STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065139	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society -- Loveland Village	2101 S Garfield Ave Loveland, CO 80537

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident's representative about a change in condition. Specifically, the facility failed to ensure staff reported a change in condition to the resident representative for Resident #1.Findings include: I. Facility policy and procedureThe Interact-Change in Condition Evaluation policy, revised [DATE], was provided by the nursing home administrator (NHA) of the campus on [DATE] at 12:58 p.m. It revealed in pertinent part, Before completing a change in condition evaluation, review the resident's medical record including diagnosis, medications, recent progress notes from a medical doctor/nurse practitioner/physician's assistant (MD/NP/PA) and consultants, as well as the most recent interdisciplinary notes. Check with other staff members who have regular contact with the resident to obtain an accurate picture of the change in condition. Staff members who can provide useful information about the situation include the nursing assistants, rehabilitation staff members, social workers and activity staff members. Environmental staff members may be able to provide useful information about the situation, as well as others such as family members, visitors, chaplains and beauticians. Review advance directives if available. A conversation with a family member or healthcare proxy may be needed to clarify advance directives.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and expired on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included unspecified dementia, dysphagia (difficulty swallowing) and anxiety. The [DATE] minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) score of five out of 15. She required maximal assistance with toileting and dressing and moderate assistance with mobility. C. Record reviewA nursing progress note on [DATE] documented that Resident #1 complained of right leg pain. A nursing note on [DATE] documented that Resident #1 was yelling out, had a furrowed brow and was complaining of left hip pain. It documented that as needed (PRN) Tylenol and aspercreme with Lidocaine was administered. A review of Resident #1's hospice notes from [DATE] documented that the hospice provider added as needed morphine to Resident #1's plan of care and the hospice nurse spoke to Resident 1's daughter (representative). A review of Resident 1's hospice notes from [DATE] documented that Resident #1's nurse called the hospice nurse to notify her of Resident #1's increase in pain in her left hip that radiated down to her groin. There was a new order of morphine placed at this time. A review of Resident 1's hospice notes from [DATE] documented that Resident #1 had a noticeable outward rotation of her right leg and when asked if she was in pain, she stated no. When the nurse initiated inward rotation of the right leg, Resident #1 winced and grimaced and had noticeable non-verbal signs of pain. It documented that Resident #1 had not been out of bed in about a week and that Resident #1 had pain with cares and rolling in bed and the facility staff were pre-medicating with morphine prior to care. -However, review of Resident #1's electronic medical record (EMR) did not reveal documentation regarding the facility discussing the resident's increased pain or reviewing treatment decisions with the resident or her representative. D. Staff interviewsLicensed practical nurse (LPN) #3 was interviewed on [DATE] at 4:35 p.m. She said Resident #1 had dementia and would sundown (increased confusion) in the evening. LPN #3 said Resident #1 required one person assistance for (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walking with her walker. She said Resident #1 never complained of pain. LPN #3 said around the beginning of February 2026, Resident #1 stopped getting out of bed and complained of pain in her left side. Certified nurse aide (CNA) #2 was interviewed on [DATE] at 4:40 p.m. She said Resident #1 was slightly confused, but pleasant. CNA #2 said Resident #1 walked and would often get up and try to do things on her own, although she required one person to assist her. She said if Resident #1 needed something, instead of using her call light, she would scream out for help. CNA #2 said she heard about a potential fall Resident #1 had in February 2026. CNA #2 said after that potential fall when she was working with Resident #1, she tried to get her up and Resident #1 heavily favored her right side. She said CNA #2 had to help support Resident #1's left side because it was so weak. CNA #2 said Resident #1 screamed out in pain and complained of pain in her left hip and leg after the incident of a potential fall. CNA #2 said she would tell the nurse when Resident #1 was experiencing pain. CNA #3 was interviewed on [DATE] at 4:50 p.m. She said Resident #1 was very confused and thought she could do things by herself. CNA #3 said Resident #1 required assistance for activities of daily living. She said she walked with her walker and supervision from staff. CNA #3 said Resident #1 needed encouragement to eat her meals. CNA #3 said she had heard about a potential fall and noticed after that incident, Resident #1 experienced a lot of pain. CNA #3 said she could tell by the grimace on her face at all times. CNA #3 said Resident #1 would try to sit up in bed but it would hurt too badly. CNA #3 said she did not see Resident #1 get out of bed once she started having the pain. CNA #3 said she told the nurse right away when she saw Resident #1 was in pain. -Review of the resident's EMR revealed documentation that the resident had pain in her left and right leg. The DON, the nurse manager and the NHA of the campus were interviewed on [DATE] at 1:25 p.m. The DON said the steps taken when a resident falls included assessing the resident, notifying the provider, notifying the resident representative, hospice agency if applicable, and management, complete neurological checks, create a safe event (incident report), huddle with the CNAs working and create an intervention and follow any additional orders from the provider. She said the interdisciplinary team (IDT) reviewed it the next day and changed the intervention if needed. The nurse manager said they reviewed the fall as an IDT a week post fall to ensure the intervention was successful. The DON said when she was made aware of Resident #1 potentially having a fall, she mentioned it to the provider. She said Resident #1's representative was notified and offered to evaluate and treat the resident further. The DON said the representative declined. The DON said it was the responsibility of the hospice provider and the nurse at the facility to discuss who was going to contact the resident's representative and in this case the hospice nurse spoke to the representative when there was an increase in pain and morphine was needed. -However, there was no documentation that the resident's representative was notified of the resident's increase in pain.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident's provider about a change in condition. Specifically, the facility failed to ensure staff reported a change in condition to the resident's provider for Resident #1.Findings include: I. Facility policy and procedureThe Interact-Change in Condition Evaluation policy, revised [DATE], was provided by the nursing home administrator (NHA) of the campus on [DATE] at 12:58 p.m. It revealed in pertinent part, Before completing a change in condition evaluation , review the resident's medical record including diagnosis, medications, recent progress notes from a medical doctor/nurse practitioner/physician's assistant (MD/NP/PA) and consultants, as well as the most recent interdisciplinary notes. Check with other staff members who have regular contact with the resident to obtain an accurate picture of the change in condition. Staff members who can provide useful information about the situation include the nursing assistants, rehabilitation staff members, social workers and activity staff members. Environmental staff members may be able to provide useful information about the situation, as well as others such as family members, visitors, chaplains and beauticians. Review advance directives if available. A conversation with a family member or healthcare proxy may be needed to clarify advance directives.As the Change in Condition Evaluation is completed, questions will appear based on information entered. The INTERACT Care Paths and Change in Condition File Cards have been incorporated into the Change in Condition Evaluation. These decision support tools are designed to assist in evaluating the resident's condition, collecting information that will allow and will help the provider/practitioner to make the best possible decision regarding the resident's condition.Notify the provider of the change in condition as indicated by the Notifications hyperlink.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and expired on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included unspecified dementia, dysphagia (difficulty swallowing) and anxiety. The [DATE] minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) score of five out of 15. She required maximal assistance with toileting and dressing and moderate assistance with mobility. C. Record reviewA nursing progress note on [DATE] documented that Resident #1 complained of right leg pain. A nursing note on [DATE] documented that Resident #1 was yelling out, had a furrowed brow and was complaining of left hip pain. It documented that as needed (PRN) Tylenol and aspercreme with Lidocaine was administered. A review of Resident 1's hospice notes from [DATE] documented that Resident #1's nurse called the hospice nurse to notify her of Resident #1's increase in pain in her left hip that radiated down to her groin. There was a new order of morphine placed at this time. A review of Resident 1's hospice notes from [DATE] documented that Resident #1 had a noticeable outward rotation of her right leg and when asked if she was in pain, she stated no. When the nurse initiated inward rotation of the right leg, Resident #1 winced and grimaced and had noticeable non-verbal signs of pain. It documented that Resident #1 had not been out of bed in about a week and that Resident #1 had pain with cares and rolling in bed and the facility staff were pre-medicating with morphine prior to care. -However, there was no documentation that the facility contacted Resident #1's physician regarding the increase in pain. D. Staff interviewsLicensed practical nurse (LPN) #3 was interviewed on [DATE] at 4:35 p.m. She said Resident #1 had dementia and would sundown (increased confusion) in the evening. LPN #3 said Resident #1 would get up and walk with one assist and her walker. She said she never complained of pain. LPN #3 said around the beginning of February 2026, Resident #1 had stopped getting out of bed and complained of pain in her left side. -However, review of Resident #1's electronic medical record (EMR) did not reveal documentation indicating the physician was notified that the resident was not getting out of bed as often due to the increased pain.Certified nursing aide (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA) #2 was interviewed on [DATE] at 4:40 p.m. She said Resident #1 was slightly confused, but pleasant. CNA #2 said Resident #1 walked and would often get up and try to do things on her own, although she required one assist. She said if Resident #1 needed something, instead of using her call light, she would scream out for help. CNA #2 said she heard about a potential fall Resident #1 had in February 2026. CNA #2 said after that potential fall when she was working with Resident #1, she tried to get her up and Resident #1 heavily favored her right side and CNA #2 had to help support Resident #1's left side because it was so weak. CNA #2 said Resident #1 screamed out in pain and complained of pain in her left hip and leg after the incident of a potential fall. CNA #2 said she would tell the nurse when Resident #1 was experiencing pain. CNA #3 was interviewed on [DATE] at 4:50 p.m. She said Resident #1 was very confused and thought she could do things by herself. CNA #3 said Resident #1 required assistance for activities of daily living. She said she walked with her walker and supervision from staff. CNA #3 said Resident #1 needed encouragement to eat her meals. CNA #3 said she had heard about a potential fall and noticed after that incident, Resident #1 experienced a lot of pain. CNA #3 said she could tell by the grimace on her face at all times. CNA #3 said Resident #1 would try to sit up in bed but it would hurt too badly. CNA #3 said she did not see Resident #1 get out of bed once she started having the pain. CNA #3 said she told the nurse right away when she saw Resident #1 was in pain. -Review of the resident's EMR revealed documentation that the resident had pain in her left and right leg. The DON, the nurse manager and the NHA of the campus were interviewed on [DATE] at 1:25 p.m. The DON said the steps taken when a resident falls included assessing the resident, notifying the provider, notifying the resident representative, hospice agency if applicable, and management, complete neurological checks, create a safe event (incident report), huddle with the CNAs working and create an intervention and follow any additional orders from the provider. She said the interdisciplinary team (IDT) reviewed it the next day and changed the intervention if needed. The nurse manager said they reviewed the fall as an IDT a week post fall to ensure the intervention was successful. The DON said when she was made aware of Resident #1 potentially having a fall. She said she mentioned it to the provider. -However, there was no documentation that the resident's physician was notified of an increase in pain.

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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 protect one (#3) of three residents reviewed for abuse out of eight sample residents. Specifically, the facility failed to ensure Resident #3 was kept free from physical abuse from Resident #2. Findings include:I. Facility policy and procedureThe Abuse and Neglect policy and procedure, revised 4/7/25, was provided by the nursing home administrator (NHA) of the campus on 4/2/26 at 12:03 p.m. It read in pertinent part, The resident/client has the right to be free from abuse, neglect, misappropriation of resident/client property and exploitation. Residents/clients must not be subjected to abuse by anyone, including, but not limited to, location employees, other residents/clients, consultants or volunteers, employees of other agencies serving the individual, family members or legal guardians, friends or other individuals. II. Incident of physical abuse between Resident #3 and Resident #2 on 2/14/26A. Facility investigationThe 2/14/26 abuse investigation documented there was a physical altercation between two residents (Resident #2 and Resident #3). The residents were separated and assessed. Resident #3 had discoloration on her hands. Resident #2, Resident #3 and other resident witnesses were interviewed. Resident #2 and Resident #3 were placed on hourly checks. Resident #3 was interviewed on 2/14/26. Resident #3 said Resident #2 told her there was not enough room for her at the table. Resident #3 said Resident #2 shook his fists at Resident #3. Resident #3 said Resident #2 said just try it, just do it. Resident #3 said Resident #2 grabbed her hands and squeezed them for about two minutes. Resident #3 reported left hand pain of 7 out of 10. She said it felt like pinched nerve pain and shocks going up and down. Resident #3 stated she was not fearful of Resident #2 and that she wanted to go after him. Resident #3 thought Resident #2's actions were purposeful and he was a grouchy old man. Resident #3 stated Resident #2 meant to hurt her. The investigation documented Resident #3 was educated to always inform staff of any event or if she was uncomfortable in any situation. Resident #2 was interviewed on 2/14/26. Resident #2 stated that Resident #3 was crowding his space and there was not enough room for her. Resident #2 stated Resident #3 was not supposed to be there unless welcomed there. Resident #2 reported Resident #3 grabbed his hands and he grabbed Resident #3's hands. He said he could not remember who grabbed whose hands first. Resident #2 stated it was a little scuff. Resident #2 denied any pain or discomfort and did not think Resident #3 had pain or discomfort that he knew of. Resident #2 stated that he tried to get away and that there was a reason for everything. The investigation documented Resident #2 was educated to use communication and to notify staff of concerning events. The investigation documented Resident #8 was interviewed on 2/14/26. Resident #8 said Resident #2 and Resident #3 were goofing off. Resident #8 stated that Resident #2 took it to another level and got mad. Resident #8 stated Resident #2 grabbed Resident #3's left hand and twisted it using his other hand also. Resident #8 stated Resident #2 looked like he was going to punch Resident #3. Resident #8 stated that Resident #2 took it too far and there was not much conversation but just physical contact. Resident #8 stated Resident #2 was trying to show off his mighty man strength. Resident #8 reported Resident #3 laughed at him and that it was all Resident #2's doing. Resident #8 reported that he should have stopped it. Three nurses and five certified nurse aides (CNA) that were working on 2/14/26 were interviewed and nobody had witnessed the altercation. The investigation documented physical contact occurring between the two residents was substantiated. It was determined that it was a spontaneous conflict between both residents which was not predictable to occur and then escalated. It was determined to be an isolated incident and there were no threatening behaviors noted from these residents toward each other in the past. III. Resident #3 - victim A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included schizoaffective disorder (bipolar type), anxiety and depressive episodes. The 12/31/25 minimum data set (MDS) assessment (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was independent with activities of daily living (ADL) and mobility and required one-person assistance for showering. The MDS assessment documented no behaviors for Resident #3. B. Resident interviewResident #3 was interviewed on 4/1/26 at 1:20 p.m. Resident #3 said Resident #2 and Resident #8 were sitting in the common area together at a table. She said she went up to them because she wanted to talk with Resident #8. She said Resident #2 started to shake his fists at her and said there was not enough room for her. She said to Resident #2 to go ahead and try it. She said Resident #2 grabbed her hands and started squeezing them hard. She said he finally let go. She said one of the CNAs had seen it and reported it to her nurse. She said three of her fingers went numb and it took a couple weeks to get the feeling back in them. She said she was wearing a ring on one of her fingers and it dug into her hand. She said she tried to report it to her nurse and the nurse had told her she already knew about it from the CNAs report and would not let her report it to the nurse. She said the social worker came in the following Monday and Resident #3 had reported to her that she wanted to file a restraining order against Resident #2. She said the social services worker had said it was not worth them coming out for. Resident #3 said another nurse had told her to stay away from Resident #2. She said she tried to stay away from Resident #2 in the hallway and common areas. She said Resident #2 used to sit at her table prior to the incident and he would sometimes sass her and call her names, which she reported to staff. C. Record reviewThe mental health care plan, initiated on 2/17/26, revealed Resident #3 had diagnoses of bipolar disorder and schizoaffective disorder. The care plan documented the resident had poor self-awareness and boundaries and could be intrusive with others leading to frustration among peers. Interventions included removing the resident to a calm, safe environment and allowing the resident to vent/share feelings (initiated 2/17/26), observing for stressors which may be early warning signs of problem behavior (initiated 2/17/26), providing the resident with as many choices as possible which gives control over the resident's environment and care delivery (initiated 2/17/26), consulting with pastoral care and psychologist (initiated 2/17/26), assisting with identifying healthy/appropriate boundaries with peers (initiated 2/17/26) and monitoring interactions with peers and assist in redirecting and de-escalating as needed (initiated 2/17/26). The interdisciplinary team (IDT) note, dated 2/14/26, documented that the IDT reviewed the incident from 2/14/26 from 4:30 p.m. It documented a potential abuse or injury of unknown source. It documented that Resident #3's left hand was squeezed hard by another resident (Resident #2). Resident #3 sat too close to Resident #2 and Resident #2 was not okay with Resident #3 being so close and squeezed her hand. The staff ensured both residents were kept separate and that both residents were safe. Resident #3's family/responsible party and the physician were notified of the incident. A trauma assessment completed on 2/17/26 documented that Resident #3 was still feeling really upset about how Resident #2 treated her. Resident #3 stated she had bruising on her finger and three of her fingers were still tingling. A skin assessment completed on 2/22/26 documented that Resident #3 had resolving bruising to the back of both hands. IV. Resident #2 - assailant A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included chronic venous insufficiency, osteoarthritis, type 2 diabetes and mild cognitive impairment of uncertain or unknown etiology. The 12/31/25 MDS assessment documented the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. He required one assist with mobility and ADLs. The assessment documented that he had no behaviors. B. Observations and resident interviewOn 4/1/26 at 1:50 p.m. Resident #2 was sitting in his wheelchair in the common area next to a side table. He was moved into his room and interviewed. Resident #2 said he did not get along with Resident #3 because she was obnoxious. He said he remembered the incident with Resident #3 a couple months ago. He said Resident #3 was trying to get between him and another resident that he was talking with. He said he cleared it up and got her out of the way. He said he wanted her to know he was in control and that was why he squeezed her hands. He said he did not remember who grabbed whose hands first. C. Record reviewThe care plan, initiated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/16/24 and revised 2/17/26, documented Resident #2 had behavior symptoms related to advanced aging, poor impulse control, diminished filter based on antagonist behaviors toward his roommates and peers, verbal and physical aggression, argumentative, egging on of others and frequent complaints about others. Pertinent interventions included intervening as necessary to protect the rights and safety of others (initiated 8/9/24), providing opportunity for positive interaction (initiated 8/9/24), educating and assisting the resident to develop more appropriate methods of coping and interacting such as removing himself from the situation when frustrated and seeking assistance from staff to resolve conflicts with peers (initiated 2/17/26), monitoring the resident's interactions with peers, redirect, deescalate and separate from peers as needed (initiated 2/17/26), discussing the resident's behaviors if reasonable (initiated 2/17/26), praising any indication of his progress (initiated 8/9/26) and monitoring him during the shift for sexually inappropriate behaviors (initiated 1/16/24). V. Additional resident interviews Resident #8 was interviewed on 4/1/25 at 1:35 p.m. He said himself and Resident #2 were sitting next to each other at a table in the common area. He said Resident #3 came up to them and Resident #3 and Resident #2 exchanged a few words. He said Resident #2 had Resident #3's hand and he squeezed her hand. He said Resident #2 looked really mad and he looked like he wanted to hurt Resident #3. Resident #8 said to let her go and Resident #2 let go. He said it caused an injury to Resident #3's hand and that she was wearing a ring that dug into her hand. He said a staff member came and talked to him about what happened but he did not remember who it was. He said Resident #2 had a habit of grabbing mostly women's hands as they walked by him and holding their hand. He said sometimes the women would have to shake their hands to get them away from Resident #2. VI. Staff interviewsRegistered nurse (RN) #1 was interviewed on 4/1/26 at 2:05 p.m. RN #1 said she was the nurse working the day of the physical altercation between Resident #2 and Resident #3. RN #1 said Resident #2 had a usual spot where he preferred to sit in the common area that was next to a small table. RN #1 said a CNA had asked RN #1 if she had heard about what happened between Resident #2 and Resident #3 and told RN #1 about what she had heard. RN #1 said she made sure the two residents were separated and safe. She said an activities assistant had rearranged the common area furniture so that the table near where Resident #2 usually sat, was moved. She said she moved the furniture back in its place. She said a while back, Resident #2 was involved in another physical altercation in which she noticed the tables had been moved out of place. She said she moved them back into place if she noticed them being out of place and tried to keep others from getting too close to Resident #2. She said she talked to the director of nursing (DON) about this trigger for Resident #2. CNA #1 was interviewed on 4/2/26 at 8:40 a.m. CNA #1 said Resident #2 could be possessive of things he believed were his. She said an example of this was that he got possessive of the newspaper each day thinking that it belonged to him and would get upset if someone tried to take it. She said he preferred to sit in his usual spot in the living room in the corner next to the table. She said he liked to grab women's hands as they walked by him and hold their hand. She said Resident #3 did not really come out to the common area much. She said Resident #3 was independent with most things and would call staff if she needed assistance.The DON, the nurse manager, NHA of the campus and the social services director (SSD) were interviewed together on 4/2/26 at 1:25 p.m. The DON said a couple years ago Resident #2 had a history of sexual behavior with a roommate. She said he liked to sit in the common area and talk with people. She said Resident #3 had squeezed herself between Resident #2 and Resident #8 at a small round table where they were sitting. She said the root cause of the incident was due to Resident #3 wanting to sit next to Resident #8. The nurse manager said Resident #2 and Resident #3 were educated to tell staff to help them if they were uncomfortable and they made sure the residents were separated. She said the SSD checked in on them periodically after the incident. She said Resident #3 had a small bruise to her finger. The SSD said she reported the incident between Resident #2 and Resident #3 to the police, adult protective services (APS) and the state initially. She said when she checked in with Resident #3 and completed her trauma assessment a couple days after the incident, Resident #3 was scared of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065139	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society -- Loveland Village	2101 S Garfield Ave Loveland, CO 80537

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 and avoided him in the common areas. She said she offered support through her psychologist and said Resident #3 had a lot of good peer support. She said when she checked in with Resident #2, he said he did not know why everyone was making a big deal about it. She said even though Resident #2 did not have a diagnosis of dementia, his memory ebbed and flowed but at the time of the incident, he acknowledged that it happened.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for one (#1) of three residents reviewed for neglect out of eight sample residents.Specifically, facility staff failed to report an allegation of injury of an unknown origin to the facility's abuse coordinator and the State Agency. Findings include: I. Facility policy and procedureThe Abuse and Neglect policy and procedure, revised [DATE], was provided by the nursing home administrator (NHA) of the campus on [DATE] at 12:03 p.m. It read in pertinent part, The purpose is to ensure that all identified events of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the event, or sooner as designated by state law. If the alleged or suspected violation is verified, appropriate corrective action will be taken.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and expired on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included unspecified dementia, dysphagia (difficulty swallowing) and anxiety. The [DATE] minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. She required maximal assistance with toileting and dressing and moderate assistance with mobility. B. Record review A nursing progress note, dated [DATE], documented that Resident #1 complained of right leg pain. A nursing note, dated [DATE], documented that Resident #1 was yelling out, had a furrowed brow and was complaining of left hip pain. It documented that as needed (PRN) Tylenol and aspercreme with Lidocaine was administered. A review of Resident 1's hospice notes from [DATE] revealed that Resident #1's nurse called the hospice nurse to notify her of Resident #1's increase in pain in her left hip that radiated down to her groin. There was a new physician's order for morphine placed at this time. A review of Resident 1's hospice notes from [DATE] revealed that Resident #1 had a noticeable outward rotation of her right leg and when asked if she was in pain, she stated no. When the nurse initiated inward rotation of the right leg, Resident #1 winced and grimaced and had noticeable non-verbal signs of pain. It documented that Resident #1 had not been out of bed in about a week and that Resident #1 had pain with cares and rolling in bed and the facility staff were pre-medicating with morphine prior to care. Review of the State Agency reporting portal did not indicate the facility reported Resident #1's injury of unknown origin. III. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on [DATE] at 4:35 p.m. LPN #3 said Resident #1 had dementia and would sundown in the evening. LPN #3 said Resident #1 would get up and walk with one-person assistance and her walker. She said she never complained of pain. LPN #3 said around the beginning of February 2025, Resident #1 had stopped getting out of bed and complained of pain in her left side. Certified nurse aide (CNA) #2 was interviewed on [DATE] at 4:40 p.m. CNA #2 said Resident #1 was slightly confused, but pleasant. CNA #2 said Resident #1 walked and would often get up and try to do things on her own, although she required one-person assistance. She said if Resident #1 needed something, instead of using her call light, she would scream out for help. CNA #2 said she heard about a potential fall Resident #1 had in February 2026. CNA #2 said after that potential fall (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when she was working with Resident #1, she tried to get her up and Resident #1 heavily favored her right side and CNA #2 had to help support Resident #1's left side because it was so weak. CNA #2 said Resident #1 screamed out in pain and complained of pain in her left hip and leg after the incident of a potential fall. CNA #2 said she told the nurse when Resident #1 was experiencing pain. -Review of the resident's electronic medical record (EMR) revealed documentation that the resident had pain in her left and right leg. CNA #3 was interviewed on [DATE] at 4:50 p.m. CNA #3 said Resident #1 was very confused and thought she could do things by herself. CNA #3 said Resident #1 required assistance for activities of daily living. She said she walked with her walker and supervision from staff. CNA #3 said she had heard about a potential fall and noticed after that incident, Resident #1 experienced a lot of pain. CNA #3 said she could tell by the grimace on her face at all times. CNA #3 said Resident #1 would try to sit up in bed but it would hurt too badly. CNA #3 said she did not see Resident #1 get out of bed once she started having the pain. CNA #3 said she would tell the nurse right away when she saw Resident #1 was in pain. The DON, the nurse manager and the NHA of the campus were interviewed together on [DATE] at 1:25 p.m. The NHA said the steps taken when investigating an incident included ensuring resident safety, notifying the appropriate people (physician, management, resident representative), reporting the incident, calling the police, interviewing all the staff members that were working that shift, interviewing both cognitively intact residents and residents not cognitively intact that were in similar situations, meeting up again as an interdisciplinary team to talk through what had been found and determining what changes had to be made. She said if there was education required, they provided that and figured out whether they could substantiate it. She said they documented interviews, notification to ombudsman, family, physician, police and adult protective services if needed. She said some incidents required a safe event (incident report) and this included finding a root cause for the incident.