STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A192	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Manor	561 W 1st St N Cheyenne Wells, CO 80810

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five of five certified nurse aides (CNA).Specifically, the facility failed to complete annual performance reviews for CNA #1, CNA #3, CNA #4, CNA #5 and CNA #6 in order to determine potential training needs. Findings include:I. Facility policy and procedureThe Performance Evaluation policy, undated, was provided by the nursing home administrator (NHA) on 10/28/25 at 3:51 p.m. It read in pertinent part, The performance evaluation process provides a means for discussing, planning and reviewing the performance of each employee. Performance expectations are set with employees and measured throughout the year. Performance Evaluation process is designed to help managers and their employees define their objectives and goals that align with the Mission, Vision, and Values of [NAME] Manor. Performance results are highlighted in the process and areas of development will include guidance for improvement. All employees are provided an annual performance review and consideration for merit pay increases as warranted.Performance reviews are done on an annual basis. In addition to the annual review, a supervisor may initiate a Performance Improvement Plan (PIP) if deterioration in performance has taken place or if the employee needs additional, specific direction. Evaluations are performed by immediate supervisors. Performance reviews allow employees an opportunity to provide input as part of the performance process.II. Record reviewAnnual performance reviews were requested on 10/28/25 at 10:10 a.m. for CNA #1 (hired 3/12/12), CNA #3 (hired 4/24/24), CNA #4 (hired 4/12/23), CNA #5 (hired 11/17/1998) and CNA #6 (hired 2/8/07).-The facility was unable to provide documentation indicated CNA #1, CNA #3, CNA #4, CNA #5 and CNA #6 had annual performance evaluations.The NHA said the five CNAs did not have annual performance reviews and had not completed annual in-service education based on the outcome of their reviews.III. Staff interviewThe NHA was interviewed on 10 /28/25 at 2:29 p.m. The NHA said the facility did not conduct annual performance reviews. She said the CNA raises were based on the cost of living and decided by the board of directors. She said performance evaluations were not conducted and regular in-service education based on the outcome of the reviews was not provided.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain a system of documenting grievances and demonstrating prompt action for one (#17) of four residents reviewed for grievances out of 17 sample residents. Specifically, the facility failed to effectively address, resolve and demonstrate the facility's response to individual grievances for Resident #17.Findings include:I. Facility policy and procedureThe Grievance policy, undated, was provided by the nursing home administrator (NHA) on 10/29/25. It read it pertinent part, The person designated to resolve complaints will confer with persons involved in the incident and other relevant persons within three days of the grievance and shall provide a written explanation of the findings and proposed remedies to the complainant. Where appropriate due to a mental or physical condition of the complainant or aggrieved party, an oral explanation shall accompany the written ones. II. Resident #17A. Resident statusResident #17, age greater than 75, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included anxiety, osteoarthritis of the right shoulder and unspecified dementia. The 10/20/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment revealed the resident required moderate staff assistance with dressing, transfers, and bathing. B. Resident interviewResident #17 was interviewed on 10/27/25 at 1:45 p.m. Resident #17 said her toilet was too low and she needed a toilet seat riser to use her toilet comfortably. She said she had requested a toilet seat riser from the facility for a few months but had not received one and had reported this grievance at least three times. Resident #17 said she had also filed a grievance about her window blinds that she was unable to close because she could not raise her arms. She said she had requested curtains so she could let light in or block the light. Resident #17 said she had also filed a grievance regarding the activities assistant because the assistant would set up an activity and then leave the activity.-During the interview with Resident #17 in her room, no toilet seat riser or curtains were observed. C. Record reviewThe comprehensive care plan, revised 7/29/25, the resident had complaints of pain in her wrists and hands due to chronic arthritis, right wrist carpal tunnel syndrome and osteoarthritis in both shoulders. Interventions, dated 7/29/25, included providing the resident with one person staff assistance with activities of daily living (ADL). A review of Resident #17's electronic medical record (EMR) failed to reveal documentation indicating Resident #17's grievances had been addressed.On 10/29/25 at 9:45 a.m., grievances submitted for Resident #17 were requested from the social services director (SSD). The facility was unable to provide any grievances from the resident.III. Staff interviewsThe SSD was interviewed on 10/29/25 at 1:00 p.m. The SSD said the facility's process for grievances was that when a resident had a grievance, the resident was encouraged to report the concern to the SSD. She said she then would talk to the resident, family, and any staff that were involved and take the concern to the department manager who was responsible for the department pertaining to the grievance. The SSD said depending on the grievance, she would also offer to schedule a meeting with the third party resident advocate. The SSD said she did not use formal grievance forms and the facility did not have specific grievance forms. She said she would type up the details of the resident's grievance in a word document and save the documentation. She said if another department resolved the grievances, the SSD would include in her word document what the department manager did to resolve the grievance. The SSD said there was no written documentation provided to the resident or complainant and no documentation was signed by the resident or complainant to show a resolution was provided. The SSD said she did not have any written grievances for Resident #17. She said the facility had provided the resident with a new toilet and several different toilet risers, but she said there was no documentation of that. She said she was unaware of any grievances for Resident #17 related to the window or activities. The NHA was (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed on 10/29/25 at 1:45 p.m. The NHA said the facility did not have a formal grievance process which included grievance forms for complainants to complete and documentation to be provided back with the resolution. She acknowledged the facility needed to improve their process to ensure grievances were documented, responded to timely, and resolved in a satisfactory way for the complainant.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#12) of three residents reviewed for abuse out of 17 sample residents were free from abuse. Specifically, the facility failed to protect Resident #12 from caregiver neglect when a staff member refused to provide the resident care.Findings include:I. Facility policy and procedureThe Resident Abuse policy, undated, was provided by the nursing home administrator (NHA) on 10/27/25 at 12:21 p.m. It read in pertinent part, During an active investigation any employee who is an 'alleged perpetrator' will be immediately suspended without pay and sent home until an investigation is completed. II. Resident #12A. Resident statusResident #12, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury, vascular dementia and stroke. The 8/13/25 minimum data set (MDS) assessment revealed Resident #12 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The resident required moderate to extensive staff assistance with activities of daily living (ADL) and required a mechanical lift to transfer from the bed, chair, or toilet. Resident #12 had impairments to his right side with a contracture to the right hand related to his stroke. B. Resident and resident's representative interview Resident #12's spouse was interviewed on 10/28/25 at 2:15 p.m. He said in September 2025, he went to the nurses' station and certified nurse aide (CNA) #1 was at the nurses' station with registered nurse (RN) #3. He said when he asked CNA #1 to transfer Resident #12, she ignored him and refused to transfer Resident #12 even after being asked by RN #3. He said CNA #1 used profanity at him when he complained about her not providing care to Resident #12. He said RN #3 had to find another CNA to transfer Resident #12.Resident #12 was interviewed on 10/29/25 at 9:00 a.m. Resident #12 said he did not like the drama between his spouse and the staff. He said he just wanted to go home with his spouse and became emotional. He said he no longer wanted to discuss the incident. C. Record reviewThe ADL care plan, revised 8/19/25, revealed Resident #12 had an ADL deficit related to a stroke and required staff assistance for transfers with a mechanical lift. III. Staff interviewsRN #3 was interviewed on 10/29/25 at 11:08 a.m. RN #3 said on 9/4/25, Resident #12's spouse came to the nurses' station and asked CNA #1 to transfer Resident #12 from his recliner. RN #3 said that CNA #1 ignored the spouse twice. RN #3 said when the spouse told RN #3 that CNA #1 had ignored him, she asked CNA #1 to go and transfer Resident #12. RN #3 said CNA #1 replied that she was busy charting notes. RN #3 said Resident #12's spouse then became upset and said he was going to report CNA #1. She said CNA #1 responded by using profanities and telling the spouse she did not care what he did and she would do what she wanted. RN #3 said she had to find a different CNA to provide care to Resident #12, because CNA #1 was unwilling to assist. RN #3 said if a caregiver refused to provide care to a resident, that would constitute neglect. She said she reported the incident to the director of nursing (DON) right after she ensured Resident #12 was transferred. CNA #1 was interviewed on 10/29/25 at 12:19 p.m. CNA #1 said that Resident #12's spouse had previously accused her of being mean to the resident and yelling at him, so she would not interact with the spouse any longer. CNA #1 said that when the spouse would come into the facility, he would direct her to do things for the resident. She said she was aware of her responsibilities, therefore she would ignore him. She said she felt after he made accusations against her, she had the right to not respond to him. CNA #1 said that she did not have to speak to anyone that she did not want to speak to and she had the right to choose to ignore him when he spoke to her. She said on the day of the incident, the spouse had come to the nurses' station demanding that she transfer Resident #12 and she told the nurse she would transfer the resident. CNA #1 said she did ignore the spouse initially, but after being asked by the nurse, she went to complete the transfer. -However, according to interviews with, RN #3 and the DON two other CNAs completed the transfer, because CNA #1 refused to provide assistance. CNA #1 said there was never an investigation done against her, nor at any time was she ever (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspended or removed from providing care to Resident #12.The social services director (SSD) was interviewed on 10/29/25 at 1:00 p.m. She said the facility's process for investigating potential resident abuse included interviewing other residents to determine if they had experienced anything similar to the allegation, interviewing all the employees present along with any other employees that may have worked in the same area and suspending the employee alleged in the abuse. The SSD said the reason for suspending any employees that had been named in an abuse allegation was to ensure the resident's safety and that no retaliation would occur. The SSD said the definition of caretaker neglect was not giving the resident care to ensure their well-being and safety. The SSD said if an employee refused to provide care to a resident, that would constitute caretaker neglect. The SSD said she had not been notified of CNA #1 refusing to provide care to Resident #12. She said if she had been notified, she would have investigated the incident as potential abuse to determine if CNA #1 had refused to care for any other residents. She said using profanity at a family member and refusing to provide care was not a customer service issue but potential neglect of a resident's needs. The NHA and the DON were interviewed together on 10/29/25 at 1:45 p.m. The DON said that staff received abuse training during their onboarding and annually. She said examples of caregiver neglect included ignoring call lights, not providing care that was needed and not responding to a resident's needs. The DON said if a caregiver responded to a write-up or a complaint by lashing out or not taking care of the resident involved, this would be considered retaliation. The DON said there had been a build up of negativity between CNA #1 and Resident #12's spouse. The DON said the two did not get along. She said on 9/4/25, the spouse came to the front desk and asked CNA #1 for assistance transferring Resident #12. The DON said CNA #1 did not respond to him. The DON said when the spouse told her he was going to file a compliant, CNA #1 began using profanity and told him she did not care what he did. She said two other CNAs went to assist Resident #12. The DON said CNA #1 had told her that she did not want to have contact with the spouse because of disagreements the two have had in the community outside of the facility. The DON said CNA #1 expressed she did not want anything to do with the spouse. She said CNA #1 was never suspended, investigated, or removed from Resident #12's hall. The DON said the potential impact of CNA #1 refusing to respond to Resident #12's spouse when he requested care for the resident was that the resident may not receive care or his care may be delayed.The NHA said the facility's process when suspected abuse of any kind occurred was to suspend the potential staff involved, interview other staff and interview other residents that the staff member may have been providing care for. She said after the disciplinary write up on 9/4/25 with CNA #1, the facility checked in with Resident #12 to ensure he was receiving care from CNA #1. The NHA said the facility also checked in with the staff. She said there had not been an investigation regarding the incident on 9/4/25. The NHA said the staff and other residents were not interviewed to determine if this was a pattern or if there had been other potential victims, because she had viewed the incident as a customer service issue. The NHA said the refusal to provide care should have been treated as potential neglect and the facility should have conducted an investigation.