STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065247	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Village Care Center	110 W Van Buren 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of four residents were provided the care and services necessary to ensure a safe discharge from the facility to the community out of 11 sample residents. Specifically, the facility failed to allow Resident #1 to return to the facility after an unplanned discharge to the hospital.Findings include: I. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included dementia, respiratory failure, diabetes and asthma. The 9/11/25 minimum data set (MDS) assessment identified Resident #1 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The MDS assessment indicated the resident was dependent on staff for eating, personal hygiene, dressing and transferring. B. Record review A nursing progress note on 10/26/25 at 10:32 p.m. documented in pertinent part, Resident #1 was transferred to the hospital per family request . A nursing progress note on 10/27/25 at 7:34 a.m. documented Resident #1 was hospitalized with pneumonia and hyponatremia (low sodium) diagnoses. An admissions department progress note on 10/31/25 at 2:25 p.m. documented the department contacted the hospital social worker and notified the social worker that the facility would be unable to readmit Resident #1 to the facility. The note documented the nursing home administrator (NHA) would be reaching out to the hospital social worker to discuss the situation in further detail. An Expedited Notice of Transfer (With Less than 30 Days' Notice and Expedited Appeal) form for Resident #1, dated 10/31/25, was provided by the NHA on 1/6/26 at 11:00 am. The notice read in pertinent part, This notice is to inform you that (facility name) seeks to discharge you on 10/31/25. The specific reason for this transfer is as follows: The safety of the individuals in the facility would otherwise be endangered. -However, Resident #1 did not display behaviors that engaged others (see interviews below). -Review of Resident #1's electronic medical record (EMR) did not reveal the facility reassessed the resident once she returned to baseline at the hospital prior to issuing an immediate discharge notice. II. Staff interviews The admissions director was interviewed on 1/6/26 at 10:50 a.m. The admissions director said Resident #1 was not permitted to return to the facility upon discharge from the hospital and the resident's situation required an immediate discharge by the facility. The admissions director said there were family dynamics involved, but she did not know the specific reason for discharging the resident. The director of nursing (DON) was interviewed on 1/6/26 at 11:09 a.m. The DON said Resident #1 was not permitted to return to the facility after her hospitalization because there were issues with Resident #1's family. The DON said there had been no issues with Resident #1's care or the resident's behavior while at the facility. The DON said Resident #1's family member had demonstrated behaviors that were inappropriate while the resident was at the facility, including pushing a certified nurse aide (CNA). The DON said a facility could not refuse to allow a resident to return following hospitalization based (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: 065247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon the behavior of the resident's family. The DON said Resident #1 should have been permitted to return to the facility. The DON said the NHA contacted the hospital and did not allow Resident #1 to return to the facility. The NHA was interviewed on 1/6/26 at 11:32 a.m. The NHA said Resident #1 was a great resident and the resident treated staff well while she was at the facility. The NHA said Resident #1's family member was verbally and physically abusive to staff. The NHA said Resident #1's family never mistreated other residents while Resident #1 was at the facility. The NHA said the facility team decided not to allow the resident to return to the facility at the end of her hospital stay due to the previous behavior of the resident's family member. The NHA said he was concerned that Resident #1's family member's behavior would continue if the resident was allowed to return to the facility, and this might cause staff to resign from the facility. The NHA said Resident #1 had the right to return to the facility and the facility was able to manage Resident #1's medical needs. The NHA said the decision to not allow Resident #1 to return to the facility was made quickly and the Expedited Notice of Transfer notice was not completed or provided to the resident or family prior to discharge from the hospital. Registered nurse (RN) #1 was interviewed on 1/6/26 at 12:45 p.m. RN #1 said Resident #1 had no significant behavior issues and the resident was friendly toward staff. RN #1 said CNAs had reported one of Resident #1's family members had been directing Resident #1's care decisions and the decisions often conflicted with the resident's wishes.