STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interviews, the facility failed to ensure four (#1, #2, #3 and #4) of eight residents out of nine sample residents were free from abuse.Specifically, the facility failed to:-Protect Resident #2 and Resident #1 from physical abuse by each other;-Protect Resident #3 from physical abuse by Resident #1;-Protect Resident #4 from physical abuse by Resident #1; and,-Protect Resident #2 from physical abuse by Resident #1.Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 8/13/25 at 8:30 a.m. via email. 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. “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. “Providing a safe environment for the resident is one of the most basic and essential duties of our facility.” II. Incident of physical abuse between Resident #1 and Resident #2 on 6/18/25 A. Facility investigation The facility investigation was provided by the NHA on 8/11/25 at 4:30 p.m. The investigation, documented on 6/18/25, revealed Resident #1 dumped a glass of water on Resident #2 and Resident #2 retaliated by kicking Resident #1 in the right thigh. The investigation documented Resident #1 was having frequent aggressive behavior with labile mood. The intervention put in place as a response to the event was to change the antipsychotic medication for Resident #1. The facility investigation documented the allegation of abuse on 6/18/25 was substantiated. B. Resident #1 (victim and assailant) (continued on next page)

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
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged on 7/3/25. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease with early onset, frontal lobe dementia, unspecified mood disorder dementia and other diseases elsewhere classified with unspecified severity with other behavioral disturbance, severe with agitation, anxiety disorder and major depressive disorder. The 5/23/25 minimum data set (MDS) assessment identified Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of one out of 15. According to the MDS assessment, Resident #1 had inattention, disorganized thinking and delusions. The assessment indicated Resident #1 had physical and verbal behavioral symptoms directed towards others. The assessment identified she had other behavioral symptoms to include rejections of care and wandering. The assessment indicated she did not have upper or lower extremity impairment and did not require a mobility device. 2. Record review Resident #1’s trauma informed care plan, initiated 4/21/25, indicated Resident #1 had behavior related to a history of trauma related to abandonment. Interventions included involving family support in the care of Resident #1, providing peer support services, providing unsolicited validation for prosocial behavior, providing consistent caregivers whenever possible, speaking with Resident #1 in a calm soothing voice, approaching Resident #1 directly and avoiding approaching from the side or behind Resident #1. Resident #1’s anti-anxiety care plan, initiated 6/3/25, indicated Resident #1 had anxiety related behaviors including pacing, slapping/hitting themself and pulling their own hair. Interventions included administering anti-anxiety medication as ordered, behavior monitoring, side effect monitoring and quarterly medication review. The care plan documented non-pharmacological interventions for anxiety included cold, range of motion activities, massage, relaxation and breathing techniques, imagery and distraction techniques, aromatherapy and therapeutic touch. Resident #1’s behavior care plan, initiated 4/21/25, indicated Resident #1 had aggressive behaviors including yelling, screaming, hitting, biting and scratching. Interventions included administering antipsychotic medication as ordered, behavior monitoring, side effect monitoring and quarterly medication review. The care plan documented non-pharmicological interventions for aggressive behavior included redirecting Resident #1 outside, reducing stimuli, staff were not to respond to argumentative or sarcastic statements and remove of other residents from the area when Resident #1 was agitated. The progress note, dated 6/18/25 at 1:42 p.m. and entered into Resident #1’s electronic medical record (EMR) on 6/19/24, revealed Resident #1 was standing at the nurses’ cart, while Resident #2 was in her wheelchair. The two residents were talking with licensed practical nurse (LPN) #3. Both residents were at arms length apart. The note documented Resident #1 became agitated and threw a glass of water at Resident #2. Resident #2 was startled and kicked Resident #1 in the right thigh from her wheelchair. LPN #3 separated the two residents and Resident #1 denied any pain. No injuries were found on assessment. Both residents were placed on 15-minute observations for the rest of the shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #2 (victim and assailant) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, unspecified, with behavioral disturbances, neurocognitive disorder with Lewy bodies, degenerative disease of the nervous system and anxiety. The 6/20/25 MDS assessment identified Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. According to the MDS assessment, Resident #2 had inattention, disorganized thinking and delusions. The assessment indicated Resident #2 had physical and verbal behavioral symptoms directed towards others. The assessment indicated she did impairment to her lower extremities and required a walker or wheelchair. Resident #2 was dependent on staff for toileting and footwear, and required assistance with bathing, dressing and hygiene. 2. Record review Resident #2’s behavior care plan, initiated on 2/26/25 and revised 7/7/25, indicated Resident #2 had behaviors including verbal aggression, cursing, yelling, crying, hitting, pushing and kicking. Interventions included using yes/no questions to determine needs, providing low stimuli environments when Resident #2 was overwhelmed, providing activities including crafts, gardening, puzzles, music, looking at photos, therapeutic massage and going outdoors. The progress note, dated 6/19/25 at 1:44 p.m., documented Resident #2 was sitting at the nurses’ cart with Resident #1 at arm’s length also talking with LPN #3. The note documented Resident #1 became agitated and threw a glass of water at Resident #2. Resident #2 was startled and kicked Resident #1 in the leg from her wheelchair. LPN #3 separated the two residents and no injuries were found on assessment. Both residents were placed on 15-minute observations for the rest of the shift. The nurse practitioner (NP) visit note, dated 6/24/25 at 5:30 p.m. The note documented Resident #1 had modestly improved behavior since the medication change from Seroquel to Zyprexa and addition of non-pharmacological interventions. The note documented a plan to continue to monitor Resident #1 for medication effectiveness with the plan to taper and discontinue Resident #1’s as needed (PRN) anti-anxiety medication as Resident #1 adjusted to the scheduled Zyprexa and the environment. III. Incident of abuse of Resident #3 by Resident #1 on 6/21/25 A. Facility investigation The facility investigation was provided by the NHA on 8/11/25 at 4:48 p.m. The investigation documented that on 6/21/25 a physical altercation occurred between Resident #3 and Resident #1 that involved yelling and pushing. The altercation resulted in Resident #3 sustaining a skin tear on her right great toe. No other injuries were identified as a result of the incident. The residents were separated and monitored. The investigation identified Resident #1, who had a history of resident-to-resident altercations, was the aggressor in the altercation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation included an analysis of the potential root cause of the altercation. According to the analysis, there was a baby with her mother in the secured unit prior to the altercation. Resident #1 attempted to pick up the baby and staff intervened, upsetting and possibly embarrassing Resident #1. The analysis identified Resident #1 had difficulty calming down after she became upset. The facility investigation included an interview with certified nurse aide (CNA) #4. CNA #4 said the incident occurred after dinner. CNA #4 described the environment after dinner as busy and a little chaotic, which was normal. Resident #1 had been upset since before dinner and declined encouragement to eat outside. CNA #4 said when dinner concluded, Resident #1 pushed Resident #3 into a chair causing Resident #3 to stub her toe. The facility investigation revealed education was conducted with the memory care staff on 6/25/25. The minutes from the education indicated Resident #1 liked Resident #4’s walker and would regularly try to take it (see 7/2/25 incident of physical abuse below). According to the minutes, Resident #1’s behaviors would be triggered when her representatives would leave her after they visited with her. Resident #1 was very difficult to redirect when she was upset, to include after dinner when everyone was getting up from their meal and the environment was busy. The minutes identified staff recommended calming music be played at that time to help with sundowning behaviors. The minutes documented staff felt that residents would become scared when Resident #1 was upset. The facility investigation documented the allegation of abuse on 6/21/25 was substantiated. B. Resident #3 (victim) 1. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included Alzheimer's disease, unspecified dementia and other diseases classified elsewhere, unspecified severity, with psychotic disturbances, unspecified dementia other disease classified elsewhere, severe with mood disturbance. The 7/1/25 MDS assessment identified Resident #3 had moderate cognitive impairments, per a staff assessment for mental status. According to the MDS assessment, Resident #3 had a short term and long term memory problem with fluctuating inattention and disorganized thinking but could recall staff names and faces. The assessment indicated Resident #3 did not have physical or verbal behavioral symptoms directed towards others. She was independent with mobility without the use of a mobility device. 2. Record review The secured memory care placement care plan, revised 11/22/23, identified Resident #3 required placement in a secure neighborhood due to senile degeneration of the brain and dementia with agitation and psychotic disturbance. The care plan goal was to keep Resident #3 safe. The delirium care plan, revised 11/22/23, identified Resident #3 had delirium or an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acute confusion episode related to dementia but was able to communicate her wants and needs verbally and nonverbally with simple communication. According to the care plan, she was easily redirected. Pertinent interventions, initiated 10/4/23, included the staff should promote the appropriate sensory stimulation and monitor/address environmental factors such as noise and commotion. The 6/21/25 nursing progress note documented Resident #3 was standing with the nurse (LPN #1) when another resident (Resident #1) proceeded to yell at Resident #3 and was in close proximity to Resident #3’s face. According to the note, the nurse attempted to stand between both residents as Resident #1 was pushing the nurse. Resident #3 turned around with her back facing Resident #1 and Resident #1 pushed Resident #3. The note identified the push caused Resident #3 to stumble forward and stub her toe on the table in front of her. C. Resident #1 (assailant) 1. Record review The 6/21/25 nursing progress note documented the resident-to-resident altercation. The progress note identified Resident #1 was taken outside away from Resident #3 and was placed on 15-minute checks and her physician and responsible party was notified. The 6/22/25 nursing progress note documented Resident #1 was placed on alert charting following the incident and was administered a PRN dose of Ativan (an antianxiety medication. According to the note, Resident #1 was in good spirits until later in the day when she began to display increased agitation but allowed staff to provide activities of daily living (ADL) care. The progress note indicated the resident’s agitation did not rise to the level of physical aggression. IV. Incident of abuse of Resident #4 by Resident #1 on 7/2/25 A. Facility investigation The facility investigation was provided by the NHA on 8/11/25 at 4:48 p.m. The investigation documented that a physical altercation on 7/2/25 occurred between Resident #4 and Resident #1 without injury or redness. The residents were separated and monitored. The investigation identified Resident #1 was the aggressor in the altercation. The investigation identified Resident #1 attempted to take Resident #4’s walker. Resident #1 became upset when she could not have Resident #4’s walker and open hand slapped Resident #4 in the face. The residents were separated and Resident #1 spent most of the day off the secured unit with nurse management staff providing one-to-one visitation and supervision. According to the investigation, Resident #1’s representative was contacted. The facility recommended and sent out referrals to other facilities that had a less stimulating environment. The investigation documented the facility would conduct a medication review and offer Resident #1 supervised time off the unit when her behaviors escalated. The facility investigation included an interview with CNA #1. CNA #1 said Resident #1 was agitated prior to the resident-to-resident altercation on 7/2/25. Staff offered interventions of one-to-one visits, taking her outside and toileting her. The interview indicated Resident #1 had refused to let staff change her brief. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation included an analysis of the potential root cause of the altercation. According to the analysis, Resident #1 was overestimulated by the general activity of the secured memory care unit. The analysis also indicated Resident #1 would take anything that rolled in front of her, such as rolling carts, rolling chairs and, in the case of the 7/2/25 altercation, Resident #4 used a walker (with wheels). The facility investigation documented the allegation of abuse on 7/2/25 was substantiated. B. Resident #4 (victim) 1. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the August 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. The 6/25/25 MDS assessment identified Resident #4 had moderate cognitive impairments, per a staff assessment for mental status. According to the MDS assessment, Resident #4 short term and long term memory problems with fluctuating inattention and disorganized thinking but could recall staff names, faces and location of her room. The assessment indicated Resident #4 did not have physical or verbal behavioral symptoms directed towards others. The assessment indicated she was independent with mobility with use of a walker. 2. Record review The 7/3/25 nursing progress note identified (on 7/2/25) that Resident #1 and Resident #4 were observed by the shower room together as Resident #1 tried to take Resident #4’s walker, became upset and slapped Resident #4 across the left side of her face. According to the progress note, the CNA immediately intervened and redirected Resident #1. Resident #4 was able to tell the staff she was slapped by Resident #1. The 7/3/25 interdisciplinary team (IDT) note documented the IDT reviewed the 7/2/25. According to the note, Resident #4 had no changes from mood or cognition baseline and was not able to recall the event. C. Resident #1 (assailant) 1. Record review The 7/3/25 nursing progress note described the incident between Resident #1 and Resident #4. According to the note, all appropriate parties were notified including the physician and the representative. V. Incident of physical abuse between Resident #1 and Resident #2 on 7/3/25 A. Facility investigation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation was provided by the NHA on 8/11/25 at 4:30 p.m. The investigation documented that on 7/3/25 at 3:20 p.m. Resident #1 was agitated, intermittently hitting herself and pulling her hair out and pacing between the common area and the dining area. The investigation documented Resident #1 was walking with the activities assistant. Resident #2 was being assisted out of the dining area by CNA #3. Resident #1 grabbed Resident #2 by the wrist with both hands, twisting and pulling on Resident #2’s arm. CNA #3 and the activities assistant separated the two residents but their attempts to redirect Resident #1 were unsuccessful as Resident #1 pushed and knocked over furniture in the common area. The unit manager notified the director of nursing (DON), who called 911. A police officer arrived to the scene but was unable to redirect Resident #1. Emergency medical services (EMS) were called after police were unable to de-escalate Resident #1. Resident #1 attempted to kick and bite EMS staff and police. The investigation documented EMS staff administered Haloperidol (an antipsychotic medication) 5 milligrams (mg) intramuscular (injection) into Resident #1. Resident #1 remained combative with EMS staff and required soft restraints to be placed by EMS in order to transport Resident #1 to the local area hospital. Resident #2 was assessed for injuries. Bruises were found on her arm, but Resident #2 had full range of motion and denied pain. The investigation documented the DON contacted Resident #1’s daughter (one of her representatives) to inform of the event and to inform her that Resident #1 was not safe to return to the facility at this time because Resident #1 was a danger to herself and others. The intervention listed in the facility investigation was that Resident #1 would not be allowed to return to the facility unless the resident received additional support and medication management in an inpatient setting and Resident #1’s behavior symptoms were stable. The facility investigation documented the allegation of abuse on 7/3/25 was substantiated. VI. Staff interviews LPN #2 was interviewed on 8/12/25 at 11:25 a.m. LPN #2 said Resident #1 had very unpredictable behavior. LPN #1 said she remembered the facility working with the resident’s representative, who was providing care to find approaches and interventions that Resident #1 responded well to. LPN #2 said one of the interventions was for staff to report they needed to use the restroom and to ask Resident #1 if she wanted to go with them instead of informing Resident #1 they were incontinent or they needed to be changed. LPN #2 said this was helpful as Resident #1 was very agitated when incontinent, but not always aware that the source of her discomfort was incontinence. CNA #1 was interviewed on 8/12/25 at 12:19 p.m. CNA #1 said Resident #1 had increasingly unpredictable behaviors in the last week or two prior to her discharge. CNA #1 said she remembered attending unit education about different interventions specific to Resident #1 in June 2025. CNA #1 said one of the interventions was for staff to mention they needed to use the restroom and then ask Resident #1 if she wanted to go with them, instead of informing Resident #1 she was incontinent and needed to be changed. CNA #1 said some of the interventions to redirect Resident #1 would work the first few times but then would stop being effective. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and the NHA were interviewed together on 8/12/25 at 1:18 p.m. The DON said the facility started weekly care conferences with Resident #1’s representatives in June 2025 due to Resident #1’s frequent agitated and combative behavior. The NHA said one of the issues identified in the facility’s investigation was that the resident’s representative and caregiver for Resident #1 prior to admission continued to provide most of the bathing and incontinence cares to Resident #1. The NHA said the staff needed the opportunity to build rapport with Resident #1 and asked the representative to avoid coming to the facility for a week. The NHA and the DON said Resident #1’s behavior improved temporarily and Resident #1 was more cooperative with care and assessments during the time Resident #1’s representatives were not visiting. The NHA said the representative and caregiver returned to visit the next week and Resident #1’s behavior escalated again. The NHA said it appeared to be related to Resident #1’s trauma history related to abandonment. The DON said she remembered the events on 7/3/25 when Resident #1 was hospitalized and discharged from the facility. The DON said she received a call from the unit manager asking for help with Resident #1. The DON said the situation sounded emergent so she called 911. The DON said when she arrived to the unit, the unit manager had already cleared all other residents out of the area near Resident #1. The DON said Resident #1 was pushing staff into walls, hitting herself and pulling her hair out. The DON said the police arrived but were unable to direct Resident #1 to her room and the police officer contacted EMS. The DON said EMS was also unable to de-escalate Resident #1 and Resident #1 attempted to hit and bite EMS staff. The DON said the police and EMS spoke with her and told her that Resident #1 was a danger to herself and others and everyone was in agreement that Resident #1 needed to be hospitalized . The DON said EMS had to give intramuscular haloperidol and use soft restraints to get Resident #1 onto the stretcher. The DON said she contacted Resident #1’s representative and told her about the situation. The DON said the resident’s representative said she was not surprised by Resident #1’s aggressive behavior and agreed at the time that Resident #1 needed hospitalization. The NHA was interviewed again on 8/12/25 at 4:41 p.m. The NHA said physical abuse could occur any time willful contact was made between two people, even if those people did not intend to harm each other. The NHA said abuse could also be verbal or sexual and that all reports in which abuse could have occurred were investigated by the facility. The NHA said when the facility was conducting investigations, they would interview the managers, any staff that witnessed the incident, any staff that were working on that unit and any pertinent residents. The NHA said Resident #1 was a complex case due to her diagnosis of frontal-lobe dementia. The NHA said the nurse practitioner for Resident #1 provided education to unit staff about the disease process, including extremely impulsive behavior and rapid mood swings. The NHA said the facility tried to implement multiple interventions to keep Resident #1, other residents and unit staff safe. The NHA said an intervention would be successful for Resident #1 for a short period of time and then stop working for no clear reason. The NHA said the facility planned to be more diligent in their referral process. The NHA said the current population of the memory care unit could be overstimulating to younger residents with frontal lobe dementia compared to their current population, which was a majority of older residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of seven residents out of nine sample residents were kept free from physical restraints. Specifically, the facility failed to prevent manual holds being used on Resident #1 during incontinence care. Findings include:I. Facility policy and procedureThe Abuse policy, revised February 2024, was provided by the nursing home administrator (NHA) on 8/13/25 at 8:30 a. m. It 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's symptoms.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged on 7/3/25. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease with early onset, frontal lobe dementia, unspecified mood disorder dementia and other diseases elsewhere classified with unspecified severity with other behavioral disturbance, severe with agitation, anxiety disorder and major depressive disorder.The 5/23/25 minimum data set (MDS) assessment identified Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of one out of 15. According to the MDS assessment, Resident #1 had inattention, disorganized thinking and delusions. The assessment indicated Resident #1 had physical and verbal behavioral symptoms directed towards others. The assessment identified she had other behavioral symptoms to include rejections of care and wandering. The assessment indicated she did not have upper or lower extremity impairment and did not require a mobility device.B. Facility investigation of bruises of unknown origin on 6/6/25The facility investigation was provided by the nursing home administrator (NHA) on 8/11/25 at 4:30 p.m. The investigation documented that on 6/6/25 the resident's representative brought bruises of unknown origin found on the resident's back and left shoulder to the attention of the facility. The investigation documented the resident's representative did not know when the bruising occurred and initially did not report the bruises because he was not concerned and was aware how combative Resident #1 could be with care. The investigation documented Resident #1's representative told the facility he saw the bruises approximately three weeks prior to the report made to the facility on 6/6/25. The investigation documented interviews with all staff assigned to Resident #1 in the three weeks prior to the report.The investigation documented licensed practical nurse (LPN) #2 was interviewed on 6/8/25 at 11:15 a. m. LPN #2 said approximately three weeks ago, Resident #1 was incontinent of bowel in the common area. Resident #1 had severely agitated behavior, pacing in the common area and would not follow staff cues to the bathroom for incontinence cares. LPN #2 and the director of nursing (DON) had their arms underneath Resident #1 holding her hands to guide Resident #1 to her bathroom. The investigation documented when the staff and Resident #1 arrived to her room, Resident #1 went limp with her legs, putting her weight on LPN #2 and the DON, causing Resident #1 to slide to the floor. LPN #2 and the DON lifted Resident #1 from the floor to the bed. The investigation documented LPN #2 thought this event could have caused the unknown bruising on Resident #1. LPN #2 said she provided incontinence care to Resident #1 while certified nurse assistant (CNA) #1 and the DON held Resident #1's hands and CNA #2 held Resident #1's feet to prevent Resident #1 from hitting or kicking staff during care. The investigation documented the DON was interviewed on 6/8/25. The DON said she assisted with incontinence care for Resident #1 approximately three weeks prior. The DON said Resident #1 was very combative at this time and the DON had to hold her arm to prevent Resident #1 from hitting staff. The DON said Resident #1 threw herself onto the bed and slid to the floor and she assisted her back into bed. The DON said it was possible the bruises came from the bed frame. The investigation documented CNA #2 was interviewed on 6/9/25 at 11:48 a.m. CNA #2 said she remembered assisting with care for Resident #1 approximately three weeks prior. CNA #2 said Resident #1 was covered in bowel movement and would not follow the cues from CNA #2 or other staff. CNA #2 said the DON and another staff member held Resident #1's hands, looping their arms under Resident #1 to guide her to her room. When CNA #2 entered the room to assist with care, Resident #1 was combative with staff. CNA #2 said she saw the legs of Resident #1 drop out from under her and Resident #1 landed on the bed. CNA #2 said she held Resident #1's legs during the incontinence care because Resident #1 was trying to kick the nurse cleaning her up. CNA #2 said she remembered another time when Resident #1 grabbed and pulled CNA #2's hair. CNA #2 said she hugged Resident #1 so she could not hit her, then Resident #1 threw herself