STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065231	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Care Center	945 Desert Flower Blvd Pueblo, CO 81001

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for one of three abuse allegations. Specifically, the facility failed to thoroughly investigate an allegation of physical abuse involving Resident #1 on 8/2/25 in order to prevent a second incident from occurring on 9/13/25.Findings include:I. Incident of alleged physical abuse between Resident #1 and his spouse on 8/2/2025A. Facility investigation The investigation of the alleged physical abuse incident between Resident #1 and his spouse was provided by the nursing home administrator (NHA) on 11/19/25 at 4:15 p.m. The facility investigation report revealed the witness stated Resident #1 was asking his spouse to leave so he could be alone. The spouse replied to be alone with her, pointing to the female one one-on-one staff member. Resident #1 and his spouse started arguing and the resident was getting closer to the spouse so the spouse put her hand up to stop Resident #1 from getting closer. The spouse's open hand made contact with the resident's chest and Resident #1 moved back slightly, not more than an inch. The witness stated the spouse's hand up was intended to create space but it was not a shove. The witness separated Resident #1 and his spouse and the spouse left the facility and Resident #1 remained with the witness. The alleged assailant (the spouse) was interviewed by the social services director (SSD) and the alleged assailant said Resident #1 wanted to be alone with his girls so she was getting ready to leave and he came up to her and she put her hand up to stop him from getting any closer. -The investigation failed to reveal documentation to indicate the date the interview occurred with the alleged assailant or what questions were asked of the alleged assailant, Resident #1's spouse.-The investigation failed to reveal that a statement was completed by the registered dietitian (RD) who witnessed the 8/2/25 incident to determine what the RD specifically saw related to the alleged pushing of Resident #1 by his spouse. The facility investigation report revealed the resident was kept safe during the investigation by separating Resident #1 and his spouse and the spouse left the facility. The investigation documented that there was education provided to the spouse about safety and de-escalation techniques and to let the facility staff handle the resident when he was agitated. Resident #1 was on one-on-one supervision for an unrelated incident. Resident #1 remained on one-on-one supervision for safety. -However, the investigation failed to reveal documentation that the alleged assailant was unable to enter the facility during the investigation process. -The investigation report failed to reveal documentation regarding when the education was provided to the alleged assailant. The 8/2/25 nurse event note revealed Resident #1's sitter reported the resident was pushed on the chest by his spouse, no fall occurred and the resident was noted to become agitated. Tylenol was given for pain and the resident declined a skin assessment. Resident #1 became combative. There was no visible skin tear or bruising noted at the time of the incident. Staff would continue to monitor the resident for safety. The 8/3/25 nurse behavior note revealed Resident #1's spouse arrived to the unit to take the resident out of the facility. The one-on-one staff member walked off when the spouse asked the resident if he was going to behave the way he did yesterday. Resident #1 appeared anxious but eventually left the facility with the spouse. Resident #1 returned from the outing with his spouse agitated and pacing. A report gathered from the family indicated the resident was not comfortable and wanted to get out of the car. Staff tried to calm the resident after (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pushed by the RD. The 8/4/25 SSD note revealed she spoke with the spouse. The SSD asked the spouse about the 8/2/25 incident. The spouse denied pushing the resident and denied doing anything considered aggressive. The spouse said she was frustrated with the resident and told him to stop coming towards her. The spouse said she did not understand why she was asked to leave the facility. The SSD informed the spouse the facility took physical abuse allegations seriously and explained the investigation procedure. The spouse said she understood the procedure. The SSD requested to call the spouse along with her three children to let them know the outcome of the investigation. The spouse agreed and agreed to refrain from visits until the investigation was concluded. The 8/6/25 SSD note revealed she spoke with the spouse and the resident's three children on a conference call. The SSD explained that due to the incident that occurred on 8/2/25, the spouse was to allow the CNAs to provide care and a one-on-one sitter would be in the room at all times with the resident, even when the spouse visited. The SSD encouraged the spouse to walk away or possibly take a drive if she became overwhelmed or frustrated with the resident during visitation. The SSD explained that all transportation for appointments for the resident could be provided by the facility and if the family wanted to transport the resident that one of the children, son-in-law or grandchildren needed to accompany them in the vehicle. All parties stated they understood the education and only wished to keep the resident safe. The SSD explained the facility had the resident's safety and well being as their priority as well as their other residents in the unit.