet therapy was not offered to Resident #17. He said he would talk to the activity director (AD) to ensure residents in their room were offered activities such as pet therapy. The AD was interviewed on 7/24/25 at 2:00 p.m. The AD said she had worked at the facility for the past year. She said she was fully staffed with herself, one full-time activities coordinator and two part-time activities staff. She said one staff member worked eight hours on Saturdays and AA #1 worked 15 hours per week, from 1:00 p.m. to 4:00 p.m. She said AA #1 was responsible for covering the activities in the secured unit. She said when AA #1 was not scheduled, she or the full-time staff covered the activities in the secured unit. The AD said if residents were in the secured unit at the dining room tables, the nursing staff should offer independent activity supplies. She said she had a closet full of activity supplies in the secured unit as well as crossword puzzles and other games next to the television. She said word searches, coloring and a sewing kit should be offered every day. She said the independent activities should be offered because residents in the secured unit could not express themselves so staff should offer individual activities. She said everyone should be invited and encouraged to participate in an activity. The AD said she documented if a resident attended or refused to attend the activity in the resident’s EMR under tasks. She said activities were important because activities could make a difference in residents’ lives and change how they felt about living in a facility. She said the residents needed to be in the facility so she wanted to make it fun for them. She said if a resident participated in pet therapy, it would be documented as an emotional activity in the resident’s chart and if it was a ball activity, it should be documented as a social activity. The AD said she was familiar with Resident #17. She said the resident was a really good artist and she liked fresh air. She said the resident liked to color and participate in pet therapy. She said she did not know that when pet therapy was an activity on 7/22/25 that Resident #17 did not get invited to participate. She said she did not know Resident #17’s activities participation record only documented that she participated in intellectual activities. The AD said she was familiar with Resident #36. She said the resident had her days when she did not participate in anything. She said sometimes she participated in activities in the main unit. She said if Resident #36 agreed to attend the ball activity and was distracted by Resident #47, staff should have attempted to invite her back to attend the activity. She said did not know Resident #36’s activities participation record only documented that she participated in intellectual activities. V. Resident #42 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #42, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 CPO, diagnoses included chronic respiratory failure, dementia, bipolar 2 disorder, borderline personality disorder, generalized anxiety disorder and depressive episodes. The 7/7/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. B. Resident interview and observations Resident #42 was interviewed on 7/21/25 at 10:15 a.m. Resident #42 said she wanted to start going to more activities. Resident #42 said she had gone to bingo one time but she could not see the numbers on the bingo cards. Resident #42 reiterated that she wanted to start going to more activities. On 7/22/25 at 3:07 p.m. AA #1 came into the facility with her dog. AA #1 went up and down Resident #42’s hallway and stopped into rooms to greet the residents with her dog and allow the residents to socialize with her dog. -However, AA #1 did not knock on Resident #42’s door or otherwise offer to socialize with Resident #42. Resident #42 was in her room at the time of the observation. On 7/23/25 at 2:20 p.m. an activity was being conducted in the main dining room. Resident #42 was in her room lying in her bed with no meaningful activity occurring. C. Record review The activity care plan, revised 1/2/25, revealed Resident #42 enjoyed independent activities and would participate in group activities if food or drinks were involved. Pertinent interventions included having care staff invite and encourage Resident #42 to participate in programs of interest such as food groups and to remind and encourage the resident to participate in group activities. The nutritional care plan, revised 3/28/25, revealed Resident #42 was at risk for nutritional problems due to her dementia. Pertinent interventions included inviting and encouraging Resident #42 to participate in physical activity and offer her activities of choice to help divert her attention away from food. Review of Resident #42’s one-on-one activity task log from 6/24/25 to 7/24/25 revealed the following: -No one-to-one activities were documented for the resident during the time frame. No activity refusals were documented. Review of Resident #42’s emotional activity task log from 6/24/25 to 7/24/25 revealed the following: -No emotional activities were documented for the resident during the time frame. No activity refusals were documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Rehabilitation and Nursing, LLC	1340 E Fillmore St Colorado Springs, CO 80907

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42’s outing activity task log from 6/24/25 to 7/24/25 revealed the following: -No outing activities were documented for the resident during the time frame. No activity refusals were documented. Review of Resident #42’s physical activity task log from 6/24/25 to 7/24/25 revealed the following: -No physical activities were documented for the resident during the time frame. No activity refusals were documented. Review of Resident #42’s social activity task log from 6/24/25 to 7/24/25 revealed the following: -No social activities were documented for the resident during the time frame. No activity refusals were documented. Review of Resident #42’s special event activity task log from 6/24/25 to 7/24/25 revealed the following: -No special event activities were documented for the resident during the time frame. No activity refusals were documented. Review of Resident #42’s spiritual activity task log from 6/24/25 to 7/24/25 revealed the following: -No spiritual activities were documented for the resident during the time frame. No activity refusals were documented. Review of Resident #42’s intellectual activity task log from 6/24/25 to 7/24/25 revealed the following: -On 6/26/25 at 3:49 p.m. Resident #42 participated in independent leisure. -On 6/27/25 at 1:42 p.m. Resident #42 participated in independent leisure. -On 7/1/25 at 2:41 p.m. Resident #42 participated in independent leisure. -On 7/7/25 at 3:07 p.m. Resident #42 participated in independent leisure. -On 7/22/25 at 8:20 a.m. Resident #42 participated in independent leisure. -On 7/23/25 at 3:43 p.m. Resident #42 participated in independent leisure. -On 7/24/25 at 11:53 a.m. Resident #42 participated in independent leisure. The intellectual activity task log did not document any refusals from Resident #42. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 7/23/25 at 2:56 p.m. CNA #4 said Resident #42 went to her birthday party activity in March 2025 and went to an activity two weeks prior. CNA #4 said Resident #42 had not left her room between those two activities. CNA #4 said the activities staff brought Resident #42 supplies for individual activities but Resident #42 did not want to leave her room. The AD was interviewed on 7/24/25 at 1:45 p.m. The AD said she visited every resident every day and invited and encouraged them to come to activities that day. The AD said refusals of each activity offered each day were documented in the residents’ EMRs under tasks. The AD said residents were assessed on admission to see what their life was like before they were admitted to the facility and see what their interests were. The AD said activities were important because they changed how the residents felt about being in a facility and allowed them to be comfortable and have fun. The AD said pet therapy, provided by AA #1, was considered an emotional activity. The AD said AA #1 should go to each resident’s room and usually went room to room with her dog. The AD said the facility provided three to four activities per day every day of the week. The AD said she tried to have residents attend activities at least twice per week. The AD said the activities assistants would document refusals for each resident in their tasks. The AD said she wanted the activities assistants to document refusals so she had proof the resident was invited to the activity. The AD said she had seen issues with the activities assistants’ documentation. The AD said she had tried implementing different color coding methods for charting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#18) of four residents reviewed for treatment and care in accordance with professional standards of practice out of 39 sample residents. Resident #18 was admitted on [DATE] for long term care with diagnoses of hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body), wound on the right ankle, contracture of muscles on the right lower leg, gait and mobility abnormalities and generalized muscle weakness.On 1/3/25 Resident #18 had a wound to his right lateral malleolus (outer ankle) that was healing per the wound physician. On 4/21/25 the wound physician documented the resident's wound had resolved.On 6/9/25 Resident #18 developed a new trauma wound to his right lateral malleolus. The wound physician began regularly rounding on the resident upon the redevelopment of the wound. The physician's orders directed staff to place a boot to Resident #18's ankle at all times. However, observations and interviews revealed the staff did not consistently implement the boot and offloading as ordered by the physician. Interviews revealed the wound physician determined the wound was created by friction from Resident #18's wheelchair. However, the facility failed to implement an intervention to prevent further friction from the wheelchair. Specifically, the facility failed to implement interventions to prevent Resident #18's recurring wound. Findings include:I. Facility policy and procedureThe Provision of Quality Care policy, dated 4/11/25, was provided by the regional clinical resource (RCR) via email on 7/24/25 at 5:34 p.m. It read in pertinent part, Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choice. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. A comprehensive care plan will be developed for each resident in accordance with procedures for development of the care plan.II. Resident #18A. Resident statusResident #18, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 computerized physician's orders (CPO), diagnoses hemiplegia and hemiparesis , wound on the right ankle, contracture of muscles on the right lower leg, gait and mobility abnormalities and generalized muscle weakness.The 7/9/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. The resident was dependent on staff for most activities of daily living (ADLs).The assessment documented the resident did not have any issues with his skin. B. Resident interview and observationsResident #18 was interviewed on 7/21/25 at 10:46 a.m. Resident #18 said he had a skin issue on his right ankle. Resident #18 said he had the skin problem on his right ankle for years, and said it started when he received a wheelchair with smaller wheels that rubbed against his ankles. On 7/22/25 at 11:25 a.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right foot was in a plastic bag attached to a Vaporox machine (a wound treatment device that used vapor and high oxygen concentrations for rapid wound healing). Resident #18 said it was the first day the facility had used the Vaporox machine for him.At 11:57 a.m. licensed practical nurse (LPN) #4 left Resident #18's room after applying a dressing to his right ankle. -However, LPN #4 did not apply a boot to Resident #18's right foot.At 11:59 a.m. Resident #18 was sitting in his wheelchair in his room wearing nonskid socks and was not wearing any boots or pressure-relieving devices. Certified nurse aide (CNA) #3 entered Resident #18's room and gave him his lunch tray.At 1:20 p.m. Resident #18 was sitting in his wheelchair in his room wearing nonskid socks and was not wearing any boots or pressure-relieving devices.At 3:25 p.m. Resident #18 was lying on his bed on his back. Resident #18 was wearing nonskid socks and was not wearing any boots or pressure-relieving devices.On 7/23/25 at 8:26 a.m. Resident #18 was sitting in his wheelchair in his room wearing nonskid socks and was not wearing any boots or pressure-relieving devices. Resident #18 said his right ankle hurt and rated his pain a 9 out of 10. Resident #18 said he did not tell his nurse he was in pain. At 1:10 p.m. Resident #18 was sitting in his wheelchair in his room wearing nonskid socks and was not wearing any boots or pressure-relieving devices. At 1:35 p.m. Resident #18 was lying on his back in bed with his legs under the blanket with a boot on his right foot visible through the blanket. Resident #18 said he was wearing one boot and the boot was not comfortable.On 7/24/25 at 8:39 a.m. Resident #18 was sitting in his wheelchair in his room wearing nonskid socks and was not wearing any boots or pressure-relieving devices.-There was padding to the wheelchair next to Resident #18's right ankle.C. Record reviewThe skin integrity care plan, revised 7/10/25, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0686 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 observations, record review and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries from occurring or worsening for one (#14) of four residents reviewed out of 39 sample residents. Specifically, the facility failed to ensure staff provided consistent interventions to Resident #14, who had a pressure ulcer.Findings include:I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved on 7/29/25 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin LossPartial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.Category/Stage 3: Full Thickness Skin LossFull thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.Category/Stage 4: Full Thickness Tissue LossFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpableUnstageable: Depth UnknownFull thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth UnknownPurple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.III. Resident #14A. Resident statusResident #14, age less than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included spinal stenosis (a condition where the spaces within the spinal canal narrow, putting pressure on the spinal cord and nerve roots), cerebral infarction (stroke), chronic pain and generalized muscle weakness. The 6/9/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. The resident was dependent on staff for most activities of daily living (ADL). The assessment documented the resident was dependent on staff for rolling left and right in bed.The assessment indicated the resident was at risk of developing pressure ulcers. The assessment indicated the resident had a stage three pressure ulcer. The assessment indicated the resident was not on a turning or repositioning program.B. ObservationsDuring a continuous observation on 7/22/25, beginning at 1:19 p.m. and ending at 5:03 p.m., the following was observed:At 1:19 p.m. Resident #14 was lying on his air mattress on his back with his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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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 0688 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 residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one (#18) of two residents reviewed for mobility out of 39 sample residents. Specifically, the facility failed to ensure Resident #18's hand splint was applied as ordered to help maintain the resident's limb function and mobility.Findings include:I. Facility policy and procedureThe Prevention of Decline in Range of Motion policy and procedure, undated, was provided by the regional clinical resource (RCR) on 7/24/25 at 5:21 p.m. It read in pertinent part, The facility will provide treatment and care in accordance with professional standards of practice. This includes appropriate equipment, including braces or splints. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record.II. Resident #4A. Resident statusResident #18, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body), wound on the right ankle, contracture of muscles on the right lower leg, gait and mobility abnormalities and generalized muscle weakness.The 7/9/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. The resident was dependent on staff for most activities of daily living (ADL).B. Resident interview and observationsResident #18 was interviewed on 7/21/25 at 10:46 a.m. Resident #18 said he did not wear a splint for his hand. Resident #18's right hand had several fingers that were contracted and pointing downward.On 7/22/25 at 11:25 a.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right hand was contracted and resting in his lap. Resident #18 was not wearing a splint on his right hand.At 11:57 a.m. licensed practical nurse (LPN) #4 left Resident #18's room after applying a dressing to his right ankle. -However, LPN #4 did not apply a splint to Resident #18's right hand. At 11:59 a.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right hand was contracted and resting in his lap. Resident #18 was not wearing a splint on his right hand. Certified nurse aide (CNA) #3 entered Resident #18's room and gave him his lunch tray but did not apply a splint to the resident's hand.At 1:20 p.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right hand was contracted and resting in his lap. Resident #18 was not wearing a splint on his right hand.At 3:25 p. m. Resident #18 was lying on his bed on his back. Resident #18 was not wearing a splint on his right hand. On 7/23/25 at 8:26 a.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right hand was contracted and resting in his lap. Resident #18 was not wearing a splint on his right hand.At 1:10 p.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right hand was contracted and resting in his lap. Resident #18 was not wearing a splint on his right hand.At 1:35 p.m. Resident #18 was lying on his back in bed. Resident #18 was not wearing a splint on his right hand.On 7/24/25 at 8:39 a.m. Resident #18 was sitting in his wheelchair in his room. Resident #18's right hand was contracted and resting in his lap. Resident #18 was not wearing a splint on his right hand.On 7/24/25 at 9:55 a.m. LPN #5 entered Resident #18's room and asked him if he had a splint for his right hand, to which Resident #18 said he did. LPN #5 found a splint on Resident #18's bedside table and applied it to the resident's right hand.C. Record reviewReview of the comprehensive care plan, revised 7/22/25, did not reveal any care plan focus regarding Resident #18's hand contractures or therapeutic devices.Review of Resident #18's July 2025 CPO revealed the following physician's orders:Apply right upper extremity wrist cockup splint (a type of orthotic device designed to immobilize and support the wrist in a slightly extended (or cocked-up) position) and c-grip (a type of hand splint designed to support the wrist and encourage finger extension, particularly for managing contractures) hand splint daily as tolerated per restorative therapy, ordered 9/27/22. Resident will don (put on) right resting hand splint as tolerated per restorative, along with skin checks, sensation and movement, ordered 10/3/24.Review of the splint task documentation, which documented the amount of minutes Resident #18's splint was applied, revealed the resident wore his splint for 240 minutes on 7/24/25 (during the survey process). -However, there was no documentation to indicate Resident #18 had worn his splint from 6/24/25 through 7/23/25.D. Staff interviewsCNA #1 was interviewed on 7/23/25 at 2:10 p.m. CNA #1 said Resident #18 did not have any splints for his hands that she had seen.CNA #4 was interviewed on 7/23/25 at 2:56 p.m. CNA #4 said Resident #18 got out of bed first thing in the mornings and sat in his chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for tone (#4) of four residents reviewed for accidents out of 39 sample residents.Resident #4 was admitted on [DATE] for long term care with a diagnosis of dementia. According to the care plan, Resident #4 was determined to be a high fall risk. On 3/4/25 Resident #4 had an unwitnessed fall in her room and sustained an abrasion to her left knee and a bruise to her forehead. The facility failed to implement a new person-centered fall intervention after the fall. On 3/17/25 Resident #4 sustained another unwitnessed fall in her room where she sustained a right hip fracture that was diagnosed when she was sent to the hospital for evaluation. Upon return to the facility, the facility failed to implement person-centered interventions to prevent or reduce future falls. Resident #4 sustained 12 additional falls (two falls on 4/11/25, 4/21/25, two falls on 4/25/25, 5/8/25, 5/13/25, two falls on 5/16/25, 6/2/25, 6/12/25 and 6/14/25). Observations revealed the facility failed to consistently implement the fall interventions on the resident's care plan. Specifically, the facility failed to ensure timely person-centered fall interventions were implemented and added to the care plan for Resident #4 after she sustained multiple falls and sustained a major injury from a fall. Findings include: I. Facility policy and procedureThe Fall Prevention Program policy and procedure, implemented 4/11/25, was providedby the regional clinical resource (RCR) on 7/24/25 at 3:01 p.m. It read in pertinent part, Each resident will be assessed for fall risk and will receive care and services inaccordance with their individualized level of risk to minimize the likelihood of falls. The facility utilizes a standardized risk assessment for determining a resident's fall risk. The risk assessment categorizes residents according to low, moderate, or high risk. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. Low/Moderate Risk Protocols: implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to a clear pathway to the bathroom and bedroom doors. The bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. Call light and frequently used items are within reach. Adequate lighting. Wheelchairs and assistive devices are in good repair. Implement routine rounding schedule. Monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. Encourage residents to wear shoes or slippers with non-slip soles when ambulating. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. Monitor vital signs in accordance with facility policy. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program. Indicate fall risk on care plan. Implement interventions from Low/Moderate Risk Protocols. Provide interventions that address unique risk factors measured by the risk assessment tool such as medications, psychological, cognitive status, or recent change in functional status. Provide additional interventions as directed by the resident's assessment, including but not limited to: Assistive devices. Increased frequency of rounds. Increased supervision, if indicated. Medication regimen review. Low bed. Alternate call system access. Scheduled ambulation or toileting assistance. Family/caregiver or resident education. Therapy services referral. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. When any resident experiences a fall, the facility will review the resident's care plan and update as indicated.II. Resident #4A. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included dementia, muscle weakness, abnormal mobility, confusion and history of falls.The 3/24/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for a mental status (BIMS) score of four out of 15. She required supervision assistance with transferring, toileting and personal hygiene. The MDS assessment indicated the resident had a fall prior to her admission. B. ObservationsOn 7/21/25 at 10:50 a.m. Resident #4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 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 observations, record review and interviews, the facility failed to ensure residents with indwelling catheters received the appropriate care and services according to professional standards for one (#7) of three residents reviewed for catheter care out of 39 sample residents.Specifically, the facility failed to:-Use privacy bag for Resident #7's catheter drainage bag;-Ensure Resident #7's catheter was placed appropriately to ensure the urine could flow freely; -Ensure Resident #7's catheter bag was emptied timely; and,-Consistently monitor Resident #7's intake and output per physician's orders. Findings include: I. Facility policy and procedure The Catheter Care policy and procedure, implemented 5/24/25, was provided by the regional clinical resource (RCR) on 7/24/25 at 9:11 a.m. It read in pertinent part, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Catheter care will be performed every shift and as needed by nursing personnel. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Privacy bags will be changed out when soiled, with a catheter change or as needed. Empty drainage bags when bag is half-full or every three to six hours. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. Document care and report any concerns noted to the nurse on duty. III. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, urinary tract infection (UTI), and obstructive and reflux uropathy (a condition where urine flow is blocked and urine flows backward from the bladder into the kidneys).The 6/23/25 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. He was dependent with toileting hygiene, bathing/showers, lower body dressing, personal hygiene and bed to chair transfers. He was non ambulatory and used a wheelchair for mobility.The MDS assessment indicated he had an indwelling catheter and was always incontinent of bowel and bladder.B. Resident interview and observationsResident #7 was interviewed on 7/21/25 at 1:48 p.m. Resident #7 said he had penis pain around his catheter insertion site. Resident #7 said he told the staff today (7/21/25) and they should be taking care of it. Resident #7 said he got the catheter put in while he was at the hospital prior to admission. Resident #7 said he was trying to increase his intake of water because he had been told he was dehydrated. During the interview the resident's catheter bag was hooked to the side of his bed. Resident #7 was interviewed on 7/22/25 at 3:15 p.m. Resident #7 said that his pain was much better and mostly gone today. He said the UTI medication was working. Resident #7 was resting comfortably in his bed and the catheter bag was hanging on the side of the bed. Resident #7 said the care staff had not emptied his catheter bag yet today. The resident's catheter bag was full or urine. On 7/22/25 at 3:44 p.m. certified nurse aide (CNA) #3 was in Resident #7's room. CNA #3 emptied dark yellow urine from Resident #7's catheter bag without donning (put on) gloves or a gown. On 7/23/25 at 1:23 p.m. CNA #1 and CNA #4 assisted Resident #7 with getting dressed, out of bed and into a wheelchair. The resident was assisted to the hallway. Resident #7's catheter bag was under his chair with no privacy bag covering the catheter bag. The catheter tubing was coming up and out of the top of Resident #7's pants at the waistband to the front right side. C. Record reviewThe indwelling catheter care plan, initiated 4/11/25 revealed the resident had a catheter. The interventions included monitoring for signs and symptoms of discomfort on urination and frequency, monitoring and documenting for pain/discomfort due to the catheter and monitoring/recording/reporting to medical doctor for signs and symptoms of a UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns.The EBP care plan, initiated 6/6/25, revealed the resident was on EBP to prevent the spread of multi-drug resistant organisms. The antibiotic therapy care plan, initiated 7/21/25 revealed the resident was on an antibiotic. Pertinent interventions included administering antibiotic medications as ordered by physician, monitoring/documenting side effects and effectiveness, monitoring/documenting/reporting as needed and adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat) and monitoring/documenting/reporting as needed any signs and symptoms of secondary infection related to antibiotic therapy: oral thrush (white coating in mouth, tongue), persistent diarrhea, and vaginitis/itchy perineum/whitish discharge/coating of the vulva/anus -The antibiotic therapy

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	065225	A. Building B. Wing	07/24/2025

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0693 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 observations, record review and interviews, the facility failed to ensure residents with a feeding tube received appropriate treatment and services for one (#22) of two residents reviewed out of 39 sample residents. Specifically, the facility failed to ensure Resident #22's feeding tube was in place prior to administering a bolus feeding per physician's orders.Findings include: I. Facility policy and procedureThe Care and Treatment of Feeding Tubes policy and procedure, undated, was provided by the regional nurse consultant (RNC), on 7/24/25 at 5:34 p.m. It read in pertinent part, In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location. Tube placement will be verified before beginning a feeding and before administering medications.II. Resident statusResident #22, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 computerized physician orders (CPO), the diagnoses included hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) and dysphagia (difficulty swallowing).The 7/22/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview status (BIMS) score of ten out of 15. The resident required substantial to maximal assistance from staff with most activities of daily living (ADL).The assessment documented the resident had coughing or choking during meals or when swallowing medications. The assessment documented the resident was receiving 51% or more of her calories through a feeding tube and 501 cubic centimeters (cc) a day of fluid through a feeding tube. III. Resident observations and interviewResident #22 was interviewed on 7/21/25 at 9:23 a.m. Resident #22 said she was unable to eat, drink or take medications by mouth. Resident #22 said she received tube feeds five times per day. On 7/24/25 at 11:34 a.m. licensed practical nurse (LPN) #5 performed hand hygiene, donned (put on) a gown and gloves and entered Resident #22's room. LPN #5 removed a stopper from Resident #22's percutaneous endoscopic gastrostomy (PEG) tube, inserted the barrel of a syringe into the tube, poured a small splash of water from a plastic cup into the syringe and watched it drain into the PEG tube. LPN #5 then poured the entire contents of one 237 milliliter (ml) carton of Glucerna nutritional supplement into the syringe barrel slowly, allowing the contents to feed by gravity into the PEG tube. Once finished with the Glucerna, LPN #5 flushed the PEG tube again by pouring the remaining contents of the cup of water into the syringe barrel, disconnected the syringe and replaced the stopper.-However, LPN #5 did not check Resident #22's PEG tube to ensure it was placed and functioning properly prior to administering the bolus feeding and water flushes (see interviews below).IV. Record reviewThe nutrition care plan, revised 5/14/25, revealed Resident #22 was at a nutritional risk due to her dysphagia and had a PEG tube in place. Pertinent interventions included providing nocturnal feedings by administering Glucerna at a rate of 55 ml per hour over 12 hours, and flushing with 120 ml of water before and after feeding and every four hours. -However, the care plan did not reflect the updated physician's orders for Resident #22's bolus feeding amount and frequency.The gastrointestinal care plan, revised 5/25/25, revealed Resident #22 had an alteration in her gastrointestinal status due to her PEG tube. Pertinent interventions included avoiding snacks that aggravated her condition and administering medications as ordered.Review of the July 2025 CPO revealed the following physician's orders for Resident #22:-Enteral feed order: enteral tube placement will be checked each shift. Hold enteral feeding and notify physician if tube migration is suspected, ordered 6/28/25; and,-Enteral order: give 220 ml of 1.5 Glucerna bolus with 75 ml water before and after feeding five times per day, ordered 7/10/25.Review of the July 2025 treatment administration record (TAR) revealed the order to check Resident #22's enteral tube placement was marked completed twice daily from 7/1/24 through 7/24/25. V. Staff interviewsLPN #5 was interviewed on 7/24/25 at 11:34 a.m. LPN #5 said she used approximately 60 ml of water to flush Resident #22's PEG tube before her bolus and about 75 ml of water to flush after her bolus. LPN #5 said she measured it using a measuring cup at her medication cart and poured it into the plastic water cup, so she would pour about half of the cup before the bolus and a little bit over half of the cup after the bolus. LPN #5 said she did not know how to check to see if Resident #22's PEG tube was correctly positioned. LPN #5 said if Resident #22's PEG tube was migrating the facility staff would have to send her to the hospital.LPN #5 was interviewed a second time on 7/24/25 at 12:22 p.m. LPN #5 said she had checked Resident #22's PEG tube placement and marked it accordingly on the TAR as she saw the water flush went into Resident #22's PEG tube at an appropriate speed and her bolus feeding went in. LPN #5 said the physician's order to check PEG tube placement may have had something to do with aspirating the PEG tube

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0744 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 observations, record review and interviews, the facility failed to ensure residents who displayed or were diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practical physical, mental, and psychological well-being for one (#47) of two residents reviewed for dementia care out of 39 sample residents. Specifically, the facility failed to develop and implement effective dementia management-focused interventions to prevent Resident #47 from wandering into other residents' rooms, shower rooms, the nurses' station and standing over the top of other residents. Findings include: I. Resident #47 A. Resident status Resident #47, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, anxiety disorder, depression and cognitive communication deficit. The 7/23/25 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. She required set up assistance with eating, was dependent on staff for oral hygiene, toileting, showering, dressing and personal hygiene. The MDS assessment revealed the resident wandered one to three days and exhibited physical behavioral symptoms, such as hitting, kicking, and pushing, directed toward others during the look back assessment period. B. Observations During a continuous observation on 7/22/25, beginning at 9:09 a.m. and ending at 11:01 a.m., the following observations were made in the facility's secured unit: There were ten resident rooms and five of the ten rooms had their doors open. The doors of room [ROOM NUMBER], #24, #25, #27 and #29 were open. The shower room door was additionally open. Five residents were sitting at various dining tables in the dining room. Resident #47 was sitting in a chair across from the nurses' station, sleeping. At 10:04 a.m. Resident #47 woke up. At 10:11 a.m., activities assistant (AS) #1 started a ball activity with four residents at a dining table.From 10:13 a.m. to 11:01 a.m. Resident #47 was observed continuously walking up and down the one hallway in the secured unit. Resident #47 stood at the door to the main unit, standing over the top of residents who were sitting in their wheelchairs or chairs at the dining room tables and trying to push a resident in their wheelchair. -However, staff did not attempt to redirect or distract Resident #47 in order to reduce the resident's repetitive exit-seeking behavior, standing over the top of other residents sitting down and trying to push other residents in their wheelchairs. During a continuous observation on 7/23/25, beginning at 1:29 p.m. and ending at 2:54 p.m., the following observations were made in the facility's secured unit:Nine of the ten resident room doors were open. The doors of room [ROOM NUMBER], #21, #23, #24, #25, #26, #27, #28 and #29 were open. At 1:35 p.m. Resident #47 was observed entering room [ROOM NUMBER]. She closed the door once she entered the room.From 1:46 p.m. to 2:54 p.m., Resident #47 was observed standing over the top of a resident sitting in a chair at a dining table, walking in and out of room [ROOM NUMBER], looking at the door handles on the door to the facility's main unit and on the door to the facility's courtyard and touching a resident's wheelchair handles. -However, staff did not attempt to redirect or distract Resident #47 in order to reduce the resident's repetitive exit-seeking behavior, standing over the top of other residents sitting down and touching other residents' wheelchair handles. C. Record review Resident #47's elopement care plan, revised 10/25/24, revealed the resident was a risk for wandering and elopement related to Alzheimer's disease. Resident #47 wandered aimlessly, significantly intruding on the privacy or activities of others. The 2/1/25 nurse note revealed Resident #47was very agitated and restless. She continued to take food and drinks from other residents. She was unable to be redirected. The 2/8/25 nurse note revealed the resident was easily agitated when trying to redirect her. She continued to take other residents' drinks and snacks. The 2/11/25 nurse note revealed Resident #47 continued to ambulate, went into other residents' rooms and picked up other residents' belongings and moved furniture around. The 2/16/25 nurse note revealed the resident continued to ambulate up and down the hallway. She frequently stood over other residents and would attempt to squeeze into small spaces. She was difficult to redirect and became angry with the staff. The 2/18/25 nurse note revealed Resident #47 continued to ambulate up and down the hallway, going in and out of other residents' rooms. She was unable to redirect with offers of food, drink, activity, toileting. The 3/8/25 nurse note revealed the resident continued to ambulate up and down the hallways and in and out of other residents' rooms. She became angry when trying to redirect. The 3/9/25 nurse note revealed Resident #47 went into another resident's room, causing some aggravation to other residents. Fifteen-minute checks were started and no skin issues were noted. She continued to ambulate up and down the hallway with staff frequently redirecting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065225	A. Building B. Wing	07/24/2025

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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	065225	A. Building B. Wing	07/24/2025

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F 0757 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 drug regimens were free from unnecessary medications for two (#61 and #42) of five residents reviewed for unnecessary medications out of 39 sample residents. Specifically, the facility failed to ensure Resident #61 and Resident #42 were monitored for hours of sleep for insomnia (difficulty sleeping) medications.Findings include: I. Facility policy and procedureThe Use of Psychotropic Medications policy and procedure, revised 4/28/25, was provided by the regional clinical resource (RCR) on 7/24/25 at 5:08 p.m. It read in pertinent part, The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis and in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.II. Resident #61A. Resident statusResident #61, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician's orders (CPO), diagnoses included anxiety disorder, insomnia, dementia and mood disorder.The 7/3/25 minimum data set (MDS) revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) assessment score of five out of 15.B. Record reviewReview of the comprehensive care plan, revised 7/10/25, did not reveal any focus related to Resident #61's insomnia or use of medications to treat his insomnia.Review of the July 2025 CPO revealed the following orders:-Melatonin 3 milligram (mg) oral tablet. Give 3 mg by mouth at bedtime for insomnia, ordered 1/23/25 and discontinued 7/11/25; and,-Trazodone HCl 50mg oral tablet with instructions to give 25mg by mouth in the evening related to insomnia, ordered 5/30/25.-However, there were no physician's orders to monitor or document the number of hours Resident #61 slept each shift.Review of the Resident #61's medication administration records (MAR) from7/1/25 through 7/23/25 revealed Resident #61 had been administered melatonin and trazodone as ordered each day throughout the period.Review of the resident's electronic medical record (EMR) did not reveal any documentation of the number of hours Resident #61 slept each day during that period.III. Resident #42A. Resident statusResident #42, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 CPO, diagnoses included chronic respiratory failure, dementia, bipolar 2 disorder, borderline personality disorder, generalized anxiety disorder and depressive episodes.-Resident #42 did not have a documented diagnosis of insomnia.The 7/7/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. B. Resident interviewResident #42 was interviewed on 7/21/25 at 10:15 a.m. Resident #42 said she had talked with her physician earlier and told them she did not want to be on so many medications because they made her so tired. Resident #42 said her physician told her as long as he was her doctor she had to take all of her medications. Resident #42 said she felt like she was on too many medications.C. Record reviewReview of the comprehensive care plan, revised 7/8/25, did not reveal any focus for Resident #42's insomnia or use of medications to treat insomnia.Review of the July 2025 CPO revealed a physician's order for melatonin 1 mg oral capsules with instructions to give one capsule at bedtime for insomnia, ordered 1/31/25.-However, there were no physician's orders to monitor or document the number of hours Resident #42 slept each shift. Review of the Resident #42's MAR from 3/1/25 through 7/23/25 revealed Resident #42 had been administered melatonin 1 mg each eveningReview of the resident's EMR did not reveal any documentation of the number of hours Resident #42 slept each day during that period.IV. Staff interviewsLicensed practical nurse (LPN) #4 was interviewed on 7/23/25 at 4:47 p.m. LPN #4 said residents on psychotropic medications should be monitored for side effects and medication efficacy to see if they were effective. LPN #4 said for medications for insomnia, the nursing staff monitored the number of hours of sleep at night and if the residents were sleeping during the day. LPN #4 said the nursing staff monitored the hours the residents slept to see if the sleep medication was working or to see if they were taking too much medication and were too sleepy during the day. LPN #4 said she documented the number of hours slept in the TAR. LPN #4 said a physician's order was obtained to monitor the number of hours the resident slept whenever a resident was receiving insomnia medications.Registered nurse (RN) #1 was interviewed on 7/24/25 at 9:06 a.m. RN #1 said the nursing staff monitored behaviors and side effects for residents on psychotropic medications. RN #1 said insomnia medications could cause residents to appear drowsy or tired, so the nursing staff monitored the residents' number of hours slept and documented it in the TAR. RN #1 said there were also physician's orders to monitor hours of sleep for residents on insomnia medications. RN #1 said the nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious disease. Specifically, the facility failed to ensure the staff followed proper infection control procedures for Resident #7, who was on enhanced barrier precautions (EBP).Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 3/20/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part,Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status.II. Facility policy and procedureThe Catheter Care policy and procedure, implemented 5/24/25, was provided by the regional clinical resource (RCR) on 7/24/25 at 9:11 a.m. It read in pertinent part, Catheter care will be performed using EBP or additional precautions as directed. Perform hand hygiene. [NAME] (put on) gloves and gown.III. ObservationsOn 7/22/25 at 3:44 p.m. certified nurse aide (CNA) #3 was in Resident #7's room. CNA #3 emptied dark yellow urine from Resident #7's catheter bag without donning gloves or a gown.IV. Staff interviewsCNA #5 was interviewed on 7/23/25 at 2:00 p.m. CNA #5 said she had not received any catheter care training while at the facility. She said when she was emptying catheter bags, she should wear gloves and a gown. The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 7/23/25 at 3:17 p.m. The IP and the DON said CNAs needed to follow EBP when providing care to a resident with a catheter. The DON said this included when the CNAs were emptying the resident's catheter bag. The DON said it was improper for the CNAs to empty Resident #7's catheter bag without putting on a gown and gloves.