STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Red Rocks	150 Spring St Morrison, CO 80465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#5 and #12) of 14 residents were free from verbal abuse out of 27 sample residents.Resident #5 was admitted to the facility's secured unit with diagnoses of frontal temporal neurocognitive disorder (type of dementia that leads to changes in personality, behavior and language), Huntington's disease (progressive breakdown of the nerve cells in the brain), dementia with behavioral disturbances, tremors, and depression on 6/25/25. Despite the prison referral paperwork that identified Resident #5 had aggressive behaviors, the facility admitted the resident to the secured unit from prison. The resident had spent the majority of his life in prison or homeless. The prison's physician recommended that the resident have a one-on-one caregiver for an adjustment period. However, record review and observations revealed the facility did not consistently implement the one-to-one caregiver. Documentation revealed Resident #5 had verbally aggressive behaviors towards other residents on the secured unit. Observations revealed Resident #5 was aggressive, yelling, screaming and shaking his fists in the faces of residents and staff. He was observed placing his face inches away from Resident #12's face while screaming profanities at him. The facility staff were unable to redirect Resident #5 effectively. Resident #4 said she was afraid of Resident #5 and hid in her room. A staff member locked another resident out in a courtyard due to the concern that their PTSD (post traumatic stress disorder) would be triggered due to Resident #5's behaviors. On 7/21/25 the facility staff called the local police department to come help with Resident #5. Resident #5 was taken to a local hospital and placed on an M1 hold (a mental health hold due to someone being at risk of harm to themselves or others). Specifically, the facility failed to protect Resident #4, Resident #12 and other residents on the secured unit from verbal and physical abuse by Resident #4, which led to Resident #4 hiding in her room due to fear. Findings include:I. Facility policy and procedureThe Abuse, Neglect, and Exploitation policy 6/1/25, was provided by the nursing home administrator (NHA) on 7/24/25 at 2:42 p.m. via email. It read in pertinent part, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. An assessment of the individual's functional and mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission. The facility will make individual determinations in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Possible indicators of abuse include, but are not limited to: Verbal abuse of a resident overheard. Psychological abuse of a resident observed. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.II. Resident #5 (assailant)A. Resident statusResident #5, age less than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included frontal temporal neurocognitive disorder, Huntington's disease, dementia with behavioral disturbances, tremors and depression. The 6/30/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of zero out of 15. He had hallucinations. He had physical behavioral symptoms directed towards others such as hitting, kicking, pushing, scratching and grabbing. He had verbal behavioral symptoms directed toward others such as screaming, threatening, and cursing. The resident required supervision with oral hygiene and bathing. B. Record reviewThe admissions paperwork from the State Department of Corrections revealed the

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#1) of three residents reviewed for medications errors out of 27 sample residents. Specifically, the facility failed to ensure Resident #1 received intravenous (IV) vancomycin (an antibiotic used to treat bacterial infections) for a diagnosis of staphylococcus hominis bacteremia (a bloodstream infection) per physician's orders. Findings include:I. Professional referenceAccording to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment.Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:-The right medication;-The right dose;-The right patient;-The right route;-The right time;-The right documentation; and,-The right indication.II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included status epilepticus (seizure lasting longer than five minutes), bacteremia (infection of the blood stream), acute aspiration pneumonia (pneumonia caused by inhaled substances such as food or liquids) and acute encephalopathy (altered mental state).The 6/26/25 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15 the resident was unable to participate. The BIMS was completed by staff assessment and scored moderately impaired. He required total assistance with all of his activities of daily living (ADL).B. Resident #1's representative interviewResident #1's representative was interviewed 7/22/25 at 7:00 p.m. She said when she visited the resident on 6/20/25, the evening after his readmission from the hospital, she had noticed there was not an IV pole in his room. She asked an unidentified nurse about the IV vancomycin and was informed the medication had not been delivered from the pharmacy. The representative said the resident did not receive any doses since his return from the hospital on 6/19/25. Resident #1's representative said the resident was to receive a dose on 6/19/25 and two doses on 6/20/25. She said she had not been notified about the missed doses and was not able to get an answer on when the IV vancomycin would be delivered from the pharmacy. She said she was frustrated with the situation and insisted the resident return to the hospital so he could receive the IV vancomycin. C. Record reviewA review of Resident #1's electronic medical record (EMR) revealed the resident had been in the hospital from [DATE] through 6/19/25. The hospital discharge orders included sodium chloride 0.9% Actbag 250 milliliter (ml) with vancomycin 1.25 gram recon solution 1250 milligram (mg) (medication infused with fluids) every 12 hours for six days for the diagnosis of staphylococcus hominis bacteremia. The June 2025 medication administration record (MAR) revealed the physician's order had been placed 6/19/25 with a start date of 6/20/25. The MAR indicated the resident did not receive IV vancomycin on 6/19/25 or 6/20/25. The nursing progress note, dated 6/19/25, documented the medications were verified with the provider and the pharmacy, including the IV vancomycin. The 6/20/25 nursing progress note documented at 10:01 a.m. revealed the facility was still waiting for the pharmacy to deliver the medication. The 6/20/25 nursing progress note documented at 11:00 p.m. revealed Resident #1's representative expressed her frustration that the resident had not received the medication since his return and demanded the resident return to the hospital. The 6/21/25 nursing progress note documented at 7:50 a.m. the resident was sent to the emergency room.-The resident was admitted to the hospital on [DATE] for three days. The 6/21/25 nursing progress documented at 3:51 p.m., revealed the assistant director of nursing (ADON) was notified the IV vancomycin was not available. The ADON called the pharmacy and was told the pharmacy had not received the order. The ADON informed the resident's physician of the situation.-The physician was not called until 6/21/25, after the resident had missed three doses and after the resident returned to the hospital. -The pharmacy was not called until 6/21/25, after the resident had missed three doses and after the resident returned to the hospital. III. Staff interviewsThe ADON was interviewed on 7/23/25 at 8:38 a.m. The ADON said Resident #1 should have received the first dose on 6/19/25 when he returned from the hospital. She said she had placed the order for the IV vancomycin on 6/19/25. She said he was not notified of the missed doses until 6/21/25. She notified the physician on 6/21/25, after the resident missed three doses.The ADON