

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Poudre Canyon Rehabilitation and Nursing, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S Lemay Ave Fort Collins, CO 80524	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#6) of one resident reviewed for accidents and hazards received adequate supervision to prevent an elopement out of 26 sample residents. Resident #6 was admitted on [DATE] with diagnoses of dementia with behavioral disturbance, chronic respiratory failure and traumatic brain injury. Beginning in January 2026, the resident began displaying elopement seeking behavior and was telling staff he wanted to leave the facility. His exit-seeking behaviors escalated, which prompted a review from the physician, who recommended a wanderguard device and expressed serious concerns regarding his safety, poor insight, and impaired judgement. On 3/23/26 facility leadership told Resident #6 he would no longer be permitted to leave the facility unsupervised, after an assessment by his physician determined the resident was no longer safe in the community. The resident got angry with this information and became increasingly agitated. The resident argued with facility staff and threatened that he was leaving against medical advice (AMA). Despite the entire facility being securely locked and alarmed at each entrance/exit doors, being accessible for residents to exit when staff deactivated the lock doors, to let residents in and out of the building Resident #6 found a way to elope for the building without staff knowledge. On 3/23/26 Resident #6 went outside on the secured back patio, where he was observed by another resident to be pushing on the gate. Resident #6 was able to break the gate open and elope from the facility unsupervised by staff. The resident who observed this, reported the incident to staff. The facility was unable to locate the resident following a search of the neighborhood. The facility did not learn of the resident's whereabouts until 3/27/26 (four days after he left the facility) when the hospital contacted the facility. After eloping from the secured back patio, Resident #6 walked approximately three miles, where he was found by emergency medical services (EMS) lying on the side of the highway by a local hotel. As a result of his fall, the resident sustained a hip fracture and left elbow fracture, which required surgery. The resident was additionally treated for pneumonia. On 7/5/26, Resident #6 again eloped from the facility, through a window in an office. The facility was unsure how long the resident was missing for. The resident was found sitting underneath a tree outside of the facility. Specifically, the facility failed to: -Implement adequate interventions to prevent Resident #6 from eloping from the secured community building on 3/23/26, which resulted in the resident being missing from the facility for four days before being located in a local hospital after being treated for his injuries; and, -Prevent Resident #6 from eloping from the facility again (on 7/5/26), three months after he eloped on 3/23/26. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 7/20/26 to 7/28/26, resulting in the deficiency being cited as past noncompliance with a correction date of 7/16/26. I. Facility plan of correction The facility's plan of correction was provided by the corporate (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 0689 Level of Harm - Actual harm Residents Affected - Few	nurse consultant on 7/23/26 at 11:00 a.m. The plan of correction documented the facility took action after Resident #6's 7/5/26 elopement to examine the root cause of his ability to elope out of the building without staff's awareness and to look at the factors in his ability to successfully exit the building. The corrective actions taken included providing education to staff that when a resident was actively exit-seeking, the resident was not to be left alone until the interdisciplinary team (IDT) determined the resident was no longer an elopement risk. The maintenance staff secured all of the facility's windows so they were only able to open six inches. The maintenance staff additionally secured all of the office doors to be kept locked when unoccupied by a staff member. In addition, Resident #6's care plan was reviewed for appropriate interventions and updated accordingly. The facility examined all residents in the facility who were at risk of elopement and assessed their care plans for accurate person-centered intervention and educated staff of any updates. All corrective actions were in place as of 7/16/26. II. Facility policy and procedure The Elopement and Wandering policy implemented 4/30/25 and revised 6/2/26 was provided by the nursing home administrator (NHA) 7/23/26. It read in pertinent part, This facility ensures that residents who exhibit wandering behavior and or are at risk for elopement, receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary team. Charge nurses and unit managers will monitor the implementation of interventions, and responses to interventions will be documented. Effectiveness of interventions will be evaluated and changes will be made as needed. III. Resident #6A. Resident status Resident #6, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physicians orders (CPO), diagnoses include dementia with behavioral disturbance, chronic respiratory failure and traumatic brain injury. According to the 5/12/26 minimum data set (MDS) assessment, the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment indicated the resident did not have symptoms of inattention or disorganized thinking. -However, a physician's note, dated 4/14/26, documented the resident had significant deficits in attention, insight and judgment, with the inability to understand or reason. The assessment documented the resident was ambulatory and able to walk at least 150 feet with only verbal cues and or touching/steadying assistance. B. Record review The elopement risk care plan, initiated 4/3/26 revised 4/7/26, revealed Resident #6 was at risk for elopement related to a history of elopement attempts, anger over his placement in the facility and a strong desire to leave the facility. Pertinent interventions included providing frequent checks related to poor safety awareness, identifying triggers for wandering or elopement, offering to assist the resident to the enclosed courtyard and offering approved tobacco products. The nurse practitioner (NP) note, dated 2/23/26, revealed Resident #6 was unable to demonstrate understanding of the purpose of a wanderguard device or the risks and safety concerns associated with wandering into the community without staff support. The resident held a fixed belief that he would not get lost while out in the community unsupervised. During the assessment, the resident was distractible and unable to demonstrate understanding of the purpose of the wanderguard. He was unable to explain why staff were concerned about wandering or articulate potential risks associated with leaving the secured area. When asked about possible consequences, he repeatedly stated that he would not get lost and was unable to engage in further reasoning regarding personal safety. The resident demonstrated impaired attention, insight, and judgment with inability to understand, appreciate, or reason through the safety implications of wandering. The note documented since the resident lacked medical decision making capacity, the recommendation was to continue safety measures to prevent (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	elopement. A community assessment, dated 3/23/26, revealed Resident #6 had a desire to leave the facility independently. The assessment documented the resident's physician had several concerns regarding the resident's declining cognition and his current ability to demonstrate safe decision making/choices when in the community unsupervised. Despite having a BIMS score revealing intact cognition and being alert and oriented to person, place and time, he was not oriented to situational matters, the resident had a St. Louis University Mental Status Exam (SLUMS) score of 12, which indicated the resident had moderate cognitive impairment driven by a diagnosis of dementia. The resident had a substance use disorder and his recovery status was unknown. Additionally, the resident was prescribed psychotropic and antiseizure medications to manage symptoms of agitation and paranoia. The assessment documented his symptoms were well managed when he took the medications. The resident was unsteady while walking without an assistive device and he demonstrated poor safety awareness while in a community (unstructured) setting. The resident was at risk of injury in high vehicle traffic areas as evidenced by a prior history of getting into the street and being struck by a motor vehicle and was seriously injured when he lived in a prior setting back in March of 2022. The recommendation after this assessment was to no longer allow Resident #6 the ability to leave the facility and be in the community unsupervised. The resident was informed of this assessment and the resident did not agree. The nursing note, dated 3/23/26, documented Resident #6 had a history of leaving against medical advice several times in the past. He insisted on getting out of the building and tried exiting multiple entry doors; however, alarms went off each time. Resident #6 was advised that he should not leave the building unplanned without food and shelter. The resident told the staff I don't care, if you don't open the door, I will kick the door open and leave. Resident #6 later managed to get out of the building through the smoking courtyard gate. The missing person incident report, dated 3/23/26, revealed Resident #6 was informed that he could not go into the community alone because his physician assessed him to not be safe outside of the facility unsupervised. Upon receiving notice that he could not leave the facility, the resident grew increasingly agitated. He argued with staff and IDT members. He threatened that he was leaving against medical advice. The resident was seen by another resident in the secured courtyard, pushing his weight on the gate until he was outside of the facility grounds. That resident reported Resident #6's elopement. A search of inside the facility and the facility grounds was conducted and staff were unable to locate Resident #6. The incident report documented the facility's leadership team conducted a root cause analysis and determined that a failure to implement adequate elopement risk interventions after a change in a resident's capacity; lack of care plan update following physician documentation of incapacity; an insecure gate in the courtyard and insufficient staff monitoring and supervision of a known at-risk resident contributed to Resident #6's ability to elope from the facility and become a missing person. The emergency room provider note, dated 3/23/26 at 11:01 p.m., revealed Resident #6 was brought in by ambulance after being found at the side of the highway three miles away from the facility. Clinical impressions included dehydration, generalized weakness, lightheadedness, COPD exacerbation and pneumonia to both lungs. A 3/24/26 staff education, regarding Resident #6's 3/23/26 elopement, documented staff were educated that if staff noticed signs of an impending elopement, they should redirect the resident and notify the supervisor immediately. If a resident was actively exit-seeking or trying to leave the facility, staff were educated not to leave the resident unsupervised. The hospital note, dated 3/26/26, documented Resident #6 underwent a left elbow open reduction internal fixation (surgical repair) as well as a left femur intramedullary rod insertion trochanteric (surgical repair of a broken left hip using a metal rod inserted directly into the center of the thigh bone) on 3/26/26. The hospital after-visit note, dated 4/3/26, (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documented Resident #6 was treated in the hospital from [DATE] to 4/3/26. A wandering/elopement risk evaluation, dated 5/12/26, revealed Resident #6 was at high risk for eloping due to anger over his placement in the facility, previous elopement attempts, a history of substance use disorder, short and long-term memory impairment and impaired decision-making skills. The incident report, dated 7/5/26 at 4:15 p.m., documented Resident #6 had been exit-seeking and had made several attempts that day to exit the building without staff awareness. Due to these behaviors, the nurse was rounding on him at regular intervals, approximately every 30 minutes. The investigation documented that the nurse said while she was doing rounds, she was unable to locate the resident. The nurse said she notified all of the staff and they began looking for the resident. The nurse located Resident #6 outside, sitting on the sidewalk beneath the peach tree on the east side of the building. -However, the investigation did not investigate if any other staff members were monitoring the resident's whereabouts after he expressed a desire to leave the facility and had been making several attempts to elope for the building, despite the plan of correction indicating the staff were provided education regarding missing persons after the 3/23/26 missing person incident. The staff had previously been educated to not leave a resident alone if they were actively exit-seeking following the 3/23/26. The 7/5/26 incident report documented that during the search for Resident #6, facility staff observed a door to an unoccupied office was open. Upon searching the office, the resident was seen outside, sitting under a peach tree on the east side of the building. Upon further observation of the office, it was noted that the window was open and the screen was pushed out. Upon interviewing Resident #6, he told staff he wanted to leave and opened the window, pushed out the screen and climbed out of the window. The resident was assessed and no injuries were observed. As a part of the investigation, the IDT conducted a root cause analysis of the elopement incident and revealed the resident had poor safety awareness, behavioral causes related to history of traumatic brain injury, and impaired decision-making. -However, the root cause analysis failed to investigate why the resident was able to elope out of a window in a staff office without staff awareness. The documentation did not indicate if the facility reviewed the interventions in place to assess if they were still appropriate. The 7/25/26 incident investigation documented new interventions included frequent checks for safety on Resident #6 during times of attempted elopements, until he was no longer displaying elopement behavior; unused spaces were to be kept secured; and window openings were to be adjusted to not exceed six inches of open clearance. IV. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 7/23/26 at 9:15 a.m. CNA #3 said Resident #6 was monitored closely when he was wandering in the hallways for risk of elopement and if he displayed elopement behaviors he was to be observed by staff every 15 minutes for safety. CNA #4 was interviewed on 7/28/26 at 10:44 a.m. CNA #4 she said Resident #6 was checked on frequently between care. CNA #4 said this included when meal trays were passed, during hydration/fluid pass and during routine check and change rounds, which occurred every two hours. CNA #4 said Resident #6 would sometimes get upset when he missed supervised smoking times and that was when he became agitated and displayed unsafe behaviors. The NHA, the director of nursing (DON) and the corporate nurse consultant were interviewed together on 7/28/28 at 4:00 p.m. The NHA, the DON and the corporate nurse consultant said Resident #6 was checked on every 15 minutes after an elopement incident or attempt. The corporate nurse consultant said the 15-minute checks were then tapered off, per nursing judgement, when the resident was no longer displaying elopement behaviors. The corporate nurse consultant said Resident #6 was checked on every one to two hours at present to monitor for elopement behaviors.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, sanitary and comfortable homelike environment for five out of five units. Specifically, the facility failed to: -Maintain comfortable temperature levels in residents' rooms and common areas; -Ensure residents' were provided clean linens; -Ensure the staff's dog(s) who visited regularly had the proper vaccinations and health care treatments; and, -Ensure the dog was sufficiently monitored by staff so that the staff could perform their job while ensuring the dog was not creating any safety concerns throughout the building with any resident or visitors in the facility. Findings include: I. Temperature failures A. professional reference History of temperatures in the community As the National Weather Service points out, the heat index quantifies what the air actually feels like by combining air temperature and relative humidity. Even though Colorado generally features lower humidity, consecutive days of temperatures climbing into the mid-to-upper 90s (and peaking at 99 F in late July) still push feels like parameters into caution zones. This prolonged environmental stress causes distinct physical, behavioral, and clinical impacts on the elderly population. According to the National Institute on Aging, Hot Weather Safety for Older Adults, September 2022, retrieved 8/6/26 from https://www.nia.nih.gov/health/safety/hot-weather-safety-older-adults Too much heat is not safe for anyone. It is even riskier if you are older or have health problems. It is important to be cautious and get relief quickly when you are overheated. Otherwise, you might start to feel sick or risk a heat-related illness that could cause serious health issues. Hotter days can cause difficulty in the body's ability to regulate its temperature. This can be challenging for older adults who typically do not adjust as well as others to sudden temperature changes. Additionally, older adults are more likely to have chronic medical conditions that affect the body's response to temperature, and to take prescription medicines that alter the body's ability to control temperature or sweat. Being overheated for too long or being exposed without protection to the sun can cause many health problems. Heat-related illnesses include the following: Heat syncope a sudden dizziness. Heat cramps: a painful tightening or spasms of muscles in your stomach, arms, or legs. Heat edema, a swelling in your ankles and feet when you get hot. Heat rash, a skin irritation from heavy sweating. Heat exhaustion, a warning that your body can no longer keep itself cool. Heat stroke, a medical emergency in which the body's temperature rises above 104 F. B Facility policy and procedure The Safe and Homelike Environment Policy, dated 4/11/25, was provided by the corporate nurse consultant on 7/23/26 at 11:00 a.m. It revealed in pertinent part, The facility will provide residents with a safe, clean, comfortable, and homelike environment. Comfortable and safe temperature levels means the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents. C. Observations and resident interviews The temperatures in the facility were observed from 7/20/26 to 7/27/26. The temperatures were as follows On 7/20/26 At 12:32 p.m., the wall thermostat ambient temperature of the 400 hallway read 84 degrees Fahrenheit (F). At 1:05 p.m., the wall thermostat ambient temperature of the 200 hallway read 85 degrees At 1:35 p.m., the wall thermostat ambient temperature in hallway 300 was set to 60 degrees F and the thermostat was reading 85 degrees F. At 2:01 p.m., the ambient temperature in hallway 400 was 85 degrees F. At 4:10 p.m., the ambient temperature in hallway 400 was 84 degrees F. At 4:48 p.m, the resident in room [ROOM NUMBER] was seated at the bedside facing her tower fan, which had a thermostat that was reading 84 degrees F. A second box (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	attempt to improve the temperature. LPN #2 and CNA #4 said the air conditioning problem continued. The maintenance director was interviewed on 7/22/26 at 2:31 p.m. The maintenance director said he began working at the facility four months ago. He said he was unsure when the air conditioning broke. He said when he started at the facility, the air conditioning was already broken. The maintenance director said the swamp cooling system had not been working for some time but did not know the history of the functionality or maintenance of the system since he just started working in the facility. He said the facility contracted with an outside heating and cooling company on 6/7/26 to service the cooling units. The contractors had to replace the missing copper piping and damaged electrical wiring to get the units up and running. The contractor was able to repair nine of the 15 swamp cooling units; however, the units still needed to be cleaned and serviced before they could be activated. The maintenance director said he cleaned the units and activated the system; however, the system was not sufficient even if all 15 swamp cooler units were working to adequately cool the building. The maintenance director said the facility corporation had made a decision to install central air to the building but they were still obtaining quotes and it was going to take several weeks to finalize the selection of the bids and get funding approval; then it would take time to install the system due to the required work to reconfigure the ducting system in the building. In the meantime, the facility was installing fans and air conditioners in the building to help cool the resident rooms and common spaces. The maintenance director said he had been instructed the temperature of the building should not exceed 81 degrees F. The NHA was interviewed on 7/21/26 at 5:03 p.m. The NHA said the facility began receiving formal complaints regarding the excessive heat in May 2026. He said the temperatures in the building became more uncomfortable by 5/30/26 and they made a decision to call in an emergency contractor to make repairs to the existing swamp cooling system. As of June 2026, the facility was receiving more formal complaints and they started to distribute fans to the residents for use in their rooms. The NHA said the maintenance staff went out yesterday (7/21/26) to purchase two big swamp coolers and additional fans to cool the building and they started checking ambient temperature in the building more regularly. The NHA said the delays in resolving the uncomfortable temperature complaints were due to the corporate process and the need for the central air conditioning project to be approved by the governing body. In the interim, the facility had made a decision to replace the six swamp coolers that were still inoperable to give the residents relief from the heat until the central air conditioning was installed; they were just waiting on quotes for the swamp cooler units so they could be purchased and installed. The NHA said the staff had been instructed to encourage residents to increase their fluid intake. The NHA provided a purchase receipt revealing that the facility purchased two large portable swamp coolers on 7/20/26 at 1:02 p.m., on the day the survey started and additional receipts for the purchased nine fans to place throughout the facility. The NHA said the facility was going to purchase an additional portable swamp cooling unit for the building during the week. The NHA said the facility had requested quotes for replacement of the cooling system and the quotes had been submitted to the corporate office for review and approval. They anticipated the results to take several weeks. Resident review On 5/21/26, a resident council meeting was held and several residents complained about the temperature in the facility is uncomfortable and the rooms are too hot or too cold, which was addressed to the maintenance staff. II. Linen failures, environmental conditions and odors in the building A. Facility policy and procedure The Safe and Homelike Environment Policy, dated 4/11/25, was provided by the corporate nurse consultant on 7/23/26 at 11:00 a.m. It revealed in pertinent part, The facility will provide residents with a safe, clean, comfortable, and homelike environment. The facility will provide and maintain bed and bath linens that are clean and in good condition. Minimize odors by disposing of soiled linens (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	promptly and reporting lingering odors and bathrooms needing cleaning to the Housekeeping Department. The housekeeping cleaning schedule was provided by the NHA on 7/21/26 at 11:00 a.m. It read in pertinent part, Immediately clean spills, body fluids or soiled linens. Daily cleaning includes high touch surfaces and bathrooms. Deeper cleaning of resident rooms were to be done weekly, including wiping walls, window sills and furniture. Monthly cleaning includes overhead light fixtures and HVAC vents, scrub baseboards and clean behind equipment and furniture. Terminal cleaning of resident rooms as needed after transfer, discharge or closure.B. Observations and resident interviewsOn 7/20/26 at 12:25 p.m. The handrails throughout the facility were sticky and the floors were heavily scuffed and visibly dirty and black scuffs. The baseboards and baseboard heat vents, as well as ceiling vents, were coated in black grime; the surrounding drywall was crumbling in several areas, which had scattered dried fluid spills on the walls. Many resident rooms were in a similar condition; floors were sticky; personal items were piled on surfaces and on the floor. The facility was observed on 7/22/26 from 9:00 a.m. to 12:40 a.m., observations included: At 9:18 a.m., room [ROOM NUMBER] had a strong smell of urine.At 9:18 a.m., room [ROOM NUMBER] bed A had a strong odor of fishy smelling urine. The bed by the door was wet and soiled with fishy smelling urine that covered the sheets and blankets on the bed. At 9:42 a.m., room [ROOM NUMBER] bed A's sheets were heavily soiled and stained with brown and yellow marks. At 12:38 p.m., the bedding in room [ROOM NUMBER] bed A the bed was unmade and the fitted sheet was stained with yellow and brown substances. The pillow cases were soiled with brown stains and the pillow's plastic covering was cracked, exposing its unprotected inner surface (a potential for pathogens to seep into the inner pillow filling. The frame was caked with a thick layer of brown and orange debris that had accumulated on the surface and in the crevices. A broken jagged mirror was on the bed. The resident said he used the mirror daily and did not want to throw it away. He sad no one had offered to convert jagged edges for his safety. The bathroom toilet and toilet seat in room [ROOM NUMBER] were stained with a heavy layer of thick urine and stuck on hair around and under the toilet seat. His wheelchair was covered with thick dirt and food crumbs on the footrests all over the wheels and around the edges of the seat. On 7/22/26At 9:22 a.m., in room [ROOM NUMBER], bed A's fitted sheet was heavily soiled with black stains and chunks of black debris. The pillowcase was also heavily stained black stains and the room had a strong smell of body odor.At 9:44 a.m., room [ROOM NUMBER] strong smell of urine.At 9:47 a.m., room [ROOM NUMBER] bed A had the same soiled sheets and pillowcase as observed the day prior (see observation above). In addition, the toilet rim was still soiled with dried urine and hair The resident who resided in room [ROOM NUMBER] was interviewed on 7/22/26 at 2:45 p.m. The resident said she wanted her bed linens changed more than once a week, but the staff would only change them once a week on shower days.On 7/27/26 At 1:39 p.m., room [ROOM NUMBER] smelled like urine and the sheets were soiled at the foot of the bed with brown and black stains.On 7/28/26 At 11:25 a.m., room [ROOM NUMBER] had a strong smell of urine.At 4:49 p.m., the resident's bed linens had brown and black stains.III. Staff interviewCNA #1 was interviewed on 7/22/26 at 9:20 a.m. He said the residents' bed sheets were changed two times per week on the residents' shower day. He said if the sheets were visibly soiled, he would change them. CNA #5 was interviewed on 7/22/26 at 9:32 a.m. CNA #5 said the residents' wheelchairs were to be cleaned on a routine basis on the night shift.HK #2 was interviewed on 7/22/26 at 9: 20 a.m. HK #2 said he cleaned the floors in the hallways and the common areas daily. He said he mops the floors by hand because the electric buffer was out of service.Housekeeper (HK) #1 was interviewed on 7/22/26 at 9:30 a.m. HK #1 said she deep cleaned one resident room per day. She said when she deep cleaned a room, she cleaned the bed frames, windows and furniture. She said there was not a formal record kept of when rooms were cleaned. She (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Poudre Canyon Rehabilitation and Nursing, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S Lemay Ave Fort Collins, CO 80524	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	said residents' wheelchairs were cleaned by CNAs. The corporate nurse consultant was interviewed on 7/23/26 at 2:47 p.m. The corporate nurse consultant said she was not sure how often the housekeepers cleaned the resident rooms. She said she was not sure how the housekeeping staff kept track of which rooms needed to be cleaned. III. Animal failures A. Facility policy and procedure The Safe and Homelike Environment Policy, dated 4/11/25, was provided by the corporate nurse consultant on 7/23/26 at 11:30 a.m. It read in pertinent part, It is the policy of this facility to provide a home-like environment and enhance our residents' quality of life by allowing companion animal visits. The Companion Animal Visits policy, dated 4/11/25, was provided by the corporate nurse consultant on 7/23/26 at 11:00 a.m. It revealed in pertinent part, The facility had adopted a companion Animal for visits and it is requiring companion animals to: be well-behaved and well-trained; be supervised by persons familiar with the animal and its behavior during visits; and be removed from the facility if the animal demonstrated behavior indicating it was not well-behaved or well-trained. Companion animals, which include animals visiting the facility as part of an activities program, must meet the following criteria in order to enter the facility: the animal must be well-behaved and well-trained, if the animal demonstrates that they are not well-behaved or well-trained, the animal handler/owner will be asked to remove the animal from the facility, the animal must be in good health and up-to-date with recommended immunizations and prophylactic medications (heartworm prevention) determined by a veterinarian based on local needs and recommendations, the animal must be routinely screened for enteric parasites and/or have evidence of a recently completed anthelmintic regimen; and, proof of the animal's current vaccination and veterinary treatment record must be provided to the activities director, or designee, prior to the animal's first visit to the facility. All visits must be supervised by persons who know the animal and their behavior. -However, the facility did not have the dog's records on file at the time of request. B. Observations and resident interviews On 7/20/26 at 11:00 a.m. the dog barked at a group of visitors who were carrying tables and then one of the staff disciplined the dog with a remote control device and the dog backed off but then started barking after a few more seconds and the staff had to made the dog to go back behind the nurses station. LPN #4 was interviewed on 7/20/26 at 11:01 a.m. LPN #4 apologized for the dog barking and said the dog barked at people carrying equipment. Resident #7 was interviewed on 7/20/26 at 1:44 p.m. The resident said she was afraid of the staff dog who was in the facility several days a week because it barked at her and also at her husband when he came to visit her. C. Record review The dog's veterinarian records revealed the staff's dog was not a trained service dog and had no record of obedience training. Current vaccination records documenting the dog had all his vaccinations; however, the dog was not screened for parasites and heartworms. Additionally, the dog was not on any type of heartworm preventive treatment as required by the facility policy. D. Staff interviews LPN #2 and CNA #4 were interviewed on 7/20/26 at 4:42 p.m. LPN #2 and CNA #4 said the dog belonged to CNA #4 and had been coming to the facility since it was a puppy. They said the dog barked at people that he was not familiar with. They said the dog would bark at people if they were carrying big items. LPN #4 was interviewed on 7/27/26 at 1:43 p.m. LPN #4 said when she was passing medications, her dog remained at the nurses' stations. She said some of the other staff would watch the dog for her. She said most of the time the dog just laid there behind the nurse desk because he was lazy. LPN #4 said the resident had a shock collar and she would buzz him when he barked in order to stop his barking. LPN #4 said sometimes the dog would stop barking when he was buzzed and sometimes she had to show him the remote before he stopped barking. LPN #2 was interviewed on 7/27/26 at 1:46 p.m. LPN #2 said when LPN #4 was passing medications or busy with residents, one of the other nurses or CNA's would watch the dog. The corporate nurse (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	consultant was interviewed on 7/28/26 at 4:16 p.m. She said the leadership was implementing a new policy for dogs in the building. Any staff wanting to bring in their dog will need to be screened by the NHA and approved for visitation. The dog will need to have all vaccinations and health treatments as per the facility policy and be well mannered. When the nurse is working, the dog will have to be leashed or in a secure area. The corporate nurse consultant said the NHA talked to LPN #4 about leashing the dog at all times and the dog will not be back in the facility until all medical treatments are completed.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#12) of one resident out of 26 sample residents. Specifically, the facility failed to ensure an assessment was completed to determine whether the self-administration of medications was clinically appropriate for Resident #12. Findings include: I. Facility policy and procedure The Resident Self Administration Medication dated 4/11/25, was provided by the corporate nurse consultant on 7/23/2026 at 1:30 p.m. It read in pertinent part, The facility policy is to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: the medications appropriate and safe for self-administration; the resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections; the resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; the resident's capability to follow directions and tell time to know when medications need to be taken; the resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff. Once evaluated for ability to self-administer medication orders are obtained from the medical provider to self-administer and the individual orders are updated to indicate self-administration. II. Resident #12A. Resident status Resident #12, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician's orders (CPO), diagnoses included acute chronic diastolic congestive heart failure, acute pulmonary edema, morbid obesity, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, fibromyalgia, and obstructive sleep apnea. The 6/8/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Observations and interviews Resident #12 was interviewed on 7/22/26 at 10:00 a.m. During the interview, there was a small round white pill left in a medication cup on the resident's bedside table. Resident #12 she had not noticed the pill until it was pointed out to her. Resident #12 said it was usually for the nurses to leave her medications on the bedside table when she was asleep. Resident #12 recognized the pill as a pill she took around 11:00 a.m., but could not remember the name of the medication. Licensed practical nurse (LPN) #3 was interviewed on 7/22/26 at 11:18 a.m. LPN #3 said he could not remember what the pill was that was left in Resident #12's room. LPN #3 entered Resident #12's room and said the pill was lasix (diuretic medication) that was scheduled for administration at 11:00 a.m. Resident #12 was interviewed on 7/27/26 at 11:39 a.m. During the interview, there was a larger white pill in a medicine cup sitting on the resident's bedside. The resident said she did not see the nurse leave the medicine at her bedside; she might have been asleep at the time. Resident #12 said she did not take the pill because she was not sure what it was and she wanted to ask the nurse what it was before taking the pill. The nurse on duty was called to the resident's room but the resident took the pill before the nurse arrived. C. Record review A review of Resident #12's comprehensive care plan revealed the care plan did not have a care focus for the resident to self-administer any medications. Review of the self-administration assessment, dated 1/7/26, revealed the resident was assessed and approved to self-administer fluticasone propionate (nasal spray) and cough drops and no other medications. The resident was assessed to keep the medication at bedside and administered unsupervised. Review of (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the July 2026 CPO did not reveal a physician's order that the resident could self administer any of her prescribed medication. -However, observations revealed a pill medication was left at the resident's bedside (see observations above). D. Staff interviews LPN #3 was interviewed at 1:05 p.m. LPN #3 said he looked in the resident's CPO and was unable to find an order that the resident was permitted to self administer her own medication. He said there was a self medication administration assessment, dated 1/7/26, that documented the resident was able to self administer a nasal spray and cough drops. -However, a pill was found at the resident's bedside (see observations above).The corporate nurse consultant and the director of nursing (DON) were interviewed on 7/28/26 at 3:56 p.m. The corporate nurse consultant said if a resident requested to self administer medication the nurse performed an assessment to determine if the resident was able to understand the medication orders and what the medication if prescribed to treat. The corporate nurse consultant and the DON said if the resident was assessed to be competent to self administer their medication. The DON and the corporate nurse consultant said if the resident was approved to hold their medication at the bedside they were given and instructed to use a locked box to secure their medications. She said sometimes the nurse kept the medication in the medication cart until the resident requested them.The corporate nurse consultant said they would assess Resident #12 to determine if she would be competent to self administer her medications. The corporate nurse consultant said if she was able they would request an order from the physician to permit the resident to self administer her own medications.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide reasonable accommodations necessary to accommodate mobility and accessibility in the resident's environment for one (#8) of three residents reviewed for accommodation of needs out of 26 sample residents. Specifically, the facility failed to ensure Resident #1, who relied on bedside bed rails and transfer poles for mobility, had appropriate accommodations after the facility removed all bedside bed rails and transfer poles from the resident's room. Findings include: I. Facility policy and procedure The Use of Assistive Devices policy, revised 6/15/26, was provided by the corporate nurse consultant on 7/23/26 at 3:15 p.m. It read in pertinent part, The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and or dignity. The use of assistive devices will be based on the residents comprehensive assessment in accordance with the residents care plan. II. Resident #8A. Resident status Resident #8, age less than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO) diagnosis include hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral infarction affecting the left side. The 6/10/26 minimum data set (MDS) assessment revealed Resident #8 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had limited mobility in his upper extremities (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). He needed substantial to maximal assistance to roll left and right; from lying on back to left and right side, to return to lying on back on the bed; to move from a sitting position to lying position from sitting on side of bed to lying flat on the bed; and from a lying position to sitting on side of bed. He was dependent on staff for surface to surface transfers. B. Resident interview Resident #8 was interviewed on 7/21/26 at 12:25 p.m. Resident #8 said he was not happy and was frustrated after the facility made the decision to remove his transfer pole and bed rails. He said the decision significantly impacted his ability to transfer from bed to chair as well as impacted his ability to move freely in bed without having to call staff for assistance. Resident #8 said he fell out of bed while trying to reposition himself in bed as a direct result of the facility removing his bed rails (see fall incident report 5/18/26 below). He said the process of using the sit to stand mechanical lift was time consuming and inconvenient for both himself and staff and had negatively impacted his quality of life because he had to wait longer to transfer and staff seemed frustrated due to the transfer taking longer. C. Record review The impaired mobility care plan, revised on 3/16/26, revealed the resident had limited mobility related to hemiplegia and hemiparesis affecting his left side. Pertinent interventions included: evaluating the need for assistive devices, providing an assist rail while the resident was in bed. According to a quality assurance and performance improvement (QAPI) document initiated 5/5/26, it was determined that bed rails and other assistive devices were in place at facilities when risk outweighs the benefits of use. The facility would eliminate unnecessary bed rails and other assistive devices to ensure compliance. A physical therapy evaluation, dated 5/8/26, the resident trialed use of a sit to stand mechanical lift for functional transfers from bed to wheelchair. On the first attempt the resident demonstrated difficulty with pulling into a full stand to allow for paddles to be lowered under hips for safe transfer. The resident became upset and reported that he would not attempt to use the lift again. The interdisciplinary team (IDT) note dated 5/18/26 documented, the IDT reviewed unwitnessed fall occurring 5/18/26 at approximately 2:30 a.m. The root cause was believed to be that the resident slid off of the side of bed while repositioning himself in bed. The note documented bolsters were to be (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added to the mattress to assist to define edges of the bed. A physician note, dated 5/18/26, documented the resident was evaluated post-fall after sliding out of bed. The resident denied injury, trauma, or pain, though he expressed anger and frustration regarding removal of bedrails causing a decrease in his ability to preposition himself. An occupational therapy (OT) evaluation, dated 7/22/26 (during the survey), documented the resident required supervision or touching assistance to transfer from surface to surface. The resident completed the transfer with a transfer pole and required only supervision to complete the transfer. The resident reported that utilizing the transfer pole was more effective than using the sit to stand mechanical lift.-However, the facility removed the resident's transfer pole on 5/5/26.The 7/22/26 OT evaluation revealed for the resident to perform bed mobility the resident required substantial to maximal assistance when the bed rails were not installed and with the bed rails in place he needed minimal assist to full turn; however, the resident was unable to turn to the right side. The resident utilized the gait belt to pull, but this method was ineffective and not always accessible. The evaluation revealed the resident would benefit from bed rails to increase independence with rolling laterally as well as increasing participation in supine to sit transitions. The resident was able to safely complete a transfer utilizing a transfer pole in the restroom to get from chair to toilet. The assessment documented the resident utilized a grab bar and reported less efficiency and needing increased assistance from the certified nurse aides (CNA) to complete the transfer compared the level of assistance he needed when using the transfer pole. The assessment revealed the resident would benefit from utilizing transfer poles to increase participation and maximize independence in transfer and other activities of daily living (ADL). D. Staff interviewsCNA #4 was interviewed on 7/21/26 at 12:25 p.m. CNA #4 said it was much easier and more efficient to assist Resident #8 to transfer from his bed to his wheelchair with the transfer pole then the sit to stand lift. The corporate nurse consultant and the DON was interviewed on 7/23/26 at 3:00 p.m. The corporate nurse consultant said the facility removed all of the transfer poles and bed rails for the resident room to avoid a potential regulatory citation as a directive from the corporate office in May 2026. She said the equipment was in the resident's room when the corporation took over the building and it was determined that the devices would cause regulatory issues. The corporate nurse consultant said the facility followed corporate direction and removed the devices. The corporate nurse consultant said the facility did not have record of the initial evaluations for the installation of the assistive devices (bed rails and transfer poles) and they did not complete assessments and risk benefits statements of the devices prior to their removal. The corporate nurse consultant said they did not currently have a maintenance record for the maintenance oversight of the transfer devices for the one resident who still had installed bed rails. The corporate nurse consultant said they reassessed the three residents who wanted their transfer devices back for safety and appropriateness of use and were providing them the appropriate assistive devices as their assessments indicate.		

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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 thoroughly investigate in order to prevent further potential abuse after a resident-to-resident physical altercation for one of three allegations of abuse. Specifically the facility failed to:-Complete a thorough investigation and maintain documentation of efforts to determine a root cause of the resident's abusive actions to prevent repeated resident-to-resident physical abuse incident by Resident #6 towards Resident #15; -Assess Resident #6's behavior to determine the possible root cause of why the resident suddenly presented with physically aggressive behavior towards another resident when he had never been aggressive towards another resident in the past; -Develop and implement care plan interventions to prevent Resident #6 from engaging in a physically aggressive manner towards another resident; and,-Develop a comprehensive care plan for Resident #15 regarding her risk of being a victim of resident-to-resident abuse related to her trauma informed care needs, wandering behavior and communication deficit.Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, revised 7/15/26, was provided by the nursing home administrator (NHA) on 7/23/26 at 11:00 a.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Establish policies and procedures to investigate any such allegations. Prospective residents will be screened to determine whether the facility has the capability to provide the necessary care and services for each resident. An assessment of the individual's functional and mood/ behavioral status will be reviewed prior to admission.II. Incident of physical abuse by Resident #6 towards Resident #15 on 6/5/26The 6/5/26 facility investigation documented a resident-to-resident altercation between Resident #6 and Resident #15 occurred on 6/4/26 at 5:35 p.m. The investigation documented both residents were self-propelling themselves in manual wheelchairs in opposite directions down the hallway. Resident #6 struck Resident #15 in the face with a closed fist on her left cheek, seemingly without provocation, as witnessed by certified nurse aide (CNA) #4 who was standing behind Resident #15 at the time of the incident. Resident #15 said oh and continued self-propelling herself down the hall. CNA #4 separated the residents immediately and reported the incident to the director of nursing (DON).The investigation began on 6/4/26. The DON interviewed both residents. Resident #6 said he knew he should have not done it and said he heard a voice in his head that said If I didn't hit her, she would never have moved. The investigation revealed Resident #6 did not have a history of auditory hallucinations or physical aggression towards staff or other residents. After the incident, Resident #6 said he would not do it again. Other residents were interviewed and none were able to give any details of what happened or did not see what happened, but all of them said they felt safe. The investigation documented both residents were immediately separated and Resident #6 was placed on every 15 to 30 minute checks.CNA #4 was interviewed following the incident. CNA #4 told investigators she observed the resident-to-resident altercation She said Resident #6 and Resident #15 were both self-propelling themselves in manual wheelchairs down the hallway going in opposite directions. She said Resident #6 struck Resident #15 in the face with a closed fist on her left cheek, without any observed provocation. CNA #4 said she was standing right behind Resident #15 when this occurred. She said Resident #15 responded oh when hit and continued self-propelling herself down the hallway. CNA #4 said she stayed with Resident #6 and took him to see the charge nurse and then the DON at that time. -However, the timeline of events and where the incident occurred differed from interviews (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the time of the survey (see interviews below).Resident #6 was interviewed on 6/5/26 at 12:14 p.m. after the incident. Resident #6 told the facility investigators he knew he should not have hit Resident #15 but he heard a voice that told him if he did not hit her she would never move. Resident #6 said he would not do it again and never should have hit Resident #15. Resident #15 was interviewed following the incident and did not recall the incident. She stated yes when asked if she felt safe. No injuries to Resident #15 were observed. -However, there was contradictory information between the investigation and in the witness accounting of events reported weeks later, during the survey from 7/20/26 to 7/28/26. During the survey, both the NHA and CNA #4 said that the altercation between Resident #6 and Resident #15 occurred in the dining room and not in the hallway as was previously reported after the incident. There was no justification provided about the discrepancy of the account of the events and what might have led up to the findings and root cause of the altercation (see the NHA and CNA# 4's interviews below).III. Resident #6 (assailant) A. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physicians orders (CPO), diagnoses include dementia with behavioral disturbance, chronic respiratory failure and traumatic brain injury. The 5/12/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. B. Record reviewThe mood and behavior care plan, revised 6/10/26, revealed Resident #6 had a history of alteration in mood or exhibition of behavioral symptoms related to major depressive disorder and a history of traumatic brain injury. His behaviors included wandering; exit seeking; auditory hallucinations; agitation and physical aggression; inappropriate behaviors and unmet needs. Pertinent interventions included monitoring and documenting each behavioral event; allowing the resident time to calm down and approaching at a later time; providing psychological counseling; and interacting in an empathetic and supportive manner-However, the recommendations following the 6/7/26 psychiatric assessment were not included in the care plan, including managing symptoms of aggression, hallucinations and precautions for administering ativan (see psychiatric note below). A nurse note, dated 6/5/26, documented Resident #6 remained on alert charting following an altercation with another resident. Resident #6 was observed throughout the shift and was noted to be calm and cooperative with staff and peers. No aggressive behaviors, verbal outbursts, threats, physical aggression, or attempts to strike others were observed during the shift.A psychiatry note, dated 6/9/26, documented Resident #6 was seen for urgent psychiatric follow-up after a recent resident-to-resident altercation reportedly associated with a one-time auditory hallucination. The note documented the resident's presentation was most consistent with dementia with behavioral disturbance, with recently reported auditory hallucination associated with physical aggression.The note documented delirium superimposed on dementia was ruled out due to acute behavioral change, cognitive impairment, hospice status, medical frailty, chronic respiratory disease, seizure history, and lack of ongoing psychosis after the incident. Resident #6 was unable to meaningfully participate in the visit due to cognitive impairment. Per staff report, no ongoing hallucinations, paranoia, responding to internal stimuli, verbal threats, physical aggression, or attempts to strike others had been observed since the incident. The note documented Ativan (anti-anxiety medication) was not used prior to the event, making benzodiazepine-related disinhibition less likely. The note documented that the provider recommended that the facility continue monitoring and non-pharmacological interventions. The note documented that if auditory hallucinations, paranoia, agitation, or aggression recurred, low dose antipsychotics may be considered for comfort and safety after coordination with the hospice provider, the primary care physician and the resident's guardian/power of attorney. The psychiatrist's recommendations included in pertinent part: continue non-pharmacological interventions, including (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calm approach, reassurance, redirection, low stimulation environment, consistent staff approach, and avoiding crowding during care when possible; monitor for recurrence of auditory hallucinations, paranoia, responding to internal stimuli, agitation, threats, or physical aggression; and, monitor for possible triggers, including pain, dyspnea, toileting needs, constipation, hunger, fatigue, poor sleep, overstimulation, or resident-to-resident conflict. The note documented if hallucinations, paranoia, agitation, or aggression recurred, may consider low-dose antipsychotic for comfort and safety after hospice/guardian/primary care physician coordination. The note documented to continue Ativan as needed, as ordered by hospice; use cautiously due to risk for sedation, falls, worsening confusion, respiratory suppression, and paradoxical agitation. The note recommended continuing other psychotropic medications as ordered.-However, not all recommendations were assessed and developed into a person-centered care plan with appropriate interventions for Resident #6 (see care plan above).A physician's note, dated 6/10/26, documented,the resident was seen for follow-up after the behavioral health services evaluation for auditory hallucinations and aggression toward another resident. The resident reported no acute concerns today and no recurrent auditory hallucinations since the incident. A behavioral health services evaluation was performed on 6/9/26. No ongoing psychosis or recurrent aggression has been reported since the incident. No scheduled antipsychotic was recommended at this time. Recommendations include: continuation of nonpharmacologic interventions (calm approach, reassurance, redirection, low-stimulation environment, consistent staff approach) and ativan as needed per hospice order, used cautiously, with monitoring for recurrence of psychosis or aggression and monitoring for possible triggers.IV. Resident #15 (victim)A. Resident statusResident #15, age [AGE], was admitted on [DATE]. According to the July 2026 CPO diagnosis included dementia, without behaviors, psychotic or mood disturbance, anxiety, and failure to thrive.The 7/14/26 MDS assessment revealed the resident had severely impaired cognition for decision making and recall ability with inattention and disorganized thinking per staff assessment. Resident #15 was able to navigate her environment in a manual wheelchair and needed maximal assistance from staff to complete most activities of daily living. B. Record reviewReview of Resident #15's care plan revealed a care plan focus for trauma-informed care, initiated 12/31/26, due to a history of trauma that affected her negatively. Pertinent interventions included being conscious of the resident's position when in groups, activities and the dining room to promote proper communication with others; and, providing a safe environment.-However, her care plan failed to identify the type of trauma or identifiable triggers. Additional interventions included administering medications as ordered; encouraging the resident to express her feelings, concerns, and thoughts in a safe space; and monitoring the resident's health status. A nursing note, dated 6/5/26, documented Resident #15 remained on alert charting following an incident in which the resident was punched by another resident (Resident #6) on the previous day (6/4/26). An assessment was completed. Resident #15 was observed self-propelling throughout the facility in her wheelchair and participating in her usual activities without difficulty. Resident #15 appeared comfortable with no facial grimacing, guarding, bruising, swelling, redness, or other signs of pain or injury noted. Resident #15 denied pain or discomfort when questioned. No acute distress was observed. Resident #15 continued to be monitored per facility protocol, and no adverse effects related to the incident were noted at that time.A physician's note, dated 6/7/26, documented Resident #15 was seen for follow-up after an incident in which she was punched by another resident. She was doing well with no acute concerns. She had no complaints and stated she felt safe. The family was notified of the incident. The nursing assessment found no bruising, swelling, or pain on palpation of the temporal areas; neurological checks and vital signs were at baseline. The resident was self-propelling throughout the facility and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was functionally at baseline, per nursing notes.V. Staff interviews CNA #4 was interviewed on 7/28/26 at 10:44 a.m. CNA #4 said she was in the dining room when, from across the room, she witnessed the physical altercation between Resident #6 towards Resident #15. She said the incident took place in the dining room during the evening meal. She said Resident #6 was sitting in Resident #15's spot at the dining table, when Resident #15 propelled herself in her wheelchair past Resident #6. CNA #4 said suddenly and without warning, Resident #6 struck Resident #15 in the cheek with his fist. She said she intervened and separated the two residents.-However, the investigation did not match CNA #4's previous 6/4/26 interview (see investigation above). The investigation documented the incident occurred in the hallway as the two residents passed by each other, and documented that CNA #4 was standing right behind Resident #6 (see investigation above). CNA #4 said the incident was unprovoked and out of character for Resident #6. CNA #4 said she had not known Resident #6 to be physically aggressive towards other resident's and to her knowledge, Resident #6 had not displayed violent behavior since the incident. She said the only time she saw Resident #6 get angry and agitated towards the staff was when he missed his smoking time and had to wait until the next scheduled smoking time to have a cigarette. The NHA was interviewed on 7/28/26 at 12:27 p.m. The NHA said he had just spoken with CNA #4 to clarify the location and details of where the incident between Resident #6 and Resident #15 occurred. He said CNA #4 told him Resident #6 was seated in the dining room at a table located at the entrance between the dining room and the common hallway. The NHA said CNA #4 told him that Resident #15 wheeled herself passed Resident #6 and Resident #4 struck Resident #15 in the face. The NHA said the incident was unprovoked. The NHA said he did not know why CNA #4's incident details had changed.		

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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 observations, record review and interviews, the facility failed to ensure staff provided respiratory care consistent with professional standards of practice for two (#12 and #4) of two residents reviewed for respiratory services out of 26 sample residents. Specifically, the facility failed to:-Ensure there was a physician's order in place for Resident #12's respiratory therapy, bilevel positive airway pressure (BiPAP) machine and routine cleaning of the BiPAP;-Ensure there was a physician's order in place for the maintenance, cleaning and storage of Resident #4's continuous positive airway pressure (CPAP);-Ensure Resident #12 and Resident #4's comprehensive care plan had a care focus for the use of the BiPAP and CPAP treatment; and, -Ensure Resident #12 BiPAP and Resident #4's CPAP supplies were stored in a sanitary manner. Findings include: I. Professional reference According Resmed manufacturer recommendations, dated 2026, retrieved on 7/31/26 from https://www.resmed.com/en-us/sleep-health/resources/cleaning-cpap-equipment/ ResMed CPAP mask and head gear should be gently cleaned with mild soap and water, placed on a flat surface on top of a towel. The mask has three parts, head gear, cushion and frame. The cushion should be cleaned daily while the head gear and frame should be cleaned weekly. Empty the humidifier tub and wipe it thoroughly with a clean disposable cloth daily. Allow it to dry out of direct sunlight. The humidifier tub should always be clean, clear and free of discoloration. Rinse the inside and the outside of the air tubing with mild soap and water weekly. According to [NAME] Respirationics manufacturer's recommendation, dated 4/17/26, retrieved on 8/5/26 from https://www.[NAME].com/ifu [NAME] Respirationics recommends, apply cleaning agent to a soft lint-free cloth or use a disposable wipe, the cloth or wipe should be saturated but not dripping, wipe cleaning agent over the entire exterior surface and touchscreen of the ventilator, continue wiping until all visible contaminants and soiling are removed, rinse with a clean, water-dampened cloth and allow to dry completely before reuse. The approved cleaning agents for use on the touchscreen and exterior surfaces of the ventilator was soapy water with Medivators Intercept Detergent, mixed per manufacturer's recommendation at 1/3 of an ounce (10 milliliters) per gallon of warm tap water. II. Facility policy and procedure The Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy) policy, dated 6/15/26, was provided by the corporate nurse consultant on 7/23/26 at 1:30 p.m. It read in pertinent part, It is the policy of this facility to provide noninvasive ventilation as per physician's orders and current standards of practice. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CPAP, BiPAP, AVAPS, or Trilogy device must be set up and maintained by a licensed nurse or respiratory therapist following provider orders. The nurse or respiratory therapist will verify the settings on the machine prior to use. Follow manufacturer instructions for the frequency of cleaning and replacing filters and servicing the machine. III. Resident #12 A. Resident status Resident #12, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician's orders (CPO), diagnoses included acute chronic diastolic congestive heart failure, acute pulmonary edema, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and obstructive sleep apnea. The 6/8/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was on oxygen therapy and used a non-invasive mechanical ventilation device (BiPAP). B. Resident interview and observation Resident #12 was interviewed on 7/21/26 at 1:50 p.m. Resident #12 said she cleaned her BiPAP mask with antibacterial wipes every night. She said the machine was stored on her commode chair when in use because there was no other space for the device that was close enough for her to place the mask on her face and to also have the commode accessible for use, if needed. Resident #12 said the certified nurse aides (CNA) helped her set up her machine at night and helped her to store it during the day time on her dresser when not in use. During the interview, the CPAP machine was sitting on top of her commode and the mask was not in any type of protective container. On 7/22/26 at 9:49 a.m. the resident's BiPAP machine was sitting on top of her bedside commode, the mask was draped across the commode toilet seat and the mask was hanging inside the bedside commode. (The commode was empty at the time of the observation). C. Record review Review of the July 2026 CPO revealed there was no physician's order for the resident use of BiPAP therapy duration and frequency of the therapy and there was no documentation of the machine settings. Additionally, there were no orders for the care, maintenance or cleaning of the BiPAP machine and equipment. Review of Resident #12's comprehensive care plan revealed there was no care plan docs or care plan intervention for the resident use of BiPAP therapy. Additionally, there were no interventions for the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintaining the equipment for infection control purposes. D. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 7/22/26 at 11:30 a.m. LPN #3 said the BIPAP mask should be cleaned after each use and then stored in a plastic bag. He said Resident #12's BIPAP was on the commode because there was not enough room for the night stand to be moved closer to the bed and still allow her to use the bedside commode. He said the BIPAP should be stored on her dresser when not in use and not left on her commode because she used the commode throughout the day. He said he would replace the mask since it was hanging in the commode bucket which was not sanitary. III. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the July 2026 CPO diagnosis included chronic respiratory failure, chronic bronchitis hemiplegia (paralysis) and hemiparesis (weakness) affecting the left side. According to the 5/16/26 MDS assessment, Resident #4 was cognitively intact with a BIMS score of 15 out of 15. The resident required special treatments including a non-invasive mechanical ventilator (CPAP). B Observation and resident interview On 7/21/26 at 10:30 a.m. Resident #4's CPAP equipment was hanging off the side of his dresser next to his personal belongings and scattered wrappers. The mask was touching the floor. The mask was not in any type of protective covering. Resident #4 said the staff did not clean the CPAP equipment. The mask was not in any type of protective covering. On 7/23/26 at 10:30 a.m. Resident #4's CPAP machine was surrounded by the resident's personal belongings. The tubing and mask were hanging off of the side of the dresser, the mask was touching the floor and not in any type of protective covering. C. Record review Review of the July 2026 CPO revealed the following physician's orders: CPAP at home settings on room air. CPAP scheduled starts at bedtime during hours of sleep every night shift. The resident prefers to use the device between 11:00 p.m. and 1:00 a.m., ordered on 4/3/26. CPAP daily maintenance: 1. Disconnect mask and tubing from CPAP. 2. Empty humidifier chamber and discard remaining water. 3. Wipe the humidifier chamber with a clean disposable cloth and allow it to (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	air dry. 4. Clean mask cushion with warm water and mild soap; rinse thoroughly. 5. Allow all components to air dry. 6. Refill the humidifier chamber with fresh distilled water before use, every day shift. The infection control nurse can delegate tasks to a CNA, ordered on 6/23/26 and discontinued on 7/17/26. -The facility failed to ensure a new order for CPAP daily cleaning was restarted. CPAP weekly maintenance: 1.Disconnect CPAP from power source. 2. Wash mask frame, headgear, tubing, and humidifier chamber in warm water with mild soap. 3. Rinse thoroughly with clean water. 4. Air dry completely before reassembly. 5. Wipe the exterior of the CPAP machine with a clean, dry cloth. 6. Inspect tubing, mask, and chamber for cracks, discoloration, or damage and report concerns to nursing. 7. Reconnect CPAP to power source. 8. Refill Inspect and rinse CPAP/BiPAP filter weekly; replace as needed if soiled or damaged. Wipe the exterior of the machine using mild soap and water. every day shift every Sun-Order Date07/17/2026 1816 fresh distilled water before use if ordered weekly on Wednesdays. The infection control nurse can delegate tasks to a CNA, ordered on 6/23/26 and discontinued on 7/17/26. -The facility failed to ensure a new order for CPAP weekly cleaning was restarted Inspect and rinse CPAP filter weekly; replace as needed if soiled or damaged. Wipe the exterior of the machine using mild soap and water. every Sunday, ordered on 7/17/26. -However there were no physician's orders to store the CPAP mask and other related equipment in a sanitary manner to prevent possible pathogens from contaminating the mask and tubing apparatus. Review of Resident #4's comprehensive care plan did not reveal a focus regarding the resident's use of the CPAP machine. D. Staff interview Registered nurse (RN) #2 was interviewed on 7/23/26 at 9:10 a.m. RN #2 said the CPAP machines and components were to be cleaned every night shift. She said the mask should be cleaned after use and stored with the machine. The corporate nurse consultant and the director of nursing (DON) were interviewed on 7/23/26 at 1:00 p.m. The corporate nurse consultant said the CPAP and BiPAP machines, masks and tubing should be maintained in a sanitary manner. She said the mask should be cleaned after each use air dried and stored in a bag after cleaning to prevent possible contamination of any pathogens. She said the tubing and mask should be kept off the floor. She said she and the DON would look into the concern. The corporate nurse consultant and the director of nursing (DON) were interviewed on 7/28/26 at 11:00 a.m. The corporate nurse consultant said after she learned about the observations and other concerns about lack of physician's orders; care plan focus and proper cleaning and storage of the respiratory equipment (see above) she and clinical leadership audited all residents with respiratory equipment to verify and confirm appropriate order for respiratory treatments as applicable to the resident(s) and updated the residents care plans.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** -Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety throughout the facility. Specifically, the facility failed to ensure meal trays were promptly removed from the residents' rooms to ensure food was not available to residents at unsafe temperatures. Findings include: I. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 8/3/26. It revealed in pertinent part, Time/Temperature control for safety food, hot and cold holding at 135 degrees F (Fahrenheit) or higher and 41 degrees F and lower. (Chapter 3). II. Observations and interviewsOn 7/20/26 at 1:01 p.m., in room [ROOM NUMBER], the resident's breakfast tray was still in the room with uneaten food. The breakfast tray was delivered at approximately 8:00 a.m. On 7/20/26 at 4:50 p.m., in room [ROOM NUMBER], there was a lunch tray with uneaten food still at the resident's bedside. The tray contained a plate of food and a cup of milk. The tray had been sitting on the resident's bedside table unrefrigerated for over five hours. At 5:28 p.m., an unidentified certified nurse aide (CNA) delivered the dinner tray and removed the lunch tray from the room. On 7/27/26 at 1136 a.m., in room [ROOM NUMBER], the resident still had his breakfast tray in his room and he was eating his breakfast meal, which consisted of a breakfast burrito, oatmeal and milk. Breakfast trays are delivered at approximately 8:00 am. On 7/27/26 at 11:38 a.m. in room [ROOM NUMBER], there was a breakfast tray (from 8:00 a.m.) was still sitting on the resident's bedside table. A CNA arrived at 11:39 a.m. and delivered the resident's lunch tray, setting it on the resident's dresser. The resident was not in the room. The CNA said they would not take the breakfast tray away because the resident wanted it left in the room in case he wanted to eat the food. Both trays remained in the resident's room unrefrigerated. -At 11:50 am the dietary manager (DM) was requested to take temperatures of the resident's food. The breakfast meal consisted of pancakes, bacon, uncovered milk, oatmeal and an uncovered chocolate cake like pastry. There was a fly crawling on the cake. The DM took the temperature of the food. The milk tempted at 79 degrees Fahrenheit(F) the pancakes tempted at 78 degrees F. The lunch tray recently delivered consisted of a cheese enchilada, uncovered milk and uncovered lettuce salad also on the lunch tray. This meal was still within the safe zone for consumption. The DM said meal trays should not sit for more than an hour before they were removed from the residents' room to ensure the food was safe to eat. The DM said he could not remove the resident's breakfast tray. Cross-referenced to F584 for a failure to maintain comfortable ambient temperatures and have an adequate cooling system during unusually high temperatures. III. Staff interviewsCNA #6 was interviewed on 7/27/26 at 12:00 p.m. CNA #6 said the resident who resided in room [ROOM NUMBER] bed A preferred to eat at his own pace. She said the staff left the trays in his room as long as he requested to accommodate his preference. CNA #3 was interviewed on 7/23/26 at 9:30 a.m. CNA #3 said he left a breakfast tray at the resident's bedside to allow him sufficient time to eat. He said he removed the resident's meal trays when he delivered the next meal. He said the breakfast tray would remain on the resident's bedside table until the lunch tray was delivered at around 11:30 a.m. The NHA, corporate nurse consultant and the director of nursing (DON) were interviewed on 7/28/26 at 4:00 p.m. The NHA said they were accommodating resident rights by leaving their meal trays in their rooms (for extended periods of time) until the resident allowed them to remove the trays. The regional nurse said they had four residents who would not allow the staff to (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pick up their trays after the tray even when the meal trays had been left out of refrigeration for more than an hour after being delivered. She said the residents were insistent on this process and they did not want to remove the trays because they would then have to deal with escalating negative behaviors. The recreational nurse said it was the resident's right to consume the food even if it was in the temperature danger zone.		