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	12/09/2025

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 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 (#2) of five residents out of five sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #2 from physical abuse by Resident #1.Findings include: I. Incident of physical abuse of Resident #2 by Resident #1 on 9/22/25A. Facility investigationThe facility investigation was provided by the nursing home administrator (NHA) on 10/27/25 at approximately 2:00 p.m. The facility investigation documented that on 9/22/25 at 3:30 p.m. the maintenance assistant witnessed Resident #2 mumbling, prompting Resident #1 to use an expletive word towards Resident #2 and directing her not to speak. Resident #1 reached out with her left hand and lightly hit Resident #2 on the right cheek without injury. According to the investigation, Resident #2 responded to the hit by saying There is no reason for that. The maintenance assistant separated the residents and notified the nursing staff. The investigation identified that no other memory care staff working on the unit witnessed the incident.The investigation documented both of the residents were interviewed after the incident. Resident #2 said she did not hit people and it was not nice to hit people. Resident #1 was unable to answer the questions when interviewed. Resident #1 and Resident #2 were placed on 15-minute checks for 72 hours following the altercation. Review of the investigation identified the facility substantiated abuse. The investigation revealed a root cause analysis was completed to determine the possible causes on the 9/22/25 altercation. According to the analysis, Resident #1 had agitation beginning in the morning on 9/22/25. The agitation continued, prompting Resident #1 to hit Resident #2 (on 9/22/25 at 3:30 p.m.) The analysis identified the underlying issue of the agitation was related to an ingrown toenail causing Resident #1 discomfort and new medication changes. According to the investigation analysis, the ingrown toenail was not addressed prior to the incident because Resident #1 could not always verbalize pain/discomfort. The corrective action identified in the root cause analysis was to schedule a podiatry visit for Resident #1, apply Vicks Vaporub to the toe, offer the resident Tylenol and monitor her for pain. The investigation documented staff were educated after the altercation related to Resident #1's ingrown toenail. The staff were informed the resident's toenail was causing her pain and agitation. The education directed staff to encourage Resident #1 to wear non-skid socks without shoes until she was seen by a podiatrist. B. Resident #2 (victim)1. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included dementia, severe, with mood disturbance and Alzheimer's disease. The 9/23/25 minimum data set (MDS) assessment identified Resident #2 exhibited short and long term memory problems, inattention, disorganized thinking and had physical behaviors directed to others. The staff assessment for mental status indicated the resident's cognition was moderately impaired. The MDS assessment indicated Resident #2 was independent with her mobility.According to the MDS assessment, Resident #2 would significantly intrude on other resident's privacy or activity and disrupt care or living environment.2. Record reviewResident #2's wandering care plan, revised 11/22/23, identified Resident #2 was at high risk for wandering and elopement. According to the care plan, Resident #2 could easily be redirected. The care plan directed staff to monitor the resident's location frequently (initiated 6/1/23).The dementia care plan, revised 3/13/25, indicated Resident #2 had behaviors such as wandering, poor safety awareness and repetitive verbalizations. Interventions included directing staff to encourage Resident #2 to participate in simple, structured activities of interest and incorporate cues, reorientation, and supervision as needed (initiated 4/5/24). According to the interventions, staff should assist Resident #2 to a quieter environment if she became agitated in a louder environment (initiated 4/5/25). The interventions indicated Resident #2's wandering and exit-seeking behaviors may be triggered when the resident was bored and hungry. The resident should be redirected and guided from other residents' rooms/doorways when wandering, because she tended to enter the rooms and rummage through other residents' belongings (initiated 8/26/25). Additional wandering interventions directed staff to de-escalate the wandering behavior by involving the resident in activities of choice, engagement, one-to-one supervision and providing snacks/meals (initiated 3/13/25). Resident #2's communication care plan, revised 11/22/25, indicated Resident #2 had a communication problem related to senile degeneration of the brain, dementia in other diseases elsewhere, with agitation and psychotic disturbance. Interventions, revised 6/2/25, directed staff to anticipate and meet needs and encourage Resident #2 to focus on a word or phrase at a time. The 9/22/25 nursing progress note documented a maintenance assistant notified the nurse that he witnessed another