STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065386	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorado State Veterans Nursing Home - Rifle	851 E 5th St Rifle, CO 81650

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 observations, interviews, and record review, the facility failed to protect three (#1, #3, and #2) out of seven residents from physical abuse out of 12 sample residents.Specifically, the facility failed to:-Protect Resident #2 and Resident #1 from physical abuse from each other; -Protect Resident #3 from physical abuse by Resident #1; and,-Protect Resident #2 from physical abuse by Resident #1. Findings include:I. Incident of physical abuse between Resident #2 and Resident #1 on 9/12/25The facility investigation, dated 9/12/25, documented Resident #2 was agitated and verbally aggressive towards staff around 7:30 p.m. All attempts to redirect Resident #2 were unsuccessful and his aggressive behaviors continued to escalate. Staff attempted to administer his evening medications; however, he refused. Staff continued to monitor and de-escalate Resident #2's aggressive behaviors.Around 8:00 p.m. Resident #2 and Resident #1 were in the dining room together. Staff were not present in the dining room and the incident had to be viewed on the facility's video surveillance system to determine what happened as the incident began.The investigation documented the nursing home administrator (NHA) viewed the video surveillance and documented the incident. The NHA documented the following events; Resident #2 approached Resident #1, in response, Resident #1 then kicked Resident #2's walker. Resident #2 then pushed his walker into Resident #1's knees. Staff separated the two residents. The investigation documented the staff utilized therapeutic neck massages to de-escalate Resident #2. Staff said that this intervention was successful as no additional incidents occurred that evening.Resident #1 and Resident #2 were both assessed to have severe cognitive impairment and were non-interviewable. The nursing assessment after the incident revealed neither resident had any physical injuries and did not appear afraid.The facility investigation revealed Resident #2 was not given his morning antipsychotic medication because he was asleep and the nurse did not want to wake him up to administer the medications. Additionally, at the time of the altercation, Resident #2 was ordered to be on line-of-sight supervision when out of his room due to his aggressive behaviors. Line of sight was defined as staff being able to continually observe the resident to ensure his safety and the safety of other residents.-However, in an interview with CNA #6 on 11/19/25 at 12:30 p.m. revealed the majority of the dining room cannot be viewed by staff from the nurses' station or the common area lounge just outside of the dining room (see staff interviews below). CNA #6 was interviewed as part of the facility investigation. CNA #6 said that it was important for Resident #2 to receive his scheduled medications to reduce his agitation. She said aside from administering his medications as ordered, she could not think of any additional interventions staff could have used to prevent the altercation from occurring.CNA #9 was interviewed as part of the facility investigation. CNA #9 said that aside from making sure that Resident #2 took his scheduled medications, she did not have any other suggestions on how the altercation could have been prevented.-The facility concluded that physical abuse did not occur because neither resident sustained major injuries or unreasonable confinement.-However, physical abuse occurred due to Resident #1 and Resident #2 willfully hitting and kicking each other. II. Incident of physical abuse by Resident #1 toward Resident #3 on 10/6/25The facility investigation, dated 10/6/25, documented (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	registered nurse (RN) #4, who witnessed the resident-to-resident physical altercation was interviewed. She said that on the evening of 10/6/25, Resident #1 was very agitated and difficult to redirect despite the staff's attempts to de-escalate him. Around midnight, Resident #1 was in the dining room and looked like he needed assistance. When RN #4 offered Resident #1 assistance, he struck out at her and hit the pitchers that she was carrying. RN #4 reported that after he attempted to hit her, she left him alone. The investigation documented 20 minutes later, Resident #3 was headed into the dining room when Resident #1 postured and blocked the entrance to the dining room. Resident #1 then swung and hit Resident #3 in the chest. Staff separated the two residents. RN #4 said Resident #1 continued to have aggressive behaviors towards staff for the remainder of the evening until he went to sleep.RN #4 assessed both residents and determined that neither had sustained any physical injuries or psychosocial harm.Resident #3 was interviewed as part of the investigation. Resident #3 denied being involved in the altercation.-However, Resident #3 was diagnosed with dementia and determined to have severe cognitive impairment.As part of the facility investigation, CNA #10, who witnessed the altercation was interviewed. CNA #10 said Resident #1 was agitated and tried to hit all of the staff members that evening. She said that he eventually used the restroom, and calmed down after using the bathroom. CNA #10 said she suspected Resident #3's irritability was caused by needing to use the toilet. CNA #10 said she was not sure what the staff could have done differently to prevent the altercation.The facility concluded that physical abuse did not occur because neither resident sustained major injuries or unreasonable confinement.-However, abuse occurred due to Resident #1 willfully hitting Resident #3 in the chest.III. Incident of physical abuse by Resident #1 toward Resident #2 on 10/13/25The facility investigation, dated 10/14/25, documented Resident #1 approached Resident #2, who was napping in a chair in the common area, and unprovoked struck Resident #2 on the side of the face with his hand. Additional staff were called to help control the situation. The residents were then separated.CNA #7 was interviewed as a part of the facility's investigation. CNA #7 witnessed the physical altercation and said observed Resident #1 walk towards Resident #2 and thought the resident was just walking around. Then before she could respond she witnessed Resident #1 hit Resident #2 in the face. CNA #7 said the incident was unprovoked and there was no clear trigger to the event. The investigation documented the nursing staff assessed Resident #2 after the incident; resident #2 was found to have no injuries and denied any fear for his well-being.RN #4 was interviewed as a part of the facility investigation. RN #4 said Resident #1 was sitting in a recliner and threw his socks across the room, then got up out of his recliner as if to go pick up the socks, but continued walking towards Resident #2. Resident #1 appeared to be looking at the wall beside Resident #2 before struck Resident #across the face. RN #4 said after they separated the residents, Resident #1 said that Resident #2 was upsetting him. The facility concluded that physical abuse did not occur because neither resident sustained major injuries or unreasonable confinement.-However, abuse occurred due to Resident #1 willfully hitting Resident #2 in the face. IV. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the November 2025 computerized physician's orders (CPO), diagnoses include dementia of unspecified severity, with other behavioral disturbance, and aphasia (difficulty speaking).According to the 9/28/25 minimum data set (MDS), the resident was unable to participate in a brief interview for mental status (BIMS) exam. The staff assessment revealed the resident had short and long-term memory problems and severe cognitive impairment.2. Record reviewResident #1's behavior care plan, initiated on 5/23/2, revealed the resident had the potential to display aggressive behaviors.Pertinent interventions included: talking and interacting with Resident #1 on his interests, such as sports, swing music, and feeling helpful, and try to help him have a sense of purpose (initiated 10/6/25) and placing the resident on line of sight while out of his room and redirect him with one-on-one time, activities, snacks, and drinks (initiated 8/7/25).V. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses include dementia of unspecified severity, with other behavioral disturbance, and mood disorder.The 9/11/25 MDS (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment revealed the resident had severe cognitive impairments with a BIMS score of seven out of 15.B. Record reviewResident #2's behavior care plan, initiated, 6/15/25, revealed the resident had the potential to display physical and verbal aggression. Pertinent interventions included: keeping the resident in line of sight and engaging the resident with activities that he preferred. VI. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE] and discharged from the facility on 10/16/25 to inpatient hospice. According to the October 2025 CPO, diagnoses included alcohol dependence with alcohol-induced persistent dementia, abnormalities of gait and mobility, and dementia of unspecified severity, with other behavioral disturbance.The 10/14/25 MDS assessment revealed the resident was unable to participate in a BIMS exam. Staff assessment of the resident revealed the resident had short and long term memory problems. VII. Staff interviewsThe activities director (AD) was interviewed on 11/20/25 at 9:40 a.m. The AD said if residents were aggressive or combative, the activities staff would not interact with the residents. She said staff would try to reapproach the resident at a later time in the day to engage the resident in activities. The AD said residents who socially isolate or have behavioral concerns would be placed on the friendly visit program or on individual activity sessions. She said that despite Resident #1's aggressive behaviors, he did not receive friendly visits or one-to-one activities. The AD said Resident #2 was on the friendly visit program due to his aggressive behaviors; the activities department would meet with him three times a week for individual visits.The NHA, social services director (SSD) and director of nursing (DON) were interviewed together on 11/20/25 at 10:00 a.m. The SSD said the staff were expected to know the resident's care plans so they could appropriately intervene if a resident becomes aggressive. The SSD said that staff were encouraged to respond to aggressive residents by intervening in the situation, distracting the aggressor, and ensuring a safe environment for other residents.The SSD said that one staff member was expected to monitor the day room at all times to ensure resident safety. She said some residents have care plan orders to be line of sight in common areas for behavioral concerns. The NHA said if staff were needed in many places at once, the staff should use their best judgment to determine which situation needs their attention first or call for a manager to provide additional supportCNA #4 was interviewed on 11/19/25 at 9:13 a.m. CNA #4 said she did not know what was on Resident #1's care plan nor could she identify his specific behavioral triggers or interests. She said that he might become more agitated in the evening and in response to care assistance, but she wasn't sure. She said that if he became agitated, she would try to have one staff person interact with him, try to decrease stimuli, and notify the nurse. CNA #6 was interviewed on 11/19/25 at 12:30 p.m. CNA #6 said she had worked with Resident #1 for a while. She said that when he was agitated, she would try to de-escalate him. CNA #6 said an example was when Resident #1 was grumpy and kept trying to get out of his chair in the day room, she would encourage him to stay seated because he was a fall risk. She said he would calm down when she got him a snack. CNA #6 said that her other strategy for interacting with aggressive residents was to physically stand in the way to protect another resident. CNA #6 said Resident #2 used to become agitated frequently. She said that when he became agitated, she would offer him a snack and encourage him to watch television. CNA #7 was interviewed on 11/19/25 at 4:11 p.m. CNA #7 said she saw Resident #1 hit Resident #2 on 9/12/25.RN #3 was interviewed on 11/19/25 at 12:15 p.m. RN #3 said she had a lot of experience working with Resident #2. She said he needed a lot of redirection. She said sometimes, she would offer him a snack or a drink if he became irritable. She said it was often difficult to figure out why he was agitated and that sometimes she was able to help him and sometimes she was not.RN #3 said sometimes she would redirect him by encouraging him to sit in a recliner in the dayroom. She said that when it came to his specific likes and dislikes, she thought he might like western movies, but was not sure.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review the facility failed to provide necessary respiratory care and services, for one (#11) one resident out of 12 residents reviewed for oxygen therapy.Specifically the facility failed to:-Provide Resident #11 oxygen therapy as ordered; and,-Ensure the physician's order for Resident #11's oxygen therapy included the prescribed liter flow, method of delivery and duration of use. Findings include:I. Professional referenceAccording to the American Lung Association, Oxygen Therapy, updated 4/15/25, retrieved online 12/3/25 from https://www.lung.org/lung-health-diseases/lung-procedures-and-tests/oxygen-therapy Oxygen is a gas that is vital to human life. It is one of the gases that is found in the air we breathe. If you have a chronic lung disease, you may need additional (supplemental) oxygen for your organs to function normally.II. Facility policy and procedureThe Oxygen Therapy policy and procedure, reviewed on 12/16/24, was provided by the nursing home administrator (NHA) on 11/20/25. The facility policy read in pertinent part, It is the policy of the (Colorado State Veterans Nursing) that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician. Oxygen is administered under orders of a physician, except in the case of an emergency. In such a case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. Personnel authorized to initiate oxygen therapy include physicians, licensed nurses, and respiratory therapists. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to:-The type of oxygen delivery system.-Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered.-Monitoring for complications associated with the use of oxygen.III. Resident # 11A. Resident statusResident #11, age greater than 65, was admitted to the facility on [DATE]. According to the November2025 computerized physician's orders (CPO), diagnoses included diabetes, chronic kidney disease and chronic atrial fibrillationThe 10/6/25 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of 12 out of 15. The MDS did not indicate that the resident was oxygen dependent. -However, the resident was prescribed oxygen therapy on 11/18/25.B. ObservationsDuring a continuous observation on 11/18/25,from 1:40 p.m. to 3:20 p.m. Resident #11 was observed without oxygen, sitting in a recliner in the common area lounge. Certified nurse aide (CNA) #1 approached Resident #11 at 3:20 p.m., one hour and 40 minutes after the resident was first observed without oxygen and asked the resident where his oxygen was. CNA #1 then proceeded to leave the common area room and down the hall to the residents room. CNA #1 returned back to the common area and was looking around the area. CNA #1 assisted the resident with a transfer to the wheelchair with the assistance of CNA #2 and took the resident to his room. At 3:22 p.m. CNA #1 came back to the common area lounge to search for the resident's oxygen concentrator. After finding the resident oxygen concentrator in the common area CNA #1 rolled it down to the resident's room. At 3:40 p.m. CNA #1 assisted the resident to apply his oxygen by nasal cannula. Resident #11 was observed in bed with nasal cannula on.The resident was observed taking labored breaths between speaking his words. C. Record reviewThe resident's comprehensive care plan. initiated 6/27/23 and revised on 11/13/25, revealed no interventions for oxygen therapy. The November 2025 CPO revealed a physician's order for oxygen therapy: Oxygen therapy, titrate to keep oxygen saturation level above 90 percent, (normal blood oxygen levels are between 90 to100 percent, measured by a device placed on the finger) start date 11/18/25 at 7:00 a.m. -The order failed to include the prescribed liter flow, method of delivery and duration of use.V. Staff interviewsCNA #2 was interviewed on 11/18/25 at 3:42 p.m. CNA #2 said Resident #11's oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy order was new this morning as a result of the resident presented with poor respiratory status and low oxygen levels. CNA #2 said she was not aware of how many liters of oxygen was ordered. She said the resident did not refuse oxygen therapy. She reported residents who were oxygen dependent were checked on frequently to check for portable oxygen fill needs and to ensure they are on oxygen. CNA #1 was interviewed on 11/18/25 at 3:50 p.m. CNA #1 said Resident #11 only had night time oxygen and often refused day time oxygen. He reported the resident was without his oxygen during the observation to provide transfer assistance and reported he was unaware if daytime oxygen was needed. Registered nurse (RN) #5 was interviewed on 11/20/25 at 10:20 a.m. RN #5 said all oxygen orders should include a prescribed oxygen liter flow, method of delivery and duration of therapy. RN #5 said if the order did not provide all applicable details the floor nurse was to reach out to the prescribing physician to get a corrected order following the facility's template for required details of the order. The director of nursing (DON) was interviewed on 11/20/25 at 12:00 p.m. The DON said she contacted Resident #11's physician to obtain a corrected oxygen order with the proper ordered information included. She said the new physician's order read Oxygen: 2 LPM (liters per minute - oxygen flow) via nasal cannula, monitor oxygen saturations every shift and notify the physician if unable to maintain oxygen saturation greater than 90 percent.