

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2025
NAME OF PROVIDER OR SUPPLIER The Lodge at Red Rocks		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to protect three (#7, #3 and #5) of seven residents reviewed for abuse out of 10 sample residents. Resident #8 was admitted to the facility on [DATE] and was moderately cognitively impaired. He had a history of traumatic brain injury, dementia and diabetes. Resident #7 was admitted to the facility on [DATE] and had a history of dementia, was dependent on staff for all cares and was non-verbal. On 9/29/25 the facility was looking for Resident #8, who was identified as missing. The facility located Resident #8 in Resident #7's room by staff. Resident #8 was found lying on top of Resident #7 with his pants and incontinence brief pulled down below his knees and hips directly over the face of Resident #7. Resident #7 and Resident #8 were separated by staff and police. Resident #7 was sent to the hospital where a sexual assault nurse exam (SANE) was conducted. Hospital records indicated a male (Resident #8) was found with his penis around her mouth and he had stated he attempted vaginal intercourse with Resident #7. Resident #8 was given an immediate discharge notice. Resident #8 was removed from the facility on 9/29/25 by police and was taken to jail. Resident #4 was admitted to the facility on [DATE] and had moderate cognitive impairments. He had a history of dementia, viral hepatitis C and sexually inappropriate behaviors towards female staff. Resident #3 was admitted to the facility on [DATE] and was discharged on 8/29/25. She was cognitively intact and had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (paralysis and weakness). On 8/14/25, Resident #4 requested Resident #3 to have sex with him. Resident #3 informed the facility that Resident #4's actions upset her. The facility implemented 15-minute checks starting on 8/14/25 until 8/16/25. However, the facility did not reassess to ensure if it was appropriate to discontinue the checks. On 8/20/25, Resident #4 again requested Resident #3 to have sex, which Resident #3 declined. The facility failed to implement effective interventions regarding Resident #4's sexual behaviors, which resulted in Resident #4's continued sexual comments on three occasions that were upsetting to the residents. After the incident on 8/20/25, the facility placed both Resident #3 and Resident #4 on 15-minute checks for 72 hours. The facility discontinued the 15-minute checks after 72 hours with no documentation to indicate the residents were reassessed for safety prior to discontinuing the checks. Resident #5, was admitted on [DATE] and had severe cognitive impairments. Resident #5 had diagnoses of unspecified dementia without behavioral disturbance, moderate intellectual disabilities and cognitive communication deficit. On 8/26/25 Resident #5's representative notified the facility that Resident #4 had approached Resident #5 and asked her if she wanted to go to his room to have sex. The facility unsubstantiated the allegations and determined Resident #4 had the right to ask other residents any questions. However, Resident #5's representative said Resident #5 was upset for about a week following the incident. On 8/26/25 the facility implemented a one-to-one caregiver for Resident #4. However, documentation and interviews revealed inconsistencies with a continuous one-to-one caregiver for Resident #4. Specifically, the facility failed to: -Protect Resident #7 from sexual abuse by Resident #8; -Protect Resident #3 from sexual harassment by Resident #4; and, -Protect Resident #5 from sexual harassment by Resident #4. Findings include:</p> <p>I. Immediate jeopardy</p> <p>A. Findings of immediate jeopardy</p> <p>Resident #8 was admitted to the facility with diagnoses of dementia and a traumatic brain injury. When Resident #8 was reported missing, the facility staff found Resident #8 in Resident #7's room. Resident #7 had severe cognitive impairments and was non-verbal. Resident #7's pants and brief were pulled down and his hips were above Resident #7's face.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility failed to protect Resident #7 from sexual abuse from Resident #8.</p> <p>Resident #4 who admitted to the facility on [DATE] had a history of being sexually inappropriate with female staff.</p> <p>The facility's failure to implement effective, long term interventions to address Resident #4's sexually inappropriate behaviors, resulted in Resident #4 sexually harassing Resident #3 and Resident #5.</p> <p>The facility's failure to ensure all staff members were aware of Resident #4 behaviors, what to monitor for and how to address the behaviors resulted in further incidents that made Resident #3 and Resident #5 uncomfortable and upset.</p> <p>After Resident #7 was sexually abused, the facility began taking Resident #4's behaviors into consideration and implemented a one-to-one caregiver for Resident #4.</p> <p>B. Facility notification of immediate jeopardy</p> <p>On 10/30/25 at 2:28 p.m., the nursing home administrator (NHA) was notified the facility's failure created an immediate jeopardy situation.</p> <p>C. Facility plan to remove immediate jeopardy</p> <p>On 10/30/25 at 6:33 p.m. the facility submitted a plan to remove immediate jeopardy. The plan read:</p> <p>Identification of residents affected or likely affected: the director of nursing (DON), the social services director (SSD), and designee were to interview/assess residents with brief interview for mental status (BIMS) assessment scores of eight or above for potential abuse, concerns were not identified and completed on 10/30/25.</p> <p>For residents who had a BIMS score below eight, the power of attorney (POA) or residents' representatives would be contacted to identify any concerns regarding abuse, initiated 10/30/25.</p> <p>Resident #8 was issued an immediate discharge notice on 9/29/25 to prevent further abusive behaviors.</p> <p>The following actions were taken to prevent Resident #4 from perpetrating additional abusive behaviors:</p> <p>He was placed on a one-to-one caregiver on 10/1/25 until alternate placement can be found.</p> <p>The one-to-one caregivers were provided resident specific education defining what they were watching for (sexually inappropriate comments, monitoring for any inappropriate responses in sexual nature, with history of sexual assault allegations). The one-to-one caregivers were educated on who to notify if any behaviors were identified/observed. The education would be completed prior to the next scheduled shift.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The plan documented that in the event of any future resident-to-resident sexual abuse, the perpetrating resident would immediately be placed on one-to-one supervision until the primary care physician, nursing, and psychology evaluations were completed. Outcomes of these evaluations would result in continued one-to-one supervision or the initiation of discharge planning to a facility with a focus on behavior management. This was provided to the IDT team in the form of education on 10/30/25.</p> <p>D. Removal of immediate jeopardy</p> <p>On 10/30/25 at 7:10 p.m. the NHA was notified the facility plan to remove immediate jeopardy was accepted based on the facility's plan and evidence of implementation of the measures outlined in the plan. However, the deficient practice remained at a G level, actual harm that is not immediate.</p> <p>II. Facility policy and procedure</p> <p>The Abuse, Neglect and Exploitation policy, revised 6/1/25, was received on 10/28/25 at 10:44 a.m. from the DON. It revealed 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.</p> <p>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. 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.</p> <p>Criminal sexual abuse is serious bodily injury/harm and shall be considered to have occurred if the conduct caused the injury. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.</p> <p>Sexual Abuse is non-consensual sexual contact of any type with a resident.</p> <p>The facility will develop and implement written policies and procedures that: prohibits and prevents abuse, neglect, and exploitation of residents and misappropriation of resident property; policies and procedures to investigate any such allegations; includes training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention; and, establishes coordination with the quality assurance and performance improvement (QAPI) program.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.</p> <p>The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p> <p>Possible indicators of abuse include, but are not limited to: resident, staff or family report of abuse; p marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body; physical injury of a resident, of unknown source; verbal abuse of a resident overheard; physical abuse of a resident observed; 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.</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; protection from retaliation; providing emotional support and counseling to the resident during and after the investigation, as needed; revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>III. Incident of sexual abuse towards Resident #7 by Resident #8 on 9/29/25</p> <p>A. Facility investigation</p> <p>The 9/29/25 facility investigation was provided on 10/28/25 at 3:41 p.m. by regional clinical resource #1.</p> <p>The investigation documented Resident #8 was found in Resident #7's room lying in her bed facing her. His pants and briefs were pulled down and his pelvis was near her face. The investigation documented Resident #7 was unable to give consent.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A psychosocial note, dated 9/29/25 at 2:46 p.m., documented the resident was resting in bed with no visible signs of pain or discomfort. There was no redness around the resident's mouth, as was reported by the hospital. Staff reported Resident #7 consumed 100% of her breakfast and lunch.</p> <p>A physician's progress note, dated 9/29/25 at 5:01 p.m., documented the physician saw Resident #7 at the facility's request after a sexual assault. The note documented the incident involved a male resident (Resident #8), who was found in Resident #7's room with his pants down and uncovered. The male resident that was found in her room reported that they were having a consensual relationship. However, the resident was nonverbal and unable to provide consent.</p> <p>F. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 10/28/25 at 3:42 p.m. CNA #1 said she did not know what the colored door tags meant on residents' rooms. CNA #1 said she was not aware there was an education binder available to her.</p> <p>Licensed practical nurse (LPN) #4 was interviewed on 10/30/25 at 9:46 a.m. LPN #4 said she did not know what the colored tag on the residents' rooms were for. LPN #4 said she was not aware that there was a binder available to her that contained education material.</p> <p>-The facility failed to educate all staff on the implementation of the colored tags on the residents' doors to indicate residents that required frequent rounding, per their correction plan, following the incident of sexual abuse on 9/29/25 (see facility investigation above).</p> <p>Regional clinical resources #1 was interviewed on 10/28/25 at approximately 4:45 p.m. Regional clinical resources #1 said Resident # 7 stayed in her room and she was receiving hospice services.</p> <p>Regional clinical resource #2 was interviewed on 10/28/25 at 4:53 p.m. Regional clinical resources #2 said Resident #7 had been on hospice services on and off since her admission to the facility. She said Resident #7 was non-verbal and relied on staff for needs. Regional clinical resource #2 said the facility staff completed an in-house audit of sexual abuse and feeling safe questions after the 9/29/25 occurrence to ensure residents were safe and no other residents had experience sexual abuse.</p> <p>The social service assistant (SSA) was interviewed on 10/29/25 at 12:46 p.m. The SSA said Resident #7 was non-verbal. She said she checked in with Resident #7 after the sexual abuse incident on 9/29/25. She said during the check-in, she observed non-verbal body language that could indicate fear, such as jumping when touched. The SSA said Resident #7 may not have been aware of the sexual encounter due to her disease process.</p> <p>The SSA said Resident #8 had not had any issues in the facility to her knowledge until the day he left in police custody.</p> <p>IV. Incidents of abuse towards Resident #3 by Resident #4 on 8/14/25 and 8/20/25</p> <p>A. Facility investigation on 8/14/25</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Lodge at Red Rocks		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Spring St Morrison, CO 80465	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The 8/14//25 facility investigation documented Resident #4 poured coffee on Resident #3 after she denied his advances to go to his room. The investigation revealed Resident #4 did pour coffee on Resident #3 after she declined his offer to join him in his room. Resident #3 was visibly upset by Resident #4's requests. The investigation documented the facility determined there was no intention of harm from Resident #4.</p> <p>-However, Resident #3 was observed to be upset and crying after the incident.</p> <p>The investigation documented the facility placed Resident #4 on 15-minute checks from 8/14/25 to 8/16/25. The 15-minute checks were discontinued after an IDT team discussion.</p> <p>-However, there was no documentation to indicate why 15-minute checks were discontinued.</p> <p>-Review of Resident #4's care plan on 10/30/25 revealed the facility did not update Resident #4's with any interventions to prevent further sexual abuse or for sexually inappropriate advances towards female residents.</p> <p>The investigation documented the facility substantiated the abuse towards Resident #3 by Resident #4 on 8/14/25.</p> <p>B. Facility investigation on 8/20/25</p> <p>The 8/20/25 facility abuse investigation, documented at 4:28 p.m., revealed Resident #3 reported that Resident #4 asked to engage in sexual behavior with her. Immediate safety measures included temporarily moving Resident #3's room and placing both residents on 15-minute checks. The police were notified on 8/20/25 at 3:47 p.m.</p> <p>The investigation documented Resident #3 was assessed by the assistant director of nursing (ADON) on 8/20/25 with no new concerns. Resident #3 was interviewed and said she had previously consented with Resident #4 but did not want to at the time.</p> <p>Resident #4 was interviewed and denied the allegation. He said he did not remember this happening. Interviews with staff and other residents revealed Resident #3 and Resident #4 were often together in the smoking area communicating with each other. The investigation documented that Resident #3's care plan was updated to reflect her behavior and wishes and Resident #4 remained on 15-minute checks.</p> <p>-However, review of Resident 3's care plan on 10/30/25 did not reveal updates to the care plan following the 8/20/25 incident.</p> <p>The investigation concluded the occurrence was unsubstantiated.</p> <p>-However, abuse occurred due to Resident #4's continued sexual harassment towards Resident #3, despite Resident #3 not wanting to engage in sexual activity with Resident #4.</p> <p>B. Resident #4 (assailant)</p> <p>1. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #4, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia with behavioral disturbance and viral hepatitis C without hepatic coma (blood borne disease).</p> <p>The 10/7/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of nine out of 15. He required partial assistance with bathing. He was independent with other activities of daily living (ADL).</p> <p>The MDS assessment documented no behavioral symptoms toward others.</p> <p>2. Observations</p> <p>On 10/28/25 at 10:45 a.m. Resident #4 was in his room while staff was seated outside the room and provided continuous one-on-one supervision.</p> <p>On 10/28/25 at 4:17 p.m. Resident #4 stepped out of his room and asked CNA #5, who was providing one-on-one supervision, if he could go to the smoking area. He received a cigarette from the nurse and he was escorted outside to the designated smoking area.</p> <p>A 4:22 p.m. Resident #4 was escorted back inside the building and he sat in the lobby area while CNA #5 continued to provide one-on-one supervision.</p> <p>At 4:30 p.m. CNA #5 escorted the resident back to his room.</p> <p>On 10/29/25 at 9:40 a.m. an unidentified staff member was seated outside Resident #4's door while he was in his room.</p> <p>On 11/3/25 at 11:30 a.m. Resident #4 was walking back from the smoking area with a one-on-one caregiver next to him.</p> <p>3. Record review</p> <p>The behavioral care plan, initiated 8/5/24 and revised 11/15/24, documented Resident #4 had dementia and at times displayed inappropriate behaviors related to his diagnosis. The care plan indicated the resident occasionally made unwelcome and inappropriate, sometimes sexual, comments directed toward female staff. Pertinent interventions, initiated on 11/4/24, included documenting each instance of inappropriate comments, noting any potential triggers, time of day, location, and response strategies that were effective, responding to inappropriate comments with a calm, neutral tone, monitoring behavior episodes to determine underlying causes and intervening as necessary to protect the rights and safety of others. The care plan included interventions, initiated on 11/4/24, for staff to monitor Resident #4 closely when in common areas, especially around female staff or residents, and to provide frequent redirection. The care plan documented additional interventions, initiated on 10/10/25, which included that Resident #4 was to receive one-to-one care from staff and was to be closely monitored at all times with readiness to de-escalate any behaviors.</p> <p>The 7/14/25 IDT note revealed Resident #4 was able to make his needs known verbally and effectively. The note revealed Resident #4 had demonstrated inappropriate behavior toward female residents and continued to ha</p>		

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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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents had adequate supervision to prevent accidents for one (#2) of three residents reviewed for accident hazards out of 10 sample residents. Specifically the facility failed to provide adequate supervision to prevent an elopement for Resident #2 after he informed staff he was not staying at the facility on the day he was admitted to the facility. Resident #2, who had diagnoses of dementia, Alzheimer's disease and history of a traumatic brain injury, was admitted to the facility on [DATE]. Upon the resident's admission, during initial completion of admission paperwork with the resident and his family, Resident #2 stated to licensed practical nurse (LPN) #5 that he was not staying at the facility.-However, LPN #5 failed to notify the appropriate staff regarding the resident's comment or put immediate interventions in place to prevent the resident's elopement.Upon completion of the admission paperwork, Resident #2's family left the facility. The resident followed his family outside when they left and was redirected back into the facility by the admissions coordinator. The admissions coordinator sat with the resident briefly in the lobby and then left. When she returned to the lobby, Resident #2 was gone. -The admissions coordinator failed to notify staff that Resident #2 followed his family outside and failed to ensure he was further supervised.Resident #2 was found by bystanders at a gas station near the facility where he had fallen. The resident was transported by emergency medical services (EMS) to the hospital where it was discovered he had a fracture of his right hand. The resident did not return to the facility. Findings include:I. Facility policy and procedureThe Elopements and Wandering Residents policy, dated June 2025, was received on 10/30/25 from the director of nursing (DON). It read in pertinent part, The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Adequate supervision will be provided to help prevent accidents or elopements.The New admission Dementia Protocol, undated, was received on 11/3/25 at approximately 4:40 p.m. from the regional clinical resource. It read in pertinent part, Review with resident and family dementia protocol prior to admission. Request wander guard (a device which tracks the location of the resident and alarms at exit points) placement for the first seven days for any mobile resident with or without an assistive device. Review the increased risk for elopement. Explain that the skilled admit unit has easy access to the outside and that to increase safety and security while we get to know their loved ones this is our protocol. Ensure wander guard consent is signed. admission assessment to be completed by floor nurse that includes the elopement assessment. Order placed for wander guard including location and to check placement and functioning every shift. Order to be placed for review of ongoing need for a wander guard after seven days of behavior tracking. On day seven, the interdisciplinary team (IDT) will review all documentation, update elopement evaluations and evaluate the ongoing need for wander guard.II. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia, Alzheimer's disease (a brain disorder that causes memory loss and confusion), history of traumatic brain injury (damage to the brain caused by a sudden external force) and conversion disorder with seizures or convulsions (a mental health condition where a person experiences physical symptoms such as seizures or convulsions).The minimum data set (MDS) assessment was not completed. Progress notes revealed Resident #2 was alert and was walking and talking upon his arrival to the facility.B. Facility investigation of Resident #2's elopement incident on 8/12/25 Review of the facility's investigation of Resident #2's elopement incident, dated 8/12/25, revealed the resident was admitted to the facility on [DATE] and was ambulatory without an assistive device. The investigation revealed Resident #2 was admitted to an unsecured unit. He was in his room with family and a nurse while the admission paperwork was completed. He then went to the lobby to say goodbye to his family and followed them outside the facility. Resident #2 was redirected to come back inside the facility by the admissions coordinator who then sat with Resident #2 in the lobby briefly. The admissions coordinator left and upon her return to the lobby, she noticed the resident was gone. The resident was reported missing and an immediate search was initiated at 3:45 p.m. Resident #2 was found at a gas station in town at 3:55 p.m. The investigation indicated staff conducted an assessment on the resident and he was observed to have minor abrasions (superficial wearing off of skin) to bilateral (both) knees and a laceration (cut) to the forehead The</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for staff based on the facility assessment and resident population for four of five certified nurse aides (CNA) reviewed. Specifically the facility failed to:-Ensure CNA #6 and CNA #7 had dementia training;-Ensure CNA #6, CNA #7 and CNA #8 had behavioral health management training;-Ensure CNA #5 and CNA #7 had resident rights training;-Ensure CNA #5 and CNA #7 had infection control training;-Ensure CNA #5, CNA #6 and CNA #7 had quality assurance performance improvement (QAPI) training; and,-Ensure CNA #7 had effective communication. Findings include:I. Record reviewA request for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics, and resident rights training was made on 11/3/25 at 10:30 a.m. for CNA #5, CNA #6, CNA #7 and CNA #8.The facility was unable to provide documentation that CNA #5 (hired on 6/1/25) had received QAPI training upon hire.The facility was unable to provide documentation that CNA #6 (hired 6/1/25) had received dementia, behavioral health, QAPI training upon hire. The facility was unable to provide documentation for CNA #7(hired on 8/15/25) had received effective communication, resident rights, dementia, QAPI, Infection control and behavioral health management training upon hire.The facility was unable to provide documentation for CNA #8 (hired 6/1/25) had behavioral health training upon hire. II. Staff interviewsThe staff development coordinator (SDC) was interviewed on 11/4/25 at 9:20 a.m. The SDC said she had only worked at the facility since late June 2025. The SDC said she provided education and in services to staff as education opportunities arose. She said she provided education during monthly staff meetings, and by placing an education binder at the nurses' station and providing tests to ensure the staff knew the information. The SDC said staff education was important to ensure staff were aware of what they were required to do and how to complete their job duties.The SDC said the facility held a skills fair at the end of June 2025 where different departments educated the staff on different topics.The nursing home administrator (NHA) was interviewed on 11/4/25 at 10:04 a.m. He said he had only worked at the facility a month. The NHA said he was informed there were gaps in staff education requirements and would be working with human resources to ensure staff files were up to date, which would include mandatory education. The NHA said they had recently set up an online training platform to help improve tracking of education. He said currently education was provided at staff meetings and at time of hire.</p>		