STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision and intervention to prevent physical abuse for two (#1 and #2) of three residents reviewed for abuse out of three sample residents. Specifically the facility failed to protect Resident #1 from physical abuse by Resident #2.Findings include: I. Facility policy and procedure The Residents Rights and Abuse Prevention policy and procedure manual, revised March 2025, was provided by the nursing home administrator (NHA) on 10/21/25. It read in pertinent part, As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents. Abuse of any kind against residents is strictly prohibited. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse toward a resident can occur as resident-to-resident abuse. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical abuse includes, but is not limited to hitting, slapping, biting, punching or kicking. Examples of injuries that could indicate physical abuse include, but are not limited to: facial injuries, including but not limited to, broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. II. Incident of physical abuse of Resident #1 by Resident #2 on 8/13/25 (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
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Facility investigation The facility's investigation, dated 8/14/25, was provided by the NHA on 10/21/25. The investigation revealed the following: Resident #1 woke up on 8/14/25 with a developing black eye of unknown origin. One of five staff members interviewed witnessed the incident. On 8/13/25 at 6:40 p.m. certified nurse aide (CNA) #1 heard Resident #1 screaming. She went towards Resident #1's voice and found Resident #1 in Resident #2's bedroom. Resident #2 was upset that Resident #1 was in his bed, and was trying to pull Resident #1 out of the bed. Resident #1 had a couple drips of blood coming from her nose. -However, CNA #1 failed to report the incident (see below). On 8/14/25 CNA #2 went to get Resident #1 up for the day and noticed a small amount of dried blood on her blanket and a little bit of dried blood on her nose. CNA #2 immediately notified licensed practical nurse (LPN) #1. Resident #1, who was cognitively impaired, was interviewed and her response was, Someone was punching me and he was not a friend. Resident #2 was interviewed and unable to provide a clear or coherent explanation of the incident. Due to his cognitive impairment, Resident #2 was unable to recall the event. It was determined that he was not of sound mind and unable to meaningfully participate in the interview. CNA #1 was immediately suspended for failing to report the incident at the time it occurred on 8/13/25 and later terminated by the facility. Resident #1 was sent to the emergency room (ER) for further evaluation. Resident #1 received a room change to provide more space and separation from Resident #2. -However, observations during the survey revealed Resident #1's room was located right next door to Resident #2's room (see observations below). The facility investigation identified immediate safety measures to be put in place included the use of a magnetic stop sign added to Resident #2's room, and encouraging Resident #2 to keep his door shut as tolerated. -However, observations during the survey revealed no stop signs was observed on Resident #2's door and Resident #2's bedroom door remained opened and other residents laid in Resident #2's bed (see observations below). The facility's investigation did not identify whether or not the facility substantiated the abuse, however, abuse occurred as Resident #1 stated that someone punched her (which resulted in a bloody nose and a black eye) and Resident #2 was observed trying to remove Resident #1 from his bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident #1 (victim) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, mood disturbance, anxiety, dysphagia (difficulty swallowing) and anemia. The 8/16/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of one out of 15. The resident required substantial assistance for activities of daily living (ADL). The MDS assessment revealed the resident exhibited wandering behaviors on one to three days during the assessment look-back period. 2. Record review A health status progress note, dated 8/14/25 at 7:20 a.m. noted Resident #2 had a bruise on her left eye and both CNAs on duty were interviewed. CNA #2 reported getting Resident #2 up in the morning and it was noted that the resident had dry blood on her nostril and a little on her blanket. CNA #2 did not notice bruising. CNA #4 reported Resident #2 was heading out of the dining room and CNA #4 noticed redness under Resident #2's left eye. CNA #4 turned Resident #2 for better lighting and noticed bruising around her left eye and notified the nurse. A long term care follow-up progress note, dated 8/14/25 at 1:37 p.m. revealed Resident #2 was seen by the physician per staff request. Staff stated when they got Resident #2 out of bed in the morning they had noticed a black eye on the resident who had had no recent injuries or falls noted. Upon assessment, purple bruising was noted around the resident's entire left eye orbit and nasal bridge. There was partial purple bruising under the resident's right anterior eye orbit. Facial swelling was noted to the resident's upper nasal root. Ice was applied and a neurological assessment was performed, and the resident's pupils were equal, round and reactive to light (PERRL) and extraocular muscles (EOMs). Due to Resident #2's cognition, she was unable to complete the exam. The nurse spoke with the physician who recommended Resident #2 be evaluated in the emergency room (ER). The after visit ER summary, dated 8/14/25, revealed that Resident #1 was seen in the ER for facial swelling and diagnosed with a contusion (bruise). Resident #1 was discharged back to the facility the same day (8/14/25). An interdisciplinary team (IDT) progress note, dated 8/14/25 at 4:16 p.m. revealed the IDT team met to discuss Resident #2 and the reported incident. Resident #2 was found to have a bruised eye and dried blood on her nose. After investigation, it was discovered that Resident #2 had gotten into another resident's bed and received an injury while the other resident was attempting to remove Resident #2 from their bed. Resident #2 was sent to the ER for evaluation of facial trauma and the results of an Xray and computerized tomography (CT) scan were unremarkable. The resident's representative was notified and followed up with by the DON. Resident #2 was moved to a room closer to the nurses' station. C. Resident #2 (assailant) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the October 2025 CPO, diagnoses included type 2 diabetes mellitus, traumatic subdural hemorrhage, unspecified dementia, psychotic disturbance, mood disturbance and anxiety. The 9/20/25 MDS assessment revealed Resident #2 was severely cognitively impaired with a BIMS score of six out of 15, with continuous disorganized thinking. He was independent with transfers, bathing and toileting. 2. Observations During a continuous observation on 10/21/25, beginning at 12:23 p.m. and ending at 2:07 p.m., the following were observed: At 12:27 p.m. Resident #2's room was observed. Resident #2's room was located right next door to Resident #1's room. There was not a stop sign observed on Resident #2's door and the room door was open. -However per the investigation report dated 8/14/25, the facility implemented a room change to provide more space and separation between Resident #1 and Resident #2 and a stop sign was implemented for Resident #2's door to keep other residents out of Resident #2's room (see investigation above). At 12:55 p.m. an unidentified male resident wandered down the hallway into Resident #2's bedroom and laid down in Resident #2's bed. -No staff member identified that another resident had gone into Resident #2's room and laid down in the resident's bed. At 1:19 p.m. Resident #2 went into his room and discovered the resident in his bed. Resident #2 did not react aggressively and left the room. -However, staff continued to be unaware of the other resident lying in Resident #2's bed. At 1:23 p.m. an unidentified staff member discovered the other resident sleeping in Resident #2's bed. The staff member woke up the other resident and redirected him to his correct room. 3. Record review Review of Resident #2's comprehensive care plan, initiated 3/19/24, care plan documented that Resident #2 had impaired cognitive function and dementia but was able to communicate his needs. He required the care of the secure unit for safety and well-being due to increasing confusion, wandering, and dementia. Interventions included communicating with the resident's family and caregivers regarding the resident's capabilities and needs, closely monitoring when the resident went outside, reporting changes in conditions and behaviors, participating in low stimulation activities, keeping the resident's environment free of hazards, providing pleasant interactions when he was confused and removing and redirecting him from unsafe behavioral confrontations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/14/25 progress note documented Resident #1 had a black eye the morning after an incident of unknown origin. After investigation, the staff found that Resident #1 and Resident #2 were involved in an altercation on 8/13/25 at approximately 6:40 p.m. CNA #1 heard Resident #1 screaming and went to assist the residents, finding Resident #1 on Resident #2's bed. Resident #2 tried to move Resident #1 out of his bed. CNA#1 assisted Resident #1 out of bed and noticed the resident had a nosebleed. The staff notified Resident #1's physician, who ordered a behavioral health evaluation. D. CNA #1 record review Review of the facility's skills fair invoice, dated 8/13/25, revealed that CNA #1 successfully completed the abuse awareness/prevention training provided by the NHA on 8/13/25 (the day the incident between Resident #1 and Resident #2 occurred). -However, despite the training received on 8/13/25, CNA #1 failed to report the incident between Resident #1 and Resident #2 on the evening of 8/13/25. Review of the facility's Dementia workshop education, dated 6/25/25, revealed CNA #1 had successfully completed the training. III. Staff interviews CNA #2 was interviewed on 10/21/25 at 1:45 p.m. CNA #2 said the nurses and the CNAs were both responsible for charting behaviors on the residents. She said CNAs were supposed to notify the nurses of any significant behaviors and the nurse would chart in more detail on the residents' behaviors. CNA #2 said she would attempt to redirect the residents in order to prevent resident abuse. CNA #2 said she would notify the nurse on duty if there was a resident incident and then the nurse would notify the director of nursing (DON) and the NHA. CNA #2 said the NHA gave staff his personal cell phone number on the first day of training so everyone should have the NHA's number in their personal cell phones. CNA #2 said she was not present on the day of the incident between Resident #1 and Resident #2, but she said this was the first time such an incident had occurred between the residents. CNA #2 said the incident was a weird occurrence because Resident #2 walked away when something made him uncomfortable, and he had not hit anybody else in the past. CNA #2 also said she had not seen Resident #2 become upset with anybody because he was good at redirecting himself. CNA #3 was interviewed on 10/21/25 at 2:21 p.m. and said she was aware that Resident #1 frequently got out of her wheelchair to wander because the resident thought she could self transfer. CNA #3 said that to ensure the safety of all the residents, one CNA would stand in the hallway between 2:00 p.m. and 4:00 p.m. to monitor for wandering. CNA #3 said if she encountered a resident-to-resident incident, she would remove one of the residents to get them away from the situation while figuring out what the residents were upset about. CNA #3 said she would then report the incident to the nurse right away. CNA #3 said Resident #1 did not have the ability to recall the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 10/21/25 at 2:00 p.m. RN #1 said CNAs had their own system of charting, but CNAs would report to the nurse any behavioral changes and the nurse would document it. RN #1 said she would contact the DON immediately for resident-to-resident. She said if the incident was physical it would be reported to law enforcement as an assault. RN #1 said that Resident #1 was a target in the secured unit because of her petite size and she frequently bumped into or ran over other residents' feet with her wheelchair. RN #1 said to ensure Resident #1's safety, the resident was provided with constant verbal reminding from staff. RN #1 said she was always aware of Resident #1 being a target and said it was important to anticipate Resident #1's behavior before anything could happen. RN #1 said Resident #1 sometimes just wandered into other residents' rooms, but in a very peaceful way, and that was the only time that Resident #2 hit someone. RN #1 said that in the past, Resident #2 was involved only in verbal altercations due to his short-term memory issues. RN #1 said the staff dispersed residents when they saw someone exhibiting behaviors, prevented residents from going to other people's rooms, and, when arguments began, separated them as quickly as possible. RN #1 said it was easy to redirect Resident #2 when he was agitated, and that calling his son calmed him down. RN #1 said that, at times, Resident #2 allowed others to sleep in his bed. The social services director (SSD) was interviewed on 10/21/25 at 4:26 p.m. and said the process for investigating a resident-to-resident began with interviewing the assailant and the victim. She said if the resident was not interviewable, she interviewed five other residents, five employees and five family members. The SSD once interviews were completed, all the information was given to the NHA to report the incident and file the investigation. The SSD said she completed the reports within 48 hours of the incident. The SSD said she had worked a little with Resident #1 and was aware that Resident #1 wandered a lot and ended up in other residents' rooms and other residents' beds. The SSD said the staff was good about redirecting Resident #1. The SSD said stop signs were used as an intervention in an attempt to deter other residents from going into other residents' rooms. The SSD was unsure if a stop sign was used as an intervention for residents currently. She said she knew that there were stop signs at one point, but the residents kept moving them off the walls so staff stopped using them. The SSD said stop signs should be care planned and the care plans would be completed during an interdisciplinary team meeting (IDT) because someone was actively updating care plans during the IDT meetings. The SSD said room changes would be necessary for roommates, but if the residents involved in an incident were in the same hall, the staff would separate the residents to provide more space between them. The SSD said she was unaware that Resident #1 and Resident #2's rooms were right next to each other. The SSD said Resident #2 was usually okay with other residents laying in his bed and told staff to just let the other residents sleep, but sometimes Resident #2 could become defensive. The DON was interviewed on 10/21/25 at 4:43 p.m. The DON said all staff had been educated to notify her immediately for abuse incidents, and if it was a physical altercation, staff should separate the residents and notify her immediately. The DON said she then checked on the residents involved and talked to the nurse. The DON said she would speak with the SSD and provide the SSD with a list of potentially interviewable staff members who were present at the time of the incident, as well as providing the SSD with any progress notes associated with an incident. The DON said the abuse coordinator was the NHA. The DON said that in cases of resident-to-resident altercations, she reviewed the reports, staff received education, and staff monitored residents frequently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Ridge Nursing & Rehabilitation Center	515 Fairview St Canon City, CO 81212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said there were no clinical changes reported to her prior to the altercation between Resident #1 and Resident #2. The DON said she recalled Resident #1 had significant bruising to her face. The DON said neither resident could recall the incident if someone was to ask them about it at this time. The DON said prevention for future altercations was having a CNA monitor the hallway during the high trafficked time between 2:00 p.m. and 4:00 p.m. The DON said the facility had had some new residents placed in the secured unit and there was an adjustment period. The DON said staff was good about performing bed checks to ensure residents were sleeping in the appropriate bed. The DON said the incident with Resident #1 and Resident #2 was a very unusual incident because Resident #2 was usually very protective of female residents. The NHA was interviewed on 10/21/25 at 5:39 p.m. The NHA said the process for handling resident-to-resident abuse was first ensuring the residents' safety and removing or separating them as necessary. He said an assessment was completed to make sure there were no injuries, and the investigation process was initiated. The NHA said he would notify the necessary individuals, such as family members, primary physicians and law enforcement .The NHA said he was the abuse coordinator and his personal cell phone number was given to every new employee on their first day of orientation and his personal cell phone number was also posted at the nurses' station along with the DONs personal cell phone number. The NHA said CNA #1 was no longer employed with the facility.