STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065305	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Heights	12205 Gunstock Dr Colorado Springs, CO 80921

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure residents were treated with dignity and respect for one (#4) of three residents out of six sample residents. Specifically, the facility failed to ensure Resident #4 was treated with dignity and respect by certified nurse aide (CNA) #1.Findings include: I. Facility policy and procedure The Skilled, Promoting, Maintaining Resident Dignity policy, dated 9/10/25, was provided by the executive director on 4/16/26 at 3:38 p.m. The policy read in pertinent part, It is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and environment that maintains or enhances resident quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident identity and respect resident rights. During interactions with residents, staff must report and act upon information regarding resident preferences, and interview results will be documented. The provision of care and care plans will be revised, if appropriate, based on information obtained from resident interviews. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the residents needs and preferences. When interacting with a resident, pay attention to the resident as an individual. Respond to requests to assist in a timely manner. Explain care and procedures to the resident before initiating the activity, groom and dress the resident according to the resident preference and speak respectfully to the resident.II. Facility investigation of the incident involving Resident #4 and CNA #1 on 2/28/26The 2/28/26 facility investigation of the incident involving Resident #4 and CNA #1 was provided by the executive director on 4/15/26 at 12:30 p.m. The investigation revealed Resident #4's alleged assailant (CNA) #1 told the resident he stunk and really needed a shower. During the bedbath given by CNA #1, Resident #4 experienced pain due to his back issues and had tears in his eyes when CNA #1 was rolling the resident from side to side. Despite the resident's pain, CNA #1 finished providing care prior to getting the nurse. The resident reported being in a lot of pain and stated CNA #1 was too rough in completing the care. Resident #4 was interviewed by the nursing home administrator (NHA) and the director of nursing (DON) on 3/2/26, Resident #4 reported that CNA #1 told him he stunk and CNA #1 was too rough during the bedbath. The resident described starting a new medication around the same time as the alleged incident, and believed it may have affected him. At the resident's request, the medication was discontinued and the resident stated his initial allegations about CNA #1 were more severe because of his reaction to the medication. Resident #4 stated the care provided by CNA #1 could have been more gentle and he was in pain during the bed bath, but he did not believe CNA #1 was physically abusive or intended to hurt him during the bed bath. CNA #1 was suspended once the allegations from Resident #4 were reported. CNA #1 was interviewed on 3/2/26 about the incident. CNA #1 stated that she spoke with the resident an hour prior to the bath to give him time to take pain medications. She said she proceeded to assist the resident with a bedbath, turning him side to side four or five times. She said she explained to him he may be uncomfortable with the bed linen change from rolling often. She said she noticed he had tears and stopped the bed bath and went to get the nurse.Three additional residents who received (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed baths and cares provided by CNA #1 were interviewed for similar situations. None of the residents expressed concerns that their bed baths were too rough.The conclusion of the facility's investigation of the incident was that CNA #1 did tell Resident #4 that he stunk and needed to bathe, and that the resident did experience pain during the bed bath. The resident stated there was no physical abuse and CNA #1 should have been more careful while rolling him over during care.The facility did not substantiate that abuse occurred, but did substantiate that Resident #4 was not treated with dignity by CNA #1 and CNA #1 was educated regarding her communication and approach with residents and recognition of resident's non-verbal queues. III. Resident #4 A. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included methicillin staphylococcus aureus (infection in the blood), spinal stenosis (narrowing of the spinal canal), discitis (inflammation of the disc), osteomyelitis (infection of the bone) and osteoporosis. The 4/8/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 of 15. He required substantial maximum assistance with activities of daily living (ADL) for bathing. The assessment indicated the resident experienced pain.B. Resident interviewResident #4 was interviewed on 4/15/26 at 11:45 a.m. Resident #4 said CNA #1 told him he stunk and he needed a bath. He said her approach bothered him and he felt she needed continued education. He said he requested for her not to care for him in the future. He said he did experience pain during the bed bath provided by CNA #1 and he felt she was rough when turning him side to side; however, he did not feel like she physically abused him. Resident #4 said he had increased pain and the physician was working with him on medication changes. He said he was more concerned about CNA #1 getting properly trained on providing care to residents. C. Record review The potential for pain care plan, dated 2/3/26, revealed Resident #4 was at risk for pain related to discitis and osteomyelitis. Interventions included identifying, recording and treating existing conditions which may increase pain and or discomfort, monitoring and documenting probable causes of each pain episode and removing or limiting causes of pain where possible.A progress note, dated 2/28/26 at 2:47 p.m., revealed Resident #4 was reporting increased pain not alleviated with non-pharmacological interventions and the nurse was unable to administer PRN (as needed) medications at the time.A progress note, dated 2/28/26 at 7:10 p.m., revealed the resident had sharp stabbing pain daily with positioning and as needed medication was provided. The resident reported increased pain after a bed bath today (2/28/26). A progress note, dated 3/3/26 at 6:21 a.m., revealed Resident #4 was reporting significantly more pain in his lumbar back since the weekend (of 2/28/26). He was describing the pain as very sharp jabbing pain, similar to previous pain he had, but much worse. The resident stated the pain started after a transfer over the weekend (of 2/28/26). He said he started a new pain medication Friday (2/27/26) and Saturday (2/28/26), but he became more tearful and angry and requested the medication be discontinued. IV. Staff interviews The NHA and the DON were interviewed together on 4/15/26 at 2:58 p.m. The NHA said he completed an investigation related to the incident with CNA #1 and Resident #4. He said CNA #1 was suspended for a few days and the facility decided she would no longer care for Resident #4. The NHA said he verbally spoke with CNA #1 about her remarks made to the resident, about the resident stinking, and educated her on approach. He said he did not have anything documented to show he completed the training with her. The NHA said the facility had annual training on treating residents with dignity and respect and a class was scheduled for 4/21/26 and 4/23/26. The DON said she had conversations with CNA #1 regarding her approach with residents and implemented the intervention to have CNA #1 not care for Resident #4 any longer. She said she did not complete a hands-on care skills demonstration with CNA #1 since the allegation from Resident #4, but she said she would do so going forward. -The facility was unable to provide documentation of the education completed for CNA #1.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#1) of three out of six sample residents who required respiratory care were provided such care consistent with professional standards of practice.Specifically, the facility failed to ensure Resident #1 received oxygen according to the physician's orders.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/15/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/18/26.I. Incident on 3/17/26On 3/17/26 Resident #1's representative visited the resident in the dining room during the dinner meal. The representative said the resident appeared anxious and he noticed she was cyanotic (a bluish or purplish discoloration of the skin, lips, or nail beds, indicating that the blood oxygen is low) in her lips and fingers. The resident's representative noted that the resident's portable oxygen tank, which should have been at 6 LPM (liters per minute), was turned off. The representative turned the portable oxygen tank on as high as it could go and the resident's cyanosis went away after about 10 minutes.The resident's representative informed the certified nurse aide (CNA) and the nurse that Resident #1's portable oxygen was not on when he arrived in the dining room and the resident was assessed by the nurse and her oxygen saturations were noted to be at baseline.II. Facility's corrective actionThe corrective action plan the facility implemented in response to Resident #1's oxygen incident on 3/17/26 read as follows: A. Immediate corrective actionResident #1's portable oxygen tank was immediately turned on and she received a full assessment from the nurse on 3/17/26 and was noted to be at her baseline.B. Identification of othersThe facility has determined that all residents at the facility are potentially at risk. An oxygen administration audit was performed 3/18/26 by the director of nursing (DON) on all residents to ensure all residents are receiving oxygen according to physician's orders. Plan of care was updated on all residents with oxygen use.C. Systemic changesOn 3/18/26, the DON re-educated all nursing staff on oxygen use and administration. An attendance sheet was kept and reconciled with the active staff roster and those staff unable to attend in-servicing will be provided one-to-one re-education prior to working with the residents. Oxygen administration will be included in the new hire orientation.D. MonitoringOngoing monitoring will continue through weekly oxygen audits using a spreadsheet by the DON/designee for a minimum of 90 days or until compliance is established to review resident oxygen use and administration. Any issues identified will be corrected immediately and also reported to the nursing home administrator (NHA). Results of the audits will be discussed at the community's monthly QAPI (quality assurance performance improvement) meetings.III. Facility policy and procedureThe Oxygen Administration policy and procedure, revised 9/9/25, was provided by the NHA on 4/15/26 at 2:00 p.m. It read in pertinent part, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans and the resident's goals and preferences.IV. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE], readmitted on [DATE] and discharged to the hospital on 3/24/26. According to the March 2026 computerized physician orders (CPO), diagnoses included heart failure, acute and chronic respiratory failure with hypoxia, pulmonary hypertension, congestive heart failure (CHF) (chronic, progressive condition where the heart muscle is too wreck or stiff to pump blood efficiently, causing blood to back up and fluid to accumulate in the lungs, legs and other tissues), pleural effusion (abnormal buildup of fluid in the space between the lungs and chest cavity) and Alzheimer's disease.The 2/6/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She was dependent on staff assistance with toileting, bathing, dressing and moderate assistance with bed mobility, personal hygiene and transfers.The MDS assessment indicated the resident used continuous oxygen.B. Resident's representative interviewResident #1's representative was interviewed on (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/15/26 at 1:34 p.m. The resident's representative said he visited Resident #1 on 3/17/26 at the facility. He said she was sitting in the dining room and she looked like she was having an episode of anxiety, but when he got closer, he noticed she was cyanotic in the lips and fingers. He said the portable oxygen tank, which should have been at 6 LPM, was turned off. He said he immediately cranked it as high as it could go to bring the resident's blood oxygen level up. He said the cyanosis went away after about 10 minutes.Resident #1's representative said he informed the CNA and the nurse that Resident #1's portable oxygen was not on when he arrived. He said the nurse checked it and informed him that it was on. He said he told the nurse he was the one that turned it on. He said the nurse took Resident #1's vital signs and said the resident's oxygen saturation level was normal. The resident's representative said he told the nurse it was normal because he had put her on a high flow of oxygen before the nurse walked over.Resident #1's representative said he was concerned that Resident #1 was sitting in the dining room and no one noticed she was having difficulty breathing and was cyanotic.C. Record reviewReview of Resident #1's March 2026 CPOs revealed the following physician's order:Continuous oxygen at 6 LPM due to hypoxia. Administer via nasal cannula. Notify the provider if oxygen saturation is less than 90% for further orders, ordered 2/6/26.The oxygen use care plan, initiated 2/6/26, documented Resident #1 used oxygen therapy related to CHF, ineffective gas exchange, COPD (chronic obstructive pulmonary disease - a progressive, incurable lung disease that causes obstructed airflow, making it hard to breathe), emphysema and acute and chronic respiratory failure. The pertinent interventions included giving medications as ordered by the physician; monitoring for signs and symptoms of respiratory distress and reporting to the physician as needed; and providing oxygen via nasal cannula at 6 LPM.The 3/17/26 nursing progress note documented the nurse was notified by the previous shift's nurse during shift change report that Resident #1's representative notified staff that there was a lack of oxygen to the resident during mealtime. After mealtime, the nurse assessed the resident and vital signs were all within normal range for the resident with no signs or symptoms of cyanosis. The resident's oxygen saturation was 92%.-A review of Resident #1's electronic medical record (EMR) did not reveal an assessment of the resident at the time of the incident in the dining room; the nurse waited until after mealtime was over to assess the resident. -Additionally, documentation did not reveal the physician had been notified of the resident's lack of oxygen during the mealtime.The facility's investigation of the incident on 3/17/26 documented Resident #1 was assessed by a nurse following the incident, and nursing staff received education from the DON regarding oxygen use best practices. A nurse assessed Resident #1 in the dining room once the resident's oxygen was turned on, and the resident was assessed again after the incident when the resident returned to her unit. The investigation indicated the resident's representative was interviewed and stated that upon his arriving to visit Resident #1 that evening (3/17/26), he noticed the resident's lips and fingers were blue. The resident's representative checked Resident #1's oxygen tank and encouraged the resident to take deep breaths. This did not seem to help, so the resident's representative checked the oxygen tank again and noticed it was turned off. The resident's representative turned on the oxygen tank then got up in the dining room and exclaimed that Resident #1's oxygen tank was not turned on.The investigation documented the nurse who was in the dining room came over and checked on Resident #1. The nurse saw that the resident's oxygen tank was turned on, reported the resident was at her baseline, and the resident had resumed eating her dinner.The internal investigation concluded that Resident #1 was transported to the dining room the evening of 3/17/26 with a full tank of oxygen, which may not have been turned on.Nursing staff received education on oxygen use and best practices to ensure continued understanding of procedures. Management initiated random audits of multiple residents' oxygen use to ensure compliance with care plans by staff.V. Staff interviewsThe NHA, the DON and the executive director were interviewed together on 4/15/26 at 2:16 p.m. The NHA said he was notified of the incident with Resident #1 on 3/17/26, the night it happened. He said the resident's representative reported he found Resident #1 in the dining room without her oxygen concentrator turned on. The NHA said by the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time the nurse got to the resident, the oxygen had been turned on and the resident was not showing signs or symptoms of cyanosis.The NHA said when he interviewed the CNA who took Resident #1 to the dining room on 3/17/26, the CNA said she filled the portable oxygen concentrator and remembered turning it on.The executive director said the facility provided immediate education to the facility staff on professional standards of practice for oxygen usage. She said the facility put a performance improvement plan in place, which included audits being conducted and monitoring through the facility's quality assurance meeting.The executive director said the nurses and the CNAs were both responsible for checking each residents' portable oxygen concentrator to ensure it was turned on and at the appropriate oxygen liter flow rate according to the physician's orders.