STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065396	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinidad Rehabilitation and Healthcare Center	409 Benedicta Ave Trinidad, CO 81082

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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 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 residents were kept free from physical abuse for six (#3, #1, #7, #2, #5 and #6) of 9 residents reviewed for abuse out of nine sample residents.Specifically, the facility failed to: -Protect Resident #3 from physical abuse by Resident #4;-Protect Resident #1 from physical abuse by Resident #2;-Protect Resident #7 and Resident #2 from physical abuse by each other; and,-Protect Resident #5 and Resident #6 from physical abuse by each other.Findings include:I. Facility policy and procedureThe Abuse Investigating and Reporting policy, revised July 2017, was provided by the nursing home administrator (NHA) on 2/18/26 at 2:04 p.m. It read in pertinent part: All reports of resident abuse shall be reported and investigated by facility management.II. Incident of physical abuse of Resident #3 by Resident #4 on 9/25/25A. Facility investigationThe 9/25/25 facility investigation revealed that an altercation occurred between Resident #3 and Resident #4. The investigation revealed Resident #4 positioned his wheelchair next to Resident #3. Resident #3 asked Resident #4 not to run into her with his wheelchair. Resident #4 responded and struck Resident #3 on the face, and Resident #3's eyeglasses were bent, causing a laceration on the bridge of her nose. Resident #4 was placed on monitoring with observations every 15 minutes and moved to a room in another hallway. Resident #4 was prescribed sertraline (selective serotonin reuptake inhibitor) once a day for physical aggression.The investigation substantiated the incident of physical abuse. B. Resident #3 (victim)1. Resident statusResident #3, age greater than 65, was admitted on [DATE] and discharged home on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included dementia, anxiety and depression.The 9/1/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of seven out of 15.The assessment revealed Resident #3 required substantial to maximum assistance from staff for bed mobility and transfers, and was dependent on staff for walking. Resident #3 used a manual wheelchair for mobility.The assessment documented Resident #3 had no physical or verbal behaviors towards others. 2. Record reviewThe communication care plan, initiated 9/3/25, revealed Resident #3 had impaired communication. Pertinent interventions included allowing ample time for Resident #3 to comprehend what was said, allowing time for response and using simple and direct communication to promote understanding.The 9/25/25 nurse progress note revealed Resident #3 had an incident with another resident (Resident #4). Resident #3 sustained a 0.5 centimeter (cm) by 0.5 cm laceration on the right side of her nose and a 1.5 cm by 2.0 cm laceration on the left side of her nose. The progress note documented Resident #3 was transferred to the emergency department for evaluation and had no additional injuries. The lacerations were treated by the nurse with first aid.The 10/2/25 nurse progress note revealed the resident's lacerations were healing and Resident #3 denied pain from the lacerations.The 10/8/25 progress note revealed Resident #3 discharged home with her responsible party.C. Resident #4 (assailant)1. Resident statusResident #4, age less than (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 - Some	65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia, anxiety, a history of traumatic brain injury and epilepsy. The 12/2/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of six out of 15. The assessment revealed Resident #4 was dependent on staff for bed mobility and transfers. dressing. Resident #4 used a manual wheelchair for mobility.The assessment documented Resident #4 had no physical or verbal behaviors towards others.2. Record reviewThe physical aggression care plan, initiated 9/29/25, revealed Resident #4 had aggressive behavior by striking out towards another person. Pertinent interventions included educating about negative behavior, encouraging talking when frustrated or anxious, redirecting from others if behaviors were present, monitoring for signs of frustration, and escalating behaviors.The 9/29/25 nurse progress note revealed that a staff member observed Resident #4 raise his open hand towards Resident #3, but Resident #4 did not make contact with Resident #3. The progress note revealed the physician was contacted and gave a new order for sertraline 25 milligrams (mg), one time a day for physical aggression for eight days.III. Incident of physical abuse of Resident #1 by Resident #2 on 11/15/25 A. Facility investigationThe 11/15/25 facility investigation revealed Resident #1 exited her room as Resident #2 walked past her in the hallway. Resident #1 approached Resident #2 in an attempt to hold his arm and walk in the hallway. Resident #2 responded by pushing Resident #1, and Resident #1 lost her balance and fell to the ground. The investigation revealed staff intervened and separated Resident #1 and Resident #2. The nurse completed an assessment on Resident #1, who had a skin tear that was treated with first aid. Resident #2 had no injuries.The investigation revealed after the altercation, the staff separated the residents, and the staff monitored both residents every 15 minutes.The investigation substantiated the incident of physical abuse. B. Resident #1 (victim) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia and difficulty walking. The 2/12/26 MDS assessment revealed Resident #1 was unable to complete the BIMS assessment. Per the staff assessment for mental status, Resident #1 had severe cognitive impairment with daily decision making and had continuous inattention and disorganized thinking. The assessment indicated Resident #1 had no physical or verbal behavior symptoms during the assessment look-back period. 2. Record reviewThe wandering care plan, initiated 4/3/25, revealed Resident #1 wandered on the secured unit. Pertinent interventions included keeping Resident #1 safe during episodes of behaviors and monitoring and documenting episodes of inappropriate behaviors. The 11/15/25 nurse progress note revealed a staff member found Resident #1 on the floor. The nurse completed an assessment of a 6.0 cm by 1.5 cm skin tear on Resident #1's right forearm. C. Resident #2 (assailant)1. Resident statusResident #2, age greater than 65, was admitted on [DATE]. Diagnoses included Alzheimer's disease and dementia with behavioral disturbance.The 12/23/25 MDS assessment revealed Resident #2 was unable to complete the BIMS assessment. Per the staff assessment for mental status, Resident #2 was moderately cognitively impaired with daily decision-making. Resident #2 required supervision from staff for dressing, bed mobility, transfers, and walking.The assessment indicated Resident #2 had physical behaviors directed toward others for one to three days of the assessment look-back period.2. Record reviewThe dementia care plan, initiated 6/12/25, revealed Resident #2 lived in the secured unit for a therapeutic environment. Pertinent interventions included encouraging Resident #2 to avoid doorways to avoid injury when others entered and exited the secured unit The physical aggression care plan, initiated 12/1/24, revealed Resident #2 attempted to strike another resident when he felt threatened. Pertinent interventions included administering medications as ordered (12/1/24), redirecting when exhibiting behaviors (1/2/25), approaching Resident #2 in a calm manner (1/2/25) and providing a calm and safe environment (1/23/25).Review of Resident #2's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	electronic medical record (EMR) revealed there were no corresponding progress notes regarding the altercation with Resident #1 on 11/15/25.IV. Incident of physical abuse between Resident #7 and Resident #2 toward each other on 11/18/25A. Facility investigationThe 11/18/25 facility investigation revealed Resident #2 and Resident #7 were in the common area. Resident #2 lifted and swung his feet over the armrest of the chair. Resident #2's foot bumped Resident #7. Resident #7 pushed Resident #2's foot away, Resident #2 kicked Resident #7 in the leg and Resident #7 slapped Resident #2. The investigation revealed staff separated the residents immediately and Resident #2 was placed on one-to-one care for safety monitoring. The facility investigation revealed Resident #2 had a history of pushing others away if they touched him. The nurse assessed Resident #7 and found no injuries.The investigation substantiated the incident of physical abuse. B. Resident #2 (victim and assailant) 1. Record reviewReview of Resident #2's EMR revealed there were no corresponding nurse progress notes regarding the altercation with Resident #7 on 11/18/25.The 11/18/25 physician progress note revealed Resident #2 had refused medications. The physician and the interdisciplinary team (IDT) reviewed the resident's non-pharmacological and pharmacological interventions for physical aggression. The physician gave a new order for aripiprazole (antipsychotic) two milliliters (ml), every morning for dementia with behaviors. C. Resident #7 (victim and assailant) 1. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included schizoaffective disorder and depression.The 11/4/25 MDS assessment revealed Resident #7 had mild cognitive impairment with a BIMS score of 13 out of 15. Resident #7 required supervision or touching assistance from staff for bed mobility, transfers, dressing, and walking.The assessment indicated Resident #7 had no behavioral symptoms directed at others during the assessment look-back period. 2. Record reviewThe behavioral care plan, initiated 10/22/25, identified Resident #7 had an incident of misconduct with another resident. Interventions included providing one-to-one social services for decreased stimuli, discussing feelings and providing non-judgmental support, increasing sessions with the mental health provider and monitoring for mood and/or behavioral changes.Review of Resident #7's EMR revealed there were no corresponding progress notes regarding the altercation with Resident #2 on 11/18/25.V. Incident of physical abuse between Resident #5 and Resident #6 toward each other on 12/7/25A. Facility investigationThe 12/7/25 facility investigation revealed a staff member heard a male and a female resident yelling in the common area. Staff responded and observed Resident #5 and Resident #6 rolling away from each other in their wheelchairs.The investigation revealed staff separated the residents and monitored both residents every 15 minutes. The nurse completed assessments on both residents and determined Resident #6 had an abrasion above his right eye.The investigation substantiated the incident of physical abuse.B. Resident # 5 (victim and assailant) 1. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia and Wernicke's encephalopathy (a neurological condition caused by a vitamin deficiency). The 1/1/26 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 13 out of 15. Resident #5 required supervision and/or touching assistance for bed mobility, transfers, dressing, walking, and using a manual wheelchair for mobility.The assessment indicated Resident #5 had no behavioral symptoms directed at others during the assessment look-back period.2. Record reviewThe physical altercation care plan, initiated 12/7/25, included pertinent interventions for monitoring at 15-minute intervals (initiated 12/8/25), educating staff on protocol to report resident altercations (initiated 12/8/25) and redirecting from Resident #6 while in the smoking area (initiated 12/8/25).Review of Resident #5's EMR revealed there were no corresponding progress notes regarding the altercation with Resident #6 on 12/7/25.C. Resident #6 (victim and assailant) 1. Resident statusResident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#6, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included stroke, difficulty walking, and dementia.The 2/16/26 MDS assessment revealed Resident #6 had severe cognitive impairments with a BIMS score of six out of 15. Resident #6 required setup to maximum assistance from staff for dressing and bed mobility. Resident #6 was dependent on staff for transfers, was non-ambulatory, and required supervision/touching assistance for using a manual wheelchair.The assessment documented Resident #6 had verbal symptoms directed toward others for four to six days during the assessment look-back period.2. Record reviewThe behavior care plan, initiated 12/7/25, included pertinent interventions for monitoring at 15-minute intervals (initiated 12/8/25), educating staff on protocol to report resident altercations (initiated 12/8/25), redirecting from Resident #5 while in the smoking area (initiated 12/8/25), and monitoring the abrasion above the right eye (initiated 12/9/25). The wheelchair safety care plan, initiated 6/25/24, revealed Resident #6 was at risk for abuse from other residents due to running into others with his wheelchair. Pertinent interventions included intervening to avoid confrontations with others, redirecting to a safe area when agitated and administering medications as ordered.The 12/7/25 nurse progress note revealed staff heard Resident #6 and a female resident arguing in the lobby. Staff investigated and observed Resident #5 and Resident #6 self-propelling their wheelchairs away from each other. The 12/7/25 facility investigation revealed Resident #6 sustained an abrasion above his right eye during the altercation with Resident #5. The 12/8/25 nurse progress note revealed no concerns regarding the abrasion above the right eyebrow. The resident had no complaints of pain. The 12/8/25 progress note revealed the physician gave a new order to start Risperdal 0.5 mg, every day at bedtime for aggression. VI. Staff interviewsRegistered nurse (RN) #1 was interviewed on 2/18/26 at approximately 2:30 p.m. RN #1 said she had worked at the facility for one year. RN #1 said after she was hired, the facility provided abuse prevention training. RN#1 said staff training included monitoring all residents for potential for altercations. RN #1 said when residents had increased risk for altercations, behavior monitoring needs were documented in residents' care plans and also at each change of shift report. RN #1 said if residents were involved in altercations, it was facility policy to separate all the residents and to complete nursing assessments for any changes in conditions. RN #1 said it was the facility policy to place residents involved in altercations on close monitoring, every 15 minutes. The NHA, the director of nursing (DON) and the social services director (SSD) were interviewed together on 2/18/26 at 4:45 p.m. The NHA said after resident altercations, residents involved in altercations were separated and monitored closely, every 15 minutes, or sometimes one-to-one assignments were necessary if residents had increased agitation.The DON said after the altercation between Resident #3 and Resident #4, Resident #4 was transferred to another unit in the facility. The DON said the new room assignment was on a unit that had less stimuli, to avoid increased anxiety or agitation for Resident #4. The NHA said Resident #4 had no behavioral altercations towards others after he moved to his new room and after the physician adjusted his medications. The SSD said Resident #3 had no changes in her mood or behaviors after the altercation. The NHA said Resident #1 had behaviors of approaching other residents to walk with them. The NHA said Resident #1 had one-to-one monitoring when she was out of her room to prevent her from approaching and reaching out towards other residents. The DON said staff involved Resident #1 with their tasks to keep Resident #1 on one-to-one monitoring. The SSD said the physician adjusted medications for Resident #2 after he pushed Resident #1. The SSD said after Resident #2 had his medications adjusted, he had not had altercations with other residents.The NHA said after the altercation between Resident #6 and Resident #5, the common area furniture was rearranged to allow a greater passing area for residents in wheelchairs. The NHA said Resident #6 had updates to his (continued on next page)

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