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	05/15/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the resident's right to be informed of, and participate in his or her treatment for one (#77) of two residents out of 32 sample residents reviewed for the right to be informed and make treatment decisions. Specifically, the facility failed to inform Resident #77 and/or her legal representative of her laboratory (lab) bloodwork values before being sent to the hospital for a transfusion or her lab values after returning from the hospital. Findings include: I. Facility policy and procedure The Resident Rights policy, undated, was provided by the nursing home administrator (NHA) on 5/13/25 at 2:29 p.m. It read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be notified of his or her medical condition and of any changes in his or her condition, be informed of, and participate in, his or her care planning and treatment and access personal and medical records pertaining to him or herself. Copies of our resident rights are posted throughout the facility, and a copy is provided to each employee, provider and contracted staff member. In addition, staff will have appropriate in-service training on resident rights prior to having direct-care responsibilities for residents. II. Resident #77 A. Resident status Resident #77, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included anemia, generalized weakness, chronic heart failure and chronic respiratory failure. According to the 4/4/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial/maximal assistance with chair/bed and bed/chair transfers. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065247	A. Building B. Wing	05/15/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #77 was interviewed on 5/12/25 at 3:59 p.m. Resident #77 said she was sent to the hospital for a blood transfusion in March 2025. Resident #77 said she asked the nurses about her bloodwork values after she returned from the hospital, but she did not get an answer. Resident #77 said she still did not know what her blood levels were because staff did not tell her. C. Record review The 3/21/25 at 12:15 p.m. nursing progress note indicated Resident #77's labs came back and her hemoglobin (HGB - an iron-rich protein within red blood cells that is essential for transporting oxygen throughout the body) level was 5.7 grams per deciliter (g/dl). The nurse practitioner (NP) ordered a stat (immediate) CBC (complete blood count) to be drawn for the resident. Nursing staff was to call the results of the CBC into the resident's physician for further orders. The resident's previous HGB was 5.7 g/dl. The 3/21/25 at 11:44 p.m. nursing progress note documented the on-call physician was notified at 9:00 pm with an update regarding Resident #77's stat CBC results. The resident's HGB level was 6.4 g/dl and the physician ordered for the resident to be sent to the emergency room. The progress note indicated the director of nursing (DON) and the resident's family were notified of the transfer. -However, the progress note did not indicate the resident or the resident's representative were informed of the resident's HGB level or the specific reason for the transfer to the hospital. Review of Resident #77's May 2025 CPO revealed the following physician's orders related to laboratory blood work: Laboratory blood work CBC with differential, Vitamin B12 level for diagnosis of anemia, depression and paresthesias, ordered 5/2/25. -There was no documentation in the resident's EMR to indicate the resident or the resident's representative was notified of her most recent HGB lab values or if the resident's lab values would be retaken. The 5/1/25 at 11:36 p.m. physician's progress note documented the physician discussed Resident #77's recent hospital stay with her and informed her that a source of bleeding was not identified. The physician documented she did not review the resident's hospital records, but it did seem as if no source of bleeding was located and the resident was scheduled for a colonoscopy in one month. III. Staff interviews Licensed practical nurse (LPN) #5 was interviewed on 5/15/25 at 1:13 p.m. LPN #5 said if a resident was having a change of condition, such as critically low lab values, it was the nursing staff's responsibility to inform the resident of their test results and plan of care right away because it was their right to be informed. (continued on next page)

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	05/15/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 5/15/25 at 1:44 p.m. The DON said nursing staff was to inform residents of any change of condition. She said this is important to do because the facility wanted the residents to stay informed of their current medical status. The DON said she was aware of Resident #77's transfer to the emergency room for a blood transfusion and she made sure to check in with the resident when she returned to see how she was doing and if she had any questions. The DON said she did not remember specifically discussing Resident #77's HGB levels with the resident. -There was no documentation to indicate the DON or nursing staff had informed the resident of her HGB levels (see record review above).

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	05/15/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#46) of one resident out of 32 sample residents. Specifically, the facility failed to ensure Resident #46 was assessed for self-administration of Visine eye drops. Findings include: I. Facility policy and procedure The Self Administration of Medication policy, revised February 2021, was provided by the nursing home administrator (NHA) on 5/15/25 at 1:45 p.m. It read in pertinent part, Residents have the right to self-medication administrations if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. As part of the comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers several factors when determining resident self-medication administration. The resident must be able to safely and securely store the medication. Self-administered medications are stored in a safe and secure place that is not accessible to other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests it. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. II. Resident #46 A. Resident status Resident #46, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included bipolar disorder, unspecified dementia, anxiety disorder and unspecified symptoms and signs involving cognitive function and awareness. The 2/13/25 minimum data set (MDS) assessment revealed Resident #46 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was independent with mobility, dressing and eating. B. Observation and resident interview Resident #46 was interviewed on 5/13/25 at 1:18 pm. She was sitting on her bed in her room. There were three bottles of Visine eye drops lying on the resident's bedside table. The resident said she used the eye drops by herself, so the facility let her keep them by her bedside. Resident #46 said she did not know how often to use the eyedrops, however, she said she used the eye drops every day. (continued on next page)

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	05/15/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review A review of the May 2025 CPO revealed the following physician's order: Visine dry eye relief ophthalmic solution. Instill one drop in both eyes every two hours as needed for dry eyes, ordered 3/19/25. -The physician's order did not indicate Resident #46 was approved to self-administer the eye drops. Review of Resident #46's May 2025 medication administration record (MAR), from 5/1/25 to 5/11/25, revealed no documentation that the Visine eyedrops had been administered to the resident. -However, Resident #46 said she used the Visine eye drops every day (see resident interview above). The cognition care plan, initiated 2/10/25 and revised 2/22/25, revealed Resident #46 had an impaired thought process related to dementia. Interventions included administering medication as ordered, reviewing medications and recording possible causes of cognitive deficit. -A review of Resident #46's electronic medical record (EMR) did not reveal an assessment for the self-administration of Visine eye drops had been completed for the resident. III. Staff interviews Registered nurse (RN) #4 was interviewed on 5/13/25 at 1:18 p.m. RN #4 said Resident #46 had a diagnosis of dementia and she did not think the resident could remember the number of times she used the Visine eye drops. RN #4 said Visine eye drops were medication and needed a physician's order before administering them. RN #4 said Resident #4 was capable of self-administering the eye drops and the eye drops were kept on top of the resident's bedside dresser unsecured. -However, there was no assessment in the resident's EMR to indicate she was safe to administer the Visine eye drops (see record review above). The director of nursing (DON) was interviewed on 5/15/25 at 1:39 p.m. The DON said Visine eye drops were medication and needed to be securely stored. She said before a resident could begin self-medication administration, the resident should be properly assessed and a physician's order obtained for the self-administration of the medications. The DON said she did not know why Resident #46, who had a diagnosis of dementia, would be allowed to administer her medication without being properly assessed. The DON said Resident #46 was assessed for self-administration of the Visine eye drops and a new physician's order was obtained for the resident to self-administer the medication, during the survey. She said the nursing staff was being re-educated to ensure all residents on self-medication administration were properly assessed and a physician's order was obtained before the residents were allowed to self-administer medications. E. Facility follow-up (continued on next page)

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	05/15/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 7:00 p.m. (during the survey), the facility obtained a physician's order for Resident #46 to self-administer her Visine eye drops. A self-medication evaluation was completed for the resident.

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	05/15/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group. Specifically, the facility failed to make prompt efforts to resolve resident grievances about missing clothing that were brought up by the resident council. Findings include: I. Facility policy and procedure The Grievance/Complaints Filing policy, revised July 2022, was provided by the nursing home administrator (NHA) on 5/13/25 at 12:23 p.m. It read in pertinent part, All grievances, complaints, or recommendations stemming from resident or family groups concerning resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. II. Resident group interview Six alert and oriented residents (#40, #76, #51, #25, #64 and #20) who regularly attended the resident council meetings were interviewed on 5/14/25 at 10:08 a.m. The residents were identified as alert and oriented through the facility and assessment. The group of residents said the facility did not follow up on grievances brought up in the resident council meetings. Resident #3 said when a grievance came up in the resident council meeting the department head tried to address it during the meeting. Resident #3 said if it was an individual grievance the department head would follow up with the individual resident. Resident #3 said if it was a group grievance a resolution was not brought back to the next resident council meeting by the facility. Resident #40 said the resident council had been bringing up the issue of items going to the laundry and then being delivered to the wrong residents by housekeeping for several months. He said this happened even if the residents labeled their clothes before the clothes went to the laundry. Resident #51 said when the subject of the clothes not coming back from laundry to the right rooms was brought up during resident council, the facility managers told the residents it was because residents are not labeling their own clothes and it was the resident' s responsibility to ensure their clothes were labeled. Resident #51 said the staff delivering the clothes to the residents did not take the time to read the names on the clothes. Resident #25 said the issue with the clothes going to the wrong rooms had not been resolved and the facility expected the residents to be responsible for labeling their own clothes with markers even though there was a label maker in the laundry department. Resident #25 said she asked her roommate to help her label her clothes. (continued on next page)

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	05/15/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #76, Resident #64 and Resident #20 said they were in agreement that the laundry issue had not been resolved and the facility had not advised them in resident council how or when it would be resolved. III. Record review A review of the resident council meeting minutes, dated 2/20/25, revealed the residents brought up a concern regarding clothes not being returned to the correct rooms even with the residents' names being on the clothing tag. -Review of the February 2025 resident council minutes did not reveal documentation indicating the facility had addressed the residents' concern regarding missing laundry. A review of the resident council meeting minutes, dated 3/20/25, revealed the residents brought up a concern regarding clothes not being returned to the correct rooms even with the residents' names being on the clothing tag. -Review of the March 2025 resident council minutes did not reveal documentation indicating the facility had addressed the residents' concerns regarding missing laundry. A review of the resident council meeting minutes, dated 4/17/25, revealed the previous months concerns brought forward by the group regarding missing clothing were not discussed. IV. Staff interviews The social services director (SSD) was interviewed on 5/14/25 at 2:07 p.m. The SSD said the facility had a process for addressing individual resident grievances but there was no process for following up on group grievances generated during resident council. She said the manager present at the meeting whose department would be responsible for the grievance, would talk about how they planned to resolve it in the meeting. The activities director (AD) was interviewed on 5/15/25 at 1:01 p.m. The AD said all the department managers attended the resident council meeting. She said when a grievance was brought up, the manager present at the meeting, whose department would be responsible for the grievance, would talk about how they planned to resolve it in the meeting. The AD said the grievance was recorded in the resident council meeting minutes but not on an actual facility grievance form. She said the wasn't a process that ensured the department manager handling the grievance returned and provided an update on the resolution of the group grievance to the resident council members.

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	05/15/2025

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 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 (#44, #45 and #41) of four residents were free from chemical restraint out of 32 sample residents. Specifically, the facility failed to: -Document resident specific care approaches, to include medication specific target behaviors and person-centered interventions for Resident #44, Resident #45 and Resident #41's psychotropic medications; and, -Document consistent behaviors or a physician's rationale for Resident #44, Resident #45 and Resident #41 to justify the continued use of psychotropic medications. Findings include: I. Facility policy and procedure The Antipsychotic Medication Use policy, revised July 2022, was provided by the nursing home administrator (NHA) on 5/13/25 at 12:23 p.m. It read in pertinent part, Diagnosis alone does not warrant the use of antipsychotics. Antipsychotic medications will generally only be considered if the following conditions are met: behavior interventions have been attempted and included in the plan of care. For enduring psychiatric conditions, antipsychotic medications will not be used unless the behavior symptoms are not sufficiently relieved by non-pharmological interventions. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. The Behavioral Assessment, Interventions, and Monitoring policy, revised March 2019, was provided by the NHA on 5/13/25 at 12:23 p.m. It read in pertinent part, Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities. Interventions and approaches will be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behaviors. The care plan will include at minimum, targeted and individualized interventions for the behavioral/psychosocial symptoms, the rationale for the interventions and approaches, specific and measurable goals for the targeted behaviors, and how the staff will monitor the effectiveness of the interventions. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Non-pharmological approaches will be utilized to the extent possible to avoid and reduce the use of antipsychotic medications to manage behavioral symptoms. II. Resident #44 A. Resident status Resident #44, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included disorganized schizophrenia. The 2/10/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. Resident #44 required one-person staff assistance with toileting, bathing and personal hygiene. He ambulated independently. The MDS assessment indicated the resident did not exhibit hallucinations or delusions, did not refuse care and did not have physically or verbally abusive behaviors during the assessment look back period. B. Record review The mood care plan, revised 4/29/25, revealed Resident #44 had alterations in mood related to disorganized schizophrenia. He preferred to be alone and not interact with others. The behaviors identified to monitor included hallucinations, delusions, pacing and refusing care. Resident #44 frequently refused showers, changing his clothes, or allowing the nurses to check his legs or feet. He suffered from a paranoid delusion his feet would fall off or he would die if he removed his socks. Interventions included to identify strengths and use positive coping skills to reinforce these, encourage and reassure, identify approaches that contributed to behaviors, attempt non-pharmacological approaches to redirect, offer praise for compliance with care and encourage Resident #44 to express his feelings. -The care plan failed to indicate what person-centered approaches were effective in redirecting the resident. Review of Resident #44's May 2025 CPO revealed the following physician's orders: Monitor behaviors for antipsychotic use (Latuda, Zyprexa, Clozapine). Behaviors: hallucinations, delusions, and pacing. Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication- ordered on 8/12/24. Clozapine (antipsychotic medication) 100 milligrams (mg). Give 100 mg by mouth every evening with 400 mg dose to equal 500 mg for schizophrenia- ordered 2/17/25. Clozapine 200 mg. Give 400 mg by mouth every evening for schizophrenia, ordered 2/17/25. Latuda (antipsychotic medication) 120 mg. Give 120 mg by mouth every evening for disorganized schizophrenia, ordered 3/17/25. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior monitoring for care refusals that are detrimental to resident's health. Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication, ordered 3/25/25. Behavior monitoring for refusal of lotion to bilateral lower extremities (legs and feet). Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication, ordered 3/25/25. Behavior monitoring for refusal to remove socks. Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication, ordered 3/25/25. Behavior monitoring for refusal to change clothes. Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication, ordered 3/25/25. Behavior monitoring for refusal to take showers. Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication, ordered 3/25/25. -The non-pharmological interventions documented for all six of Resident #44's behavior monitoring physician's orders indicated the same identical, non person-centered non-pharmological interventions were to be used for every behavior, regardless of the behavior. Resident #44's Level II preadmission screening and resident review (PASRR) evaluation for mental illness and/or intellectual disabilities, dated 8/16/23, revealed Resident #44 had a history of psychiatric symptoms at a young age, isolating himself, self harming behaviors (cutting himself, stabbing himself), exposure to violence in the home, hallucinations, delusions, repeated psychiatric hospitalizations, and stabbing his mother. The evaluation revealed symptoms of decompensation to his mental health included increased smoking, sleep disturbances, and distractions by internal stimuli (delusions, paranoia). The resident expressed during the evaluation that he enjoyed watching movies, smoking, going out to dinner and listening to music. -The resident's specific behaviors, symptoms of decompensation, and non-pharmological interests identified in the Level II PASRR were not incorporated in Resident #44's behavior monitoring physician's orders or the resident's care plan (see physician's orders and care plan above). Review of Resident #44's medication administration records (MAR) and treatment admission records (TAR) from 2/1/25 to 5/14/25 revealed the following: The February 2025 MAR/TAR, from 2/1/25 to 2/28/25, revealed there was no documentation to indicate Resident #44 exhibited behaviors during the month. The March 2025 MAR/TAR, from 3/1/25 to 3/31/25, revealed there was no documentation of behaviors of refusals detrimental to Resident #44's health, or refusals of showers, applying lotion, changing his clothes or changing his socks during the month. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident exhibited two behaviors of hallucinations on 3/23/25 with interventions of staff redirection and offering food and fluids documented as being used. The documentation did not indicate if the interventions used on 3/23/25 were effective or not. The April 2025 MAR/TAR, from 4/1/25 to 4/30/25, revealed one behavior of refusals detrimental to Resident #44's health on 4/6/25 with the interventions of staff redirection and other documented as being used. The documentation did not indicate if the interventions used on 4/6/25 were effective or not. There was one behavior of Resident #44 refusing to allow lotion to be applied on 4/6/25 with the interventions of staff redirection and other documented as being used. The documentation did not indicate if the interventions used on 4/6/25 were effective or not There was one behavior of Resident #44 refusing to change his clothes on 4/5/25 and 4/6/25 with interventions of staff redirection and one-on-one documented as being used. The documentation did not indicate if the interventions used on 4/5/25 and 4/6/25 were effective or not. There was one behavior of Resident #44 refusing to change his socks on 4/5/25 and 4/6/25 with interventions of staff redirection and one-on-one documented as being used. The documentation did not indicate if the interventions used on 4/5/25 and 4/6/25 were effective or not. -A review of Resident #44's progress notes for 4/5/25 and 4/6/25 failed to identify what the term other indicated or what resident-specific redirection or one-on-one interventions were attempted when the resident exhibited refusal behaviors on 4/5/25 and 4/6/25. The May 2025 MAR/TAR, from 5/1/25 to 5/14/25, revealed Resident #44 had one behavior of refusing to change his socks on 5/3/25 with interventions of offering an activity and medication documented as being used and marked as effective. There was one behavior of Resident #44 refusing to change his socks on 5/4/25 with interventions of staff redirection and offering to use the toilet documented as being used. The documentation did not indicate if the interventions used on 5/4/25 were effective or not. There was one behavior of Resident #44 refusing to change his clothes with no interventions documented as being attempted on 5/13/25. -A review of the progress notes for 5/3/25 and 5/13/25 failed to identify what resident-specific activities of interest or redirection interventions were attempted when the resident exhibited refusal behaviors on 5/3/25 and 5/13/25. Review of the facility's quarterly psychotropic meeting minutes revealed Resident #44 was reviewed by the interdisciplinary team (IDT) on 2/17/25. The meeting minutes revealed Resident #44 had not had any behaviors within the three month look back period. -The 2/17/25 psychotropic meeting note did not indicate the facility had concerns regarding any behaviors for the resident and there was no documentation to indicate the justification for the continued use of the resident's antipsychotic medications. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's electronic medical record (EMR) from 2/1/25 to 5/14/25 revealed the following progress notes: Between 2/1/25 and 2/28/25, the progress notes documented Resident #44 had two refusals for care (the notes did not specify what care was refused), one refusal to take a shower and change his clothes and one refusal of a physician ordered test. -The progress notes did not indicate any non-pharmological interventions were attempted for the refusals. -There was no documentation to indicate the resident was experiencing hallucinations, delusions, paranoia or sleep disturbances (see care plan and Level II PASRR above). Between 3/1/25 and 3/31/25, the progress notes documented Resident #44 had seven refusals to take a shower, one refusal to change his clothes, six refusals to allow skin checks, three refusals to allow the nurse to apply medicated lotion and one refusal to allow the nurse to take his blood pressure. -The progress notes did not indicate any non-pharmological interventions were attempted for the refusals. -There was no documentation to indicate the resident was experiencing hallucinations, delusions, paranoia or sleep disturbances. Between 4/1/25 and 4/30/25, the progress notes documented Resident #44 had seven refusals to allow the nurse to apply medicated lotion. -The progress notes did not indicate any non-pharmological interventions were attempted for the refusals. -There was no documentation to indicate the resident was experiencing hallucinations, delusions, paranoia or sleep disturbances. Between 5/1/25 and 5/14/25, the progress notes documented Resident #44 had three refusals to allow the nurse to apply medicated lotion and one refusal to take a shower. -The progress notes did not indicate any non-pharmological interventions were attempted for the refusals. -There was no documentation to indicate the resident was having hallucinations, delusions, paranoia or sleep disturbances. -Review of Resident #44's EMR did not reveal documentation of a physician's rationale to justify the continued use of the resident's antipsychotic medications. III. Resident #45 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
	065247	A. Building B. Wing	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45, age [AGE], was admitted on [DATE]. According to the May 2025 CPO, diagnoses included Parkinson's disease, anxiety, obsessive compulsive disorder (OCD) and depression. The 4/16/25 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #45 required one-person staff assistance with toileting and bathing. He ambulated using a walker. The MDS assessment indicated the resident did not exhibit hallucinations or delusions, did not refuse care and did not have physically or verbally abusive behaviors within the assessment look back period. B. Resident interview Resident #45 was interviewed on 5/13/25 at 9:43 a.m. Resident #45 said he felt anxious sometimes over things he could not control but what helped him was to read, walk around the facility and leave his room to try to socialize in activities with staff and other residents. C. Record review The mood care plan, revised 4/7/25, revealed Resident #45 had a diagnosis of depression exhibited by increased sleep, decreased appetite and a fixation on events. He had a diagnosis of OCD, moderate. Interventions included to monitor for changes in mood and offer one-on-one interaction. The anxiety care plan, revised 4/7/25, revealed Resident #45 had a diagnosis of anxiety manifesting as verbalizations of anxiety, pacing and weighing himself after meals. Interventions included to assist him in problem solving abilities and logical strategies he could use when experiencing anxiety, encourage relaxation techniques, provide a quiet environment and reassurance. Review of Resident #45's May 2025 CPO revealed the following physician's orders: Prozac (antidepressant medication) 40 mg. Give two tablets a day by mouth for OCD, ordered 4/19/22. Abilify (antipsychotic medication) 15 mg. Give one tablet in the morning for OCD, ordered 8/21/24. Ativan (antianxiety medication) 0.25 mg. Give 0.25 mg one time a day in the afternoon for anxiety, ordered 12/26/24. Ativan 0.5 mg. Give 0.5 mg in the morning and 0.5 mg in the evening for anxiety,ordered 12/26/24. Behavior monitoring for weighing himself after meals and pacing. Document yes or no if the behavior occurred, ordered 8/7/24. Behavior monitoring for verbalizations of anxiety and pacing. Document yes or no if the behavior occurred, ordered 8/7/24. Behavior monitoring for increased sleep, decreased appetite and fixation on events. Document yes or no if the behavior occurred, ordered 8/7/24. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There were no non-pharmological interventions indicated on the behavior monitoring physician's orders. Resident #45's Level II PASRR evaluation, dated 11/26/23, revealed the resident had behaviors of avoidance, excessive handwashing, counting and checking things related to his diagnosis of OCD. The resident expressed during the evaluation that he enjoyed going to weekly Catholic mass, bible study, reading, watching television and playing games. The evaluation revealed if unable to follow rituals, the resident could feel anxious and stressed. -The resident's specific behaviors and non-pharmological interests identified in the Level II PASRR were not incorporated in Resident #45's behavior monitoring physician's orders or the resident's care plan (see physician's orders and care plan above). Review of Resident #45's MAR and TAR from 2/1/25 to 5/14/25 revealed the following: The February 2025 MAR/TAR, from 2/1/25 to 2/28/25, revealed there was no documentation to indicate Resident #45 exhibited behaviors during the month. The March 2025 MAR/TAR, from 3/1/25 to 3/31/25, revealed Resident #45 experienced one episode of increased sleep on 3/22/25 with no non-pharmological interventions being attempted. -There was no documentation to indicate Resident #45 exhibited any other behaviors during the month. The April 2025 MAR/TAR, from 4/1/25 to 4/30/25, revealed there was no documentation to indicate Resident #45 exhibited behaviors during the month. The May 2025 MAR/TAR, from 5/1/25 to 5/14/25, revealed Resident #45 experienced one episode of increased sleep on 5/3/25 with no non-pharmological interventions being attempted. -There was no documentation to indicate Resident #45 exhibited any other behaviors during the month. Review of the facility's quarterly psychotropic meeting minutes revealed Resident #45 was reviewed by the IDT on 3/17/25. The meeting minutes revealed Resident #45 had not had any behaviors within the three month look back period. -The 3/17/25 psychotropic meeting note did not indicate the facility had concerns regarding any behaviors for the resident and there was no documentation to indicate the justification for the continued use of the resident's antidepressant, antipsychotic or anti-anxiety medications. Review of Resident #45's EMR from 2/1/25 to 5/14/25 revealed two behavior progress notes, one dated 4/5/25 and the other dated 5/3/25. -Both notes revealed a behavior had occurred for Resident #45, however, neither note indicated what the behavior was or if a non-pharmological intervention had been attempted. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #45's EMR did not reveal documentation of a physician's rationale to justify the continued use of the resident's antidepressant, antipsychotic or anti-anxiety medications. IV. Resident #41 A. Resident status Resident #41, age less than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included childhood onset conduct disorder, unspecified intellectual disability, major depressive disorder and a traumatic brain injury (TBI). The 3/17/25 MDS assessment documented the resident was cognitively intact with a BIMS score of 13 out of 15. Resident #41 required one-person staff assistance with bathing. She ambulated using a walker. The MDS assessment indicated the resident had daily behaviors of wandering during the assessment look back period. B. Resident interview Resident #41 was interviewed on 5/13/25 at 9:17 a.m. Resident #41 said she was very unhappy living at the facility and she tried to occupy herself so she would not become depressed. Resident #41 said her family had placed her in the facility but she would like to go out on more activities and be part of a day program in the community. Resident #41 said she expressed her feelings to the staff and the staff would listen but she was unable to say what specifically the staff did that helped when she was feeling angry or sad about her placement in the facility. C. Record review The mood care plan, revised 4/7/25, revealed Resident #41 had a diagnosis of depression, TBI, unspecified intellectual disability and childhood onset conduct disorder. Depressive indicators include increased sleep, decreased appetite and verbalizations of depression. Interventions included to assist with positive coping skills, offer reassurance, encourage her to express her feelings and identify approaches contributing to behaviors. Review of Resident #41's May 2025 CPO revealed the following physician's orders: Zoloft (antidepressant medication) 100 mg. Give 100 mg one time a day for depression, ordered 12/14/24. Behavior monitoring for increased sleep, decreased appetite and decrease in complaints of depression. Document yes or no if the behavior occurred, ordered 9/13/24. -There were no non-pharmological interventions indicated on the behavior monitoring physician's order. Review of Resident #41's MAR and TAR from 2/1/25 to 5/14/25 failed to reveal any documentation to indicate the resident exhibited behaviors during that time period. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's quarterly psychotropic meeting minutes revealed Resident #41 was reviewed by the IDT on 2/17/25. The meeting minutes revealed Resident #41 had not had any behaviors within the three month look back period. -The 2/17/25 psychotropic meeting note did not indicate the facility had concerns regarding any behaviors for the resident and there was no documentation to indicate the justification for the continued use of the resident's antidepressant medication. Review of Resident #41's EMR from 2/1/25 to 5/14/25 did not reveal any progress notes to indicate the resident had exhibited any behaviors during that time period. A review of Resident #41's psychiatrist visit notes revealed the last visit note was dated 12/29/24. The psychiatrist documented he had received an e-mail from the facility's social services director (SSD) on 12/13/24 which contained an attachment from an e-mail sent to the SSD by Resident #41's representative. The resident's representative stated in her e-mail to the SSD that Resident #41 had been extremely angry, having outbursts, and uncontrollable temper tantrums. The representative requested a review of Resident #41's medication by the psychiatrist. As a result of this communication, the psychiatrist increased Resident #41's Zoloft from 50 mg daily to 100 mg daily. The psychiatrist documented in his note that he later reviewed the documentation in Resident #41's EMR and found there were no progress notes written by the SSD describing her communications with Resident 41's representative. The psychiatrist documented in his note that he was having concerns regarding the lack of documentation as Resident #41's Zoloft dosage was increased for no apparent reason. The psychiatrist requested documentation that described the communications between the SSD and the resident's representative, as well as expressing the importance of having documentation due to no documented behaviors by staff since 11/26/24. When the psychiatrist met with Resident #41 on 12/29/24, the resident told him her behavioral outbursts were related to agitation towards her representative. The psychiatrist indicated during his visit that the resident did not display any evidence of agitation or anger and appeared no different than any prior visit he had had with her. -However, despite the psychiatrist's documented concerns on 12/29/24, regarding the increase in Zoloft, the medication was not decreased and Resident #41 continued to receive the increased dose of Zoloft (see physician's orders above). V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/13/25 at 3:00 p.m. CNA #1 said Resident #45 did not have any behaviors, he was just particular about how he liked things to be done. CNA #1 said she was not aware of any specific non-pharmological interventions used for Resident #45. She said she did not know Resident #44. She said Resident #41 had behaviors of verbalizing being unhappy and not wanting to live in the facility but CNA #1 said she had a hard time understanding what Resident #41 was saying and was not aware of any interventions to use when Resident #41 was having these verbalizations of depression. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said the CNAs documented behaviors on the CNA behavior monitoring task but the behaviors and interventions indicated on the task were generic and the same for all the residents. She said the CNAs could not customize the behaviors observed or interventions tried, and so if there were behaviors observed or intervention tried that were not on the generic list, she would notify the nurse for them to document in the residents' EMR. Licensed practical nurse (LPN) #2 and registered nurse (RN) #2 were interviewed together on 5/13/25 at 3:15 p.m. LPN #2 and RN #2 both said Resident #45 had behaviors of being compulsive and particular in how he wanted things done for him. RN #2 said what interventions worked with Resident #45 were to support him in being independent and accommodate how he wanted things done as much as possible. She said he enjoyed leaving his room, walking around the facility and talking to staff and other residents. RN #2 and LPN #2 both said they were unaware of any behaviors for Resident #44. RN #2 said Resident #41 had behaviors of verbalizations of being unhappy and sad about her placement in the facility. RN #2 said she was not aware of any specific interventions that helped the resident when she was feeling that way. She said the residents' behavior monitoring was in the physician's orders and popped up on the nurses' TAR to complete every shift. RN #2 said the director of nursing (DON) would email the nurses' specific behaviors to monitor for residents because the behaviors and interventions on the physician's orders were generic. CNA #4 was interviewed on 5/14/25 at 8:45 a.m. CNA #4 said Resident #45 did not have any behaviors. CNA #4 said Resident #44 had behaviors of frequently going outside to smoke cigarettes and refusing to perform basic hygiene tasks (changing his socks, clothes or showering). She said he would refuse to clean his own bottom after a bowel movement, claiming he was unable to reach the area even though the staff had tried to provide him encouragement and reassurance he could complete the task independently. She said the non-pharmological interventions indicated for Resident #44 on his behavior monitoring, such as offering to toilet the resident, offering a back-rub and offering activities, were not effective as these interventions would agitate him more if offered. She said she was not aware of any specific interventions that helped with Resident #44 when he was refusing care. CNA #4 said she was not aware of any behaviors for Resident #41. LPN #4 was interviewed on 5/14/25 at 9:00 a.m. LPN #4 said Resident #44 had behaviors of refusing to clean his own bottom after a bowel movement but she was not aware of what interventions the CNAs used with him for this behavior. LPN #4 said many of the non-pharmological interventions on the behavior monitoring physician's orders (offering activities, offering a back rub, offering toileting, repositioning and changing room temperature) for Resident #44 did not apply to him because he was independent and preferred to be alone. LPN #4 said Resident #45 did not have any behaviors and she did not know Resident #41 very well. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed on 5/14/25 at 9:13 a.m. LPN #3 said Resident #44 had behaviors of refusing to change his clothes, socks or take a shower. LPN #3 said the interventions that worked were for staff to allow him to take the lead during personal cares, such as asking him what personal care he wanted to do first, what he needed from the staff and continuously providing positive reinforcement throughout the process. She said there were some staff he would perform these tasks for because the staff allowed him to direct the care and he felt comfortable with this approach. LPN #3 said Resident #45 had behaviors of weighing himself daily and pacing. She said he was concerned with his weight loss and wanted to gain weight and this was why he compulsively weighed himself. LPN #3 said when he started pacing, interventions that worked for him were to redirect him to an activity of interest, especially when there was an activity involving watching movies. The SSD and the social services consultant (SSC) were interviewed together on 5/14/25 at 2:07 p.m. The SSD said when a resident began taking a psychotropic medication, the DON and the SSD put together a behavior monitoring physician's order. She said the behaviors included on the order came from a list of standard behaviors that were associated with the specific drug classification, such as hallucinations for antipsychotic medications. The SSD said once the facility got to know the resident, the behavior monitoring physician's order would be modified in order to make it more resident-specific and personalized. The SSD said the purpose of monitoring residents' behaviors was to determine the efficacy of the psychoactive medication and to ensure there were non-pharmological interventions being tried and the facility was not solely relying on the psychoactive medications to help with decreasing the residents' behaviors. The SSD said she gathered information from the behavior monitoring documentation in the residents' TARs and progress notes before the monthly psychotropic medication meetings. She said she did not look at the CNA behavior monitoring tasks or interview the CNAs for the collection of information for the psychotropic medication meetings. The SSD said if a resident did not have any documented behaviors for three months, the medication associated with those behaviors should be reduced or discontinued. The SSD said she reviewed the residents' progress notes and the TARs for behaviors to discuss in the psychotropic medication meetings, but she said she had not noticed that the behavior monitoring physician's orders for Resident #44 had the same non-pharmological interventions or that Resident #41 and Resident #45 had no non-pharmological interventions indicated on their behavior monitoring physician's orders. She said she had not noticed that the TARs for Resident #45 or Resident #41 documented the residents had exhibited minimal or no behaviors for February 2025, March 2025, April 2025 and May 2025. She said she was unaware of Resident #44's history of self harm and harming others that was documented in his Level II PASRR, but she acknowledged the behaviors should be included in his care plan and on his behavior monitoring. She said she did not include behaviors identified in a resident's Level II PASRR on the behavior monitoring because the DON primarily managed the behavior monitoring process. The DON was interviewed on 5/14/25 at 3:06 p.m. The DON said a behavior monitoring physician's order was entered when a resident was admitted to the facility on psychoactive medications or had a change in psychoactive medications. The DON said the behaviors indicated on the physician's order came from the resident's history and a standard list of behaviors associated with the specific medication drug classification. She said once the facility became more familiar with a resident,, the behavior monitoring physician's order would be modified to be more personalized and resident specific. (continued on next page)

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	05/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said for the psychotropic medication meetings, the SSD brought a spreadsheet of the residents' behavior information she had compiled for the three month look back period. The DON said she assumed the SSD collected this information from the residents' TARs and progress notes. She said the behavior monitoring information was an important part of the psychotropic medication meetings because it helped the physicians make decisions about residents' psychotropic mediation changes, and if the information was not accurate, it would affect making informed decisions about the effectiveness of medications. The DON said the facility's medical director (MD) had explained to her the importa[TRUNCATED]

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	05/15/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide provide assistance with activities of daily living (ADLs) to ensure the highest practicable quality of life for one (#45) of two residents reviewed out of 32 sample residents. Specifically, the facility failed to provide the necessary assistance for Resident #45, who required physical assistance with meals due to tremors. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL) Support policy, revised March 2018, was provided by the nursing home administrator (NHA) on 5/13/25 at 12:23 p.m. It read in pertinent part, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL). The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADLs. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognize standards of practice. The resident's response to interventions will be monitored, evaluated, and revised as appropriate. II. Resident #45 A. Resident status Resident #45, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease (a disease that causes involuntary movements), anxiety, obsessive compulsive disorder (OCD) and depression. The 4/16/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #45 required one-person staff assistance with toileting and bathing. The MDS assessment indicated the resident was independent with eating. -However, observations revealed Resident #45 needed assistance with meals (see observations below). B. Resident interview (continued on next page)

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	05/15/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 was interviewed on 5/13/25 at 9:43 a.m. He said he was supposed to get help with eating because of his tremors. He said he only received help if he asked for it and did not always get help even when he asked. Resident #45 said he had weighted utensils to assist with eating, but the utensils were not very helpful when his tremors were very bad. Resident #45 said the lunch meal on 5/12/25 when his tablemate helped cut his food for him was not an unusual occurrence and he often had a difficult time getting the staff's attention for assistance (see observations below). C. Observations During a continuous observation on 5/12/25, beginning at 12:05 p.m. and ending at 1:00 p.m., the following was observed in the main dining room: At 12:10 p.m. Resident #45 was served his meal, which consisted of navy bean soup, teriyaki chicken, fried rice, vegetable blend and a bread roll. Resident #45 was provided with built-up utensils (foam handled silverware). Resident #45 attempted to cut his chicken with his fork and knife. He was having difficulty cutting his chicken due to his hands shaking continuously throughout the process of cutting. Resident #45 attempted to get the attention of two unidentified staff members. The first attempt he tried to wave down an unidentified staff member walking by serving meal trays and the second attempt he called out to an unidentified certified nurse aide (CNA) who told him she would return to help him. The unidentified CNA did not return to assist him. At 12:30 p.m. Resident #45 continued to try to cut his chicken. The residents tremors were worsening At 12:35 p.m. another resident sitting next to Resident #45 cut up his chicken for him. Resident #45 was then able to eat his chicken. During a continuous observation on 5/13/25, beginning at 12:00 p.m. and ending at 1:11 p.m., the following was observed in the main dining room: At 12:10 p.m. Resident #45 was provided juice in a regular glass, which he struggled to prevent from spilling when he would try to take a drink due to his tremors, he was able to drink some of his supplement because it had a straw and was in a carton. At 12:19 p.m., Resident #45 was served his meal, which consisted of spaghetti with three meatballs and a garlic bread. Resident #45 was provided with built up utensils and attempted to use his fork to cut one of his meatballs. He kept losing the grip on his fork due to continuous tremors in his hands. From 12:19 p.m. to 12:41 p.m., Resident #45 attempted three separate times to cut his meatballs without success. After being unable to cut the meatballs, he would finally put the entire meatball into his mouth. When Resident #45 attempted to eat the spaghetti noodles, he lowered his face very close to the plate and used his fork to push the noodles into his mouth. Resident #45 was unable to bring his fork to his mouth without the spaghetti falling off of the fork. (continued on next page)

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	05/15/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:41 p.m. Resident #45's tremors became more severe and he began to struggle to push the spaghetti with his fork into his mouth, losing amounts of spaghetti in the process. When this would occur, Resident #45 would attempt to use his other hand to push the spaghetti into his mouth or prevent the spaghetti from falling out of his mouth. At 1:15 p.m., Resident #45 had finished his meal, eating approximately 75% and only drinking approximately 50% of his beverage. D. Record review The nutrition care plan, revised 5/8/25, revealed Resident #45 had a diagnosis of Parkinson's disease which put him at risk for a decreased ability to maintain nutritional status. The care plan documented the resident had experienced unplanned weight loss. Interventions, revised 5/8/25, included providing supplements as ordered, serving the resident's diet as ordered, registered dietitian (RD) to evaluate and make diet recommendations and continuing to provide a regular diet and fortified foods. -The care plan did not indicate the resident needed assistance with cutting up his meals. An interdisciplinary team (IDT) weight variance note, dated 12/20/24, revealed Resident #45 had an average intake amount of 60%. Potential contributing factors included rigid tremors. The root cause analysis determined the likely cause of weight loss to be Resident #45's tremors and not eating his entire meal. III. Staff interviews CNA #1 was interviewed on 5/13/25 at 3:00 p.m. CNA #1 said Resident #45 only needed staff to assist with cutting his food for him when he asked. -However, observations revealed the staff did not assist Resident #45 with cutting up his food (see observations above). Registered nurse (RN) #2 was interviewed on 5/13/25 at 3:15 p.m. RN #2 said Resident #45 liked to attempt to do things for himself and if he asked the staff for assistance with something, that meant he had already tried and failed several times to do it on his own. She said he would allow the staff to assist him with things like cutting his food, if the staff were discreet about providing him assistance. Licensed practical nurse (LPN) #3 was interviewed on 5/14/25 at 9:13 a.m. LPN #3 said Resident #45 did need assistance from staff with cutting his food up sometimes due to his tremors and would ask staff for help. The director of rehabilitation (DOR) was interviewed on 5/14/25 at 11:45 a.m. The DOR said Resident #45 had not worked with therapy since October of 2024, which was for shoulder pain. The DOR said the nurses or the director of nursing (DON) would request an order from the physician for therapy to do an evaluation for residents identified as potentially needing additional assisted devices or staff assistance with eating, however, she had not received a referral for Resident #45. (continued on next page)

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	05/15/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 5/14/25 at 12:00 p.m. The DON said she had observed Resident #45 eating and it took him over an hour to eat his meals because it required a lot of energy for him to concentrate on the task of eating due to his tremors. She said since it took so long for him to eat he would not request additional food if the task of eating was exhausting. The registered dietitian (RD) was interviewed on 5/14/25 at 12:29 p.m. The RD said she had never observed Resident #45 eating to see if there were any challenges with intake. She said she thought the staff assisted him with cutting up his food when he asked. She said she had not considered adding cut up meals to his diet order so he would not have to ask the staff. The RD said Resident #45 was determined to stay as independent as possible and had refused feeding assistance but she had never offered to him to have his food precut as a means to ensure eating was easier and then wouldn't require him to exert so much energy.

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	05/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, record review, and interviews, the facility failed to ensure an environment free from risk of accident and hazards for two (#84 and #6) of five residents reviewed for accident hazards out of 32 sample residents. Specifically, the facility failed to: -Ensure the grab bar/hand rail in Resident #84's bathroom was repaired and a second one installed, per the recommendations of the occupational therapist (OT) as a fall intervention; and, -Ensure Dakin's solution (a topical antiseptic used in wound treatment) was not left unsecured in Resident #6's room. Findings include: I. Failed to ensure grab bar/hand rail was repaired and a second one installed in the bathroom for Resident #84 A. Facility policy and procedure The Falls Clinical Protocol policy, revised September 2012, was provided by the nursing home administrator (NHA) on 5/15/25 at 12:53 p.m. It read in pertinent part, As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. The risk of serious adverse consequences can sometimes be minimized, even if falls cannot be prevented. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The Accommodation of Needs policy, revised March 2021, was provided by the NHA on 5/15/25 at 12:53 p.m. It read in pertinent part, The facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. To accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptations may include providing access to assistive devices, such as grab bars and toilet risers in the bathroom, installing mirrors at a height at which a wheelchair-bound resident can see, installing adaptive handles, or providing assistive devices so that drawers are easily opened and closed. (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident #84 1. Resident status Resident #84, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included spinal stenosis, chronic obstructive pulmonary disease (COPD), major depressive disorder and personal history of transient ischemic attack (a temporary interruption of blood flow to the brain). The 3/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He was independent with toileting, dressing, eating, and personal hygiene. 2. Observation and resident interview Resident #84 was interviewed on 5/13/25 at 9:16 a.m. He was sitting in his wheelchair in his room. The resident said the grab bar in his bathroom was loose and he was afraid to use it during toileting. He said he reported it to the OT, who completed a work order for the repairs. Observation of the resident's bathroom during the interview revealed there was only one grab bar in the resident's bathroom which was loose when it was pulled on. Resident #84 said a maintenance department staff member came to assess the grab bar in April 2025 and said he was going to come back with the appropriate tool to fix the loose grab bar and install the additional grab bar on the left wall of his toilet. However, Resident #84 said the maintenance staff member did not return and the work was not completed and the grab bar was still loose. Resident #84 said if the grab bars were installed and working properly, he would not have fallen. He said he did not feel safe using his toilet due to the loose grab bar and the unavailability of the additional grab bar that was recommended by the OT after a fall evaluation was completed. 3. Record review Review of Resident #84's at risk for falls care plan, initiated and revised on 1/10/25, revealed the resident was at risk for falls and fall-related injury related to incontinence, decreased functional ability and chronic pain. Pertinent interventions included an occupational and physical therapy (OT and PT) evaluation and treatment as needed, placement of a Call Don't Fall sign in the resident's room, and OT and PT evaluations for strengthening, mobility training, and activities of daily living (ADL) self-care activities. A fall incident report, dated 3/17/25 at 4:30 p.m., documented that registered nurse (RN) #3 responded to a loud voice coming from Resident #84's bathroom. The report indicated the resident was found lying on his left side on the floor. The resident was incontinent of bowel, and his pants were down below his knees. The report revealed the resident said he wanted to go to the bathroom. The 3/26/25 OT progress note revealed that a recommendation by the OT was made to install a new grab bar on the left wall in Resident #84's bathroom and also to repair the grab bar on the right side of the wall. (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the existing grab bar was not repaired and the additional grab bar was not installed (see observation and resident interview above and OT interview below). C. Staff interviews The OT was interviewed on 5/13/25 at 2:50 p.m. The OT verified that the grab bar in Resident #84's bathroom was loose and there was no additional grab bar in the bathroom. The OT said Resident #84 was evaluated after a fall in his bathroom. The OT said she recommended an additional grab bar to be installed on the left wall of the resident's bathroom, due to his poor safety awareness, and she said she also completed a maintenance work order for the existing grab bar to be repaired. The OT said the work order was resolved as completed; however, the grab bar was not repaired and the additional grab bar was not installed. The OT said Resident #84 was a high risk for falls due to his decreased safety awareness. The maintenance director (MTD) was interviewed on 5/13/25 at 3:30 p.m. The MTD said all maintenance work orders were submitted through an electronic submission system. He said he did not remember receiving any maintenance work orders to fix and install a grab bar in Resident #84's room. The MTD said grab bars in residents' bathrooms were not part of the maintenance department's preventative list and therefore he did not routinely check them to ensure they were not loose. The MTD said he looked through all maintenance work orders he received via the electronic submission system and completed all safety concerns immediately. The MTD said when maintenance work orders were not completed promptly, it could cause injuries to the residents. Registered nurse (RN) #4 was interviewed on 5/15/25 at 11:50 a.m. RN #4 said She said she completed all maintenance work orders on the facility's electronic submission system. RN #4 said she was unaware that Resident #84 needed to have his bathroom grab bar fixed and an additional grab bar installed. She said when maintenance work orders were not completed promptly, it could potentially result in injuries for residents. The NHA was interviewed on 5/15/25 at 9:29 a.m. The NHA said all maintenance work orders should be completed promptly and any reason the work was not completed should be documented. He said all handrails and grab bars in residents' living areas, including bathrooms, should be inspected periodically. The NHA said he was unaware that residents' grab bars were not being inspected by the maintenance department. The NHA said he would immediately initiate a performance improvement plan to ensure that all maintenance work orders were completed, and periodic checks would be performed on all grab bars in the residents' bathrooms. II. Failed to ensure Dakin's solution was not left unsecured in Resident #6's room A. Facility policy and procedure The Medication Labeling and Storage policy, revised 2001, was provided by the NHA on 5/15/25 at 1:45 p.m. It read in pertinent part, (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments, including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes containing medication and biologicals, are locked when not in use, and trays or carts used to transport such items are not left unattended. B. Resident #6 1. Resident status Resident #6, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 CPO diagnoses, included bipolar disorder, epilepsy, schizophrenia and pressure ulcer of the sacral region. The 4/17/25 MDS assessment revealed Resident #6 had severe cognitive impairment with a BIMS score of seven out of 15. He required total assistance from staff for transfers, toileting, personal hygiene and set up assistance with eating. 2. Observation On 5/12/25 at 11:30 a.m. Resident #6 was lying in his bed. The resident had paintings on his bedside table, which he was coloring. Resident #6 said he required assistance getting up out of bed, however, he was able to push himself once he was in his wheelchair. There were several personal care items sitting on top of a small dresser facing Resident #6's bed. Among the items was a bottle of Dakin's half-strength solution. C. Record review A review of a medication administration note, dated 3/9/25 at 11:31 p.m., documented the following treatment was administered to Resident #6: Treatment to open sacrum, cleanse with normal saline, apply gauze moistened with 1/2 strength Dakins and cover with an ABD (abdominal pad) at bedtime for wound care. D. Staff interviews Registered nurse (RN) #3 was interviewed on 5/12/25 at 5:40 p.m. RN #3 confirmed Resident #6 had a bottle of Dakin's solution sitting on his bedside table. She said the Dakin's solution was for the resident's wound care. RN #3 said the staff left the bottle of solution in the resident's room once it was opened to avoid contamination. RN #3 said the Dakin's solution was kept in the Resident's room to prevent contamination. (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/15/25 at 1:39 p.m. The DON said Dakin's solution was a form of medication and needed to be stored in a secured location and not in Resident #6's room at his bedside. The DON said all medications and treatments must be stored securely. The DON said the bottle of Dakin's solution was removed from Resident #6's room after being discovered on 5/12/25 and the nurses were re-educated to check his room for medications and treatments. The DON said Dakin's solution should not be left unsecured because it could cause potential harm if ingested by a resident.

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	05/15/2025

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 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#74) of two residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing out of 32 sample residents. Specifically, the facility failed to monitor Resident #74, who had a history of suicide attempts, for worsening signs and symptoms of identified depression. Findings include: I. Resident #74 A. Resident status Resident #74, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included mild dementia with anxiety, personality disorder, adjustment disorder, major depressive disorder, suicidal ideations and bipolar disorder. The 4/23/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. B. Resident interview Resident #74 was interviewed in her room on 5/14/24 at 11:00 a.m. Resident #74 said her depression had worsened in the last month due to her declining health. She said it was very difficult for her to physically go down to the activities room to find crafts and puzzles. Resident #74 said she had a history of depression and at least four hospitalizations related to her depression. She said what triggered her depression was the loss of abilities (no longer being able to drive, travel or take photographs) and changes in her health. She said she stayed in her room a lot more and tried to keep herself busy with projects and crafts. C. Record review The suicidal ideations care plan, revised 5/7/25, revealed Resident #74 had a history of suicidal ideations, per her preadmission screening and resident review (PASRR) evaluation for mental illness and/or intellectual disabilities. Interventions, revised 2/27/25, included administering medications as ordered, being alert for signs and symptoms of increased depression and engaging the resident in conversation during medication pass to assess mood. The mood care plan, revised 5/7/25, revealed Resident #74 had behaviors related to major depressive disorder. Interventions, revised 8/27/24, included to identify strengths and use positive coping skills to reinforce these, encourage and reassure and identify approaches that contributed to behaviors. (continued on next page)

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	05/15/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2025 CPO revealed the following physician's orders: Lexapro (antidepressant medication) 10 milligram (mg). Give one tablet in the morning for depression; ordered 1/31/24. Lithium (mood stabilizer medication) 150 mg. Give one tablet at bedtime for major depressive disorder, ordered 2/2/24. Abilify (antipsychotic medication) 2 mg. Give one tablet in the morning for major depressive disorder, ordered 1/29/25. Monitor hours of sleep, ordered 1/31/24. Behavior monitoring for increased sleep, decreased appetite and verbalizations of sadness. Document yes or no if the behavior occurred, ordered 9/13/24. Behavior monitoring for physician aggression. Interventions: redirect, one-on-one, see nurses notes, activity, return to room, toilet, offer food/fluids, change position, adjust room temperature, backrub, or medication, ordered 4/21/25. -The physician's orders did not include an order to monitor the resident for suicidal ideations. A review of the resident's depression screens, dated 12/5/24 to 4/21/25, revealed Resident #74's depression score increased from four (minimal depression) to an eight (mild depression) with expressions of feeling bad about herself and feeling hopeless. Resident #74's Level II PASRR, dated 1/27/24, revealed Resident #74 had been admitted to the hospital for suicidal ideations on 1/23/24. She had a history of expressing suicidal ideations without intent, however, she was admitted to the hospital after being found with antidepressants in her pocket after expressing depression. Her assisted living facility had been closed abruptly and she had to live with her son temporarily, causing her anxiety and depression. Resident #74 had expressed to the hospital staff that she felt like she had to depend on medication to walk and sleep and felt like she could no longer be me. She had a history of being active, social, and artistically creative (crafts and photography). The evaluation revealed she had taken pills in the past to overdose but was unsuccessful. -The resident specific identification of triggers (loss of abilities and medical decline) and non-pharmacological interests identified in the Level II PASRR were not incorporated in Resident #74's behavior monitoring physician's orders or the resident's care plan (see physician's orders and care plan above). Review of Resident #74's medication administration records (MAR) and treatment admission records (TAR) from 2/1/25 to 5/14/25 revealed the following: The February 2025 MAR/TAR, from 2/1/25 to 2/28/25, revealed there was no documentation to indicate Resident #74 exhibited behaviors during the month, however, the hours of sleep monitoring documentation revealed the resident had been sleeping an average of 10 hours a day. (continued on next page)

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	05/15/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2025 MAR/TAR, from 3/1/25 to 3/31/25, revealed there was no documentation to indicate Resident #74 exhibited behaviors during the month, however, the hours of sleep monitoring documentation revealed the resident had been sleeping an average of 11.5 hours a day. The April 2025 MAR/TAR, from 4/1/25 to 4/30/25, revealed there was no documentation to indicate Resident #74 exhibited behaviors during the month, however, the hours of sleep monitoring documentation revealed the resident had been sleeping an average of 10.5 hours a day. The May 2025 MAR/TAR, from 5/1/25 to 5/14/25, revealed there was no documentation to indicate Resident #74 exhibited behaviors during the month, however, the hours of sleep monitoring documentation revealed the resident had been sleeping an average of 10 hours a day. Review of Resident #74's electronic medical record (EMR), from 1/28/25 to 5/14/25, revealed the following progress notes: A psychiatrist visit note, dated 1/28/25, revealed Resident #74 expressed to the psychiatrist she was beginning to become more depressed and that it felt like episodes in the past when she became severely depressed. A Patient Health Questionnaire-9 (PHQ-9 - a tool used to screen for depression) note, dated 1/31/25, revealed Resident #74's depression score was an eight out of 27 (indicating mild depression) and she expressed feeling bad about herself and feeling hopeless to the social services director (SSD). A PHQ-9 note, dated 4/21/25, revealed Resident #74's depression score was an eight and she expressed decreased appetite and increased sleep to the SSD. -Despite Resident #74 expressing symptoms indicated on her behavior monitoring for depression (increased sleep, decreased appetite and verbalizations of sadness) on 1/28/25, 1/31/25 and 4/21/25 and her hours of sleep monitoring showing increased hours of sleep, there was no documentation to indicate the SSD followed up with the resident or that staff was made aware to increase monitoring of Resident #74 for worsening symptoms of depression and/or suicidal ideation. II. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/13/25 at 3:00 p.m. CNA #1 said Resident #74 did not have any history of depression or expressions of suicidal ideations. CNA #1 said sometimes Resident #74 isolated herself in her room away from the other residents but CNA #1 did not know why. Registered nurse (RN) #2 was interviewed on 5/13/25 at 3:15 p.m. RN #2 said sometimes Resident #74 could be tearful and isolate herself in her room but as long as she had an art craft to work on in her room, Resident #74 was fine. CNA #4 was interviewed on 5/14/25 at 8:45 a.m. CNA #4 said Resident #74 did not have any history of depression or expressions of suicidal ideations. CNA #4 said if Resident #74 became tearful, she would try to encourage her to do an art craft. (continued on next page)

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	05/15/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD and the social services consultant (SSC) were interviewed together on 5/14/25 at 2:07 p.m. The SSD said she was aware Resident #74 had a history of suicidal ideations and attempts but she did not recall any identified triggers from the resident's Level II PASRR. The SSD confirmed she was the one who completed the PHQ-9 screens with Resident #74 when her score increased, but she said she did not find the increase in the scores concerning. The director of nursing (DON) was interviewed on 5/14/25 at 3:06 p.m. The DON said she was not aware of Resident #74's history of suicidal ideations and attempts. She said the facility should be monitoring Resident #74 for resident specific signs and symptoms of depression so the staff could advise her (the DON) or the SSD of any concerning behaviors exhibited or statements made by Resident #74.

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	05/15/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications and biologicals were stored in accordance with accepted professional standards for one of two medication storage refrigerators. Specifically, the facility failed to ensure controlled medications were in a locked storage container that was permanently secured to the inside of the medication storage refrigerator. Findings include: I. Facility policy and procedure The Medication Labeling and Storage policy and procedure, undated, was provided by the nursing home administrator (NHA) on 5/13/25 at 4:45 p.m. It read in pertinent part, Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. II. Observation On 5/14/25 at 10:32 a.m. the medication storage room on the third floor was observed with registered nurse (RN) #4. There was a lock on the outside of the medication storage refrigerator, however, the refrigerator was unlocked. A locked narcotic medication box, which contained two vials of liquid lorazepam (a narcotic medication for anxiety), was sitting on a shelf inside of the medication storage refrigerator. The locked narcotic medication box was not permanently affixed to the inside of the refrigerator. III. Staff interviews RN #4 was interviewed on 5/14/25 at 10:42 a.m. RN #4 said the narcotic box and the medication storage refrigerator should be locked at all times to avoid unauthorized access to the narcotic medications. RN #4 said she was the only nurse who currently had access to the medication storage refrigerator and the lock box and it was her responsibility to make sure the refrigerator was locked. She said she forgot to lock the refrigerator. RN #4 said there were only two nurses working on the third floor who had access to the locked medication storage room. RN #4 said she was the only one who had access to the contents inside the refrigerator. -However, the refrigerator was unlocked when observed (see observation above). (continued on next page)

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	05/15/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/14/25 at 10:55 a.m. The DON said the medication storage refrigerator and the narcotic medication lock box inside the refrigerator should both be locked for the safety of the residents and it was the standard of care. The DON said she did not know that the refrigerated controlled medications should be in a permanently affixed container inside the medication storage refrigerator. The DON said she would see what she could do about affixing the narcotic medication lock box to the inside of the medication storage refrigerator. Licensed practical nurse (LPN) #4 was interviewed on 5/15/25 at 11:45 a.m. LPN #4 said the refrigerated controlled medications should always be in the narcotic medication lock box with the medication storage refrigerator locked as well. LPN #4 said this was important to make sure the medication was only accessed by the nurses.

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	05/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** II. Failure to ensure Resident #46 followed appropriate infection control procedures when emptying her own indwelling catheter A. Facility policy and procedure The Catheter Care, Urinary policy and procedure, revised August 2022, was received from the NHA on 5/15/25 at 2:29 p.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. B. Resident #46 1. Resident status Resident #46, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included bipolar disorder, unspecified dementia, anxiety disorder and unspecified symptoms and signs involving cognitive function and awareness. The 2/13/25 MDS assessment revealed Resident #46 was cognitively intact with a BIMS score of 15 out of 15. She was independent with mobility, dressing and eating. The MDS assessment indicated the resident had an indwelling catheter. 2. Observations and resident interview Resident #46 was interviewed on 5/13/25 at 1:18 p.m. Resident #46 said she emptied her catheter bag herself. Resident #46 said she did not remember being educated about the appropriate way to manage the care of a urinary catheter. During the interview, Resident #46 was sitting on her bed and left her catheter bag lying on the floor in front of her bed. The catheter bag was not contained inside of a privacy bag to protect it from becoming contaminated while lying on the floor. Resident #46 stood up, picked up the catheter bag from the floor, attached it to her waistband and started walking towards her bathroom. The resident went to her bathroom and began emptying the urine in her catheter bag into the toilet bowl without washing her hands. Resident #46 touched the toilet seat and the catheter bag with her bare hands. After emptying her catheter bag, Resident #46 exited the bathroom but did not perform hand hygiene. 3. Record review Review of Resident #46's urinary catheter care plan, initiated 3/20/25, revealed the resident had an impaired urinary elimination pattern due to neuromuscular dysfunction of the bladder. -The urinary care plan failed to include that Resident #46 was emptying the catheter bag by herself and the steps staff should take to ensure proper handling of the catheter, including hand hygiene. (continued on next page)

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	05/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #46's May 2025 CPO did not reveal a physician's order for routine catheter care maintenance by the resident. -Review of Resident #46's electronic medical record (EMR) revealed there was no documentation to indicate the resident had been assessed, educated or monitored to ensure she was adhering to appropriate infection control guidelines, including hand hygiene, when emptying her catheter. C. Staff interviews CNA #4 was interviewed on 5/13/25 at 3:25 p.m. CNA #4 said Resident #46 emptied her own catheter bag. CNA #4 said she did not know whether Resident #46 was assessed before allowing her to manage her catheter bag. Registered nurse (RN) #4 was interviewed on 5/13/25 at 3:35 p.m. RN #4 said there was no documentation in Resident #46's EMR which indicated the resident was assessed to ensure she performed appropriate hand hygiene before and after emptying her catheter bag to prevent infections. The assistant director of nursing (ADON) was interviewed on 5/13/25 at 4:15 p.m. The ADON said Resident #46 was admitted with a catheter due to her diagnosis of neuromuscular dysfunction of the bladder. The ADON said catheters could lead to infections and monitoring them was important to prevent infections. She said Resident #46 should have had an assessment completed to ensure the resident was capable of performing appropriate hand hygiene when emptying her catheter bag in order to prevent infections. The DON was interviewed on 5/15/25 at 1:39 p.m. The DON said Resident #46 should have been assessed to ensure she was able to perform proper hand hygiene when emptying her catheter bag to prevent infections. The DON said she was not sure how the assessment was missed before allowing the resident to empty her catheter bag. The DON said she would immediately provide education to all nursing staff regarding ensuring assessments were completed on residents who emptied their own catheters. She said she would complete an assessment to ensure Resident #46 could empty her catheter bag appropriately. Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one of two units. Specifically, the facility failed to: -Ensure staff wore the appropriate personal protective equipment (PPE) when providing care for Resident #62, Resident #27 and Resident #30, who were on enhanced barrier precautions (EBP); and, -Ensure Resident #46 followed appropriate infection control procedures when emptying her own indwelling catheter. Findings include: (continued on next page)

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	05/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Failure to wear appropriate PPE when providing care for Resident #62, Resident #27 and Resident #30, who were on EBP A. Professional reference According to 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), retrieved on 5/16/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs (multidrug resistant organisms). The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy, revised March 2024, was received from the nursing home administrator (NHA) on 5/13/25 at 4:45 p.m. The policy read in pertinent part, EBP should be used as an infection prevention and control intervention to reduce the transmission of multi drug resistant organisms of (MDROs) to residents. EBP Employee targeted gown and glove use in addition to standard precautions during High contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. EBPs are indicated with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. C. Resident #62 1. Observations (continued on next page)

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	05/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 9:41 a.m. there was a sign on Resident #62's door that indicated the resident was on EBP. Certified nurse aide (CNA) #1 was providing incontinent care for Resident #62 in her bed. CNA #1 had gloves on. -However, CNA #1 failed to put on a gown prior to providing incontinence care to Resident #62, who was on EBP. D. Resident #27 1. Observations On 5/13/25 at 2:27 p.m. Resident #27 was lying in bed and had a foley catheter hanging on the side of the bed. There was a sign on Resident #27's door indicated the resident was on EBP. CNA #2 was providing incontinence care to Resident #27. CNA #2 removed the resident's soiled brief, provided foley care and applied a clean adult brief. CNA #2 put on gloves prior to providing incontinence care to the resident. -However, CNA #2 failed to put on a gown prior to providing incontinence care to Resident #27, who was on EBP. E. Resident #30 1. Observations On 5/13/25 at 3:30 p.m. there was a sign on Resident #30's door that indicated the resident was on EBP . CNA #7 and CNA #8 were assisting Resident #30 with transferring from her wheelchair to her bed via a mechanical lift Both CNAs were wearing gloves. -However, CNA #8 and CNA #7 failed to put on a gown prior to providing incontinence care to Resident #30, who was on EBP. F. Staff interviews CNA #2 was interviewed on 5/13/25 at 2:56 p.m. CNA #2 said she was supposed to wear a gown with incontinent care because the resident has a foley catheter. CNA #2 said it was important to maintain EBP to prevent the residents from getting any infections. CNA #8 was interviewed on 5/13/25 at 3:55 p.m. CNA #8 said if a resident was on EBP, she needed to put on gloves and a gown when providing resident care, such as toileting and dressing. She said she should have worn a gown when transferring Resident #30 from her chair to her bed. She said she was in a hurry to get the resident into bed quickly. CNA #8 said in the future, she would take her time to don the correct PPE for any resident who was on EBP. CNA #1 was interviewed on 5/13/25 at 4:16 p.m. CNA #1 said she was supposed to wear a gown when providing incontinent care to a resident who had pressure wounds. CNA #1 said she did not see the sign for EBP on Resident #62's door. CNA #1 said it was important to maintain EBP to prevent the residents' wounds getting infected. (continued on next page)

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	05/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #7 was interviewed on 5/13/25 at 4:53 p.m. CNA #7 said she did not see the storage bin outside of Resident #30's room and did not realize she was on EBP. CNA #7 said typically she looked for a storage bin of PPE to indicate if a resident was on EBP. CNA #7 said she would pay closer attention to individual resident requirements moving forward. Licenced practical nurse (LPN) #6 was interviewed on 5/15/25 at 10:29 a.m. LPN #6 said when a resident was on EBP, the staff providing care should don (put on) a gown and gloves when changing a wound dressing, assisting a resident with a transfer, giving medication through intravenous (IV) lines, changing a brief and changing the resident's clothes so they did not get an infection. LPN #5 was interviewed on 5/15/25 at 11:04 a.m. LPN #5 said EBP was used to prevent residents from getting an infection. LPN #5 said EBP was used during wound care, if a resident had a foley catheter or an IV. We are required to wear a gown in gloves during any type of transfer activity or incontinence care. The director of nursing (DON) was interviewed on 5/15/25 at 1:30 p.m. The DON said EBP was used when there was the potential for high-contact interaction between staff and residents. She said a resident would be placed on EBP, if they had an ostomy (surgical incision in the abdomen), wounds or foley catheter. She said the staff should wear PPE, including a gown and gloves, when assisting residents with activities of daily living who were on EBP. The DON said if a resident was on EBP, the facility's policy was to ensure there was a sign on the door to inform all staff that precautions needed to be followed. She said if the resident was on precautions, a cart with PPE was stored outside of the resident's room. She said the nursing staff was provided education upon hirer and annually and it was her expectation of all facility staff to know how to correctly care for the residents and prevent the transmission of bacteria or cause an infection.