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	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Care Center	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#38) of five residents out of 35 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #38 from physical abuse by Resident #3.Findings include: Record review, observations and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/27/26 to 4/30/26, resulting in the deficiency being cited as past non-compliance with a correction date of 2/5/26.I. Incident between Resident #38 and Resident #3 on 1/31/26On 1/31/26 at approximately 1:30 p.m. registered nurse (RN) #2 heard a commotion in the hallway, outside the room of Resident #3. RN #2 witnessed Resident #3 hit Resident #38, causing Resident #38's lip to bleed. The two residents were immediately separated from each other and placed on frequent checks. Resident #38 had a small laceration to the middle of her upper lip and a small bruise below her lower lip. II. Facility plan of correctionThe plan of correction the facility put in place in response to the physical abuse incident between Resident #38 and Resident #3 was provided by the NHA on 4/29/26 at approximately 3:00 p.m.The plan read: A. Immediate action to correct the deficient practice The plan of correction, dated 1/31/26, identified the facility's noncompliance concern was related to staffing levels. The plan documented corrective actions taken to correct the noncompliance included education to nurse management on appropriate staffing levels on the memory care unit and medication changes for pain reviewed care planned and updated for Resident #3 and Resident #38. B. Systematic changesEducation was provided to all nurse management and the staffing coordinator on 2/5/26 to ensure appropriate staffing levels included two licensed certified nurse aides (CNA) on the memory care unit on the day shift and the evening shifts and the availability of the on-call nurse until appropriate coverage was met.C. MonitoringThe staffing team, which included the nursing home administrator (NHA), the director of nursing (DON), the assistant director of nursing (ADON), the staff development coordinator , the memory care director, the human resource director and the staffing coordinator, met and reviewed the staffing needs for each day, week and weekend. A daily audit (Monday through Friday) addressing any staffing needs was implemented. A monthly review of staffing levels and needs would be reviewed in the facility's quality assurance and performance improvement (QAPI) meeting every one to three months.III. Facility policy and procedureThe Abuse policy, dated 5/3/23, was provided by the nursing home administrator in training on 4/28/26 at 11:24 a.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. 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.IV. Incident of physical abuse of Resident #38 by Resident #3 on 1/31/26A. Facility (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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