STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065192	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation and Nursing Center of the Rockies	1020 Patton St Fort Collins, CO 80524

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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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#52) of five residents had the right to choose her own attending physician out of 37 sample residents. Specifically, the facility failed to allow Resident #52 to choose their primary care provider (PCP) when the resident's previous primary care provider stopped seeing residents. Findings include: I. Facility policy and procedure The Resident Rights policy and procedure, revised June 2025, was provided by the nursing home administrator (NHA) on 6/27/25 at 4:32 p.m. It read in pertinent part, The resident has the right to choose a personal attending physician (and be informed how to contact him or her), to be fully informed in advance about care and treatment, and, unless adjudicated incompetent or otherwise found incapacitated under state law, participate in planning medical treatment. II. Resident #52 A. Resident status Resident #52, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included chronic kidney disease, stage 3, history of malignant neoplasm of cervix and uterus (cervical cancer), short bowel syndrome (a condition where the small intestine was unable to absorb enough nutrients and fluids from food), severe sepsis with septic shock (life threatening condition occurring when the body's response to an infection damages its own tissues and organs), colostomy (surgical procedure that creates an opening in the abdominal wall allowing the colon to the surface to allow stool to exit the body) agoraphobia with panic disorder (a mental health condition characterized by an intense fear of public spaces or situations where escape might be difficult), depression, bipolar 2 disease, post-traumatic stress disorder, mixed obsessional thoughts and acts. The 5/7/25 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. She had an impairment on one upper extremity and required a walker. She required set-up assistance with eating, oral hygiene, and showering. (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment revealed it was very important for her to choose what she wore, for her to take care of her personal belongings, for her to choose her bedtime and for her family or close friends to be involved in discussion about her care. B. Resident interview Resident #52 was interviewed on 6/23/25 at 10:36 a.m. Resident #52 said she loved her former PCP. She said her PCP's clinic had closed indefinitely, and she said she had to be seen by the facility's physician. She said she did not have a choice in what physician took over her care, and the facility did not provide any documentation for her to be able to select an attending physician of her choice. C. Record review The 4/15/25 nurse progress note revealed nursing received notification that Resident #52's physician was ending their provider services with the nursing facility, effective at the end of April 2025. The note documented Resident #52 was notified and wished to transfer to the facility's providers. A telephone call was placed to the facility's providers to notify them of the new resident. The social services director (SSD) and the director of nursing (DON) were aware. -However ,the facility was unable to provide documentation to indicate that Resident #52 was informed about the change in her attending physician or that the resident's permission was obtained to assign the facility's physician as her physician. III. Staff interviews The social services director (SSD) was interviewed on 6/26/25 at 4:19 p.m. The SSD said if a resident said they did not like their current physician, the facility told the current physician and then she sent a referral to other providers to see if the other providers would accept the resident. She said anyone on the interdisciplinary team (IDT) was responsible for working with the resident in selecting a physician, but she said typically it was the nursing staff and/or herself. She said the change in physician was documented as a progress note. The SSD said the facility was provided about three days notice that Resident #52's medical group was dissolving and the physicians in that group, including Resident #52's physician, quit quickly after the medical group announced they had ended services. She said there was no option for physicians provided to Resident #52 because there was no other option other than the one physician for the facility. The SSD said if a resident wanted to choose a different physician besides the facility's physician, the facility needed to make sure the physician the resident wanted to choose was credentialed and licensed. She said the facility did not have enough time in April 2025 because the change happened so quickly. The SSD said she should have explained to Resident #52 how the process to choose a different physician that was not contracted with the facility worked, and asked the resident if she was okay with the facility's physician while the facility worked on a contract for a second physician for the resident to choose from. (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interim nursing home administrator (INHA) was interviewed on 6/26/25 at 4:49 p.m. The INHA said it was the resident's choice for who they wanted for their physician. He said if a resident wanted a different physician, the choice was based on which physician was contracted with the facility. He said if a resident wanted a physician who was not contracted with the facility, the facility worked to verify that the physician had their credentials and licensing. He said it could take the facility a couple of days to weeks to months to get a contract with a new physician, depending on the physician's communication with the facility's corporate licensing department. The INHA said the SSD was responsible for working with the residents for their choice of physician. The INHA said he did not know how it was documented when a resident changed physicians. He said it was explained when the resident was admitted in the admission packet. He said he was not familiar with Resident #52. The INHA said the facility had one physician currently contracted with the facility.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to provide response, action and rationale to residents involved in group grievances. Specifically, the facility failed to effectively address, resolve and follow up with residents on the outcomes and resolutions of grievances expressed. Findings include: I. Facility policy and procedure The Grievance policy, reviewed June 2025, was provided by the nursing home administrator (NHA) on 6/27/25 at 4:42 p.m. It read in pertinent part, The grievance official or designee responds to the individual expressing the concern within three working days of the initial concern to acknowledge receipt and describe steps taken in resolution. II. Resident group interview Four residents (#14, #11, #8 and #54) who regularly attended the resident council meetings were interviewed on 6/25/25 at 9:00 a.m. The residents were identified as alert and oriented by the facility and assessment. The group of residents said the facility did not follow up on grievances brought up in the resident council meetings. Resident #14 said when a grievance came up in the resident council meeting the department head tried to address it during the meeting. Resident #14 said he did not know what happened if a resident had an individual grievance and how the facility handled it. Resident #8 said the resident council had been bringing up the issue of call light times and linens not being changed on their beds but the resolutions were never brought back to resident council. Resident #14 said he specifically complained about linens not being changed but he did not know what the resolution had been. The residents said they did not know how to file a grievance or how the staff were to notify them of resolutions. III. Record review A review of the resident council meeting minutes, dated 3/27/25, revealed the residents brought up concerns regarding cigarette butts on the ground in the smoking area, an individual resident left in the bathroom for too long a time and an individual resident had missing clothes. A review of the March 2025 grievances revealed individual grievances had been written for the missing clothes and the long bathroom wait with resolutions of staff education. A group grievance had been written for the cigarette butts outside and the patio was cleaned. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of the March 2025 grievances and the resident council meeting minutes failed to reveal the facility had followed up with any of the individual residents or the resident council as a group regarding what had been done to resolve their concerns. A review of the resident council meeting minutes, dated 4/24/25, revealed the residents brought up concerns regarding cigarette butts on the ground in smoking area, cold food, room trays taking too long, an individual resident said she was in the bathroom too long, there needed to be better communication from therapy department regarding resident schedules and the toilets and floors in the resident rooms were not being cleaned well. A review of the April 2025 grievances revealed individual grievances had been written for the call light times, dirty floors and toilets, cold food, room trays taking too long, bathroom wait times, and communication from the therapy department with resolutions of staff education. A group grievance had been written for the cigarette butts outside and a sign was put up to not throw cigarette butts on the ground. A group grievance had been written for the bed linens not being changed on a regular basis and staff were provided education. -A review of the April 2025 grievances and the resident council meeting minutes failed to reveal the facility had followed up with any of the individual residents or the resident council as a group regarding what had been done to resolve their concerns. A review of the resident council meeting minutes, dated 5/29/25, revealed the residents brought up concerns regarding a shortage of linens, dirty linens on the beds, receiving medications late, staff socializing and not helping the residents, long call light times and staff not changing bed linens. A review of the May 2025 grievances revealed individual grievances had been written for the receiving medications late, staff socializing and not helping the residents, and long call light times with resolutions of staff education. A group grievance had been written for dirty linens on the beds and staff not changing bed linens with resolutions of creating sign off sheets for the staff. -A review of the May 2025 grievances and the resident council meeting minutes failed to reveal the facility had followed up with any of the individual residents or the resident council as a group regarding what had been done to resolve their concerns. IV. Staff interviews The activities director (AD) was interviewed on 6/25/25 at 12:17 p.m. She said she helped the residents run the resident council meeting. The AD said the grievance process during the meeting was that the group talked about any grievances. She said she then wrote the concerns up on a grievance form. She said she then provided the grievance to the department manager responsible for the concern. She said the managers were to bring back the group grievance resolutions to the next meeting. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social services director (SSD) was interviewed on 6/25/25 at 12:26 p.m. She said she was the grievance official. She said the grievance process was for the person receiving the grievance to complete a grievance form and provide it to the department manager responsible. She said once an individual grievance or group grievance had been resolved, it was documented at the bottom of the grievance form. She was not able to explain why the group and individual grievances from March 2025 through May 2025 failed to include any documentation at the bottom of a follow up with the resident or family making the complaint. The SSD said the facility needed to improve this process to ensure resident concerns were being addressed timely.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#207 and #21) of five residents were free from chemical restraints and were receiving the least restrictive approach for their needs out of 37 sample residents. Specifically, the facility failed to: -Ensure Resident #21's behavior care plan had resident specific behaviors and triggers identified; -Document consistent behaviors for Resident #207 and Resident #21 to justify the continued use of psychotropic medications; and, -Document resident specific care approaches, to include medication specific target behaviors and person-centered interventions, for Resident #207 and Resident #21's psychotropic medications. Findings include: I. Facility policy and procedure The Chemical Restraint and Psychotropic Medication Management policy, dated April 2025, was provided by the nursing home administrator (NHA) on 6/27/25 at 4:42 p.m. It read in pertinent part, The facility's interdisciplinary team (IDT) will review the comprehensive assessment to ensure the plan of care shows individualized, person-centered care approaches to manage with non-pharmological interventions. II. Resident #207 A. Resident status Resident #207, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included anxiety, insomnia (difficulty sleeping) and dementia. The 5/28/25 minimum data set (MDS) assessment revealed Resident #207 was severely cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. The MDS assessment indicated the resident had not had any behaviors during the assessment look back period. B. Resident interview (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #207 was interviewed on 6/25/25 at 9:57 a.m. Resident #207 said she missed her husband and was lonely without him. Resident #207 said it made her feel anxious when she could not remember where he was and depressed when she thought he left her there. She said it made her feel better when the staff helped her call him and offered her reassurance and reminders that she would be with him again. C. Record review The behavior care plan, revised 5/28/25, revealed Resident #207 used psychotropic medications related to dementia with anxiety. Interventions included monitoring for occurrences of target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication and violence or aggression towards staff or others (initiated 5/28/25). The mood care plan, revised 6/9/25, revealed Resident #207 used anti-anxiety medication related to an anxiety disorder. Interventions included monitoring for occurrences of target behavior symptoms of tearfulness, signs of over worrying and verbalizations of feeling nervous. Non-pharmacological interventions included one-on-one, offering the resident an activity, adjusting the room temperature, offering the resident a back rub, repositioning, giving food or fluids, redirecting, removing the resident from the environment and offering the resident to use the toilet (initiated 6/9/25). The depression care plan, initiated 6/23/25 (during the survey), revealed Resident #207 used anti-depressant medication related to insomnia. Interventions included educating the resident, family, and caregivers of the risks, benefits, and side effects of the medication and monitoring for hours of sleep and providing non-pharmacological interventions such as one-on-one, activities, adjusting the room temperature, offering the resident a back rub, repositioning and giving fluids (initiated 6/23/25). -Review of Resident #207's care plan did not reveal the resident's expressions of depression had been included (see depression screen below). Review of Resident #207's June 2025 CPO revealed the following physician's orders: Clonazepam (antianxiety medication) 0.5 milligrams (mg). Give two times a day for anxiety, ordered 5/23/25. Trazodone 100 mg. Give one time a day at bedtime for insomnia/anxiety, ordered 5/23/25. Monitor behaviors for antidepressant use: tearfulness, difficulty sleeping or verbalizations of feeling sad or nervous. Intervention: 1. One-on-one 2. Activity 3. Adjust room temperature 4. Back rub 5. Change position 6. Give fluids 7. Give food 8. Redirect 9. Remove the resident from environment 10. Toilet 11. Other, ordered 5/23/25. Monitor behaviors for antianxiety use: tearfulness, signs or symptoms of overworrying and verbalizations of feeling nervous. Intervention: 0. Back rub 1. Redirect 2. Speak to or approach in a calm manner 3. Reposition 4. Offer snacks, fluids, milk 5. Assess for pain, ordered 5/23/25. Venlafaxine (antidepressant medication) 300 mg. Give one time a day for anxiety, ordered 5/24/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #207's medication administration records (MAR) and treatment admission records (TAR) from 4/23/25 to 6/25/25 revealed the following: The May 2025 (5/23/25 to 5/31/25) MAR/TAR revealed there was no documentation to indicate Resident #207 exhibited behaviors during the month. The June 2025 (6/1/25 to 6/25/25) MAR/TAR revealed there was no documentation to indicate Resident #207 exhibited behaviors during the month. The 5/28/25 admission depression screen revealed Resident #207 felt down, depressed or hopeless for seven to 11 days out of 14 days, felt tired or had little energy for seven to 11 days out of 14 days, and felt bad about herself, felt she was a failure, or felt she let herself and her family down for seven to days days out of 14 days. Review of Resident #207's electronic medical record (EMR) from 5/23/25 to 6/24/25 revealed the progress notes documented for Resident #207 did not indicate the resident exhibited any behaviors. III. Resident #21 A. Resident status Resident #21, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included dementia and major depressive disorder. The 5/15/25 MDS assessment revealed Resident #21 had moderate cognitive impairments with a BIMS score of nine out of 15. The MDS assessment mood section revealed Resident #21 was, at times, socially isolated. B. Record review Resident #21's behavior care plan, revised 5/16/25, revealed Resident #21 used psychotropic medications related to depression. Interventions, revised 5/16/25, included to monitor for occurrences of target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication, and violence or aggression towards staff or other (revised 5/16/25). -The care plan did not include any resident specific non-pharmacological care approaches or resident specific target behaviors of isolation, obsessions, need for routine, and hoarding tendencies that were identified in the Level II preadmission screening and resident review (PASRR) evaluation (see Level II PASRR evaluation below). Review of Resident #21's June 2025 CPO revealed the following physician's orders: Monitor behaviors for antidepressant use: tearfulness, lack of interest in activities of choice and/or verbalizations of feeling sad. Intervention: 1. One-on-one 2. Activity 3. Adjust room temperature 4. Back rub 5. Change position 6. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give fluids 7. Give food 8. Redirect 9. Remove the resident from environment 10. Toilet 11. Other, ordered 5/9/25. Trazodone (an antidepressant medication) 50 mg. Give one tablet by mouth at bedtime for insomnia, ordered 6/5/25. Sertraline (an antidepressant medication) 25 mg. Give one time a day for major depression disorder, ordered 6/25/25. -The behavior monitoring physician's order failed to include resident specific target behaviors of obsessions, need for routine, and hoarding tendencies that were identified in the Level II PASRR evaluation and included offering activities as an intervention, despite the Level II PASRR identifying the resident's preference to be alone (see Level II PASRR evaluation below). Review of Resident #21's MAR and TAR from 4/23/25 to 6/25/25 revealed the following: The May 2025 (5/23/25 to 5/31/25) MAR/TAR revealed there was no documentation to indicate Resident #21 exhibited behaviors during the month. The June 2025 (6/1/25 to 6/25/25) MAR/TAR revealed there was no documentation to indicate Resident #21 exhibited behaviors during the month. Review of Resident #21's EMR from 5/9/25 to 6/25/25 revealed the progress notes documented for Resident #21 did not indicate the resident exhibited any behaviors. Resident #21's Level II PASRR evaluation, dated 5/27/25, for mental illness and/or intellectual disabilities included the evaluation which revealed the resident had been evaluated for mental illness due to a qualifying diagnosis of major depressive disorder. During the evaluation, it was revealed to the reviewer by Resident #21's ex-wife (whom he was still very dependent on) that he had a fall at his assisted living facility and broke his hip and some of his ribs, resulting in placement in the skilled nursing facility he was currently at. The resident's preference was to be solitary and his favorite thing, per the ex-wife, was to be alone. Due to these preferences, Resident #21 had only been successful working at night because there were fewer people on that shift. The recent placement at the facility had been upsetting for him because of all the people around. She reported that he cried the previous day because he wanted to go back to his assisted living facility so badly. The ex-wife reported that Resident #21 had obsessive compulsive traits such as hoarding tendencies and a need for structure and routine and he had a daily habit of writing down the weather report and tracking whether it was accurate. A social services note, dated 6/4/25, revealed Resident #21's community provider had informed the social services director (SSD) that the resident may not be able to return to his prior level of function due to continuing difficulty with mobility and toileting. The SSD updated the resident's daughter on his increased needs and that he may not be able to return to his prior level of functioning. -The EMR failed to reveal any documentation to indicate that the SSD spoke with Resident #21 or the staff regarding the potential trigger (see Level II PASRR evaluation above). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The EMR failed to reveal the behaviors displayed that prompted the addition of a second antidepressant medication (Sertraline) on 6/25/25 (during the survey). IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/24/25 at 2:44 p.m. She said Resident #207 had behaviors of becoming anxious and confused, hoarding items in a bag because the resident believed she was discharging home soon and worrying where her husband was. CNA #1 said Resident #207's husband was residing in the same facility, but was now at a different facility. CNA #1 said the interventions that worked were to remind her why her spouse was not there and offering to help her call him before she went to bed. CNA #1 said Resident #21 did not have any behaviors of depression and he preferred to be by himself. She said the CNAs documented in the CNA charting but there was only a list of generic, template behaviors and interventions available in the CNA charting and if the appropriate behavior or intervention were not on the template, the CNA would tell the nurse so the nurse could make a progress note. Licensed practical nurse (LPN) #1 was interviewed on 6/24/25 at 3:00 p.m. LPN #1 said Resident #207 was impulsive, did not wait for staff to assist her to the toilet, and was confused because she believed her spouse was going to take her home everyday. LPN #1 said she did not know what signs and symptoms of anxiety and depression looked like for Resident #207. LPN #1 said Resident #21 did not have any behaviors and she was not aware of any triggers for him. She said resident behaviors and interventions to monitor and to use were in a behavior monitoring physician's order and showed up on the TAR; however, it was a generic template. She said the nurses could look in the resident's care plan, but she said nurses generally did not look there. LPN #1 said if the behavior was concerning, the nurse could document a progress note. CNA #3 was interviewed on 6/24/25 at 3:30 p.m. CNA #3 said Resident #207 had behaviors of isolating from activities when sad and when she missed her husband. CNA #3 said non-pharmological interventions that the staff attempted for Resident #207 included encouraging her to attend activities, bringing activity items to her to do in her room, calling her husband so she could talk to him and providing her reassurance that she was safe without him. CNA #3 said Resident #21 did not have any behaviors or triggers for depression. CNA #3 said the CNAs documented in the CNA charting but there was only a list of generic, template behaviors and interventions available. She said new behaviors were communicated to the CNAs through verbal reports in staff huddles. Registered nurse (RN) #1 was interviewed on 6/24/25 at 4:26 p.m. RN #1 said she did not know Resident #207 or Resident #21 very well. She said the nurses documented behaviors in the progress notes as a behavior note. RN #1 said resident behaviors, interventions to monitor and to use were in a behavior monitoring physician's order and showed up on the TAR. She said new behaviors were communicated to the staff through verbal reports in staff huddles and non-pharmological interventions were on the TAR but were not customized to the specific resident. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD, the regional clinical resource (RCR) and the assistant director of nursing (ADON) were interviewed together on 6/26/25 at 2:00 p.m. The SSD said the facility determined the efficacy of psychoactive medications by ensuring the residents' behaviors associated with the medications were documented. She said all psychotropic medications should have behavior monitoring in place. The SSD said the non-pharmological interventions were listed on the behavior monitoring physician's order and the resident's care plan. She said using non-pharmological interventions was important because those interventions should be utilized first, before pharmacological interventions were explored. The SSD said the non-pharmological interventions for each resident were selected from a generic template, not customized to be resident specific. The ADON said the nursing department initiated the behavior monitoring physician's orders in the CPO and the behaviors were determined based on information from the resident, family, or medical record. She said the IDT reviewed the behavior tracking in the psychotropic medication monthly meeting with the physicians and the pharmacist. The ADON said the information from the behavior monitoring was utilized to make decisions regarding adding, changing or discontinuing medications. She said behaviors should be documented by nurses on the TAR and in a progress note and CNAs should document behaviors in their charting, which was a generic template. She said the IDT communicated new non-pharmological interventions in staff huddles and discussed what had worked and what had not worked, but did not customize the behavior monitoring with that information. The ADON said the information would be put in the resident's care plan and the expectation was that the staff looked in the care plan for the target behaviors and non-pharmological interventions. She said she was unaware the staff were not looking in the care plan for this information. The RCR said the facility did not develop resident specific care approaches, to include medication specific target behaviors and person-centered interventions for each resident on psychotropic mediations and needed to improve this process.

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Rehabilitation and Nursing Center of the Rockies	1020 Patton St Fort Collins, CO 80524

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** IV. Resident #4 - The facility failed to initiate a thorough investigation of an injury of unknown origin. A. Resident #4 1. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included systemic involvement of connective tissue (autoimmune disease), arthritis, edema, and history of stroke. The 6/3/25 MDS assessment revealed Resident #4 was cognitively intact with a BIMS score of 14 out of 15. The resident required total assistance (fully dependent) from the staff for toileting, dressing, bed mobility (the ability to sit up or roll from side to side while lying), and all transfers. The resident required (two-person) extensive assistance from the staff for bathing and personal hygiene. Resident #4 had impairments to her lower extremities and a limited full range of motion. 2. Resident interview Resident #4 was interviewed on 6/25/25 at 4:00 p.m. She said she sustained an injury in the middle of May 2025 when a male CNA she did not know came into her room to transfer her from the wheelchair to the bed. She said he told her he was going to show her how to transfer without a mechanical device, then lifted her out of her chair and put her on the bed. Resident #4 said he was rough when picking her up, and she asked him to be gentle and that her bones were fragile, but he did not say anything except to put her down on her bed in a rough manner. She said her body twisted, but not her leg, and both she and the CNA heard a popping sound, then the CNA left her room and did not send anyone in to look at her leg. Resident #4 said she experienced constant aching pain in her right leg and right foot but did not want to tell the doctor because she thought it would heal itself, but it kept swelling instead. She said when the staff would come in to take care of her, they would comment to her that her ankle looked swollen, and if they tried to turn her ankle, it was very painful. Resident #4 said a male nurse came to look at it one evening, and she told CNAs about the injury, but could not recall staff names or exactly when she told them. She said that exactly four weeks after her injury, she told her community provider, who sent her to the hospital for Xrays, and the fractures were then discovered. Resident #4 said her transfer status had changed from a sit-to-stand lift to a Hoyer (mechanical lift) lift. She said she did not like the Hoyer lift because it made her feel nervous and unstable when she was lifted. 3. Record review a. The musculoskeletal care plan, revised on 6/20/25, revealed Resident #4 had an alteration in musculoskeletal status related to a right distal tibia and fibula fracture. Interventions, revised 6/20/25, included to keep the call light within reach, provide heat and/or cold applications as tolerated, and monitor for fall risks. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. The activities of daily living (ADL) care plan, revised 6/20/25, revealed Resident #4 had ADL deficits related to generalized weakness, chronic left lower extremity and right upper extremity, pain, osteoarthritis, and right tibia and fibula fracture. Interventions, revised 6/23/25, included providing two-person Hoyer lift assistance with transfers and providing one to two-person assistance with bathing. Interventions, revised 12/27/24, included providing one to two-person assistance with toileting, bed mobility, personal hygiene, and dressing. -The care plan failed to reveal that Resident #4's ADL focus had been updated to show the resident's physical decline in all areas. c. The 3/3/25 MDS assessment revealed the resident required total assistance from the staff for toileting and toilet transfers. The resident required extensive assistance from the staff for dressing, personal hygiene, bed mobility, and chair transfers. Resident #4 did not have any impairments to her lower extremities and had a full range of motion. -Between 3/3/25 and 6/3/25, Resident #4 had a decline in abilities to include dressing, all transfers, bed mobility, and her range of motion in her lower extremities (see 6/3/25 MDS assessment above). d. The June 2025 CPO revealed the following physician orders: Weight-bearing status: non-weight bearing to right ankle - ordered on 6/17/25. Monitor right lower extremity and notify the provider of any concerns related to circulation, motion, or sensation - ordered on 6/18/25. Float right lower extremity with pillows while in bed due to ankle fracture - ordered on 6/20/25. e. The facility-reported incident on 6/17/25 of physical abuse revealed Resident #4 had been sent to the hospital for Xrays on 6/17/25, directly from her community provider, who she saw twice weekly. Included in the facility-reported incident were ten staff member interviews. Out of ten staff members interviewed, one staff member replied they had observed redness and swelling to the resident's ankle as of 6/16/25, and another staff member replied Resident #4 had expressed pain in her ankle as of 6/16/25. There were no staff names mentioned or follow-up questions reported in the incident. f. The community provider notes revealed that on 6/10/25, an Xray was ordered for 6/12/25 (but not completed until 6/17/25) due to Resident #4 complaining of ankle pain after an injury. During the visit on 6/10/25, the nurse observed pain, redness, bruising, swelling, tenderness, and changes in range of motion. g. A review of skin assessments from 5/1/25 to 6/16/25 failed to reveal observations of redness, bruising, or swelling to the right ankle. h. Progress notes were reviewed from 5/1/25 to 6/16/25 and failed to reveal any injury to the resident had been documented. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. Staff interviews 1. CNA #5 was interviewed on 6/26/25 at 10:33 a.m. She said Resident #4 used to complain to her about her foot hurting, but CNA #5 was not aware of the injury and did not ask the resident what had happened. She said she told RN #3 on 6/15/25 when she noticed bruising on Resident #4's mid calf going down her leg to her foot. 2. CNA #6 was interviewed on 6/26/25 at 10:41 a.m. She said Resident #4 used to use a sit-to-stand lift before the injury, but now required total assistance in a Hoyer lift. CNA #6 said on 6/16/25, she noticed redness to Resident #4's ankle, and the resident complained to her about pain and tenderness. She said there was no place in the CNA charting to document new injuries; the CNAs had to report it to the nurse, but she said she had not reported it. 3. RN #3 was interviewed on 6/26/25 at 12:34 p.m. He said a change of condition would constitute any change in a resident's physical or emotional baseline. He said that when a change of condition was determined, as a nurse, he would assess the change, report it to the physician and family, and make a note in the chart. -RN #3 said that a CNA brought it to his attention on the evening shift on 6/15/25 that while laying Resident #4 down, the resident had complained of pain in her ankle, and the CNA had observed swelling and bruising. RN #3 said he looked at the ankle and observed it was swollen and bruised. He said Resident #4 told him she was waiting for the Xrays to be completed by her community provider; therefore, RN #3 said he did not do a skin assessment or a pain assessment, or contact the resident's family or physician because he assumed all parties were aware since the resident was waiting for Xrays. -He said he did not ask the resident how and when the injury occurred. RN #3 said the following day was the weekly meeting between Resident #4's community provider and the facility and RN #3 advised the DON to ask the community provider if an Xray was scheduled, but he said he did not follow up any time later with the DON regarding the Xrays that the resident mentioned. He said before the injury, Resident #4 was able to propel herself in her wheelchair and participate in sit-to-stand lift transfers. 4. LPN #2 was interviewed on 6/26/25 at 12:55 p.m. She said any changes from a resident's normal baseline would be considered a change of condition. She said a swollen ankle would be considered a change of condition, and if reported to her, she would do a full body assessment to see if any other injuries were present, check vital signs, and ask the resident when and how the injury occurred. LPN #2 said it was important to gain as much information as possible to rule out a potential abuse situation, and when an injury occurred during a transfer, it had to be reported to the NHA and the DON to rule out the abuse. She said nursing documentation would include an assessment of the change of condition and a progress note. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. LPN #1 was interviewed on 6/26/25 at 12:55. She said a swollen ankle would be considered a change of condition, and if a resident was able to answer questions, she would ask when and how it occurred. LPN #1 said it was important to ask these questions to rule out the abuse, and if injury occurred during the transfer, it must be reported to the NHA and the DON as well for investigation of potential abuse. LPN #1 said a full body assessment and vital signs were taken when a resident experienced a change of condition, and all findings should be documented under progress notes and the change of condition form. She said after assessment, the physician and the family must be notified about findings. 6. The assistant director of nursing (ADON) was interviewed on 6/26/25 at 1:08 p.m. She said any unexpected changes in a resident's physical or mental condition was a change of condition, and upon a change of condition, the nurses were expected to complete a full assessment, vital signs when necessary, ask the resident about the origin and timing of the injury, and assess for pain. 7. The MDS coordinator (MDSC) was interviewed on 6/26/25 at 5:25 p.m. She said a change of condition could be exhibited by health status, physical, psychosocial, or behavioral changes. She said she expected that if a CNA observed something that appeared different about a resident, they were to report to the nurse, and then the nurse was expected to do a visual assessment of the resident to determine if further actions needed to be taken. She said if a change of condition had been determined, an assessment was completed, and the resident's provider was notified. She said if the change of condition was determined on the night shift, it needed to be passed on in report to the oncoming nurse the next morning. Based on observations, record review and interviews, the facility failed to investigate thoroughly allegations of staff-to-resident verbal abuse and failed to initiate a thorough investigation of an injury of an unknown origin. The facility failure affected two (#24 and #4) of five residents out of 37 total sample residents. 1. The facility failed to recognize, address, and thoroughly investigate allegations of staff-to-resident abuse. Interview with Resident #24, who was visibly tearful during three interviews, one on 6/23/25, and two on 6/24/25, revealed she felt mentally and verbally abused. On 6/23/25, Resident #24 said she had reported to the social services director (SSD) and other staff in leadership that registered nurse (RN) #2 accused her of medication-seeking behavior and retaliated against her by not administering her medications on time. She also reported to the SSD and other staff in leadership that certified nurse aide (CNA) #4 yelled at her when she provided her care. Resident #24 said that since she made her report to the SSD and other staff in leadership, nurses and CNAs had argued with her and made her feel bad. Resident #24 said no one followed up with her, both RN #2 and CNA #4 continued to work with her, and she had no other option but to cope with it. Interviews with the director of nursing (DON) on 6/23/25 at 4:26 p.m. and the SSD on 6/23/25 at 4:33 p.m. revealed they were aware of the incident involving Resident #24 and RN #2, and followed up with the resident unofficially, removing RN #2 from Resident #24's care for a while. The SSD said the resident told her that RN #2 ignored her on purpose and CNA #4 was brisk and not friendly, and in response, she had informally educated staff on customer service. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to recognize Resident #24's report of her interactions with RN #2 and CNA #4 as potential allegations of staff-to-resident abuse and thoroughly investigate them created a situation that was likely to result in serious harm. 2. The facility failed to initiate a thorough investigation of an injury of unknown origin. Interview with Resident #4, who was alert and oriented and required total assistance from staff for all transfers, revealed she sustained right lower extremity injuries in the middle of May 2025 when a CNA picked her up without a mechanical lift device and put her down in bed in a rough manner. She said she experienced constant aching pain and swelling in her right leg and ankle. Record review revealed Resident #4 was seen by a community provider on 6/10/25, and Xrays completed on 6/17/25 revealed right distal tibia and fibula fractures (lower leg bones). The facility reported the incident on 6/17/25 and interviewed ten staff members, two of whom reported observing injury (redness, swelling, pain) as of 6/16/25. Yet, there were no follow-up questions in the report, and a review of skin assessments and progress notes from 5/1/25 to 6/16/25 failed to reveal observations of bruising or swelling or documentation of the resident's pain. In an interview with RN #3 on 6/26/25 at 12:34 p.m., he said he looked at the resident's ankle on 6/15/25 and observed it was swollen and bruised, but when the resident told him that she was waiting for Xrays to be completed, he did not conduct an assessment or contact family or the physician because he assumed all parties were aware of the situation given the order for Xrays. In an interview with licensed practical nurse (LPN) #2 on 6/26/25 at 12:55 p.m., she said it was important to gain as much information as possible when there was a change in condition to rule out a potential abuse situation. And, when it occurred during a transfer, it had to be reported to the the nursing home administrator (NHA) to rule out abuse. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Interview with Resident #24, who was visibly tearful, on 6/23/25, revealed she felt mentally and verbally abused. She said she had reported to the social services director (SSD) and other staff in leadership that registered nurse (RN) #2 accused her of medication-seeking behavior and retaliated against her by not administering her medications on time. She also reported to the SSD and other staff in leadership that certified nurse aide (CNA) #4 yelled at her when she provided her care. She said that since she made her report to the SSD and other staff in leadership, nurses and CNAs had argued with her and made her feel bad. Resident #24 said no one followed up with her, both RN #2 and CNA #4 continued to work with her, and she had no other option but to cope with it. Staffing records documented CNA #4 continued to be scheduled to work with Resident #24, and RN #2 was taken off from Resident #24's hall but was put back on soon after. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON was interviewed on 6/23/25 at 4:26 p.m., and the SSD was interviewed on 6/23/25 at 4:33 p.m. Their interviews revealed that the DON and the SSD were aware of the incident involving RN #2. The DON said she had followed up with the resident unofficially, and the resident was satisfied with the outcome. She also said she removed RN #2 from Resident #24's care for a while; she was unsure of the length of time. The SSD said the resident told her that RN #2 ignored her on purpose, and CNA #4 was brisk and not friendly, and in response, she had informally educated staff on customer service. The SSD said that the nursing home administrator (NHA), as well as the other managers, knew about both incidents because she said she had discussed them in their morning meeting. On 6/24/25, Resident #24, visibly tearful, said that on the previous day, the NHA came into her room and drilled her on what she had said during her interview on 6/23/25 with the state. She said she found the exchange intimidating, and she had been up since midnight with anxiety and perseverating about the interaction. On 6/24/25 at 5:02 p.m., the NHA was interviewed. He said he was not aware of the verbal abuse situations involving RN #2 and CNA #4. He said he became aware of the situation on 6/23/25 when he spoke to Resident #24. On 6/23/25 at 2:25 p.m. and 6/24/25 at 10:17 a.m. and 3:51 p.m., Resident #24 was visibly tearful. She expressed feelings of harm, including retaliation, intimidation, anxiety, and mental and verbal abuse as a result of her interactions with RN #2, CNA #4, and the NHA. The facility's failure to recognize, address, and thoroughly investigate her allegations of potential abuse by staff was likely to result in serious harm if not immediately corrected. B. Facility plan to remove immediate jeopardy On 6/25/25 at 2:54 p.m., the facility submitted a plan to remove the immediate jeopardy. The plan read: Immediate actions: Resident #24 was interviewed by clinical resource (CR) #1 and the corporate licensed clinical social worker on 6/24/25, at which time they provided psychosocial support and offered additional mental health support. The NHA and RN #2 were suspended on 6/24/25 at 5:30 p.m. and CNA #4 was suspended on 6/23/25 at 5:00 p.m. Education with the NHA, the SSD, and the DON were conducted on 6/25/25 and included how to identify instances and allegations of abuse and to understand the difference between a concern and forms of abuse. Competencies for understanding of education were completed on 6/25/25, and education was given by a clinical nurse resource. Education provided to RN #2 and CNA #4 in regards to understanding the differences of concerns and forms of abuse and how to report appropriately. Education given by the clinical nurse resource to RN #2 on 6/25/25. CNA #4 will not return to work until education and return demonstration is provided in person. Identification of other residents at risk: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting on 6/25/25, initiate interviews with all residents who can participate in interviews to ensure all allegations of abuse are identified and thoroughly investigated. Any residents who are not interviewable, the facility will reach out to emergency contact or resident representative to discuss concerns. If an interview is unable to be completed, social services will complete an observation to identify any signs of psychosocial distress or change in mood. All interviews or observations to be completed by 6/25/25. Systemic changes: All staff will be educated on the identification of allegations of abuse versus customer service and abuse reporting. Education to include differentiating potential abuse allegations from concerns or customer service-related issues from residents. Staff education to be provided by social services, clinical nurse resource, or a licensed nurse. Education was initiated via video chat on 6/24/25. All education to be completed by 6/26/25. Any employee who cannot complete education in person will be educated prior to their next scheduled shift. Monitoring: The social services or designee will complete audits on five random residents weekly for 12 weeks. The audit will include identification through a resident interview: have any staff members, resident, visitor abused you? Have you observed any other resident being abused? Record review: if yes, abuse coordinator notified per regulations, thorough investigation completed with new intervention implemented to prevent reoccurrence, completion of state occurrence reporting site and police reporting completed. For identified concerns, corrective action completed. The audits will be recorded on an audit form. Discrepancies will be promptly reported to the administrator. Results will be reported monthly to the quality assurance committee. The director of nursing services or designee will interview five employees weekly for comprehension about types of abuse and signs of mental abuse, the difference between customer service concerns and allegations and reporting immediately. Social service resource or clinical nurse resource will complete oversight weekly to review investigations and audit if managers have an understanding between customer service and allegations. C. Removal of immediate jeopardy On 6/25/25 at 3:50 p.m., the interim nursing home administrator (INHA) was notified that the facility's plan to remove the 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, isolated, actual harm. Interviews conducted on 6/25/25 verified that staff had been educated on identifying abuse and the difference between an allegation and a customer service concern. -CNA #7 was interviewed on 6/25/25 at 3:35 p.m. She said staff had been getting a lot of training on abuse. She said she attended an in-service that day before her shift started. She said it was about abuse and interventions and the proper steps to take when staff saw it or heard it, who to report it to, and who to report it to if the abuse coordinator was not available. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-LPN #2 was interviewed on 6/2525 at 3:28 p.m. She said she had been getting a lot of abuse training within the last week. She said she had received training that day on the difference between a complaint and abuse. She said abuse would be yelling at a resident, and a complaint would be if a resident complained when staff forgot to knock when entering their room. The maintenance director (MTD) was interviewed on 6/25/25 at 4:58 p.m. He said they were trained on the difference between abuse allegations and customer service. The MTD said abuse was purposely not answering a call light, and customer service was not being pleasant while providing care. II. Facility abuse policy The Abuse: Prevention of and Prohibition Against Policy and Procedure, revised January 2024, was received from the NHA on 6/24/25 at 2:39 p.m. It read in pertinent part: Residents also have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This 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. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental Abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. Verbal Abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. The facility will engage in training and orienting its new and existing nursing staff on topics which relate to the delivery of care in the post-acute setting. Topics of such training will include, but not be limited to: - Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators; - Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal; (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor or the Facility administrator immediately. The facility will assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. The investigation, and the results of the investigation, will be documented. III. Resident #24 - The facility failed to recognize, address, and thoroughly investigate allegations of potential staff-to-resident abuse. A. Resident #24 1. Resident status Resident #24, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included emphysema, major depressive disorder, and anxiety. The 3/21/25 minimum data set (MDS) assessment revealed Resident #24 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The assessment revealed that Resident #24 was independent or needed supervision for the majority of her activities of daily living (ADL). 2. Resident interview and observations on 6/23/25 Resident #24 was interviewed on 6/23/25 at 2:25 p.m. She said she did not feel comfortable in the facility anymore because the staff did not like it when she stood up for herself. -She said she had gone to RN #2 and asked for her medication, and RN #2 did not put her scheduled pain medication and her scheduled antianxiety medication into her medication cup. She said when she asked about it, RN #2 told her that she had already given them to her and argued with her, which caused her to feel like she was being accused of medication seeking. She said RN #2 checked her medication card and saw that she had, in fact, not given her the medications and put them in her cup without apologizing to her. She said that since that incident, she had felt that the staff and facility had been picking on her. -She said nurses and CNAs would argue with her and make her feel bad. She said that she felt like staff were mentally abusing her. She said that CNAs would become really rude. She said CNA #4 yelled at her when she asked where the lid to her water jug was. She said CNA #4 yelled, Because there wasn't any! when she was assisting her roommate. During the interview, Resident #24 was very tearful when she was speaking about RN #2 and CNA #4. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A few minutes later, the NHA was observed entering Resident #24's room. 3. Resident interviews on 6/24/25 Resident #24 was interviewed on 6/24/25 at 10:17 a.m. She said she wanted to share that the NHA had come into her room the day before and drilled her on everything that was said during her interview with the state. She said she remembered another thing that CNA #4 had done. She said she asked CNA #4 to change the oxygen tubing because it was all twisted and she could not get any oxygen out of it, but CNA #4 refused to get it for her. Resident #24 was interviewed again on 6/24/25 at 3:51 p.m. She said the NHA did not ask her if she wanted to continue to work with CNA #4, whom she said she felt was abusive. She said she felt like the NHA was out of line to come and drill her. She said she felt like he was intimidating. -She said the SSD did not discuss the incident involving CNA #4 with her but did discuss a new counselor who would be able to spend more time with her. She said she would like someone outside of the facility to talk to because she felt like the people connected to the facility were vindictive, and she felt like she did not have anyone she could talk to. -She said she had told staff that she did not want to work with RN #2 and CNA #4. She said RN #2 was not on her hall for maybe two weeks, but then she was on her hall again. She said she felt like the management did not care, and they are going to do what they are going to do. -She said she felt like the NHA was the only one she could talk to, but after what he did the day before, she was no longer sure she can talk to him. During the interview, Resident #24 became very tearful when she spoke of RN #2, CNA #4, and the NHA. B. Facility response On 6/23/25, around 3:30 p.m., the NHA submitted a paper file stating that Resident #24 had just reported to him a situation of potential abuse, and he wanted to be proactive and show the investigation. 1. Facility investigation The facility investigation revealed that the NHA interviewed Resident #24, and she reported that several months ago, CNA #4 yelled at her without provocation. When asked what triggered the incident, Resident #24 stated that CNA #4 responded to her by yelling at her. Resident #24 expressed that she felt the interaction had been rude. The report read that Resident #24 said she did not report it to anyone because she did not want to bother anyone or cause any trouble. The investigation further revealed that the NHA interviewed CNA #4 about the allegation. CNA #4 reported she rarely provided cares for Resident #24 since she was mostly independent. She said she delivered iced tea to Resident #24's bedside while she was out of the room, and when she returned, Resident #24 questioned why there was not a lid on the tea. CNA #4 stated she told her that the kitchen was temporarily out of lids. Resident #24 then responded by saying, You don't have to yell at me, and then Resident #24 left the room. CNA #4 reported she did not raise her voice. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The investigation further revealed that the nurse who conducted Resident #24's victim assessment was RN #2. CNA #4 received training on customer service and nonverbal/verbal communication. The allegation was unsubstantiated due to not having any witnesses. 2. Failure to thoroughly investigate Resident #24's allegations of potential abuse Staffing records documented CNA #4 continued to be scheduled to work with Resident #24, and RN #2 was taken off from Resident #24's hall but was put back on soon after. -The investigation submitted by the NHA did not include any interviews with other residents who received care from CNA #4, nor any feedback from Resident #24 to see if the resolution (see above) was satisfactory. -The investigation the NHA provided did not include concerns that Resident #24 shared about RN #2. -The investigation did not include observations of interactions between Resident #24, as well as other residents cared for by RN #2 and CNA #4, and the two staff members. -The investigation did not include interviews with staff and residents who worked with or were cared for by RN #2 and CNA #4 about their interactions with the RN or CNA. -The investigation did not include documentation from the unofficial investigation by the DON or any grievances or concerns involving Resident #24, RN #2, and CNA #4. C. Staff interviews 1. RN #2 was interviewed on 6/24/25 at 4:26 p.m. She said her relationship with Resident #24 was good. -She said that Resident #24 was upset with her in the past because of the timing of her medications. She said that Resident #24's pain medication was scheduled at 4 p.m., but she wanted it at 3 p.m. S[TRUNCATED]

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide and document sufficient discharge preparation and documentation for one (#99) of three residents reviewed for a safe and orderly discharge out of 37 sample residents. Specifically, the facility failed to ensure thorough documentation, including physician notification, when Resident #99 and her representative left the facility against medical advice (AMA). Findings include: I. Resident #99 A. Resident status Resident #99, age [AGE], was admitted on [DATE] and left the facility to her representative's home on 4/2/25. According to the April 2025 computerized physician orders (CPO), diagnoses included anxiety, fracture of patella and hypertension. The 4/1/25 minimum data set (MDS) assessment revealed an assessment had not been completed for Resident #99. B. Resident representative interview The resident's representative was interviewed on 6/24/25 at 10:12 a.m. The representative said Resident #99 was admitted to the facility after a fall with a fracture at home. The representative said the resident was not allowed to turn her light on after her roommate went to sleep or she would disturb her roommate, the food served was terrible and the facility was unclean. The representative said when she told the nursing staff she wanted to discharge the resident because of the conditions, she was told by the nursing staff that they would have to speak to the physician first but they would not be able to reach the physician until the next day, so she discharged Resident #99 AMA. She said she took the resident home with her and found her placement for therapy in another facility. C. Record review The discharge care plan, initiated on 4/1/25 (the day prior to the resident's admission to the facility), revealed Resident #99 wished to discharge to her home or another facility. Interventions, initiated 4/1/25, included establishing a pre-discharge plan with the resident, family or caregivers and evaluating progress and revising the plan as needed. A medication administration record (MAR) progress note, documented by the infection preventionist (IP) on 4/2/25, revealed Resident #99 left the facility AMA. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation in the resident's electronic medical record (EMR) to indicate that the resident's physician was notified of the resident and her representative's request to discharge from the facility or why the facility could not notify the physician until the following day (see representative interview above). -There was no documentation in the EMR to indicate that the physician was notified that the resident discharged from the facility AMA. -Additionally, there was no documentation in the EMR to indicate that facility staff attempted to discuss the resident's reasons/concerns which prompted the request to discharge with the resident and her representative. -There was no documentation in the EMR to indicate the facility attempted to discuss an alternative/appropriate discharge plan (instead of AMA) with the resident or the resident's representative. An AMA discharge form, dated 4/2/25, revealed the resident's representative refused to sign the form. III. Staff interviews The IP was interviewed on 6/24/25 at 2:00 p.m. The IP said Resident #99 admitted from the hospital after a fall with a fracture. The IP said the resident's representative had not been happy with facility and discharged Resident #99 AMA on 4/2/25 to the representative's home. The IP said there should be a progress note regarding the resident leaving AMA in the EMR, but she was unable to locate any documentation. The social services director (SSD) was interviewed on 6/24/25 at 2:15 p.m. The SSD said Resident #99 was discharged back to the hospital on 4/2/25 but could not recall the details of the discharge. -However, per the resident's representative and staff interviews, Resident #99 left the facility AMA on 4/2/25 to the representative's home (see above). The minimum data set coordinator (MDSC) and the assistant director of nursing (ADON) were interviewed together on 6/26/25 at 5:25 p.m. The MDSC said there was no documentation in Resident #99's EMR regarding the resident's AMA discharge. The ADON said the process for an AMA discharge was for nursing staff to speak with the resident and find out why they wanted to leave AMA or find out what their issues were. She said if the facility could not solve the residents' issues, nursing staff would describe the AMA process and have the resident or their representative sign an AMA form. The ADON said the physician would be notified of the discharge and a progress note would be made. She said she could not explain why there was no documentation in Resident #99's EMR to explain where she was discharged to or why she left AMA.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to incorporate recommendations from the preadmission screening and resident review (PASRR) Level II determination and evaluation from the State Mental Health Agency in the case of residents with serious mental illness or a related condition for one (#21) of five residents reviewed for PASRR out of 37 sample residents. Specifically, the facility failed to arrange and incorporate recommendations from the PASRR Level II notice of determination (NOD) for Resident #21. Findings include: I. Professional reference The National Center for Biotechnology Information, National Library of Medicine guidance website, dated 5/16/23, retrieved on 7/1/25, from http://www.ncbi.nlm.nih.gov/books/NBK513310 read in pertinent part, A neurocognitive assessment, also known as cognitive testing or a neuropsychological evaluation, is a series of tests designed to measure various aspects of brain function. Neuropsychological evaluations require the use of standardized instruments to assess cognitive functions, behavior, social-emotional functioning (mood, personality), and in certain cases, adaptive functioning and academic achievement. Neuropsychologists have specialized training in brain-behavior relationships and perform comprehensive cognitive evaluations in addition to providing treatment. Clinical neuropsychologists are doctoral level health care providers who have specialized training in brain-behavior relationships and perform comprehensive evaluations in addition to providing certain forms of treatment. II. Resident #21 A. Resident status Resident #21, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included dementia and major depressive disorder. The 5/15/25 minimum data set (MDS) assessment revealed Resident #21 was cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. B. Record review Resident #21's PASRR Level II, dated 5/27/25, included the evaluation which revealed the resident had been evaluated for mental illness due to a qualifying diagnosis of major depressive disorder. The resident was to receive a neurocognitive evaluation (an assessment to determine how different parts of the brain function to understand the impact of neurological conditions and brain injuries). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21's mood care plan, revised 5/16/25, revealed that Resident #21 used antidepressant medications to treat insomnia (difficulty sleeping) and depression. The care plan indicated the resident had a Level II PASRR due to a diagnosis of major depressive disorder. Interventions included monitoring for target behavior symptoms of pacing, wandering, disrobing, inappropriate responses to verbal communication and violence/aggression towards staff/others (5/16/25), and documenting all behaviors (5/16/25) and providing medications as ordered (5/16/25). -The care plan failed to identify Resident #21's PASRR Level II recommended the resident to have a neurocognitive evaluation (see PASRR Level II above). The June 2025 CPO revealed the following physician orders: Trazodone (an antidepressant medication) 50 milligrams (mg)- give one tablet by mouth at bedtime for insomnia, ordered on 6/5/25. Sertraline (an antidepressant medication) 25 mg- give one time a day for major depression disorder, ordered on 6/25/25. The June 2025 CPO failed to reveal a physician's order for a neurocognitive evaluation since the resident's admission to the facility on 5/9/25. Progress notes were reviewed from 5/9/25 through 6/23/25 and no social service notes were found regarding scheduling or attempting to schedule a neurocognitive as recommended on REsident #21's PASRR Level II. III. Staff interviews The social services director (SSD) was interviewed on 6/25/25 at 12:26 p.m. She said she handles the PASRRs at the facility which included sending in new PASRRs, sending in updated PASRRs and implementing notice of determination recommendations. The SSD said the recommendations in the notice of determination were required for residents who were identified as having a qualifying mental illness diagnosis. She said if a resident refused the recommendations, it should be documented in the resident's electronic medical record and the care plan. The SSD said following the recommendations were important in order to identify problems, provide support to the resident, and utilize the information obtained in the PASRR evaluation. The SSD said Resident #21 had a Level II PASRR for major depression disorder and his recommendations included obtaining a neurocognitive evaluation but she could not find any notes showing the evaluation had been scheduled or completed. She said she would contact his community provider for his neurocognitive assessment. IV. Facility follow up On 6/27/25 at 4:32 p.m. the nursing home administrator (NHA) sent an email regarding Resident #21's neurocognitive assessment. It read in pertinent part, A facility therapist completed a neurocognitive evaluation with cognitive coping management. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attached was a behavioral health progress note, dated 6/10/25, conducted by the facility's corporate licensed clinical social worker, with no documentation that neurocognitive testing was completed (see above credential requirements for a neuropsychologist and definition of neurocognitive evaluations.)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure one (#78) of five residents reviewed for activities out of 37 sample residents received an ongoing program of activities designed to meet their needs and interests, and promote physical, medical, and psychosocial well-being. Specifically, the facility failed to offer and provide a personalized activity program for Resident #78. Findings include: I. Facility policy and procedure The Activities policy and procedure, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 4:32 p.m. It read in pertinent part, It is the policy of this facility to ensure that residents have the right to choose the types of activities and social events in which they wish to participate. II. Resident #78 A. Resident status Resident #78, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included dementia with agitation, anxiety disorder and insomnia. The [DATE] minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. He required set-up assistance for eating, oral hygiene, toileting, showering, dressing and personal hygiene. The [DATE] MDS assessment revealed the resident said it was somewhat important to have books, newspapers and magazines to read, to listen to music, to be around animals such as pets and to participate in religious services or practices. The assessment revealed it was very important to the resident to go outside to get fresh air when the weather was good. The assessment revealed the resident did not refuse care. B. Resident interview Resident #78 was interviewed on [DATE] at 3:50 p.m. as he was walking out of his room with his walker. He said he was going on a walk and he was going to see Oz. C. Resident observation During a continuous observation on [DATE], beginning at 12:35 p.m. and ending at 2:17 p.m., the following was observed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:35 p.m. Resident #78 was in his room sitting on his bed, eating lunch on an over-the-bed table. The door was closed. At 1:21 p.m., he was standing near his bathroom and near the window. There was a daily chronicle (a two page daily newsletter), two books and a magazine on his overbed table. During a continuous observation on [DATE], beginning at 12:13 p.m and ending at 2:13 p.m., the following was observed: At 12:13 p.m. Resident #78 was in his room sitting in a char next to his bathroom and the window. There were no activities near him. At 12:58 p.m. a therapy dog with a visitor was observed in the lobby of the facility. At 12:59 p.m., activities assistant (AA) #1 went into the room across from Resident #78's room and said the therapy dog was in the building. At 1:14 p.m. a therapy dog was observed walking down Resident #78's hallway with another resident (Resident #64). From 1:16 p.m. to 1:22 p.m. the therapy dog, a visitor, AA #1 and Resident #64 walked in and out of rooms on the right side of Resident #78's unit (unit #2). -However, the therapy dog was not directed to go in any rooms on the left side of unit #2. Resident #78 resided on the left side of the unit. D. Record review The activities care plan, revised [DATE], revealed the resident had a past interest in mountain climbing and had a lifelong interest in staying active. He was a United States [NAME] Corps Veteran. He enjoyed going outside on nice weather days, drawing and writing poetry. He resided in the facility with his spouse. He liked therapy animal visits, keeping up with current events and enjoyed being social with others. Resident #78 was a Christian and was independent in his faith. He had cognitive deficits and needed reminders of activities. Interventions included inviting him to church and bible study, offering him opportunities to go outside when the weather was nice and offering him therapy animal visits The [DATE] activities calendar was reviewed. It revealed there were eight religious activities scheduled from [DATE] to [DATE]. It revealed there were four animal therapy activities from [DATE] to [DATE]. A review of Resident #78's electronic medical record (EMR) revealed no documentation to indicate that the resident had participated in religious activities or animal therapy activities from [DATE] to [DATE]. III. Staff interviews (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on [DATE] at 3:46 p.m. CNA #1 said the activities department was responsible for carrying out the activities schedule. She said Resident #78 liked to walk by himself and he liked to go outside. She said he and his wife moved to the facility together. She said his wife died about six months ago and he had been depressed and was in his room a lot more. She said activities were important for residents because it helped the residents socialize and were an opportunity for the residents to leave their rooms. She said it helped the residents feel like the facility was not a prison. Registered nurse (RN) #1 was interviewed on [DATE] at 3:58 p.m. RN #1 said the activities department was responsible for carrying out the activities schedule. She said Resident #78 liked to exercise and he liked to walk around the facility early in the day. She said he liked to attend group activities. She said he participated in the activities as a passive participant. She said activities were important for residents because it kept the residents active and part of the community. She said it helped the residents to not be bored. She said activities brought joy to residents. The activities director (AD) was interviewed on [DATE] at 4:00 p.m. The AD said she documented activities as a progress note and the two activities assistants documented activities in the EMR under the task section. She said Resident #78 liked to go outside, waffle Wednesdays, animal therapy, reading to connect and snacks. She said he liked to observe activities but not participate. She said she did not know animal therapy skipped his room on [DATE]. She said the resident stopped attending religious activities after the resident's wife passed away. She said when a resident, such as Resident #78, was sitting in a chair with no activities in front of him, she said staff could offer the daily chronicles, offer a snack and encourage him to leave his room. She said activities were important for residents because it helped residents find a reason to live, to wake up, and most importantly, to have fun.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#4 and #207) of eight residents reviewed for accident hazards received adequate supervision out of 37 sample residents. Resident #4 was admitted to the facility for long term care on 4/5/24 with diagnoses of systemic involvement of connective tissue (autoimmune disease), arthritis, edema and history of stroke. Resident #4 was identified as cognitively intact and was able to transfer with a sit-to-stand mechanical lift (a lift device used to enhance a resident's dignity and independence by helping residents who can bear weight and participate to transition from a seated to a standing position). Resident #4 said a male certified nurse aide (CNA) transferred her without utilizing the sit-to-stand mechanical lift in May 2025. She said while the CNA was transferring her, they heard a pop. Resident #4 expressed pain and was observed by staff to have bruising, swelling, and redness to her right leg, ankle and foot. The facility failed to assess Resident #4 for pain and change of condition and failed to ensure treatment and Xrays were provided until 6/17/25. While the resident was visiting her community physician, she reported increased pain. The community physician ordered Xrays and the resident was transferred to the hospital where she was diagnosed with a right distal tibia and fibula fractures (bones of the lower leg). Due to the facility's failures to transfer the resident appropriately, Resident #4 suffered from extended pain and was not assessed for a less painful transfer status. The facility additionally failed to prevent an injury during transfers by not assessing or investigating the injury when first reported to staff. Additionally, the facility failed to implement person-centered fall interventions for Resident #207 tailored to her cognitive deficits. Specifically, the facility failed to ensure Resident #4 was transferred appropriately, which resulted in tibia and fibula fractures in the resident's right leg and ensure Resident #207 had person-centered fall interventions. Findings include I. Facility policy and procedure The Fall Monitoring and Management policy, reviewed April 2025, was provided by the nursing home administrator (NHA) on 6/27/25 at 4:42 p.m. It read in pertinent part, Falls are any unplanned change of position. The licensed nurse is responsible for assessing and evaluating the resident's fall risk on admission, quarterly, and with a significant change in condition. (continued on next page)

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Rehabilitation and Nursing Center of the Rockies	1020 Patton St Fort Collins, CO 80524

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Examples of interventions to minimize risks for injury due to falls include, but are not limited to, fall mat, raised edge mattresses, night lights, non-skid socks, hip protectors, and toileting schedule. II. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included systemic involvement of connective tissue), arthritis, edema and history of stroke. The 6/3/25 minimum data set (MDS) assessment revealed Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required total assistance from staff for toileting, dressing, bed mobility and all transfers. The resident required two-person extensive assistance from staff for bathing and personal hygiene. Resident #4 had impairments to her lower extremities and a limited range of motion. B. Resident interview Resident #4 was interviewed on 6/25/25 at 4:00 p.m. Resident #4 said she sustained an injury in the middle of May 2025 when a male CNA she did not know came into her room to transfer her from the wheelchair to the bed. She said he told her he was going to show her how to transfer without a mechanical lift device, then lifted her out of her chair manually and put her on the bed. Resident #4 said he was rough when picking her up and she asked him to be gentle and that her bones were fragile but he did not say anything to her. She said he put her down on her bed in a rough manner. She said her body twisted but not her right leg and both she and the CNA heard a popping sound, then the CNA left her room and did not send anyone in to look at her leg. Resident #4 said she experienced constant aching pain in her right leg and right foot afterwards but did not want to tell the doctor because she thought it would heal itself, but it kept swelling instead. She said when the staff would come in to take care of her, they would comment to her that her ankle looked swollen and if they tried to turn her ankle, the resident would yell out. Resident #4 said a male nurse came to look at it one evening but did not ask her about pain or assess her. Resident #4 said she had told several CNAs about the injury but she could not recall staff names or exactly when she told them. She said exactly four weeks after her injury, she told her community provider who sent her to the hospital for Xrays and the fracture was then discovered. Cross reference F610: failure to investigate an injury of unknown origin. C. Record review The musculoskeletal care plan, revised 6/20/25, revealed Resident #4 had an alteration in musculoskeletal status related to a right distal tibia and fibula fracture (fractures of the lower leg). Interventions, revised 6/20/25, included to keep the call light within reach, provide heat and/or cold applications as tolerated and monitor for fall risks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, revised 6/5/25, revealed Resident #4 had a deficit in self care. Interventions, revised 6/5/25, included to provide the resident with one to two-person assistance with transfers and stand by assistance with pivot transfers. The fall care plan, revised 12/27/24, revealed Resident #4 was at risk for falls due to a history of urinary tract infections and weakness. Interventions included anticipating the resident's needs, avoiding rearranging furniture in the room, encouraging participation in physical activities and maintaining a clear pathway (initiated 4/7/25). -The fall care plan failed to reveal Resident #4's care plan had been updated to include the recent fracture as a risk factor. Review of Resident #4's June 2025 CPO revealed the following physician's orders: Weight bearing status: non weight bearing to right ankle, ordered 6/17/25. Monitor right lower extremity and notify the provider of any concerns related to circulation, motion, or sensation, ordered 6/18/25. Float right lower extremity with pillows while in bed due to ankle fracture, ordered 6/20/25. The facility incident report, dated 6/17/25, revealed Resident #4 had been sent to the hospital for Xrays on 6/17/25 directly from her community provider, whom she saw twice weekly. The facility report revealed 10 staff members were interviewed. Out of 10 staff members interviewed, one staff member replied they had observed redness and swelling to the resident's ankle as of 6/16/25 and another staff member replied Resident #4 had expressed pain in her ankle as of 6/16/25. -There were no staff names mentioned or follow up questions reported in the incident. The community provider notes, dated 6/10/25, revealed an Xray was ordered for 6/12/25 due to Resident #4 complaining of ankle pain after an injury. During the visit on 6/10/25, the nurse observed pain, redness, bruising, swelling, tenderness and changes in range of motion. Progress notes were reviewed from 5/1/25 to 6/16/25 and failed to reveal any injury to the resident had been documented. D. Staff interviews CNA #5 was interviewed on 6/26/25 at 10:33 a.m. CNA #5 said Resident #4 used to complain to her about her foot hurting CNA #5 said she was not aware of the injury and did not ask the resident what had happened. She said she told RN #3 on 6/15/25 when she noticed bruising on the Resident #4's mid-calf going down her leg to her foot. CNA #6 was interviewed on 6/26/25 at 10:41 a.m. CNA #6 said Resident #4 used to use a sit-to-stand lift prior to the injury but now required total assistance in a Hoyer (mechanical) lift. CNA #6 said on 6/16/25, she noticed redness to Resident #4's ankle and the resident complained to her about pain and tenderness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Registered nurse (RN) #3 was interviewed on 6/26/25 at 12:34 p.m. RN #3 said a CNA brought it to his attention on the evening shift on 6/15/25 that while laying Resident #4 down, she had complained of pain in her ankle and that the CNA observed swelling and bruising. RN #3 said he looked at the ankle and observed it was swollen and bruised. He said Resident #4 told him she was waiting on the Xrays to be completed by her community provider. He said therefore he did not do a skin assessment, a pain assessment or contact the resident's family or physician because he assumed all parties were aware since the resident was waiting for Xrays. He said he did not ask the resident how and when the injury occurred. RN #3 said the following day was the weekly meeting between Resident #4's community provider and the facility and RN #3 advised the director of nursing (DON) to ask the community provider if an Xray was scheduled but he said he did not follow up any time later with the DON regarding the Xray that the resident mentioned. The minimum data set coordinator (MDSC) was interviewed again on 6/26/25 at 6:08 p.m. She provided handwritten notes by the DON from the 6/16/25 meeting with Resident #4's community provider. The MDSC said the notes indicated that Resident #4 had been discussed during the meeting but the community provider had declined to complete Xrays on 6/16/25. The MDSC said at the time RN #3 was notified by the CNA that Resident #4 had complaints of pain in her ankle, RN #3 should have completed skin and pain assessments. She said RN #3 should have offered non-pharmacological interventions for relief of pain, such as elevating Resident #4's feet, offering a cold compress or offering her as needed pain medication. III. Resident #207 A. Resident status Resident #207, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included absence of right leg above the knee, anxiety, repeated falls, lack of coordination, muscle weakness and dementia. The 5/28/25 MDS assessment revealed Resident #207 was severely cognitively impaired with a BIMS score of seven out of 15. The resident required moderate assistance (staff supports trunk or limbs) from staff for toileting, bathing, dressing and transfers. The assessment indicated the resident had falls prior to admission and one fall since admission with injury. B. Resident interview and observation Resident #207 was interviewed on 6/23/25 at 10:34 a.m. Resident #207 said she had fallen the prior day (6/22/25) and hit her head on the bar on the right side of her bed. She said she had been an amputee (right lower leg) since she was [AGE] years old and used a prosthetic leg but she did not have it at the facility currently because it needed to be refitted. Resident #207 said she did not know if the facility was assisting with follow up on the status of her prosthetic. She said she had a sign on her wall to remind her to use her call light before trying to get up on her own. She said she did not always remember to use it and sometimes she chose not to use it. Resident #207 said she was unsure of any additional fall interventions put into place for her falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #207 was observed during the interview. A call and do not fall sign was on the wall at the foot of her bed. There was not a fall mat in her room. Her side of the room had limited space to move around with her wheelchair pushed up to the middle of the right side of her bed and her bedside table was pushed up to the head of the right side of her bed. Her nightstand was behind the bedside table and her dresser was at the foot of her bed, next to her wheelchair. C. Record review The fall care plan, revised 6/24/25 (during the survey), revealed Resident #207 was at risk for falls related to dementia and weakness. The care plan indicated the resident had an actual fall with injury. Pertinent interventions included ensuring the call light was within reach (initiated 5/23/25), adding colored tape to the call light (initiated 5/28/25), adding a call and do not fall sign (initiated 5/28/25), adding colored tape to the call light in the bathroom (initiated 6/4/25), adding colored tape to the resident's wheelchair brakes (initiated 6/5/25), adding extenders to the wheelchair brakes (initiated 6/5/25) and monitoring the resident's blood sugars in the evening for five days for hypoglycemic determination (initiated 6/24/25). -Review of the resident's care plan did not identify rounds, frequent toileting, adding a fall mat, physician record review, or medication review that the staff identified as effective fall interventions (see staff interviews below). The cognitive care plan, initiated 5/23/25, revealed Resident #207 had impaired cognitive functioning and impaired thought processes related to dementia with anxiety. Interventions included providing psychosocial support and using simple, detective sentences with necessary cueing (initiated 5/23/25). A review of Resident #207's therapy notes, dated 5/25/25 to 6/21/25, revealed the following: An occupational therapy (OT) evaluation, dated 5/25/25, revealed the goals for Resident #207 included to increase safety awareness. The evaluation documented that during the evaluation, Resident #207 demonstrated uncontrolled downward movements and an instance of forgetting to lock her wheelchair brakes, saying to the therapist that's just what I do. A physical therapy (PT) evaluation, dated 5/25/25, revealed the goals for Resident #207 included ensuring she locked her wheelchair brakes to prevent falls. The evaluation documented during the evaluation, Resident #207 demonstrated needing verbal reminders to lock her brakes before transferring and then the resident forgot the instructions and the therapist had to lock the brakes for Resident #207. The evaluation further revealed the resident demonstrated poor spatial awareness (the ability to tell where objects are in space, including one's own body parts. Additionally, it involves being able to tell how far objects are from one's self and from each other) as evidenced by the bruises and scabs Resident #207 presented to the therapist. Resident #207 explained it was due to hitting her hands on doorways when propelling herself in her wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A speech therapy (ST) evaluation, dated 5/27/25, revealed the goals for Resident #207 included to increase memory skills, executive functioning (a set of mental processes that help individuals plan ahead and meet goals, display self-control, follow multiple-step directions even when interrupted, and stay focused despite distractions, among others) and sequencing (the mental process of creating an order or specific pattern of steps to complete a task). The ST identified in the evaluation that Resident #207 had impaired executive functioning, impaired problem solving and impaired short term memory. A PT treatment note, dated 5/27/25, revealed Resident #207 had been educated on the need to use her call light due to poor safety awareness. The resident demonstrated the need for assistance from the therapist to navigate the bedroom and the hallway in a wheelchair to prevent from hitting objects. A brief cognitive assessment tool (BCAT) was performed on 5/28/25 to determine various areas of cognitive functioning for Resident #207. The results indicated significant deficits in executive functioning, cognitive shifting (the ability to move seamlessly between different mental tasks to adapt to new information and judgement). The assessment also revealed significant deficits in visuospatial awareness and delayed and immediate memory recall. A PT treatment note, dated 5/29/25, revealed Resident #207 had demonstrated forgetfulness when needing to lock her wheelchair brakes and after being reminded, forgot the instruction ten minutes later. Staff were advised by the therapist to conduct frequent checks on Resident #207 due to memory and poor safety awareness. -However, frequent checks were not identified on the resident's care plan (see care plan above). An OT risk assessment, dated 6/3/25, revealed Resident #207 told the therapist that she tended to fall backwards and hit her head, she felt unsteady walking and she did not ambulate without her prosthetic leg. Her prosthetic leg was currently not with her. An OT treatment note, dated 6/5/25, revealed Resident #207 demonstrated poor safety awareness and memory recall as evidenced by the resident's failure to recall the necessity to lock her wheelchair brakes prior to transferring. The therapist provided colored tape to be placed on the brakes in order for the resident to more easily find them. A ST treatment note, dated 6/6/25, revealed Resident #207 had been provided significant education on the execution of the task of safe transferring and was shown how to use the call light in the bathroom.The therapist put colored tape on the cord for easier identification. An OT treatment note, dated 6/17/25, revealed colored tape had been put on Resident #207's wheelchair brakes to increase her attention to the locks before transferring. During treatment, the resident presented as confused and disorientated. An OT treatment note, dated 6/18/25, revealed Resident #207 neglected to lock her wheelchair brakes when distracted by something in her room and demonstrated poor safety awareness and increased risk for falls when attempting to stand up unsupported. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A ST treatment note, dated 6/18/25, revealed Resident #207 demonstrated significantly impaired safety awareness and insight. Resident #207 told the therapist that she did not use the call light because she went to the bathroom by herself. Additionally, she told the therapist that she could read the sign on her wall that told her not to get up, but she still got up. -Therapy notes revealed a focus of ensuring Resident #207 could locate, identify, and utilize her wheelchair brakes when transferring, however, all of Resident #207's falls were determined to be due to the resident trying to self transfer and then falling and not due to unsafe transferring with the wheelchair (see progress notes below). Resident #207's progress notes were reviewed from 5/23/25 to 6/24/25. The progress notes revealed the following: A nursing note, dated 5/27/25, revealed Resident #207 had an unwitnessed fall when she attempted to transfer herself from her bed to her wheelchair without calling for assistance. No injuries were noted and interventions were to add a call and do not fall sign and bright colored tape on the resident's call light. An interdisciplinary team (IDT) fall note, dated 5/29/25, revealed the DON and the director of rehabilitation (DOR) put a sign in place, colored tape was applied to the resident's call light and the resident was provided education to use her call light. A nursing note, dated 6/3/25, revealed Resident #207 had an unwitnessed fall when she attempted to transfer herself from her wheelchair to the toilet without calling for assistance. No injuries were noted and interventions were to add colored tape to the bathroom call light. An IDT fall note, dated 6/4/25, revealed colored tape was applied to the resident's bathroom call light. A nursing note, dated 6/4/25, revealed Resident #207 had an unwitnessed fall when she attempted to transfer herself from her wheelchair to her bed without calling for assistance. The resident suffered from a hematoma to her forehead as a result and interventions were to add bright colored tape to the wheelchair brakes. An IDT fall note, dated 6/5/25, revealed colored tape was applied to the resident's wheelchair brakes. A nursing note, dated 6/16/25, revealed Resident #207 had an unwitnessed fall when she attempted to transfer herself from her wheelchair to her bed without calling for assistance. No injuries were noted and the intervention was to add wheelchair brake extenders. An IDT fall note, dated 6/17/25, revealed wheelchair brake extenders were applied to the resident's wheelchair. A nursing note, dated 6/22/25, revealed Resident #207 had an unwitnessed fall when she attempted to transfer herself from her wheelchair to her bed without calling for assistance. No injuries were noted and interventions were to monitor the resident's blood sugars. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An IDT fall note, dated 6/23/25, revealed no new interventions were recommended after the resident sustained a fall on 6/22/25. -IDT fall notes dated 6/4/25, 6/5/25, 6/17/25 and 6/23/25 failed to reveal a review of the previous fall interventions for Resident #207 and an assessment of why the interventions failed (see staff interviews). IV. Staff interviews CNA #1 was interviewed on 6/24/25 at 2:44 p.m. CNA #1 said Resident #207 had behaviors of becoming anxious, forgetting she did not have her prosthetic leg on and falling. CNA #1 said the fall interventions were in the CNA documentation and the interventions for Resident #207 were to toilet her every two hours and check on her when staff passed her room. Licensed practical nurse (LPN) #1 was interviewed on 6/24/25 at 3:00 p.m. LPN #1 said Resident #207 was impulsive, did not wait for staff to assist her to the toilet and was confused because she believed her spouse was going to take her home everyday. LPN #1 said the fall interventions were communicated verbally to the staff by the IDT and Resident #207's interventions were to check her blood sugars and check on her when staff passed her room. CNA #3 was interviewed on 6/24/25 at 3:30 p.m. CNA #3 said the fall interventions for Resident #207 were to check on her hourly, remind her of the sign on her wall, answer her call light in less than five minutes and put a fall mat out on her floor in the evening. CNA #3 said the fall interventions were in the care plan. -However, the interventions indicated by CNA #1, LPN #1 and CNA #3 for Resident #207's falls were not included in the care plan (see care plan above). The MDSC was interviewed on 6/26/25 at 2:00 p.m. The MDSC said she was currently the acting DON. The MDSC said the facility's process when a resident fell, was to first notify the nurse if discovered by a CNA, implement 72-hour observations if the resident hit their head when they fell, and call the provider and the responsible party. She said that on the following day, the IDT would meet to discuss the fall, discuss the previous interventions, and assess why the prior interventions failed to prevent further falls. The MDSC said fall interventions were determined based on the fall and the resident. She said typical interventions the facility would utilize were to put a sign up in the resident's room that reminded them to call for assistance, putting colored tape on their call lights, frequent checks, frequent toileting, providing a fall mat, providing night lights if necessary, environmental assessment of the resident's room, review medications, or have the physician review the resident's record. The MDSC said the IDT communicated new fall interventions to the staff by care planning and providing verbal instruction. She said the staff were aware to look for fall interventions in the care plan. She said she was not aware the staff were not looking for interventions in the care plan. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#23) of five residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing out of 37 sample residents. Specifically, the facility failed to identify Resident #23 had a history of suicidal ideation in order to monitor for worsening signs and symptoms of depression or suicidal ideation. Findings include: I. Facility policy and procedure The Suicide Precaution policy and procedure, revised August 2022, was provided by the nursing home administrator (NHA) on 6/27/25 at 4:32 p.m. It read in pertinent part, If a resident verbalizes an intent to attempt suicide or takes any action that could be interpreted as a suicide attempt, document specific behavior and or statements of the resident, notification of physician and family or responsible party, safety interventions and actions taken. II. Resident #23 A. Resident status Resident #23, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included chronic viral hepatitis C, end-stage renal disease, type 1 diabetes mellitus with hyperglycemia, bipolar 2 disorder, depression, unspecified mood disorder, alcohol dependence and tobacco use. The 4/1/25 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. He required set up assistance with eating, oral hygiene, showering, dressing and personal hygiene. The MDS assessment revealed the resident felt bad about himself, felt he was a failure, let himself or his family down every day (12 to 14 days) and he had thoughts he would be better off dead or of hurting himself in some way for two to six days during the assessment look back period. B. Resident interview Resident #23 was interviewed on 6/23/25 at 2:03 p.m. Resident #23 said had no choices in his daily life. He said he did not like living in the facility. He said his ex-wife placed him in the facility and he had nowhere to go. He said he was unable to take showers when he wanted to because the shower rooms were always full. He said he had dialysis earlier today, 6/23/25, and he was hungry. He said he had to wait another four hours until he could eat again. He said he did not like the shakes the facility provided him; he said he only liked berry flavor. A vanilla nepro shake (a dialysis supplement shake) was observed on his nightstand. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 said he did not like the dialysis center he went to and he wanted to go to the dialysis center closer to the nursing facility. He said all of this made him frustrated. He said he had told nursing facility staff his frustrations and they said there was nothing they could do for him. C. Record review The psychosocial well-being care plan, initiated 8/9/23 and revised 6/25/24, revealed Resident #23 had potential for a psychosocial well-being problem related to bipolar 2 disease and alcohol dependence, per the pre-admission admission and resident review (PASRR) Level II recommendations. Interventions included specialized services, psychiatric case consultation, individual therapy and activities. The depression care plan, initiated 9/23/23 and revised 6/23/25, revealed Resident #23 was at risk for depression. Interventions included encouraging expression of feelings and monitoring for signs and symptoms of depression, including tearfulness, lack of appetite or overeating and verbalizations of feeling sad. The 9/28/24 MDS assessment revealed Resident #23 never felt bad about himself, he never felt he was a failure, and he never felt he let himself or his family down and he never had thoughts he would be better off dead or had thoughts of hurting himself. The 12/29/24 MDS assessment revealed Resident #23 felt bad about himself, felt he was a failure, felt let himself or his family down half or more of the days during the assessment look back period and he had thoughts he would be better off dead or of hurting himself in some way for several days during the assessment look back period. -However, despite the resident's expressions of not wanting to be here anymore and feeling bad about himself changing from the 9/28/24 MDS assessment to the 12/29/24 MDS assessment and the 4/1/25 MDS assessment (see resident status above), the facility failed to assess and monitor the resident for signs and symptoms of depression and suicidal ideation. A request for Resident #23's psychotherapy documentation was made on 6/24/25. Review of the documentation provided revealed the last documentation of a psychotherapy visit for Resident #23 was 6/14/22. The 6/14/22 psychotherapy intake note revealed Resident #23rated his anxiety at a five out of 10 and his depression was a 10 out of 10 every day. The note revealed the resident stated he was left to fight battles by himself. -No documentation was provided by the facility to indicate Resident #23 had seen a psychotherapist since 6/14/22. Review of Resident #23's June 2025 CPO revealed the following physician's orders: Counseling evaluation and treatment, ordered 6/5/25. -However, the resident was not seen by counseling services as ordered (see social services director (SSD) interview below). (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/25/25 suicide lethality assessment (completed during the survey) revealed Resident #23 did not have a suicide plan and agreed to a safety plan. The mood care plan, initiated on 6/26/25 (during the survey), revealed Resident #23 had a mood problem related to bipolar disease, living long term in a nursing facility, overall health needs and history of interpersonal relationship strains. Interventions included monitoring, recording and reporting to the physician risk for harm to self regarding suicidal plan, past attempts, risky actions, patient health questions (PHQ-9) changes, verbal statements of not wanting to live and sense of hopelessness or helplessness. -However, the suicide lethality assessment and the mood care plan were not initiated until after the concern was brought to the facility's attention during the survey. III. Staff interviews The SSD was interviewed on 6/25/25 at 5:39 p.m. The SSD said she completed the social services section of the MDS assessment. She said sometimes the MDS coordinator (MDSC) completed the section. She said if there was a significant change in the PHQ-9 score (a tool used to determine depression), she opened the current assessment and looked at the previous assessment to see what was different. The SSD said she followed up with nursing to collaborate on what interventions should be implemented to help Resident #23. She said his PHQ-9 score varied depending on when you interviewed him because he had dialysis three times a week and sometimes he did not answer the questions. She said if the MDSC had told her his PHQ-9 score increased, she would have offered counseling and seen what Resident #23 wanted to do. She said the 4/25/25 quarterly MDS assessment PHQ-9 score was high because it was the day his son was getting married. The SSD said the score was high because he answered yes to several questions and he said he felt that way several days to almost every day. She said if she completed the assessment and the PHQ-9 score was high, she would elaborate on why he answered yes to feeling better off dead. She said she would ideally document the conversation in a progress note. The SSD said Resident #23 had a break in psychiatry services for about six months because his provider went on leave. She said she did not offer for the resident to go to a psychiatrist outside of the building because the resident had dialysis three times a week and she thought that was a lot for him. She said she did not talk to the resident's physician or psychiatrist about his depression or suicidal ideation. She said she did talk to the resident's physician two weeks ago about the resident being upset about his son's wedding. She said if the physician talked about depression or suicidal ideation with the resident, it would be in the physician's progress note. Certified nurse aide (CNA) #2 was interviewed on 6/26/25 at 3:25 p.m. CNA #2 said Resident #23 did not have any behaviors. CNA #2 said she was not aware of any signs or symptoms of depression or a history of suicidal ideation or attempts for the resident. Licensed practical nurse (LPN) #1 was interviewed on 6/26/25 at 12:40 p.m. LPN #1 said Resident #23 did not have any behaviors. LPN #1 said she was not aware of any signs or symptoms of depression or a history of suicidal ideation or attempts for the resident. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDSC was interviewed on 6/26/25 at 4:28 p.m. The MDSC said she completed the last three PHQ-9 interviews on the MDS assessment for Resident #23. She said the PHQ-9 was a screening tool for signs and symptoms of depression. She said the higher the score, the higher the indication of depression. She said she collaborated with the SSD to consider offering behavioral health to residents with high PHQ-9 scores. She said if a resident answered yes to thoughts of being better off dead or hurting themselves she said she asked the resident to explain why they felt that way. She said she should document the reason in a progress note. She said Resident #23 answered yes to thoughts of being better off dead or hurting himself. She said she did not document a progress note for why the resident answered that way, but she said she should have. The MDSC said he answered yes to these questions because he was upset about his son's upcoming wedding and how he did not have money to get him a wedding present. The corporate licensed clinical social worker was interviewed on 6/26/25 at 4:28 p.m. The corporate licensed clinical social worker said there should be a progress note when residents answered yes to thoughts of being better off dead or hurting themselves. She said the most important thing was to have a conversation and provide psychosocial support. She said she would know psychosocial support occurred by a progress note. She said when there were no behavioral health services for six months, staff should have had a conversation with Resident #23 to see if the resident wanted to go out to a community behavioral health provider instead of waiting. She said if a resident expressed suicidal ideation, she said a resident could have harmed themself. IV. Facility follow-up The NHA provided the following follow-up on 6/27/25 at 4:32 p.m., following the survey exit: The NHA said Resident #23 was assessed for suicidal ideation by the SSD on 6/25/25 with no suicidal ideation noted. He said the resident was seen by a therapist on 6/26/25 (during the survey) and the therapist assessed Resident #23 as negative for suicidal ideation. -Resident #23's care plan was updated on 6/26/25, which identified a history of passive suicidal ideation and person-centered interventions. -Staff education was initiated for appropriate identification and reaction to suicidal ideation and depressive symptoms. -All residents that were interviewable were interviewed, and a PHQ-9 was completed. For the residents that were unable to be interviewed, the corporate licensed clinical social worker completed an observation of them for depression signs and symptoms on 6/26/25. Mental health services were offered for those with high PHQ-9 scores and a suicidal lethality assessment was completed as appropriate. Resident #23 attested to a conversation on 4/1/25 with the MDSC regarding mental health services. -A performance improvement plan was initiated on 5/21/25, identifying inappropriate follow-up from high PHQ-9 scores. -Audits were completed that demonstrated significant improvement in appropriate reactions to and identifying risk of suicidal ideation and depressive symptoms. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The 6/26/25 therapist note revealed Resident #23 was diagnosed with major depressive disorder, recurrent, moderate. The goal was to reduce symptoms by learning strategies to help him not feel so overwhelmed by his emotions. The note revealed the recommendations and services to be provided included a psychological consultation was recommended to assist staff in developing and implementing behavior plans to reduce the resident's affective and/or cognitive symptoms and providing the resident with individual therapy to reduce the resident's affective and/or cognitive symptoms. The service plan revealed that the estimated frequency and duration of treatment was two times per month for four months. Resident #23's PHQ-9 score was 15, indicating an increase from the facility's 4/1/25 PHQ-9 score of 13. -The 6/26/25 PHQ-9 interview and suicidal audit provided by the NHA was blank, indicating the audit was not completed.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interviews, the facility failed to ensure facility resources were administered in a manner that allowed its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in the facility. Specifically, the facility failed to: -Provide sufficient leadership to address and or avoid multiple concerns; -Prevent, report and fully investigate allegations of abuse timely to provide immediate protections to residents at risk; -Report and investigate an injury of unknown origin in a timely manner so that an accurate timeline of events could be established and the injury could be effectively treated and monitored; and, -Monitor a resident for worsening symptoms of depression who expressed suicidal ideations. Findings include: I. Abuse and neglect During the extended survey from 6/23/25 to 6/26/25, it was identified that there were concerns over the timely reporting of an allegation of abuse so that the resident could be immediately protected from a repeat incident of abuse. While staff were aware of the situation of potential verbal abuse, and reported it to the director of nursing (DON) and the social services director (SSD), the management and facility leadership did not immediately investigate the allegations so that immediate interventions could be implemented to prevent repeated attempts of abuse. Facility leadership was aware of the concerns brought by staff as it was discussed in the morning meetings. Cross-reference F610: failure to identify and investigate an allegation of abuse in a timely manner. II. Injury of unknown origin During the extended survey from 6/23/25 to 6/26/25, it was identified that there were concerns over the timely reporting of a discovered injury of unknown origin to Resident #4. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/15/25 a certified nurse aide (CNA) reported to the nurse that the resident had a swollen ankle. The nurse did not follow the protocol of the facility and did not complete a full skin assessment and did not ask the resident about how the injury occurred. Additionally, the nurse did not report the finding to the management and resident's physician or family. During the survey, Resident #4 said the fracture occurred during transfer when CNA did not use the lift but picked her up and threw her into the bed. She said her and CNA both heard the pop but the CNA did not report it to anyone. The injury was not reported to the facility's leadership until 6/17/25, when the resident was sent to the emergency room directly from her physical therapy session with an outside provider. The investigation and assessment of the injury started late; it was discovered that the resident had two broken bones on her leg that went unnoticed and untreated. According to the hospital records the fracture was at least four weeks old. Cross-reference F610: failure to investigate an injury of unknown origin. Cross-reference F689: failure to prevent an accident. III. Suicidal ideations and depression Resident #23's minimum date set (MDS) assessment in April 2025 revealed the resident felt bad about himself, felt he was a failure, let himself or his family down every day and he had thoughts he would be better off dead or of hurting himself in some way for several days during the assessment look back period. Resident's depression scores continued to increase in the next two consecutive assessments in September 2025 and December 2025 indicating worsening depression. When interviewed, the SSD said she was aware of the resident's assessment scores, however no actions were taken to help the resident. There was no evidence that the resident had seen a psychotherapist since June 2022. IV. Leadership efforts The nursing home administrator (NHA) had the responsibility to lead investigations for allegations of abuse to ensure compliance with identifying potential abuse; responding to an allegation of abuse; preventing ongoing abuse; and reporting abuse to the proper authority, all in a timely manner. During the interviews, the NHA denied the knowledge of the allegations of abuse for Resident #24. -However, management and staff, such as the DON, the SSD and registered nurse (RN) #2 were aware and said the situation was discussed during the morning meetings and the nurse named in the allegations was reassigned to another unit for a short period of time. V. Staff interviews The DON was interviewed on 6/24/25 at 4:05 p.m. The DON said she was aware of the conflict situation that occurred between the nurse and Resident #24. She said she could not recall the details and would comment on it after she reviewed the details. -The DON was not available for further interviews during the survey. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD was interviewed on 6/24/25 at 4:30 p.m. She said she was aware of the situation between Resident #24 and the nurse. The SSD said in addition, the resident later reported a CNA #4 for being rude. She said both reported situations were discussed in the morning meetings with managers. She said management was aware of the situation and her role was to continue working with the resident who reported to her no changes since the incident was brought to her attention. The interim nursing home administrator (INHA) was interviewed on 6/26/25 at 6:18 p.m. He said after spending a few days in the facility he realised that some concerns went unaddressed and unnoticed. He said his plan was to focus on currently identified areas of concerns and continue to provide support, assistance and weekly oversight to the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of four units. Specifically, the facility failed to: -Ensure housekeeping staff performed appropriate hand hygiene between cleaning resident rooms; -Ensure staff kept clean and soiled laundry separate in the laundry room; -Ensure staff handled plastic drinking cups in a hygienic manner to prevent contamination; and -Provide tracheostomy care for Resident #34 in a sanitary manner; and, -Ensure that Resident #95's urinary catheter drainage bag was cleaned appropriately and stored in a sanitary manner. Findings include: I. Failed to ensure housekeeping staff performed appropriate hand hygiene between cleaning resident rooms A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Hand Hygiene in Healthcare Settings, revised 1/18/21, retrieved from https://www.cdc.gov/handhygiene/providers/index.html on 7/1/25, Cleaning your hands reduces the spread of potentially deadly germs to patients. Alcohol-based hand sanitizers (ABHS) are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Personal Protective Equipment policy and procedure, revised August 2024, was provided by the nursing home administrator (NHA) on 6/23/25 at 3:36 p.m. It read in pertinent part, Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. Change gloves and perform hand hygiene between clean and dirty tasks. C. Observations During a continuous observation on 6/23/25, beginning at 10:00 a.m. and ending at 10:15 a.m., housekeeper (HK) #1 was observed leaving room [ROOM NUMBER] with gloves on both of his hands. He proceeded to enter room [ROOM NUMBER] with the same gloves on his hands and started to clean room [ROOM NUMBER]. -HK #1 failed to change gloves and perform hand hygiene after cleaning one resident's room and prior to cleaning another resident's room. II. Failed to ensure staff kept clean and soiled laundry separate in the laundry room A. Professional reference According to the CDC's Guidelines for Environmental Infection Control in Health-Care Facilities, revised 1/8/24, retrieved from https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html?utm_source=chatgpt.com on 7/1/25, A laundry facility should be partitioned into two separate areas; a dirty area for receiving and handling the soiled laundry and a clean area for processing the washed items. B. Laundry room observation and staff interview During a walkthrough tour of the laundry room with the maintenance director (MTD) on 6/26/25 at 10:45 a.m., the following was observed: Black tape was observed on the floor in two areas of the laundry room. The MTD said the black tape on the floor to the right side of the laundry room's two washing machines designated where facility staff placed soiled laundry. There were two plastic bags of soiled laundry and residents' soiled laundry was spilling out of one of the plastic bags. The soiled laundry crossed over the black tape and was in front of the washing machine, on the left side of the black tape. The MTD said the soiled bags of laundry should not have crossed over the black tape and he did not know why staff had put them like that. The MTD said the black tape on the floor to the left side of the two washing machines designated the clean area of the laundry room. He said soiled laundry should not be on the left side of the black tape on the ground. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the left side of the black tape and the two washing machines were two dryers, a folding table, a hanger rack and a laundry storage section. There were two laundry carts with white linen next to the black tape on the left side of the washing machines. Behind the two carts was a sign on the wall that said dirty rags here and a separate cart. The MTD said dirty rags were placed there and rags were visible in the dirty rag cart. The MTD said the facility needed to find a different location for the housekeeping staff to place soiled rags after cleaning residents' rooms and the facility. He said it was important to find a different location because the black tape on the ground designated the clean versus soiled areas of the laundry facility. He said he would work with the staff to ensure soiled and clean laundry remained separated. III. Failed to ensure staff handled plastic drinking cups in a hygienic manner to prevent contamination A. Professional reference The 2022 Food Code by the US Food and Drug Administration, revised 1/18/23, was retrieved on 7/2/25 from https://www.fda.gov/media/164194/download. It read in pertinent part, Food shall only contact surfaces of equipment and utensils that are cleaned and sanitized. Employees shall wash their hands. Except when washing fruits and vegetables, employees may not contact exposed ready-to-eat food with their bare hands and shall use suitable utensils. Food shall only contact surfaces of equipment and utensils that are cleaned. B. Observations During a continuous observation on 6/23/25, beginning at 11:31 a.m. and ending at 12:29 p.m., the following was observed in the main dining room: At 11:42 a.m. an unknown staff member, who was not wearing gloves, was putting ice in plastic drinking cups on a cart next to the ice machine. The unknown staff member grabbed a cup and placed two to three fingers inside the cup. The staff member proceeded to scoop ice into the cup. The staff member repeated placing her fingers inside the plastic cup eight times. At 11:46 a.m., the staff member grabbed seven cups and placed them face down on the cart without ensuring the cart had been sanitized. -The unknown staff member failed to handle the plastic cups in an appropriate manner in order to prevent contamination of lip contact surfaces. IV. Failed to provide tracheostomy care for Resident #34 in a sanitary manner A. Observations On 6/25/26 at 1:36 p.m. registered nurse (RN) #1 was observed performing tracheostomy care for Resident #34. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon entering Resident #34's room, RN #1 washed her hands and put clean gloves on. With clean gloves on, RN #1 grabbed a movable table by the surface and moved it closer to the resident. Using the same gloves, she gathered clean dressing supplies and dropped them on the surface of the table. -RN #1 failed to sanitize the table surface prior to putting clean dressing supplies on it. RN #1 remove Resident #34's soiled tracheostomy dressing and disposed of it in the trash. She washed her hands and put clean gloves on. With clean gloves on, she cleaned the area around the resident's tracheostomy with gauze and normal saline. Using the same gloves, RN #1 picked up a new gauze dressing, opened the package, dropped the dressing on the surface of the table, picked it up and applied it around the tracheostomy. -RN #1 failed to change her gloves and perform hand hygiene after cleaning the resident's skin around the tracheostomy site and prior to applying a new dressing to the resident's tracheostomy. -RN #1 failed to obtain another dressing after dropping a newly opened clean dressing on the unsanitized surface of the table. RN #1 applied the dressing that fell on the unsanitized table to Resident #34's tracheostomy site. B. Staff interview RN #1 was interviewed at approximately 1:50 p.m RN #1 said she should have changed her gloves after she removed the soiled dressing and before she touched the clean dressing. She said she forgot to change her gloves. She said the surface of the table was not cleaned and she should have cleaned it before putting clean supplies on it. V. Failed to ensure that Resident #95's urinary catheter drainage bag was cleaned appropriately and stored in a sanitary manner A. Observations On 6/23/25 at 1:34 p.m., a urinary catheter drainage bag was observed in Resident #95's room in their bathtub. The drainage bag still contained urine and the catheter tubing and clamp were resting inside the bathtub's soap dish. On 6/24/25 at 3:20 p.m., a urinary catheter drainage bag was observed again in Resident #95's room in their bathtub. The drainage bag still contained urine and the catheter tubing and clamp were resting inside the bathtub's soap dish. B. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 6/24/25 at 3:30 p.m. CNA #3 said urinary catheter drainage bags were not supposed to be kept in residents' bathtubs. CNA #3 said when a resident's urinary catheter drainage bag was not being used, it should be cleaned with vinegar and hung on the railing in the resident's bathroom to dry. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065192	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation and Nursing Center of the Rockies	1020 Patton St Fort Collins, CO 80524

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The infection preventionist (IP) was interviewed on 6/24/25 at 3:45 p.m. The IP said a urinary catheter drainage bag with urine in it or a catheter bag kept in a bathtub would not be sanitary to use and should be disposed of. She said once a urinary catheter drainage bag was disconnected, the drainage bag should be cleaned with a vinegar and water solution, rinsed and hung up to dry. The IP said using a urinary catheter drainage bag that had not been kept clean or in a sanitary environment could cause infections , including a urinary tract infection. VI. Additional staff interviews The minimum data set coordinator (MDSC) clinical resource (CR) #2 were interviewed together on 6/26/25 at 1:02 p.m. The MDSC said the infection preventionist (IP) and the director of nursing (DON) were not available for an interview. She said she was familiar with infection prevention and infection control. The MDSC said after removing gloves, staff members should always perform hand hygiene before putting clean gloves on. She said the housekeepers should change their gloves between cleaning one resident's room and another resident's room. She said the housekeepers should perform hand hygiene when they changed their gloves, either by washing their hands or using ABHS. The MDSC said she was familiar with the laundry facility's layout and how the room designated the dirty area versus the clean area. The MDSC said when she walked into the laundry room, the black tape on the ground on the right side of the washing machines designated the area where staff placed soiled laundry. The MDSC said the black tape on the ground on the left side of the washing machines designated the area where laundry was clean. The MDSC said she did not know staff placed their soiled rags in the dirty rag cart located in the clean area. The MDSC said staff should not touch the inside of drinking cups. She said it was important for staff not to touch the inside of cups in order to prevent contamination. She said she was not aware when the unknown staff member had filled drinking cups with ice on 6/23/25, that the staff member had touched the inside of the cups (see observation above). CR #2 said when nursing staff provided tracheostomy care and dressing changes, a clean field should be established. CR #2 said the designated surface for holding the dressing supplies should be sanitized before placing any tracheostomy care supplies on top of the surface. CR #2 said hand hygiene should be performed before putting on gloves and a gown. CR #2 said hand hygiene should be performed and gloves should be changed after touching a dirty area and before touching clean tracheostomy supplies. CR #2 and the MDSC said they were not aware of how the tracheostomy care was provided for Resident #34 on 6/24/25 (see observation above). CR #2 and the MDSC both said they would work with nursing staff to ensure a clean field was established when providing tracheostomy care. The MDSC said if a resident had a catheter attached to their leg or their wheelchair, the catheter should be lower than their bladder and it should not be on the floor. The MDSC said she was not aware Resident #95's catheter was in the resident's bathtub and the tip of the catheter was resting on the soap dish. She said Resident #95's catheter should not be in his bathtub or in the bathtub's soap dish. She said a catheter should not be in a bathtub or a soap dish to prevent infection.