

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Colorow Health Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 885 S Hwy 50 Business Loop Olathe, CO 81425	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467</p> <p>Based on observations, record review and interviews, the facility failed to ensure four (#1, #2, #3 and #4) of six residents out of six sample residents were free from abuse.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Protect Resident #1 from physical abuse by Resident #3; -Protect Resident #3 from physical abuse by Resident #1; -Protect Resident #1 from physical abuse by Resident #4; -Protect Resident #3 and Resident #1 from physical abuse from each other; and, -Protect Resident #2 from physical abuse by Resident #1. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 5/7/25 at 3:45 p. m. The policy read in pertinent part, The facility does not condone resident abuse and will take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals.</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident symptoms.</p> <p>Providing a safe environment for the resident is one of the most basic and essential duties of our facility.</p> <p>II. Incident of abuse of Resident #1 by Resident #3 on 2/15/25</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. Facility investigation</p> <p>The facility investigation was provided by the NHA on 5/6/25 at approximately 11:30 a.m. The investigation documented that on 2/15/25 at 2:13 p.m. Resident #1 attempted to enter her room but Resident #3 was in front of the door. According to the investigation, Resident #3 became upset and pushed her walker into Resident #1 and then smacked Resident #1 across the face with an open hand.</p> <p>Both residents were separated, assessed for injuries and placed on 15-minute checks for 72 hours. The investigation documented both residents were severely cognitively impaired and could not recall the incident. The investigation indicated there were no injuries to either resident.</p> <p>A witness statement from certified nurse aide (CNA) #1 documented CNA #1 witnessed Resident #3 push Resident #1 with her walker and then proceed to smack her across the face.</p> <p>A staff interview from CNA #4 documented after lunch was served, she heard a smack and a CNA say oh she just got slapped. According to staff interview, CNA #4 ran to the hall and separated the residents.</p> <p>The facility investigation identified staff observed eight non-interviewable residents, including the two residents involved in the incident. According to the investigation, there was no change in the residents' baseline behaviors after the incident. The investigation documented Resident #1 and Resident #3's care plans were updated.</p> <p>The facility investigation documented Resident #1's hospice physician was notified on 2/18/25 regarding the altercations between Resident #1 and Resident #3 on 2/15/25 and 2/17/25 (see 2/17/25 incident below). According to the physician notification, the facility was reviewing the resident's medications to determine if the incidents were related to possible pain or constipation.</p> <p>The facility investigation documented a staff inservice was conducted on 2/18/25 with 13 staff members. The inservice agenda documented that all residents who resided on the memory care unit had their care plans reviewed and individualized memory care sheets were created for each resident.</p> <p>The facility investigation documented both Resident #1 and Resident #3 were newer to the memory care unit, neither resident had prior aggression and staff were still learning their behaviors and patterns. According to the investigation, Resident #1 had limited communication and needed a way to communicate with others. A request was made with speech therapy for a communication device.</p> <p>B. Resident #1 (victim)</p> <p>1. Resident status</p> <p>Resident #1, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included degenerative disease of the nervous system, generalized anxiety disorder dementia, unspecified severity with other behavioral disturbance, senile degeneration of the brain, cognitive communication deficit and depression.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 1/25/25 minimum data set (MDS) assessment identified Resident #1 had moderate cognitive impairments, per a staff assessment for mental status. According to the MDS assessment, Resident #1 did not have inattention or disorganized thinking. She remembered the location of her room and staff names and faces. The assessment indicated Resident #1 did not have physical or verbal behavioral symptoms directed towards others. She did not use a wheelchair but she needed supervision or touching assistance for mobility.</p> <p>2. Record review</p> <p>The secured memory care placement care plan, revised 1/28/25, identified Resident #1 required placement in a secure neighborhood due to dementia with agitation.</p> <p>The communication care plan, revised 1/28/25, identified Resident #1 had a communication problem related to dysphasia (difficulty with speech) and dementia. The care plan identified she was able to use a whiteboard for communication.</p> <p>The dementia with behaviors care plan, revised 3/6/25, identified Resident #1's targeted behaviors included wandering and exit seeking, mood issues of tearfulness and increased anxiety, poor safety awareness delusions/hallucinations and pushing and shoving. According to the care plan, the resident did not like to have people getting in her face, her space, loud environments or being told what to do.</p> <p>The interventions, initiated on 1/24/25, directed staff to present just one thought, idea, question or command at a time and use task segmentation to support short term memory deficits, breaking tasks into one step at a time.</p> <p>The interventions, revised 1/28/25, directed staff to provide cues and reapproach if agitated. Provide her with a consistent routine and care givers to decrease her confusion. According to the care plan, Resident #1 understood consistent, simple and direct sentences.</p> <p>The interventions, initiated 2/20/25, directed staff to assess Resident #1 for pain and provide her with rest periods, Resident #1 liked to lay down in bed and rest, assist her with toileting and offer fluids soft food/fluids if she was pacing, give her a clear explanation when doing something and remove Resident #1 from loud environments if she became agitated, placing her in a quieter space and redirect/distract her. According to the care plan, Resident #1 preferred to eat alone in the dining room.</p> <p>The interventions, initiated 2/20/25, identified Resident #1 was routine driven and directed staff to keep Resident #1's routine free of disruption, providing her with a designated place to eat during meal time and a designated place to sit when in the common area. The care plan identified activities the resident enjoyed engaging in.</p> <p>-Review of the care plan did not indicate Resident #1 was at risk for abuse or had been a victim of physical abuse.</p> <p>The interventions, initiated 3/23/25, identified a stop sign was placed on her doorway to help redirect others from entering her space.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The care plan did not identify new interventions were put in place for Resident #1 to decrease future occurrences of resident-to-resident altercations after the 2/15/25 resident altercation with Resident #3. The care plan was not updated until 3/23/25 and after Resident #1 had had three more altercations with residents (see 2/17/25, 2/18/25 and 3/22/25 resident-to-resident altercations below).</p> <p>The intervention, revised 3/25/25, directed staff to communicate with Resident #1 with a whiteboard or pictures, using yes/no questions and work with speech therapy on communication techniques.</p> <p>The intervention, initiated 4/1/25, identified Resident #1 could target other residents/staff and push/shove them, sometimes causing them to fall. The intervention directed staff to make sure her stop sign was on the doorway and the door was shut when she was in her room. According to the care plan, staff needed to keep Resident #1 in their line of sight when she was out of her room.</p> <p>The 2/15/25 nursing progress note documented the nurse was cleaning her medication cart when she heard a slap. CNA #1 reported Resident #3 struck Resident #1 with an open hand. The note revealed Resident #1 was tearful and had some redness to the left cheek. According to the nursing note, staff was able to console Resident #1.</p> <p>The 2/16/25 nursing progress note documented Resident #1 was on 72-hour charting with 15-minute checks related to an altercation with another resident. Resident #1 was in view of staff throughout the shift and no agitation was noted. According to the note, Resident #1 was pacing the halls between her room and the dining area and had not come into contact with Resident #3. The note indicated staff would continue to monitor Resident #1.</p> <p>C. Resident #3 (assailant)</p> <p>1. Resident status</p> <p>Resident #3, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included Alzheimer's disease with late onset, dementia and other diseases elsewhere classified, severe with agitation, lack of coordination and anxiety disorder.</p> <p>The 4/1/25 MDS assessment identified Resident #3 had moderate cognitive impairments, per a staff assessment for mental status. According to the MDS assessment, Resident #3 did not have inattention or disorganized thinking. The assessment indicated Resident #3 did not have physical or verbal behavioral symptoms directed towards others. The assessment indicated she needed supervision or touching assistance for mobility.</p> <p>2. Record review</p> <p>The dementia care plan, revised 3/6/25, identified Resident #3 had impaired cognitive function or impaired thought processes related to dementia. According to the care plan, Resident #3 did not like people getting in her face or space, loud environments and being told what to do. The care plan directed staff to offer interventions that the resident believed were her idea.</p> <p>The intervention, initiated 12/24/24, directed staff to use task segmentation to support short term memory deficits and break tasks into one step at a time with just one thought, idea, question or command at a time.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The interventions, revised 12/26/24, directed staff to face Resident #3 when speaking, identifying self, reduce directions and provide her necessary cues and reapproach if she was agitated. According to the care plan, the resident understood consistent, simple and direct sentences. Staff should keep Resident #3's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion.</p> <p>The interventions, initiated 2/19/25, directed staff to ask Resident #3 yes/no questions in order to determine needs, assess her for pain, provide rest periods and use non-pharmacological pain relief prior to utilizing PRN (as needed) medications, monitor her behaviors, communicate with Resident #3/family/and caregivers of Resident #3's capabilities and needs, engage Resident #3 in simple, structured activities that avoid overly demanding tasks, give Resident #3 a clear explanation when doing something with her, provide her with a homelike environment, she enjoyed being helpful and liked visiting with others, if agitated in a loud environment, remove the resident into a quieter area, then try to redirect and distract her with something else, coordinate with her physician and review medications for pain relief and effectiveness and record possible causes of cognitive deficit such as new medications or dosage increases, anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity.</p> <p>The behavior care plan, initiated 3/6/25, identified Resident #3 was triggered for verbal/physical behaviors such as verbal outbursts, hitting/kicking and scratching. According to the care plan, Resident #3 was de-escalated by one person to assist with care, using a slow approach. More than one person caused her to become anxious and lash out at staff. The care plan directed staff to praise Resident #3's progress/improvement in her behavior, offer and document non-pharmacological interventions prior to administering medications, administer medications as ordered, monitor her for side effects and effectiveness, anticipate her needs and assist as indicated, provide Resident #3 an opportunity for positive interaction and attention by talking to her when staff was near her, explain all procedures to the resident before starting care and allow her to adjust to the changes, intervene as necessary to protect the rights and safety of others, approach Resident #3 in a calm manner, divert attention and remove her from the situation and take to an alternate location as needed, monitor behavior episodes and attempt to determine the underlying cause, consider location, time of day, persons involved, and situations and document/report behavior and potential causes if indicated.</p> <p>The intervention, initiated on 3/25/25, indicated Resident #3 did not like to be told what to do and could become agitated. The care plan directed staff to place a stop sign across her doorway to help others go into Resident #3's space and monitor her for non-wanted intrusions of others' space when she was wandering and looking into other residents' doorways.</p> <p>The 2/15/25 nursing progress note identified Resident #3 had increased agitation related to chronic pain and staff was monitoring. According to the note, she was more assertive to others.</p> <p>A second 2/15/25 nursing progress note documented Resident #3 slapped another resident with an open hand. The note indicated a different pain management was recommended and the nurse practitioner was made aware. According to the note, there were no new orders as of 2/15/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 2/16/25 nursing progress note documented Resident #3 continued on 72-hour charting with 15-minute checks related to the altercation with another resident. Resident #3 was showing signs of agitation/aggression with staff after dinner and one-to-one interventions were implemented and effective. According to the note, Resident #3 was not showing signs of pain.</p> <p>III. Incident of abuse of Resident #3 by Resident #1 on 2/17/25</p> <p>A. Facility investigation</p> <p>The facility investigation was provided by the NHA on 5/6/25 at approximately 11:30 a.m. The investigation identified Resident #1 and Resident #3 were involved in another resident-to-resident altercation. The altercation occurred on 2/17/25 at 11:00 a.m. The incident was witnessed by a CNA. According to the investigation, the residents were not able to recall the incident. There were no injuries and the residents had no changes in the baseline behaviors.</p> <p>-However, Resident #3 was identified to have injuries to her arm and Resident #1 had increased anxiety and PRN anti-anxiety medication was requested (see record review below).</p> <p>The facility investigation documented Resident #1 had a change in her bowel medication and staff was educated to utilize Resident #1's PRN pain medications. According to the investigation, Resident #1 was routine driven and Resident #3 was in her routine path so she moved Resident #3 out her way. Resident #1 did not communicate verbally. Staff was educated on Resident #1's routine. The facility continued both residents on 15-minute checks.</p> <p>-The investigation identified both residents were on 15-minute checks when the 2/17/25 resident-to-resident altercation occurred. However, the 15-minute checks did not prevent the resident-to-resident altercation from occurring.</p> <p>According to the follow-up action on the incident report, the action taken to protect the victim (Resident #3) or reduce vulnerabilities of further abuse was 15-minute checks, medication reviews and staff education.</p> <p>B. Resident #3 (victim)</p> <p>1. Record review</p> <p>The 2/17/25 nursing progress note documented a CNA reported a resident-to-resident incident between Resident #3 and another resident (Resident #1). The note indicated Resident #3 was ambulating with her walker in the hallway towards the dining room when Resident #1 exited her room. Resident #1 then stood behind Resident #3 and grabbed Resident #3's arms. Resident #1 pushed Resident #3 towards the right side, causing Resident #3 to hit the door with her arm and shoulder. According to the note, a CNA ran to the area, checked on Resident #3 and then left Resident #3 to go find Resident #1. The CNA returned to Resident #3, assisted her to a chair and notified the nurse. The nurse assessed Resident #3. Resident #3 was not able to remember the incident. The note indicated there were no injuries identified on Resident #3. The intervention documented in the 2/17/25 nursing note was for staff to make sure Resident #3 was seated or in a place where she was clear from other residents, to better monitor her safety, continue to do the 15-minute checks and to monitor her for any injuries.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 2/18/25 nursing progress note documented Resident #3 was on alert charting for a resident-to-resident incident on 2/17/25. The note identified Resident #3 had injuries.</p> <p>-The nursing note did not identify what the injuries were to Resident #3's arms.</p> <p>The 2/18/25 nursing note further documented Resident #3 also had old bruising to her arms.</p> <p>The review of the electronic medical record (EMR) did not identify what the old bruising was from.</p> <p>-Cross reference F610: failure to investigate abuse.</p> <p>According to the 2/18/25 note, Resident #3 remained in the common area so staff could monitor her safety. The note indicated Resident #3 continued to be on 15-minute checks to observe and monitor Resident #3's whereabouts and safety.</p> <p>C. Resident #1 (assailant)</p> <p>1. Record review</p> <p>The 2/17/25 nursing progress note, documented Resident #1 walked to the dining room after the resident-to-resident altercation. According to the note, Resident #1 was very anxious and restless during the shift. The note indicated Resident #1 would be monitored of her whereabouts and continue on 15-minute checks.</p> <p>The 2/21/25 interdisciplinary team (IDT) risk management review note documented Resident #1's physical aggression on 2/17/25 was related to her constipation, anxiety and possible pain. According to the note her medications were reviewed. Her bowel medication was discontinued and she was placed on a new bowel medication. Staff were educated to utilize Resident #1's PRN morphine. Resident #1 was newer to the facility and staff were still learning her behavior triggers. Resident #1 had excessive anxiety which hospice was trying to manage, she had a difficult time communicating and at times would use a white board to communicate.</p> <p>IV. Incident of physical abuse of Resident #1 by Resident #4 on 2/28/25</p> <p>A. Facility investigation</p> <p>The facility investigation was provided by the NHA on 5/6/25 at approximately 11:30 a.m. The investigation documented there was a physical abuse altercation that was witnessed between Resident #1 and Resident #4 on 2/28/25.</p> <p>The investigation report included three interviews from staff witnesses and notification of the incident to the appropriate parties. The investigation report documented that neither resident involved in the altercation and no resident witnesses were able to be interviewed due to significant memory impairments. Resident #1, Resident #4, and three other resident witnesses were placed on observation for physical or behavioral changes for 72 hours after the altercation occurred.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The investigated report documented Resident #4 pushed Resident #1 causing Resident #1 to fall backward when Resident #4 attempted to take Resident #1's shoe on 2/28/25 at 6:00 p.m. The two residents were separated and LPN #1 contacted the DON who was on site. The residents were separated and no injuries were observed. The residents were placed on 15-minute checks 72 hours after the altercation. The investigation documented Resident #4 did not like clutter and liked to clean, which led to the altercation. The investigation documented the underlying cause for the altercation was that Resident #1 was unable to communicate verbally and recently had her routine changed when her roommate had to move to a different room. Staff were educated following the interdisciplinary team (IDT) meeting 3/3/25.</p> <p>The investigation report documented LPN #1 who witnessed the event was interviewed. LPN # 1 said she observed Resident #4 attempt to take Resident #1's shoe. Resident #1 pulled the shoe back, then Resident #4 pushed Resident #1 causing Resident #1 to fall backward. LPN #1 contacted the DON who was on site. LPN #1 said that she felt she had adequate training related to preventing resident-to-resident abuse but she just could not get to the residents in time to stop the altercation.</p> <p>B. Resident #4 (assailant)</p> <p>1. Resident status</p> <p>Resident #4, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included anxiety and dementia with restlessness and agitation.</p> <p>The 4/1/25 MDS assessment revealed the resident had short-term and long-term memory deficits, per staff assessment. She required substantial assistance with personal hygiene, bathing and dressing. She required cues and supervision with toileting.</p> <p>The assessment indicated the resident exhibited verbal behaviors (yelling, cursing, or threats) towards others.</p> <p>The assessment indicated the resident exhibited physical behaviors (hitting, kicking, pushing, or grabbing) towards others.</p> <p>The assessment indicated the resident wandered daily and the wandering, as well as behaviors, significantly intruded on the privacy or activity of others.</p> <p>2. Record review</p> <p>The dementia care plan, initiated 4/10/24 and revised 3/11/25, indicated Resident #4 had behaviors of being disruptive or intrusive towards other residents, wandering and exit seeking, mood issues or tearfulness, sleep disturbances, poor safety awareness and delusions or hallucinations. Pertinent interventions included offering non-pharmacological interventions prior to administering PRN medication. The care plan indicated the non-pharmacological interventions included removing clutter from areas to reduce her anxiety, redirecting her to activities she was interested in, including gardening and cleaning, range of motion therapy, massage, relaxation and breathing techniques, imagery and distraction techniques, aromatherapy, or offering snacks or drinks, separating her from other residents when agitated and providing one-to-one support if needed until she was calm.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The anti-psychotic medication care plan, initiated 4/10/24 and revised 3/5/25, indicated Resident #4 had behaviors of physical aggression, including hitting, kicking, or biting and verbal aggression, including yelling, screaming, or cursing at others. Pertinent interventions included offering non-pharmacological interventions prior to administering a PRN medications. The care plan indicated the non-pharmacological interventions included cold therapy, range of motion therapy, massage, relaxation and breathing techniques, and use of imagery and distraction techniques to redirect the resident.</p> <p>The nursing progress note, dated 2/28/25 at 9:14 p.m., documented Resident #4 attempted to take a shoe from Resident #1. Resident #1 pulled her shoe back and Resident #4 pushed Resident #1 down causing Resident #1 to fall down. Interventions included separating the residents and initiating 15-minute checks. Both residents were assessed for injuries and no physical injuries were noted.</p> <p>C. Resident #1 (victim)</p> <p>1. Record review</p> <p>The nursing progress note, dated 2/28/25 at 8:48 p.m., documented Resident #4 attempted to take a shoe from Resident #1. Resident #1 pulled her shoe back and Resident #4 pushed Resident #1 down causing Resident #1 to fall down on her bottom with her back against the tray table. Interventions included separating the residents and initiating 15-minute checks. Both residents were assessed for injuries and no physical injuries were noted.</p> <p>V. Incident of abuse between Resident #3 and Resident #1 on 3/22/25</p> <p>A. Facility investigation</p> <p>The facility investigation was provided by the NHA on 5/6/25 at approximately 11:30 a.m. The investigation documented on 3/22/25 at 3:35 p.m. Resident #3 was making her rounds and stopped at Resident #1's doorway. Resident #3 was looking in Resident #1's room. According to a CNA witness statement, the CNA saw Resident #3 attempt to force her way into Resident #1's room. The investigation documented Resident #3's walker touched Resident #1 and Resident #1 pushed against the walker. According to the nursing note, Resident #3 made contact with Resident #1's left side of her face.</p> <p>-The note did not identify in what way Resident #3 made contact with Resident #1's face. Resident #1 then pushed Resident #3, causing Resident #3 to hit her right side hip on the floor and the right back side of her head on the door frame as the CNA entered the room.</p> <p>According to a nurse witness statement the registered nurse (RN) heard a resident's loud voice in the hallway. The RN observed Resident #3 laying on the floor on the right side of her body and the CNA was holding her head. Another resident (Resident #1) was standing in front of Resident #3 and was touching the left side of her face. There was slight redness to her face. According to the witness statement, there was no obvious injuries to Resident #3 but she complained of pain in her right elbow. The statement documented the CNA told the nurse she was redirecting another resident when she saw Resident #3 make contact with Resident #1's left side of her face. The CNA said Resident #1 placed her hands on Resident #3's bilateral arms, resulting in Resident #3 losing balance and falling to the floor. The CNA who witnessed the incident was able to hold Resident #3's head as she fell to soften the hit to the head and the resident's head made contact with the door frame.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Colorow Health Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 885 S Hwy 50 Business Loop Olathe, CO 81425	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the staff interview, the RN felt one-on-one conversations, companionship and speaking in a calm and positive tone were interventions that worked well with Resident #3. The investigation identified staff placed stop signs at both resident's doors. Resident #1 received more speech therapy treatments with collaboration with hospice to include devices such as picture boards.</p> <p>B. Resident #3 (victim and assailant)</p> <p>1. Record review</p> <p>The 3/22/25 nursing progress note documented Resident #3 was on 15-minute checks due to a resident-to-resident altercation this shift (3/22/25). According to the note, Resident #3 had a witnessed fall with head involvement from the altercation.</p> <p>The 3/23/25 at 4:39 a.m. nursing progress note identified Resident #3 was on alert charting for a resident-to-resident altercation and a witnessed fall. According to the note, Resident #3 started hitting and yelling at staff to get out (of her room) when they attempted to get her vital signs. The staff attempted to try to reassure the resident but she continued to yell and hit the staff.</p> <p>C. Resident #1 (victim and assailant)</p> <p>1. Record review</p> <p>The 3/22/25 nursing progress note documented the nurse heard a resident's loud voice in the hallway. The nurse then observed Resident #1 standing in front of her door and another resident (Resident #3) was on the floor with the CNA holding Resident #3's head. Resident #1's left hand was touching the left side of her face which was slightly red. There were no open wounds identified on either resident. Resident #1 was redirected and was kept separated from Resident #3 throughout the shift. According to the note, the residents were placed on 15-minute checks and a stop sign was placed over Resident #1's door to ensure other residents would not enter her room. The note identified the redness on Resident #1's face dissipated by the end of the shift. The note documented a CNA witnessed the event and reported the CNA was standing outside of the room, redirecting another resident. The CNA witnessed Resident #1 make contact with Resident #3's walker. Resident #3 made contact with the left side of Resident #1's face. Resident #1 then placed her hands on Resident #3's bilateral arms, which made Resident #3 lose her balance and fall to the floor.</p> <p>VI. Staff education</p> <p>The 3/24/25 staff education was provided by the NHA on 5/6/25 at approximately 11:30 a.m. The education agenda identified 10 staff members, which included two licensed practical nurses (LPN) and eight CNAs who worked on the memory care unit, attended the education. The education outlined the interventions of a stop sign on the doorway of Resident #1's and Resident #3's rooms to help keep others out of their space, utilizing pictures/whiteboard for communication speech working with Resident #1 to help her with better communication, speaking to Resident #3 in a calm manner, not telling her what to do and monitoring Resident #3 so that she does not intrude on other spaces and cause behaviors.</p> <p>VII. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The unit manager (UM) and the NHA were interviewed together on 5/7/25 at 12:15 p.m. The UM said the staff on the memory care unit should know the residents and their preferences to develop interventions and individualized care plans. She said to help prevent resident-to-resident altercations, the staff should have eyes on the residents and de-escalate/redirect residents if they became agitated. The UM said individualized resident information sheets were created. The UM said the sheets identified residents' preferences, behavior triggers, what to watch for and a quick reference to residents' interventions. The UM said sometimes behaviors were an unmet need.</p> <p>The UM said Resident #3 had behaviors with staff during care and had difficulty trusting people. She said she needed familiar and consistent staff. The UM said Resident #3 would round the hallways, checking on residents because she used to work at an assisted living facility. The UM said staff watched her as she rounded the halls to make sure she was not intrusive or disruptive to other residents. She said Resident #1 did mind if Resident #3 peeked in her room, she just did not want Resident #3 to enter her room.</p> <p>The UM said to prevent more resident-to-resident altercations from occurring between Resident #1 and Resident #3, the staff placed a stop sign across the Resident #1's room so Resident #3 did not enter her room. The UM said they also encouraged the staff to speak to the residents in a calm manner because they did not like being told what to do, offering the residents walks, intervening when needed and watching for chronic pain. The UM said staff needed to keep Resident #1 in direct line of sight when she was out of her room. She said Resident #3 did not require a direct line of sight. She said staff should just generally watch her. The UM said the resident-to-resident altercations between Resident #1 and Resident #3 occurred mainly because Resident #3 entered Resident #1's room. The UM said Resident #1 would put up her own sign and shut her door.</p> <p>The NHA said Resident #1 was not having physically aggressive behaviors prior to the 2/15/25 altercation. She said neither resident was involved in resident-to-resident altercations prior to 2/15/25. The UM said Resident #1 had no known altercations prior to the 2/15/25 until she was hit by Resident #3. The UM said after the 2/15/25 resident to resident altercation, Resident #1 initiated the other resident-to-resident altercations. The NHA said Resident #1 did not like other people in her space. The NHA said the first three resident-to-resident altercations (2/15/25, 2/17/25 and 2/28/25) involved Resident #1 and Resident #3. The UM said she thought Resident #1 recognized Resident #3 from prior[TRUNCATED]</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467</p> <p>Based on record review and interviews, the facility failed to investigate an allegation of abuse and neglect for one (#3) of four residents out of six sample residents.</p> <p>Specifically, the facility failed to complete thorough and timely investigations when Resident #3 sustained injuries of unknown origin.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 5/7/25 at 3:45 p. m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident symptoms.</p> <p>If resident abuse, neglect, exploration, 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.</p> <p>According to the abuse policy, the facility would conduct an investigation to include interviews with staff members, residents, or family members who may have knowledge of the incident.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #3, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease with late onset, dementia and other diseases elsewhere classified, severe with agitation, lack of coordination and anxiety disorder.</p> <p>The 4/1/25 minimum data set (MDS) assessment identified Resident #3 had moderate cognitive impairments, per a staff assessment for mental status. According to the MDS assessment, Resident #3 needed staff assistance with most of her activities of daily living (ADL).</p> <p>B. Record review</p> <p>The dementia care plan, revised 3/6/25, identified Resident #3 had impaired cognitive function/dementia or impaired thought processes related to dementia.</p> <p>The ADL care plan, initiated 12/18/24, identified Resident #3 required skin inspections and directed staff to observe for redness, open areas, scratches, cuts and bruises and report changes to the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The skin care plan, initiated 4/4/25, documented if the resident had a bruise or skin tear, staff should treat the injury per facility protocol and notify the physician and family. The care plan directed staff to identify potential causative factors and eliminate/resolve the causation factors when possible.</p> <p>The 2/4/25 weekly nursing documentation form documented Resident #3 had an existing skin condition identified as bruising and noted the resident had some discoloration on her forearms.</p> <p>Review of Resident #3's electronic medical record (EMR) did not identify the bruising or discoloration on her forearms prior to the 2/4/25 weekly nursing documentation form.</p> <p>The 2/18/25 nursing progress note documented Resident #3 was on alert charting for a resident-to-resident incident on 2/17/25. The note documented Resident #3 was observed to have injuries to her arms. The nursing progress note identified Resident #3 also had old bruising to her arms.</p> <p>Cross reference: F600: failure to protect residents from abuse.</p> <p>-The 2/18/25 nursing note did not document what kind of injuries were on her arms and where the injuries were on her arms.</p> <p>-The note did not identify how Resident #3 sustained the old bruising to her arms or when the bruising occurred.</p> <p>-The review of the resident's EMR did not identify what the old bruising was from or when it occurred.</p> <p>C. Staff interviews</p> <p>The NHA and the director of nursing (DON) were interviewed together on 5/7/25 at 4:03 p.m. The NHA said Resident #3's injuries to her arms on 2/18/25 were identified after she was involved in a resident-to-resident altercation on 2/17/25.</p> <p>The NHA and the DON said they did not know what the old bruising was from, when it occurred or if there was old bruising actually present, even though it was documented on a 2/18/25 nursing note. The NHA and the DON said they were not aware of the bruising/dyscoloration documented in the 2/4/25 weekly nursing documentation.</p> <p>The DON said the last known bruising on the resident's arms prior to 2/4/25 was in December 2024 when Resident #3 was combative with care.</p> <p>The NHA said she reviewed Resident #3's EMR. The NHA said the 2/4/25 bruising/dyscoloration to the resident's forearms and the old bruising to the resident's arms, identified on 2/18/25, were not documented anywhere else. The NHA said the staff should go back into Resident #3's EMR to create a risk management report or document when the bruising was first observed.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA said bruises and injuries of unknown origin needed to be investigated according to the facility's policy. She said the bruising on Resident #3's arms should have been investigated to rule out abuse. The NHA said the documented 2/4/25 bruises and the old bruises identified on 2/18/25 were not investigated. She said she should have been notified of the bruising so she could have started an investigation if Resident #3's bruising was of unknown origin. The NHA said she would interview staff today (5/7/25) regarding the 2/4/25 and 2/18/25 bruising. The NHA said she would look at the resident's skin to determine if the resident still showed bruising or discoloration.</p> <p>III. Facility follow-up</p> <p>The NHA provided documentation of a staff interview that was conducted on 5/8/25, physician notes and skin observation sheet (2/1/25 to 2/16/25) on 5/8/25 via email.</p> <p>The 5/8/25 staff interview was conducted by the unit manager (UM). It documented she interviewed licensed practical nurse (LPN) #3 regarding her 2/18/25 documentation (on Resident #3). The UM documented LPN #3 did not recall any skin issues. The staff interview sheet documented the nurse who wrote the 2/4/25 note (weekly nursing documentation) no longer worked at the facility.</p> <p>The 2/5/25 physician encounter note did not identify if there was bruising or discoloration on Resident #3's arms at the time of the exam. The note documented the resident's skin was examined and there were no physical findings pertinent to the encounter. The note identified the physician saw Resident #3 on 2/5/25 due to her lethargy and lack of intake.</p> <p>The 2/17/25 physician encounter note documented Resident #3 was involved in a resident-to-resident incident. The encounter note did not identify if there was old bruising, new or any bruising or discoloration on Resident #3's arms. The note documented the resident's skin was examined and there were no physical findings pertinent to the encounter. The note identified the physician saw Resident #3 on 2/17/25 due to the resident's family's request to review her pain control.</p> <p>The February 2025 (2/1/25 to 2/16/25) skin sheet identified the nursing staff marked no to the question is there a new skin issue on the skin observation sheet.</p> <p>-A record of the skin observation sheet after 2/16/25 was not provided.</p>		