STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A190	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Peaks Veterans Community Living Center	23500 US Highway 160 Walsenburg, CO 81089

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 (#1) of three residents reviewed for abuse out of six sample residents were kept free from abuse. Specifically, the facility failed to protect Resident #1 from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse Prohibition policy, revised January 2025, was provided by the nursing home administrator (NHA) on 6/18/25 at 3:24 p.m. The policy read in pertinent part, The policy of this facility is to make all efforts to protect its residents from abuse. The facility will educate staff and residents on how to avoid situations that may result in an abuse incident. The facility has implemented proactive rounding to identify any potential triggers that may lead residents to respond negatively to each other and to identify stimuli such as wandering residents. This proactive approach will promote a safe environment that is free of abuse and identify triggers that will help avoid abuse. II. Incident of physical abuse on 5/19/25 by Resident #2 towards Resident #1 A. Facility investigation The 5/19/25 facility investigation was received from the NHA on 6/18/25 at 11:22 a.m. The investigation documented that Resident #2 walked to Resident #1's doorway. Resident #1 told Resident #2 she could not enter his room. Resident #2 threw hot coffee on Resident #1. The investigation documented facility staff responded to the altercation and separated the residents. The nurse completed an assessment on both residents and documented that Resident #1 had a four centimeter (cm) by four cm red area on his right elbow from the hot coffee. Resident #2 had no injuries. (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	The facility investigation indicated physical abuse was substantiated. B. Resident #2 (assailant) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician's orders (CPO), diagnoses included Alzeheimer's disease and dementia. The 6/11/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. Resident #2 was dependent on staff for standing and required substantial to maximum assistance from staff for walking a distance of fifty feet. The MDS assessment documented the resident had no physical or behavioral symptoms directed towards others during the assessment look back period. 2. Record review The behavioral care plan, revised 5/19/25, revealed Resident #2 could injure other residents by lashing out, wandering into other residents' rooms and taking personal belongings. The care plan indicated Resident #2 had an episode of physical aggression when she wandered into another resident's room and threw hot coffee onto a resident. Pertinent interventions included placing door signs on other residents' doors to prevent her from wandering into their rooms (initiated 2/21/24), assisting the resident to designated areas to prevent wandering into other resident rooms (initiated 2/21/24), redirecting the resident immediately if observed wandering (initiated 2/21/24) and educating the resident not to throw items at others (initiated 5/19/25). The dementia care plan, revised 4/27/25, revealed Resident #2 had behaviors of invading others personal space and had unprovoked physical aggression towards others. Resident #2 had a history of taking food and throwing food related items at other residents. Interventions included Resident #2 was to be the last resident up for meals for close supervision when she was out of bed. Resident #2 was not to have coffee unless she was closely supervised (initiated 4/28/25). The 5/15/25 behavioral progress note, documented at 6:33 p.m., revealed Resident #2 had been wandering down hallways and entering other residents' rooms and taking their personal belongings. Immediate interventions included redirection, one-to-one observation and offering toileting, food and fluids. The nurse documented redirection and one-to-one observation was effective. The 5/19/25 behavioral progress note, documented at 2:52 p.m., revealed Resident #2 had been wandering into other residents' rooms for most of the day. Immediate interventions included redirection out of other residents' rooms to her room, one-to-one observation, offering toileting, food and fluids. The nurse documented Resident #2 was redirected to her room, which was effective. The 5/20/25 nurse progress note, documented at 4:07 p.m., revealed the nurse notified the physician Resident #2 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had increased behaviors. The physician gave a new order for gabapentin, 100 milligrams (mg) three times a day for behavior management of increased aggression. Review of Resident #2's electronic medical review (EMR) revealed Resident #2 was monitored for 72 hours after the altercation on 5/19/25 and no additional behaviors were documented. C. Resident #1 (victim) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included disorganized dementia, bipolar disorder (mental illness), anxiety, parkinsonism, and post-traumatic stress disorder (PTSD). The 5/14/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. Resident #1 was independent with standing and walking. The MDS assessment documented the resident had no physical and behavioral symptoms directed towards others during the assessment look back period. 2. Record review The 5/19/25. nurse progress note, documented at 2:51 p.m., revealed Resident #1 had slight redness noted to his right upper arm from the hot coffee that was thrown on him. Resident #1 denied pain or discomfort to the area of redness. The 5/20/25 nurse progress note, documented at 4:38 a.m., revealed Resident #1 had slight redness on his right arm where coffee was thrown on him. Resident #1 reported no pain to the area of redness. Review of Resident #1's EMR revealed the resident was monitored for 72 hours after the 5/19/25 incident and denied pain or feeling afraid of other residents. III. Staff interviews The director of nursing (DON) and the NHA were interviewed together on 6/18/25 at 2:35 p.m. The DON said Resident #2 had a history of wandering throughout the facility and throwing food items at other residents. The DON said Resident #2's care plan directed staff to monitor Resident #2 when wandering. The DON said on 5/19/25, staff assisted Resident #2 out of bed early and the resident wandered to Resident #1's room before staff were free to monitor Resident #2. The DON said Resident #2 should not have had hot coffee without staff supervision. The NHA said staff responded promptly to the altercation and separated Resident #1 and Resident #2 for safety. The NHA said Resident #1 had a red area on his arm from the hot coffee that did require medical attention. The NHA said after the altercation on 5/19/25 the facility updated Resident #2's care plan. The NHA said staff were educated to monitor Resident #2 whenever she was outside of her room. The NHA said after the 5/19/25 occurrence, Resident #2 had no additional aggressive behaviors.