STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure three (#25, #15 and #18) of seven residents were free from abuse out of 29 sample residents.Specifically, the facility failed to:-Protect Resident #18 from verbal abuse by Resident #17;-Protect Resident #15 from physical abuse by Resident #16; and,-Protect Resident #25 from physical abuse by Resident #24.Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised, April 2021, was provided by the nursing home administrator (NHA) on 5/12/26 at 9:00 a.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Develop and implement policies and protocols to prevent and identify: abuse or mistreatment of residents.II. Incident of verbal abuse of Resident #18 by Resident #17 on 11/16/25A. Facility investigationThe facility's investigation was provided by the NHA on 5/12/26 at 12:42 pm. The investigation documented Resident #18 and Resident #17 were sitting at the same lunch table when Resident #17 made an inappropriate comment and said he could reach up under Resident #18's dress. The investigation documented Resident #18 became upset and tearful and reported the incident to staff. The investigation documented the facility interviewed Resident #18 and Resident #17 regarding the incident.The facility's investigation, dated 11/18/25, documented Resident #17 said he did make the comment to Resident #18 about reaching up her dress and the resident (Resident #17) said he was joking. The facility's investigation documented Resident #18 was upset and tearful when she left lunch early to report the incident to a staff member. The facility's investigation ruled out that physical abuse occurred and indicated the incident was verbal. The investigation did not identify whether or not verbal abuse was substantiated or unsubstantiated.Per an interview with the NHA during the survey, the facility did not substantiate verbal abuse (see NHA interview below).-However, verbal abuse did occur as Resident #18 was upset and tearful related to what Resident #17 said to her when she reported the incident to staff. B. Resident #18 (victim)1. Resident statusResident #18, age less than 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic obstructive pulmonary disease, cirrhosis of the liver and generalized muscle weakness.The 3/13/26 MDS assessment revealed Resident #18 was cognitively intact with a BIMS score of 15 out of 15. The resident was dependent on staff assistance for toileting hygiene and required partial/moderate assistance for upper and lower body dressing, personal hygiene and transfers.The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Resident interviewResident #18 was interviewed on 5/12/26 at 11:09 a.m. Resident #18 said there was an incident last year (2025) when she was eating in the dining room at a table with other residents. She said she had not been feeling good and was wearing a nightgown. Resident #18 said during lunch, Resident #17 told her he could reach up her dress. Resident #18 said Resident #17's statement upset her, she was tearful and left the dining room early. She said she told activities assistant (AA) #1 what Resident #17 said to her. Resident #18 said she filed a grievance and the facility staff took care of it. Resident #18 said she had bad dreams for a few nights after the (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incident.Resident #18 was interviewed a second time on 5/14/26 at 10:25 a.m. Resident #18 said she was upset and fearful at the time of the incident because she did not know Resident #17 well or what he might be capable of.3. Record reviewResident #18's trauma-informed care plan, dated 3/19/25, revealed a focus of trauma-informed care and documented the resident was at risk for decreased psychosocial wellbeing and emotional distress related to her personal history. The care plan goal was for her to be able to express feelings of safety and security in the environment. Interventions included approaching Resident #18 in a calm, reassuring manner, encouraging the resident to verbalize feelings and monitoring for signs and symptoms of decreased psychosocial well-being. C. Resident #17 (assailant)1. Resident statusResident #17, age [AGE], was admitted on [DATE]. According to the May 2026 CPO, diagnoses included left-sided weakness, generalized muscle weakness, impaired mobility and self-care deficit.The 3/30/26 MDS assessment revealed Resident #17 had moderate cognitive impairment with a BIMS score of 11 out of 15. He was independent for all ADLs.The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Resident interviewResident #17 was interviewed on 5/12/26 at 9:48 a.m. Resident #17 said he used to see Resident #18 in the dining room, but he did not see her anymore. Resident #17 said he remembered sitting in the dining room at the table with Resident #18 in the past. He said he made a comment one time about reaching up her dress and joking around with her.3. Record reviewA physician's progress note, dated 12/30/25, revealed there was no change in Resident #17's mental status or functional status.D. Staff interviewAA #1 was interviewed on 5/13/26 at 12 p.m. AA #1 said Resident #18 reported Resident #17 had made an inappropriate verbal comment about reaching up her dress (on 11/16/25) and Resident #18 was upset and tearful at the time. AA #1said she assisted Resident #18 with reporting the grievance.III. Incident of physical abuse of Resident #15 by Resident #16 on 12/18/25A. Facility investigationThe facility's investigation of the abuse incident involving Resident #15 and Resident #16 was provided by the NHA on 5/12/26 at 12:42 p.m. The facility's investigation documented Resident #15 was doing his therapy exercises, described as tapping his fingers on the table, when his roommate, Resident #16, became irritated and grabbed Resident #15 by the wrist and told Resident #15 to stop. The investigation documented Resident #16 was in his wheelchair and rolled over the toes of Resident #15 on his way out of the room. The investigation documented there were no witnesses to the incident in the residents' room. The investigation documented the director of nursing (DON) assessed Resident #15 and found bruising on the resident's face and wrist. The facility investigation documented Resident #16 admitted that Resident #15's tapping of his fingers on his table pushed him to grab Resident #15 to stop the tapping.The investigation indicated the facility substantiated the physical abuse.B. Resident #15 (victim)1. Resident status Resident #15, age greater than 65, was admitted to the facility on [DATE]. According to the May 2026 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), chronic pain syndrome, generalized weakness, difficulty walking, reduced mobility, anxiety and depressive disorders.The 4/14/26 MDS assessment revealed Resident #15 was cognitively intact with a BIMS score of 15 out of 15. The resident required supervision/touching assistance from staff for upper body dressing, personal hygiene and transfers. He required partial/moderate assistance from staff for lower body dressing and substantial/maximal assistance for toileting.The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Resident interviewResident #15 was interviewed on 5/11/26 at 4:15 p.m. Resident #15 said he had an incident with his previous roommate, Resident #16, last year (2025) when he tapped his fingers on the table as a therapy exercise and Resident #16 became irritated. Resident #15 said Resident #16 grabbed his wrist and hit his face and told him to stop. Resident #15 said that Resident #16 was in his wheelchair, and as he was leaving the room, he wheeled over his (Resident #15's) toes. Resident #15 said he had a bruise from the incident, but his toes were not injured.Resident #15 said he reported the incident to the nursing staff and he was assessed for injury. Resident #15 said Resident #16 was moved to a different room that day.3. Record reviewResident #15's care plan report, revised 3/19/24, revealed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15 had a history of a decline in psychosocial well-being and mood state. Interventions included encouragement to openly express feelings and staff would provide emotional support as needed. A nursing progress note, dated 12/18/25 at 3:18 p.m. documented Resident #15 said his roommate had grabbed his wrist, hit his face and run over his foot.A skin assessment, dated 12/18/25, documented Resident #15 had bruising to the left wrist and right cheek.C. Resident #16 (assailant)1. Resident statusResident #16, age greater than 65, was admitted to the facility on [DATE]. According to the May 2026 CPO, diagnoses included acute and chronic kidney disease, depression, and functional decline with generalized weakness. The 3/10/26 MDS assessment revealed Resident #16 was moderately cognitively impaired with a BIMS score of nine out of 15. According to the May 2026 CPO, diagnoses included chronic and acute kidney disease, depressive disorder, functional decline with generalized weakness and reduced mobility. He required substantial/maximal staff assistance for the majority of his activities of daily living (ADL).The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Record reviewThe behavior care plan, revised 12/22/25, revealed Resident #16 had issues with self-management related to agitation, anxiety and anger. Interventions included the use of coping skills of seeking staff support, deep breathing and taking a break from situations when the resident was angry.A nursing progress note, dated 12/22/25 at 1:51 p.m., documented time was spent with Resident #16 for reviewing the resident's coping skills for managing anxiety and anger.IV. Incident of physical abuse of Resident #25 by Resident #24 on 4/22/26A. Facility investigationThe facility's investigation of the abuse incident involving Resident #25 and Resident #24 was provided by the NHA on 5/12/26 at 12:42 p.m. The facility's investigation, dated 4/22/26, documented that Resident #24 backed into Resident #25 with his wheelchair when they were both in line at the door to the outside smoking area. The investigation documented Resident #25 pushed Resident #24's wheelchair in the back and Resident #24 was startled, threw his coffee at Resident #25 and then turned around in his wheelchair and hit Resident #25 on her cheek.The investigation revealed a skin assessment was completed for both residents by registered nurse (RN) #4 and Resident #25 was noted to have a new discoloration to her right cheek. The investigation documented Resident #24 did not sustain an injury.The investigation documented Resident #25 had an xray at the facility on 4/22/26 at 2:15 p.m. The Xray revealed Resident #25 had no acute fracture or injury to her right cheek.The investigation documented the residents were separated at the time of the incident and staff monitored both residents per facility policy.The investigation revealed the NHA and RN #4 interviewed Resident #25 and Resident #24 on 4/22/26 and both residents confirmed the incident occurred.The investigation documented the facility substantiated the incident of physical abuse. B. Resident #25 (victim)1. Resident statusResident #25, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, functional decline and generalized weakness, and impaired mobility.The 3/16/26 minimum data set (MDS) assessment revealed Resident #25 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. She was independent with oral hygiene and personal hygiene. She required setup/cleanup assistance for staff for lower body dressing and supervision/touching assistance from staff for toileting, bathing, upper body dressing and transfers. The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Resident interviewResident #25 was interviewed on 5/11/26 at 11:15 a.m. Resident #25 said she was trying to get out of the door to the outside smoking area (on 4/22/26) and Resident #24 was in his wheelchair in front of her and kept scooting back into her wheelchair.Resident #25 said she gave Resident #24's wheelchair a little push to stop him from backing into her. Resident #25 said Resident #24 then threw his coffee at her and turned around and hit her on the right side of the face.Resident #25 said staff separated both residents and completed assessments of both residents at the time of the incident.3. Record reviewResident #25's care plan report initiated 3/1/25, revealed she smoked without (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supervision.Resident #25's behavior care plan, revised 5/13/26, revealed the resident could have verbal and physical confrontation with peers when she was agitated. Interventions included separating the resident from triggering situations or other individuals as needed for safety.The nursing progress note, dated 4/22/26 at 12:10 p.m., revealed Resident #24 backed into the wheelchair of Resident #25 and then Resident #24 pushed Resident #25's wheelchair to clear the path to the door. Resident #24 turned around and threw his coffee at Resident #25 and hit her on the right cheek. The residents were separated and a head-to-toe skin assessment was completed. The progress note revealed Resident #25's skin on her check was discolored. The physician gave an order for an Xray of the resident's face, neck and right wrist.A licensed psychologist clinician note, dated 4/22/26 at 1:53 p.m., revealed the psychologist met briefly with Resident #25 who expressed feelings of anger and frustration regarding an interpersonal conflict with another resident. The social services progress note, dated 4/22/26 at 5:30 p.m., revealed Resident #25 was alert and oriented with a calm mood and was cooperative during the assessment. The resident said she was doing okay and denied ongoing distress. The social services director (SSD) reported she would reinforce separation during smoking times and continue monitoring of Resident #25 to maintain a safe environment. The social services progress note, dated 4/23/26 at 3:01 p.m., revealed Resident #25 was alert, and calm with no signs of distress noted. Resident #25 said she preferred to avoid Resident #24 during smoking times to prevent further conflict. The SSD reported she would continue to monitor the mood and behavior of Resident #25.C. Resident #24 (assailant)1. Resident statusResident #24, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included diabetes, hypertension, Alzheimer's disease, and generalized weakness. The 3/16/26 DS assessment revealed Resident #24 had moderate cognitive impairment with a BIMS score of 11 out of 15. He was independent with oral hygiene. He required setup/clean up assistance from staff for personal hygiene, supervision/touching assistance for transfers and partial/moderate assistance for personal hygiene. He required substantial/maximal assistance from staff for upper and lower body dressing.The MDS assessment indicated the resident did not have physical or verbal behavioral symptoms directed toward others.2. Resident interviewResident #24 was interviewed on 5/11/26 at 3:18 p.m. Resident #24 said he remembered an incident with Resident #25 last month (April 2026). Resident #24 said Resident #25 was in back of him in the line to get out the door to the smoking area. Resident #24 said Resident #25 pushed him in the back and hit him. Resident #24 said he threw his coffee at Resident #25 and then reached over his shoulder and punched her in the face. Resident #24 said he did not have any injury from the incident. He said he was no longer in contact with Resident #25 and had no problems with her or other residents.3. Record reviewResident #24's behavior care plan, revised 5/13/26, revealed the resident sometimes was aggressive when he was uneasy. Interventions included Resident #24 would verbalize when he became uncomfortable when people were in his space.D. Staff interviewRN #4 was interviewed on 5/12/26 at 3:35 p.m. RN #4 said she did not witness the incident between Resident #25 and Resident #24 on 4/22/26, but later she observed a bruise on Resident #25's cheek.V. Additional staff interviewThe NHA was interviewed on 5/13/26 at 5:30 p.m. The NHA said Resident #18 was tearful and upset when he interviewed her about the incident with Resident #18 (on 11/16/25). The NHA said he interviewed Resident #17 about the incident and Resident #17 stated he told Resident #18 he could reach up her dress when they were sitting at the lunch table. The NHA said the facility's investigation ruled out physical abuse and did not substantiate verbal abuse.The NHA said a bruise on the arm of Resident #15 was observed from Resident #16 grabbing the forearm of Resident #15 (on 12/18/25). The NHA said an intervention after the incident included Resident #16 was moved to another room. The NHA said the facility substantiated the physical abuse.The NHA said that the smoking area was identified as a hot zone for conflict. He said Resident #25's skin assessment was completed after the incident on (4/22/26) and a red spot on her cheek was observed. He said the facility's investigation substantiated the physical abuse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide necessary services consistent with professional standards of practice to promote healing of pressure injuries for one (#9) of four residents out of 29 sample residents. Specifically the facility failed to ensure staff consistently provided wound care to Resident #9 in a timely manner, per physician's orders.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 5/18/26 from https://www.internationalguideline.com/the-international-guideline, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that did 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 were not exposed. Slough may be present but did 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.II. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), kidney failure and peripheral vascular disease (circulation disorder). According to the 3/21/26 minimum data set (MDS) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, Resident #9 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The MDS assessment identified Resident #9 required moderate assistance with eating and was dependent on staff assistance for hygiene, showering, dressing and transferring.The MDS assessment documented that the resident had a stage 4 pressure injury that was present on admission.B. Record reviewA review of Resident #9's May CPO revealed the following physician's orders:Wound care: Sacro-coccyx (tailbone), extending to right buttocks, cleanse with wound cleanser, apply skin prep, cover with hydrocolloid dressing (moisture retentive bandage) every day shift every Monday, Wednesday and Friday for wound care, ordered on 3/18/26 and discontinued on 4/6/26.Wound care: Sacrococcyx extending to right buttocks, cleanse with wound cleanser, apply skin prep to periwound, cover with hydrocolloid dressing every day shift every Monday, Wednesday, Friday, Sunday for wound care, ordered on 4/22/26.-However, a review of Resident #9's April 2026 and May 2026 treatment administration records (TAR), from 4/1/26 through 5/14/26, revealed no documentation to indicate wound care was provided for the resident on 4/1/26, 4/26/26, 4/29/26, 5/4/26, 5/10/26, and 5/13/26.III. Staff interviewsThe wound care physician assistant (PA) was interviewed on 5/14/26 at 10:35 a.m. The wound care PA said Resident #9's coccyx pressure injury had completely healed and then reopened after he was hospitalized in March 2026. The wound care PA said Resident #9's wound had not worsened recently, however, he said if nursing staff were not completing wound care as ordered, it could affect wound healing.Licensed practical nurse (LPN) #1 was interviewed on 5/14/26 at 12:00 p.m. LPN #1 said there had been several days she was unable to provide wound care to Resident #9. She said on each of the days she had been unable to provide the wound care, she had asked the nurse on the next shift to complete the resident's wound care. LPN #1 said Resident #9's wound care should have been provided as ordered.The director of nursing (DON) was interviewed on 5/14/26 at 12:12 p.m. The DON said LPN #1 was the nurse on duty five of the six times that wound care was not completed for Resident #9. The DON said LPN #1 told the DON that she did not have time to perform wound care during her shift and had communicated this to the night shift nurse. The DON said there was no documentation that the night shift nurse completed Resident #9's wound care on those dates. The DON said Resident #9's wound could worsen if wound care was not provided as ordered and the resident had missed dressing changes. The DON said if the wound care was not documented in Resident #9's electronic medical record (EMR), it was not done. The DON said she began education with nursing staff regarding the importance of completing wound care as ordered and the necessary documentation.IV. Facility follow upThe DON provided a document titled Inservice: Treatment Documentation and Sign Off Compliance on 5/14/26 at 12:12 p.m. The description of the education provided included the following: Failure to sign off on treatments assigned during your shift is considered a documentation error and may lead to delays in wound care treatment, missed treatments, and potential harm to residents. Accurate documentation ensures continuity of care among staff and provides legal and clinical proof that care was completed. Staff are reminded that: All treatments must be completed as ordered. Treatments must be documented and signed off immediately after completion. Delayed or missing documentation can negatively affect resident outcomes and facility compliance. If it is not documented, it was not done.The inservice education document was signed by 10 nursing staff on 5/13/26 (during the survey).

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents had adequate supervision and assistive devices to prevent accidents for one (#2) of four residents reviewed for accidents/hazards out of 29 sample residents. Resident #2, who was admitted on [DATE], required substantial assistance to roll from her back to her right or left side in the bed. On the afternoon of [DATE], certified nurse aide (CNA) #3 elevated Resident #2's bed and then repositioned the resident onto her side to provide incontinence care. Resident #2 rolled off the elevated bed onto the floor during care. Interviews during the survey revealed Resident #2 was communicating with staff prior to the incident, however, Resident #2's responsiveness deteriorated significantly immediately after the fall. Resident #2 said she had head pain after the fall. Resident #2 was transferred to the hospital within an hour of the fall. Resident #2 experienced cardiac arrest while en route to the hospital and expired within 10 minutes of her arrival at the hospital. Due to the facility's failure to ensure Resident #2's safety during repositioning, Resident #2 likely sustained injuries when she fell off of the elevated bed.Specifically, the facility failed to ensure Resident #2 was protected from falling during repositioning.Findings include:I. Facility policy and procedureThe Assessing Falls and Their Causes policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 4:32 p.m. It read in pertinent part, Falls are a leading cause of morbidity and mortality in nursing homes. Fear of falling may limit an individual's participation in activities. Falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly.II. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO) diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, cellulitis (skin infection) of the lower extremities, diabetes, cirrhosis of the liver and heart failure.The [DATE] minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The MDS assessment identified Resident #2 required set up assistance for eating, substantial assistance from staff for repositioning in bed (rolling left to right) and was dependent on staff assistance for hygiene, bathing, dressing and transferring. B. Resident #2's witnessed fall on [DATE]The facility's incident report of Resident #2's fall from her bed was provided by the NHA on [DATE] at 2:30 p.m. The incident report documented the following:On [DATE] at 3:45 p.m. licensed practical nurse (LPN) #2 was told by a staff member that Resident #2 rolled out of bed while the staff member was changing the resident. It documented that the staff member reported the resident was on the floor and the staff member was not sure what happened. The incident report documented that a video call was made with the director of nursing (DON), who assisted with the assessment of Resident #2 while the resident was on the floor. It documented Resident #2 had a change in her level of consciousness after the fall. It documented Resident #2's oxygen saturation level (measurement of the amount of oxygen in the blood) had dropped and her blood pressure had increased. The report documented the hospice agency and emergency medical response services were notified for transfer of the resident to the hospital. The incident report documented predisposing physiological factors for the fall included edema, incontinence and weakness. C. Additional record reviewResident #2's activities of daily living (ADL) care plan, revised [DATE], revealed Resident #2 required assistance for ADL care in bathing and toileting related to impaired balance, dizziness, recent hospitalization, COPD diagnosis, diabetes, morbid obesity, rheumatoid arthritis, glaucoma and pulmonary hypertension. Interventions included bathing twice weekly, keeping Resident #2's room warm, documenting all refusals of cares, monitoring for decline in ADL function, monitoring for pain and arranging the resident's environment to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	facilitate ADL performance. The interventions further included having two staff members at all times when entering Resident #2's room.-However, CNA #3 provided ADL care to Resident #2 without a second staff member in the room (see interviews below).-The ADL care plan had not been revised since [DATE], despite Resident #2 experiencing decline in her ADL function and being accepted to hospice care services by [DATE].A review of Resident #2's [DATE] CPO revealed the following physician's orders:May position bed against a wall for ease of care and/or resident preference, ordered [DATE].Oxygen at 2 liters per minute (LPM) via nasal cannula continuously every day and night shift for COPD, notify physician/nurse practitioner if less than 89% (oxygen saturation), ordered [DATE].Hospice evaluation and treatment, ordered [DATE].Resident admit to hospice, diagnosis COPD, ordered [DATE].A hospice agency nursing note, dated [DATE] at 1:55 p.m., documented Resident #2 was awake and oriented to person, place and time. The note documented that Resident #2 said she was doing well. The note documented the facility nurse said Resident #2 seemed to be her old self, did not need comfort medications and was taking her scheduled medications without problems. The note documented Resident #2 was watching television in her bed at the conclusion of the visit and had no concerns or needs.A nursing progress note, dated [DATE] at 3:49 p.m., documented the nurse received a call from a nursing staff member reporting that Resident #2 had experienced a fall during ADL care. The note documented the nursing staff member had turned Resident #2 onto her side and the resident rolled out of the bed. The note documented that Resident #2 was lying on the floor on her right side, slightly tilted due to her proximity to the wall. The note documented during the assessment, Resident #2 began to exhibit signs of unresponsiveness and the emergency services (EMS) and the hospice agency were notified. It documented oxygen was applied via a non-rebreather (a device used to provide high amounts of oxygen) mask. It documented the resident was less lethargic upon the arrival of EMS to the facility. It documented Resident #2 was transferred to the hospital for further evaluation.A nursing progress note, dated [DATE] at 6:00 p.m., documented the coroner had contacted the facility at 5:10 p.m. It documented the coroner notified the facility that Resident #2 had died within 10 minutes of arrival to the hospital, after she was transferred from the facility following the fall from her bed. The note documented the coroner had requested information from Resident #2's medical record.The nursing facility to hospital transfer form was provided by the NHA on [DATE] at 2:30 pm. It documented Resident #2 was transferred to the hospital on [DATE] at 4:21 p.m. for the primary reason of a fall. It documented Resident #2 was not alert at the time of her transfer to the hospital. It documented Resident #2 was dependent on staff assistance for all ADLs. The transfer form documented Resident #2 was receiving 4 LPM oxygen by nasal cannula at the time of her transfer to the hospital.-Resident #2's oxygen requirement increased at the time of the fall, as nursing documentation revealed Resident #2 had been receiving 2 LPM of oxygen until the time of the fall on [DATE].The hospital physician's note, dated [DATE] at 4:55 p.m., documented Resident #2 arrived at the hospital unresponsive, without a pulse and was receiving artificial respirations with a bag-mask device. The physician documented EMS had told her the facility had called for assistance to transfer the resident to the hospital due to the resident's fall. The note documented Resident #2 had been able to talk upon EMS initial evaluation at the facility. The physician documented due to Resident #2's do not resuscitate (DNR) wishes, Resident #2's time of death was documented on [DATE] at 4:50 p.m. The note documented the physician thought Resident #2 had some sort of injury from the fall, which likely would have resulted in prolonged, if not futile hospitalization.III. Staff interviewsLPN #2 was interviewed on [DATE] at 10:55 a.m. LPN #2 said Resident #2 was not acting normally prior to her fall (on [DATE]). LPN #2 said the resident was acting differently that day and had asked to wear a night gown. LPN #2 said the resident never liked to wear clothes and usually wanted to wear only a brief. LPN #2 said Resident #2 was sleeping more and sometimes did not take her medications. LPN #2 said CNA #3 requested her assistance after Resident #2 fell out of the bed. LPN #2 said she went to the resident's bedside and contacted the DON through a video call to assess the resident, who was lying on the floor. LPN #2 said Resident #2's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	level of consciousness kept changing. LPN #2 said the resident alternated between being responsive and not, however LPN #2 said Resident #2 said, at one point, that she wanted to go to the hospital. LPN #2 said Resident #2's bed was in an elevated position when she arrived in the room, as the resident had been receiving ADL care at the time of the fall. LPN #2 said EMS was at the bedside when the resident was transferred to a gurney using a mechanical lift.The hospice agency nurse was interviewed on [DATE] at 1:19 p.m. The hospice agency nurse said the facility contacted the hospice agency when Resident #2 fell on [DATE]. The hospice agency nurse said Resident #2 was alert and communicative during the last hospice visit on [DATE]. She said Resident #2 liked to do crossword puzzles. The hospice agency nurse said Resident #2 never complained of pain or anxiety.CNA #3 was interviewed on [DATE] at 3:02 p.m. CNA #3 said she was changing Resident #2's brief when Resident #2 fell out of the bed. CNA #3 said she turned Resident #2 onto her side and then the resident said she was falling. CNA #3 said she could not reach the resident to assist, so she went to the other side of the bed, and by that time, Resident #2 was on the floor. CNA #3 said she had taken care of Resident #2 in the past and the resident had previously been able to stay on her side without rolling over. CNA #3 said the last time she took care of Resident #2, the resident's bed was against the wall so she could not roll off the bed. CNA #3 said at the time of Resident #2's fall, the bed had been moved away from the wall. CNA #3 said Resident #2 had only needed one person for transfers in the past, but probably should have had two staff members for transfers. CNA #3 said she notified LPN #2 when Resident #2 fell. CNA #3 said Resident #2 was initially talking after the fall and the resident said that her head was hurting.The DON and the regional clinical resource nurse were interviewed together on [DATE] at 6:22 p.m. The DON said she was told Resident #2 was too close to the edge of the bed and she rolled off of the bed onto the floor (on [DATE]). The DON said she was contacted and assisted LPN #2 with a nursing assessment. The DON said the nursing team decided it was best to transfer the resident to the hospital. The DON said the resident was intermittently responsive after the fall. The regional clinical resource nurse said the hospital record documented it was likely Resident #2 had injuries related to the fall.The DON was interviewed again on [DATE] at 12:12 p.m. The DON said she did not provide education to CNA #3 or nursing staff after the fall. The DON said CNA #3 did not do anything wrong when she was assisting Resident #2 with ADLs. She said CNA #3 repositioned the resident and the resident fell out of the bed during ADL care on [DATE]. The DON said CNA #3 did not need to do anything differently than what she had done.-However, according to Resident #2's ADL care plan, two staff members were to be present at all times when entering the resident's room (see record review above).