STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065221	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Village Rehabilitation and Nursing LLC	1000 E Stuart St Fort Collins, CO 80525

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to provide choices for preference of bathing schedule for one (#20) of five residents reviewed for self-determination out of 24 sample residents.Specifically, the facility failed to provide Resident #20 per his preference. Findings include:I. Failure to provide shower as scheduledA. Resident #20B. Resident statusResident #20, age over 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included fracture of left tibia, and type 2 diabetes. The 12/14/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status score of 11 out of 15. The resident required partial to moderate assistance from staff for personal hygiene and showers. C. Resident interviewResident #20 was interviewed on 2/3/26 at 12:30 p.m. He said it was impossible to receive a shower at the facility. He said when he was initially admitted , he went several weeks without showers. He said staff would say the shower was due on the next shift and the next shift would give the same answer. He said he verbally complained to nurses, nursing aides, and managers, but his shower schedule was never fixed. He said one of the managers came into his room a few days ago and placed a sign on the end table that his shower days were Tuesdays, Fridays and Sundays. He said the sign did not solve the problem. His showers were not completed as scheduled. Resident #20 was interviewed a second time on 2/9/26 at 11:30 a.m. He said he did not receive his shower on Friday 2/6/26 or Sunday 2/8/26. He said staff kept saying it was not scheduled on their shift. D. Record reviewReview of the resident's comprehensive care plan did not include preferences or specific days for showers. Review of the resident's electronic medical record (EMR) revealed the resident's shower preferences were obtained on 12/8/25 and revealed the resident preferred his shoes twice a week on Tuesdays and Fridays evening. The 2/1/26 progress note documented the resident preferred to shower three times a week on Tuesdays, Thursdays and Saturdays. The note indicated the resident preferred to shower before 8:00 p.m. but after lunch.Shower records for the last 30 days, from 1/9/26 to 2/9/26 revealed the resident received showers on three occasions 1/18/26, 1/19/26, and 1/27/26.E. Staff interviewsCertified nurse aide (CNA) # 13 was interviewed on 2/9/26 at 2:30 p.m. She said she did not know when the resident received showers, she said it was not scheduled on her shift. She said it was confusing because at times the shower schedule was updated in the book but not communicated to CNAs. She said she did not know why the resident did not receive his shower on Friday or Sunday.Registered nurse (RN) # 1 was interviewed on 2/9/26 at 2:40 p.m. She said the resident had a very specific request that his shower was to be completed before 8:00 p.m. but not during the dinner time. She said at times it was difficult to accommodate due to the CNAs busy schedule. She said his schedule was changed multiple times and she was not sure what his most current schedule was. She said the resident did not refuse his showers unless it was offered after 9:00 p.m. when he was in bed. The director of nursing (DON) was interviewed on 2/9/26 at 3:50 p.m. She said she was not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware Resident #20 did not receive his showers. She said she asked nursing staff and came to the conclusion that staff were confused which shift was supposed to provide the shower. She said she educated staff where to locate the shower schedule. She said Resident #20 would receive a shower today.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure two (#2 and #4) of 23 out of 24 sample residents were free from abuse and neglect.Specifically, the facility failed to ensure Resident #2 and Resident #4 were kept free from physical abuse from Resident #1.Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, implemented 4/11/25, was provided by the nursing home administrator (NHA) on 2/9/26 at 9:15 a.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes, but is not limited to hitting, slapping, punching, biting and kicking. It also includes controlling behavior through corporal punishment. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:-identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms;-assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment;-the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;-addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and-assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.II. Incident of physical abuse involving Resident #1 and Resident #2 on 10/29/25A. Facility investigationThe facility's abuse investigation, dated 10/29/25, was provided by the NHA on 2/3/25 at 10:00 a.m. The investigation revealed the following:On 10/29/25 a certified nurses aide (CNA) reported to the NHA she watched Resident #1 enter Resident #2's room. As the CNA was walking toward Resident #2's room to redirect Resident #1 out of the room, she heard Resident #2 say get out of my room and then heard what sounded like a punch. The CNA entered the room and was able to redirect Resident #1 out of the room. Resident #2 had a scratch on the left side of his neck. Resident #2 was interviewed by the NHA. Resident #2 said he was his bathroom when Resident #1 entered his room. Resident #2 said he told Resident #1 to get out of his room and then Resident #1 then punched him three or four times. Resident #2 said he did not know where he was hit because he did not have his glasses on. Resident #2 said Resident #1 had something sharp come out of his knuckles and felt like he was scratched. The NHA attempted interview Resident #1, but he did not respond to questions.-However Resident #1 was Spanish speaking, it was not clear if the NHA had an interpreter present. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation documented both residents resided on the secure memory unit.Interventions following the incident included putting a stop sign across Resident #2's door to help other residents from entering his room, however Resident #2 asked for the stop sign to be removed shortly after it was put up. There were no other interventions put in place. The facility concluded they could not substantiate or unsubstantiated the allegation of abuse. The facility found the evidence to be inconclusive. The facility documented Resident #2 could not recall if he was hit and there was no evidence as to how Resident #2 sustained the skin tear on his neck.-However, during the initial interview, Resident #2 said he was hit by Resident #1 and he had something sharp in his hand. Resident #2 also verbalized that he was struck by a resident when he was seen by his physician. The CNA also said they heard what sounded like a punch prior to entering the room.B. Resident #1 - assailant1. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included Alzheimer's Disease, anxiety disorder, cognitive communication deficit, and vascular dementia, unspecified with other behavioral disturbance. The 12/10/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. Resident #1 required set up assistance with all activities of daily living (ADLs).The MDS assessment documented Resident #1's preferred language was English, did not wander and did not exhibit any behavioral symptoms.2. Record reviewThe behavior care plan, initiated 8/20/25, documented to monitor Resident #1 for behaviors related to inappropriate touching, increase in behaviors, pain, tearfulness, self isolation, and angry outbursts. The pertinent interventions included placing the resident on 15 minute safety checks; maintaining close staff supervision during meals, activities and common areas; ensuring the resident was seated in a staff visible, low risk location during dining and group activities; assessing the possible increase in behaviors and removing any triggers; and redirecting the resident if increased behaviors occurred. -However the care plan did not identify effective redirection techniques. The cognition care plan, initiated 8/20/25, documented Resident #1 had a risk for impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. The pertinent interventions included, using the resident's preferred name, identifying yourself at each interaction, facing the resident when speaking and making eye contact, reducing any distractions, asking yes or no questions in order to determine the resident's needs, providing the resident with necessary cues, stopping and returning if the resident was agitated and reorienting and supervising as needed. The communication care plan, initiated 8/20/25, documented Resident #1 had a communication problem related to a cognitive communication deficit. The pertinent interventions included being conscious of the resident position when in groups, activities, and the dining room to promote proper communication with others; allowing the resident adequate time to respond; repeating statements as necessary; not rushing the resident; requesting clarification from the resident to ensure understanding; facing the resident when speaking; making eye contact; turning off the television or radio to reduce environmental noise asking yes or no questions if appropriate; using simple, brief consistent words and cues; and using alternative communication tools as needed. -However the interventions do not identify the types of alternative communication tools that were effective for Resident #1. The communication care plan, initiated 8/20/25, documented Resident #1's primary language was Spanish. The pertinent interventions included providing Resident #1 with an interpreter.-However, the MDS assessment documented English as the resident's preferred language and he did not need or want an interpreter to communicate with a doctor or health care staff. The 10/29/25 progress note at 3:29 p.m., documented Resident #1 entered another resident's room. The other resident asked him to leave and Resident #1 started to hit him.C. Resident #2 - victim1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the February 2026 CPO diagnoses included, unspecified psychosis, personal history of traumatic brain injury, dementia unspecified severity with other behavioral disturbance, cognitive communication deficit, and other symptoms and signs involving cognitive functions and awareness. The MDS assessment revealed Resident #2 was cognitively intact with a BIMS score of 13 out of 15. The resident required supervision or touching assistance for ADLs.The MDS assessment documented the resident did not exhibit physical or verbal behaviors toward others. 2. Record reviewThe mood and behavior care plan, initiated 6/23/25 and revised on 11/2/25 documented Resident #2 had a history of an alteration in mood or exhibition of behavioral symptoms related to Alzheimer's, dementia, depression and psychosis. Pertinent interventions included evaluating the resident for a referral to psychological counseling as recommended by physician, interacting with the resident in an empathetic and supportive manner, monitoring and documenting each behavioral event and offering psychosocial support as needed. A follow up progress note, dated 10/29/25 at 7:33 a.m. by the physician documented the resident had an altercation with another resident who scratched Resident #2 on the neck. Resident #2 sustained a small skin tear to the left side of his neck and was approximated with steristrips. Resident #2 said he was startled but otherwise was doing okay. III. Incident of physical abuse between Resident #1 and Resident #4 on 12/30/25A. Facility investigationThe facility investigation, dated 12/30/25, documented CNA #12 was assisting a resident in their room when she heard a disturbance in the hallway. She responded to assess the situation and found Resident #4 and Resident #5 in a verbal dispute. CNA #12 intervened and positioned herself between the residents to deescalate the situation. While CNA #12 was deescalating the situation Resident #1 approached and swung at Resident #4, it was unclear if there was any contact. -However, CNA #12's interviewed (see below) revealed Resident #1 made contact with Resident #4.Resident #5 said Resident #4 came toward him so he grabbed his wrists to stop him but then later denied any physical contact. Resident #4 said he was walking toward Resident #5 to stop him from running his mouth. He denied hitting anyone or being hit. Resident #1 denied being involved in the altercation and said he was not hit and did not hit anyone. -However, Resident #1 was Spanish speaking and there was no indication an interpreter was used for his interview. The investigation documented all three residents resided on the secure unit.B. Resident #4 - victim1. Resident statusResident #4, age less than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dysphagia, oropharyngeal phase, cerebral infarction, cognitive communication deficit, and unspecified dementia.The 11/8/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. The resident required supervision or touching assistance for eating and was moderate to maximum assist with all his ADL.2. Record reviewThe cognitive function care plan, initiated 8/9/24 and revised on 11/4/24, documented Resident #4 had impaired thought processes related to dementia. Pertinent interventions included redirecting the resident away from other residents; providing structured and supervised activities to reduce unstructured roaming; providing increased checks due to reaction when other residents enter his room and being cursed at in Spanish;.ensure staff face the resident when speaking, making eye contact and reducing any distractions; and keeping the resident in direct line of sight while awake to prevent the resident from wandering into other residents' rooms.The behavior care plan, initiated 7/21/25 and updated 8/13/25, documented Resident #4 had an altered thought process and impulsive behavior due to dementia. Pertinent interventions included providing one to one supervision for safety, maintaining a calm and structured environment to reduce cognitive overload and frustration, monitoring for potential behavioral triggers such as unexpected intrusion into personal space, and providing de escalation support and redirection techniques when the resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appears agitated or defensive.-However, the care plan did not include any resident specific redirection techniques. A nursing progress note, dated 12/30/25 at 6:31 p.m, documented the nurse was notified by the CNA an altercation happened between Resident #4 and two other residents. Resident #4 was yelling at Resident #5 when Resident #1 walked by and punched Resident #4 in the face. Resident #4 denied being hit. Resident #4 was assessed and there were no apparent injuries. A nursing progress note, dated 12/31/26 at 9:54 a.m., documented the root cause of the altercation between Resident #5, Resident #1 and Resident #4 was cognitive decline and poor safety awareness. The preventative measure put in place was frequent safety checksIV. Staff interviewsCNA #4 was interviewed on 2/3/26 at 12:20 p.m. She said she had been trained on abuse through the facility's training program. She said she was aware of residents' triggers and what interventions to attempt through communication with other staff members. She said she received information at the morning unit meeting and through the facility communication application. CNA #6 was interviewed 2/3/26 at 3:35 p.m. CNA #6 said each shift provided a verbal report from the previous CNA about any behavior or mood changes in a resident. She said the unit had a staff meeting to discuss any resident changes. She said each resident's kardex (summary of resident care information) provided information on how to care for residents and included behavior triggers and interventions to attempt.CNA #12 was interviewed 2/4/26 at 4:00 p.m. CNA #12 said she was involved with the incident between Resident #4, Resident #5 and Resident #1. She said she was the only staff member in the secured unit since the nurse was on another unit. She said she was assisting a resident in their room when she heard two male resident voices escalating in the hall. She quickly finished with the resident she was assisting and went to intervene between the male residents (Resident #4 and Resident #5), but the situation had escalated. She positioned herself between the residents hoping to deescalate the situation. She said Resident #1 approached and swung with a closed fist, making contact with Resident #4's cheek. She tried to communicate to Resident #1, however she did not speak his primary language of Spanish. CNA #1 was able to get the residents separated, calmed down and Resident #1 to his room without further incident.CNA #8 was interviewed 2/9/26 at 11:30 a.m., CNA #8 said she was not the CNA who entered Resident #2's room at the time of the incident, however she was working the unit and walked in the room a few seconds later. CNA #8 said she heard a commotion and the was told by the CNA who did entered the room first, there was contact made between Resident #1 and Resident #2. She said Resident #2 had a scratch on this neck most likely from Resident #1's nail. She said Resident #1 only spoke Spanish and would become upset when he was not able to verbalize his needs. She said the staff tried to communicate with an interpreter application on their phones but it did not always work especially if the resident was agitated. The director of nursing (DON) was interviewed on 2/9/26 at 11:50 a.m. The DON said residents were placed on one to one supervision if behaviors escalated and resulted in an altercation. She said the one to one supervision could last a day up to several days. The one to one supervision was monitored by the interdisciplinary team (IDT) and when the IDT agreed it was no longer needed the resident was placed on frequent checks. The DON said the secured unit was staffed with one nurse, who was also assigned to another unit and one CNA. She said if a resident had a one to one supervision then there would be more than the two staff members assigned to the secured unit. She said the staff member who provided one to one supervision was not to assist with tasks on the unit and to stay with their resident. The DON said when the nurse was on the other assigned unit the CNA could be the only staff member on the secured unit. She acknowledged the staffing situation on the secure unit may not be safe and said the facility was going to add another CNA to the unit potentially in the next week. The DON said that administration staff rounded on the secured unit and provided assistance with the one to one (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision for the residents. The NHA was interviewed on 2/9/26 at 12:11p.m The NHA said he investigated both resident to resident altercations. He said the first incident involving Resident #1 and Resident #2 could not be substantiated or unsubstantiated due to the contact being not witnessed. He said there was no evidence on how Resident #2 received the scratch on his neck, however the investigation did not explore any alternatives as to the origin of the scratch to Resident #2's neck. The NHA documented on the investigation that CNA #12 was not clear if there was contact. -However, during the interview 2/4/26 interview, CNA #12 said contact was made with Resident #1 and Resident #4. The NHA said he was aware having only one staff member on the secured unit could be difficult for a staff member to assist residents and monitor behaviors. He said they had recognized this issue and would be hiring for an additional CNA for the unit. The NHA said there had been an employee from the activities department on the unit during some days providing activities, however this person was not on the unit full time and had resigned. The NHA said staff members were provided education on dementia and abuse on orientation and at least annually. He said new training had been rolled out to the staff specifically for behavior interventions on 2/6/26, and he expected those trainings to be completed within a week of the roll out.

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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 observation, records review and interviews, the facility failed to adequately monitor the resident for unnecessary psychotropic medications needed to provide effective and person-centered care for one (#13) of three residents reviewed for use of psychotropic medication out of 24 sample residents. Specifically, the facility failed to:-Ensure the physician's order for Resident #13's as needed (PRN) lorazepam (antianxiety medication) was reevaluated and a rationale was provided by the physician to justify the continued use of the psychotropic medication beyond the 14-day limit; and,-Ensure behavior and side-effect monitoring were in place for Resident #13's lorazepam and Seroquel (an antipsychotic medication) medications. Findings include:I. Facility policy and procedureThe Use of Psychotropic Medications policy and procedure, revised 4/28/25, was provided by the nursing home administrator (NHA) on 2/9/26 at 2:45 p.m. It read in pertinent part, Psychotropic medications are to be used only when a practitioner determines that the medication is appropriate to treat a resident's specific condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. Psychotropic medications used on an as-needed basis must have a diagnosed specific condition and indication for the as-needed use documented in the resident's medical record, and is subject to the following limitation: as-needed orders for psychotropic medications shall be limited to no more than 14 days, unless the attending physician or prescriber believes it is appropriate to extend the order beyond 14 days. The medical record should include documentation from the physician or prescriber for the extended time period and indicate a specific duration.II. Resident statusResident #13, age [AGE], was admitted on [DATE] and discharged to another facility on 2/9/26 (during the survey). According to the February 2026 computerized physician orders (CPO), diagnoses included neurocognitive disorder with Lewy bodies (a progressive neurodegenerative disorder caused by abnormal protein deposits (Lewy bodies) in the brain, affecting thinking, movement, sleep, and mood), parkinsonism, and anxiety.The 1/20/26 minimum data set (MDS) assessment revealed the resident had severe cognitiveimpairments with a brief interview for mental status (BIMS) assessment score of four out of 15. The assessment documented the resident had not had any physical or verbal behaviors directed towards others, or any other behavioral symptoms not directed towards others, during the assessment period.The assessment documented the resident was taking antipsychotic and antianxiety medications.III. Record reviewThe psychotropic care plan, initiated 11/19/25, revealed Resident #13 received psychotropic medications resulting from his Lewy body dementia. Pertinent interventions included administering medications as ordered and monitoring for side effects and efficacy each shift, and consulting with the pharmacist and physician to consider a dosage reduction when clinically appropriate at least quarterly.Review of Resident #13's October 2025 CPO revealed the following physician's orders:Lorazepam 0.5 milligrams (mg), give 0.5 mg by mouth every four hours as needed for anxiety until 10/18/25, ordered 10/5/25.Lorazepam 2 mg per milliliter (ml), give 0.25 ml by mouth every four hours as needed for anxiety per hospice orders, ordered 10/22/25 and discontinued 10/27/25.Lorazepam 0.5 mg, give one tablet by mouth every four hours as needed for anxiety or agitation per hospice, ordered 10/27/25 and discontinued 11/21/25.-This order was continued for a total 25 days, which was 11 days longer than the 14 day limit for as-needed psychotropic usage.Seroquel (quetiapine) 25 mg, give 0.5 tablet by mouth every 24 hours as needed for behaviors, ordered 10/17/25 and discontinued 11/8/25.-This order was continued for a total of 22 days, which was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eight days longer than the 14 day limit for as-needed psychotropic usage.Review of Resident #13's November 2025 CPO revealed the following physician's orders:Quetiapine 25 mg, give 0.5 tablet by mouth in the afternoon for behaviors, ordered 10/17/25 and discontinued 11/17/25. Quetiapine 25 mg, give one tablet by mouth in the afternoon for dementia with behaviors, ordered 11/17/25.Lorazepam 0.5 mg, give 1 tablet every four hours as needed for anxiety, pacing, tremor, increased speed of speech or mumbling related to anxiety disorder until 12/5/25 per hospice, ordered 11/21/25 and discontinued 12/5/25.Review of Resident #13's December 2025 CPO revealed the following physician's orders:Lorazepam 0.5 mg, give 1 tablet every four hours as needed for anxiety, pacing, tremor, increased speed of speech or mumbling related to anxiety disorder until 12/19/25 per hospice, ordered 12/6/25 and discontinued 12/19/25.Lorazepam 0.5 mg, give 0.5 mg by mouth every four hours as needed for anxiety and restlessness for two weeks, ordered 12/21/25 and discontinued 1/4/26.Review of Resident #13's January 2026 CPO revealed the following physician's orders:Lorazepam 0.5mg, give one tablet by mouth every four hours as needed for anxiety per hospice, ordered 1/5/26 and discontinued 1/28/26.-This order was continued for a total of 23 days, which was 9 days longer than the 14 day limit for as-needed psychotropic usage.Lorazepam 0.5 mg, give one tablet by mouth every four hours as needed for anxiety for 14 days, ordered 1/28/26.Review of Resident #13's February 2026 CPO revealed the following physician's orders:Behavior monitoring: monitor and document behaviors each shift for signs of increased agitation, including restlessness, yelling, irritability, pacing, resistance to care or changes in baseline. Utilize non-pharmacologic interventions including reorientation, redirection, comfort measures or environmental modification and document if interventions are effective every shift; ordered 2/4/26 at 10:55 p.m. (during the survey process).-Review of Resident #13's electronic medical record (EMR) did not reveal any other orders for behavior monitoring or other documentation of consistent behavior monitoring by nursing staff.-Review of Resident #13's EMR did not reveal any physician orders for side effect monitoring for his prescribed lorazepam or Seroquel, or other documentation of consistent side effect monitoring by nursing staff.Review of Resident #13's medication administration record (MAR) from 10/1/25 through 2/9/26 revealed the following:From 10/1/25 through 10/31/25 the resident received 17 doses of as-needed lorazepam.From 11/1/25 through 11/30/25 the resident received 50 doses of as-needed lorazepam.-14 of these doses were administered from 11/11/25 through 11/21/25, during the time exceeding the 14 day limit for as-needed psychotropic medications without documentation of reevaluation by the physician.Resident #13 received one as-needed dose of Seroquel 25 mg on 11/3/25 at 12:02 p.m., two days after the 14 day limit for as-needed psychotropic medications.From 12/1/25 through 12/31/25 the resident received 40 doses of as-needed lorazepam. From 1/1/26 through 1/31/26 the resident received 26 doses of as-needed lorazepam. -11 of these doses were administered from 1/19/26 through 1/27/26, during the time exceeding the 14 day limit for as-needed psychotropic medications without documentation of reevaluation by the physician.From 2/1/26 through 2/9/26 the resident received three doses of as-needed lorazepam. The medication regimen review, dated 9/27/25, revealed the facility pharmacist reviewed Resident #13's medication regiment. The pharmacist documented the following nursing recommendations: ensure all medication consents were signed, ensure behavior tracking was in place for all antipsychotic, anxiolytic and mood stabilizing medications, and ensure all as-needed antipsychotic or anxiolytic medications have an initial stop date of 14 days. The pharmacist documented after 14 days, the as-needed medication would need a new order and a progress note justifying the as-needed use. The review suggestions were implemented by the nursing staff and signed on 2/5/26 (during the survey and almost five months after the medication regimen review).The medication regimen review, dated 10/30/25, revealed the facility pharmacist reviewed Resident #13's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Creekside Village Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E Stuart St Fort Collins, CO 80525	

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication regiment. The pharmacist documented Resident #13 was on an as-needed order of Seroquel with no stop date. The pharmacist documented antipsychotic medications were not recommended for as-needed use and could not be continued for more than 14 days without a new order. The pharmacist recommended discontinuing the as-needed Seroquel order. The physician's response, undated, revealed the physician had already discontinued the order on 11/8/25.A review of Resident #13's progress notes revealed no documentation to indicate the physician had reevaluated the resident's PRN lorazepam in order to justify the use of the medication beyond the 14-day limit for PRN psychotropic medications. A review of Resident #13's hospice notes revealed no documentation to indicate the physician had reevaluated the resident's PRN lorazepam in order to justify the use of the medication beyond the 14-day limit for PRN psychotropic medications. IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 2/5/26 at 11:54 a.m. LPN #1 said if she saw a resident was wandering or exit-seeking she would try to talk with them and see what they needed and what she could do to help redirect them. LPN #1 said she did not want to drug the residents, so she tried to just talk with them before using medications. LPN #1 said she was able to redirect Resident #13 any time he was wandering by talking to him about his past career as a football player. LPN #1 said Resident #13 would light up and start talking with her if she brought up his sports career. LPN #1 was interviewed a second time on 2/9/26 at 11:18 a.m. LPN #1 said the nursing staff monitored residents receiving psychotropic medications for side effects and behaviors each shift. LPN #1 said they monitored the residents for side effects to see if the resident was having any adverse reactions to the medications. LPN #1 said the nursing staff monitored the residents' behaviors to see if the medication was working. LPN #1 said residents' behaviors and the indication for the medications varied from resident to resident, so she monitored the residents for the specific behaviors identified. LPN #1 said she documented the behavior monitoring and side effect monitoring in the treatment administration record (TAR) each shift.The pharmacy consultant (PC) was interviewed on 2/5/26 at 4:40 p.m. The PC said Resident #13's hospice provider was likely prescribing the lorazepam for end of life comfort care. The PC said the hospice provider should provide documentation every 90 days which justified their use of the as-needed lorazepam. The PC said for Resident #13's order for as-needed lorazepam, the nursing staff would typically put in orders to monitor Resident #13 for potential side effects for anxiolytics, which could include oversedation or tiredness. The PC said the nursing staff also usually added orders for resident-specific behavior monitoring, which could include pacing, picking at skin, fast-talking or other signs of anxiety. The PC said the nursing staff would put in orders for behavior monitoring and side effect monitoring for the Seroquel prescription as well. The PC said Resident #13 had resided in the facility since September 2025, so he should have been reviewed by the psych-pharm committee at least twice (between then and 2/5/26).Registered nurse (RN) #1 was interviewed on 2/9/26 at 10:58 a.m. RN #1 said for residents receiving any psychotropic medications, the nursing staff observed the residents for involuntary movements, dry eye, dry mouth, sedation and sleepiness among other side effects. RN #1 said the nursing staff also monitored the residents' target behaviors according to the resident's care plans. RN #1 said she documented any side effects or behaviors in the TAR. RN #1 said this monitoring was documented so the nursing staff could keep track of any potential side effects, and to see how effective a medication was for treating a resident's behaviors. RN #1 said a lot of psychotropic medications had the potential to cause oversedation, so the nursing staff would want to monitor the resident's medications to see if they need to adjust their medication schedule and give the medications at night to help with oversedation.The director of nursing (DON) was interviewed on 2/9/26 at 1:25 p.m. The DON said when starting a resident on a psychotropic medication, the nursing staff (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 record review, interviews, and observations, the facility failed to ensure that residents received adequate supervision and were kept free from elopement for one (#13) of three residents at risk for elopement out of 24 sample residents.Specifically, the facility failed to provide Resident #13 with the supervision necessary to prevent elopement.Resident #13 had severe cognitive impairments and was assessed to require supervision to substantial assistance from staff for most activities of daily living. He needed supervision to touching assistance to walk ten feet, had a history of wandering and exit-seeking, and was at high risk of falling.Record review revealed that in October 2025, the resident began exhibiting exit-seeking behavior, packing his clothes, wandering, and pacing, and on 11/1/25 at 2:30 p.m., a nurse was notified by another resident that Resident #13 was outside and was walking away from the facility, approximately 20 minutes after he was last seen. The nurse on duty followed Resident #13, spoke with him, and, with another staff member, was able to redirect him back into the facility. Resident #13 was placed on 15-minute checks, and the resident's hospice provider and the nursing home administrator (NHA) were notified. No other interventions were implemented.Record review continued to reveal the resident exhibited exit-seeking behaviors, and on 12/13/25 at approximately 12:40 a.m., a certified nurse aide (CNA) heard someone outside the locked door at the end of the hallway. The CNA discovered Resident #13 was attempting to come into the building. The CNA said she had not heard the alarm for the door go off, and that the door was locked and functioning properly. Resident #13 was interviewed and said he was going out to do his laundry. Resident #13 attempted to leave several more times that night but was redirected. Fifteen-minute checks were implemented, and line-of-sight observations were conducted for the remainder of the night.Record review revealed the facility did not develop a resident-centered care plan to prevent elopement following either of the elopements above, despite evaluating the resident at high risk for elopement after the 11/1/25 elopement, and despite progress notes and hospice notes documenting the resident's continued exit-seeking behaviors. When, on 1/20/26, an elopement risk evaluation assessed the resident at an even higher risk for elopement than on 11/1/25, the facility still failed to initiate a resident-centered care plan that informed staff of the level of supervision he required for his safety. Further, staff interviews revealed the resident often sat in the front lobby with the unlocked front door, an area that was infrequently visited by facility staff. The facility's failure to address Resident #13's increasing risk for elopement through interventions that would ensure adequate supervision created the likelihood for a serious adverse outcome. Findings include:I. Immediate JeopardyA. Situation of immediate jeopardyThe facility's failure to address Resident #13's increased risk for elopement and to provide adequate support and supervision to prevent elopement was likely to result in a serious adverse outcome. The facility was located on the corner of a busy street, and the resident had cognitive and physical impairments that made being unsupervised outside of the facility hazardous to his health and safety. B. Imposition of immediate jeopardyOn 2/4/26 at 5:45 p.m., the nursing home administrator (NHA) was notified that the facility's failure to take steps to ensure Resident #13 received adequate supervision to prevent elopement created an immediate jeopardy situation. C. Facility plan to remove immediate jeopardyOn 2/5/26 at 11:29 a.m., the facility submitted a plan to remove the immediate jeopardy.The removal plan read:1. Corrective actionResident #13 was placed on one-to-one supervision by facility staff and would remain on one-to-one supervision indefinitely. On 2/4/26, Resident #13's care plan was reviewed and updated by the director of nursing (DON) to reflect current wandering and elopement risk and person-centered interventions, including implementation of a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	plan, initiated 11/19/25, revealed Resident #13 received psychotropic medications for his Lewy body dementia. Pertinent interventions included administering medications as ordered and monitoring for side effects and efficacy each shift.The resident's fall care plan, revised 12/1/25, revealed Resident #13 was at risk for falls due to his diagnosis of Lewy body dementia, history of falls, unsteady gait, and hypotension. Pertinent interventions included frequent safety checks and ensuring his call light was within reach.The most recent minimum data set (MDS) assessment, dated 1/20/26, revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) assessment score of four out of 15. The assessment documented that the resident required supervision to substantial assistance from staff for most activities of daily living. The assessment documented that the resident needed supervision to touching assistance to walk ten feet. The assessment indicated the resident had not exhibited any wandering behavior during the assessment look-back period.B. Resident history of elopements in the facility1. Resident #13's representative's interviewResident #13's representative was interviewed on 2/5/26 at 2:58 p.m. The resident representative said there was an incident when Resident #13 went outside when he was first admitted to the facility. The resident representative said it was late at night when Resident #13 walked out, and the staff went outside and brought him back inside. The resident representative said there was another incident where it sounded like Resident #13 was going outside, but the facility staff saw him leave. The resident representative said Resident #13 had not had any elopement attempts since those incidents, and thought his medications were working better at the moment.2. Facility investigation of elopementsRecord review revealed Resident #13 eloped from the facility on 11/1 and 12/13/25.The facility investigation of Resident #3's elopement, dated 11/1/25, was received from the NHA on 2/4/26 at 10:25 a.m. and revealed the following:-An interview with certified nurse aide (CNA) #9, undated, revealed CNA #9 had finished giving another resident a shower and went to assist him with a meal. CNA #9 saw Resident #13 in his room as she was walking through the hallway at approximately 1:15 p.m. to 1:20 p.m. The last time CNA #9 had checked on Resident #13's roommate was approximately 2:10 p.m. to 2:15 p.m. At approximately 2:30 p.m., another resident alerted the nursing staff that Resident #13 was outside the facility. CNA #9 said Resident #13 was outside for approximately 15 minutes before the nursing staff helped him back into the facility and placed him on 15-minute checks.-An interview with registered nurse (RN) #2, undated, revealed RN #2 last saw Resident #13 around 1:30 p.m. RN #2 said another resident notified her that Resident #13 was outside the facility, so she went out to help bring him back inside. RN #2 said Resident #13 stopped in the middle of the street's crosswalk while they were trying to bring him back inside, and began asking people to call the police.The facility's investigation of Resident #13's elopement, dated 12/13/25, was received from the NHA on 2/4/26 at 10:25 a.m. and revealed the following:-An interview with Resident #13, dated 12/13/25, revealed that Resident #13 said he was leaving the facility to go do his laundry. Resident #13 said his family (who typically washed his laundry) had not come in for a while, and he had clothes that needed to be washed.-An interview with CNA #9, dated 12/13/25, revealed CNA #9 had last seen Resident #13 in his room around 12:20 a.m. on 12/13/25. At around 12:40 a.m., CNA #9 said she heard someone at the door at the end of the hallway and saw Resident #13 standing outside the door wearing long pants, a jacket, and shoes. CNA #9 said she had not heard the alarm for the door at the end of the hallway going off, and that the door was locked and functioning properly. (Review of the resident's 15-minute check sheet revealed that on 12/13/25 from 12:00 a.m. to 1:00 a.m., Resident #13's whereabouts were not documented and left blank.)C. Record review An elopement assessment shortly after Resident #13's admission on [DATE] revealed the resident was not at risk of wandering. The assessment documented Resident #13 was cognitively (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	impaired and was able to ambulate independently, but documented that he did not have any memory or decision-making impairments and did not verbalize wanting to leave the facility. The resident had a score of two, with any score greater than seven indicating a high elopement risk.However, record review (progress notes and hospice notes below) revealed that beginning in October 2025, the resident began exhibiting exit-seeking behaviors (wandering, pacing, confusion, agitation) and eloped twice; once on 11/1/25 and again on 12/13/25 (see above). Although elopement evaluations thereafter (11/1/25 and 1/20/26) revealed the resident was at high risk for elopement, record review revealed the facility failed to develop a resident-centered care plan with effective, nonpharmacologic interventions that informed staff of the level of supervision the resident consistently required for his safety until 2/4/26 during the survey (see below).Record review revealed:A progress note, dated 9/25/25 at 8:06 p.m., revealed Resident #13 was found by a facility staff member wandering in the back hall of the facility, pushing his wheelchair and approaching the elevator. Resident #13's stated intention was to ride the elevator back to his room. The staff member guided Resident #13 back to his room. Resident #13 was monitored frequently throughout the remainder of the daytime shift.A progress note, dated 9/28/25 at 9:20 p.m., revealed Resident #13 was found lying on the floor in the hallway. Resident #13 said he was going to find his way out and said he did not have his driver's license. Resident #13 was weight-bearing on both lower extremities but was slightly off-balanced. Resident #13 was frequently monitored per facility policy.An IDT note, dated 9/30/25 at 9:44 a.m., revealed the IDT team reviewed Resident #13's fall on 9/28/25. The IDT note documented that the root cause and risk factors for the fall were Resident #13's baseline cognitive decline and poor safety awareness due to his Lewy body dementia and progressive memory decline. Resident #13 also had orthostatic hypertension at times. New interventions included frequent rounding on the resident by nursing staff and reminding him to use his walker for ambulation.Progress notes on 10/5/25 at 7:37 p.m., 10/6/25 at 8:06 p.m., 10/7/25 at 6:30 p.m., 10/12/25 at 10:56 p.m., and 10/13/25 at 3:56 a.m. revealed Resident #13 was administered as-needed doses of lorazepam (an anxiety medication) due to increased agitation. A progress note, dated 10/13/25 at 11:14 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam as he was presenting with anxiety and pacing all over the facility. A progress note, dated 10/14/25 at 7:48 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam as he was presenting with anxiety and was pacing.A physician note, dated 10/14/25 at 3:45 p.m., revealed Resident #13 was seen by his physician at the request of his hospice provider. The hospice provider requested a urinalysis to evaluate Resident #13 for increased confusion and altered mental status. The hospice provider was concerned for Resident #13's disease progression, but wanted to rule out a urinary tract infection.A physician note, dated 10/17/25 at 11:15 a.m., revealed Resident #13 was seen by the physician to review his urinalysis results and behaviors. The note documented that Resident #13's urinalysis came back without any concerns. Resident #13 continued to have aggressive behaviors and agitation, so the physician would reach out to the hospice provider for them to consider reviewing his medication management.A progress note, dated 10/18/25 at 12:38 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam for increased agitation.A progress note, dated 10/20/25 at 8:28 p.m., revealed Resident #13 was administered an as-needed dose of Seroquel (an antipsychotic medication) for his increasing behaviors. Resident #13 was walking up and down the hallway, packing and unpacking his clothes and belongings, and attempting to enter other residents' rooms.A physician note, dated 10/21/25 at 3:08 p.m., revealed Resident #13 was seen by the physician per the hospice provider's request. Resident #13's as-needed lorazepam order had been discontinued, and the nursing staff noticed increased behaviors from the resident, including toileting in his laundry basket. (continued on next page)

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Creekside Village Rehabilitation and Nursing LLC	1000 E Stuart St Fort Collins, CO 80525

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospice provider would add the as-needed lorazepam back into Resident #13's orders.-However, the physician did not address Resident #13's wandering, packing, or pacing behaviors or suggest nonpharmacologic interventions.A physician note, dated 10/24/25 at 8:56 a.m., revealed Resident #13 was seen by the physician to follow up on the resident's medication changes. Resident #13's behaviors had improved per the nursing staff after adding scheduled Seroquel to his medication regimen. The physician documented that the hospice provider would continue prescribing lorazepam as it seemed to help with Resident #13's behaviors.A progress note, dated 10/28/25 at 7:30 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam. Resident #13 was exhibiting signs of restlessness and anxiety, including pacing, quick breathing and agitation.A progress note, dated 10/28/25 at 11:58 a.m., revealed Resident #13 was administered a second as-needed dose of lorazepam as he was still exhibiting signs and symptoms of anxiety.A progress note, dated 10/28/25 at 5:03 p.m., revealed Resident #13 was administered a third as-needed dose of lorazepam. Resident #13 was exhibiting signs and symptoms of anxiety. Resident #13 was pacing and going back and forth between standing and sitting in his chair.Progress notes on 10/28/25 at 11:53 p.m. and 10/29/25 at 2:21 a.m. revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. A progress note, dated 10/29/25 at 7:40 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation and anxiety. Relaxation techniques including deep breathing and redirection were used with minimal results.A physician note, dated 10/30/25 at 2:10 p.m., revealed Resident #13 was seen by the physician per the nursing staff's request. The nursing staff reported Resident #13 seemed to have been in pain earlier that day. Resident #13 denied any pain, and no other concerns were identified or documented.A progress note, dated 11/1/25 at 3:12 p.m., revealed Resident #13 took a walk with his walker to the school across the street from the facility. When a nursing staff member approached him, Resident #13 accused everyone of trying to harm him, and stopped in the middle of the street in the crosswalk to ask people driving by to call the police. Resident #13 was persuaded to move onto the sidewalk and continued walking back to the property, where he was assisted back into the building. Resident #13 was placed on 15-minute checks, and the NHA and hospice provider were informed.A progress note, dated 11/1/25 at 4:45 p.m., revealed further information regarding the incident on 11/1/25 at 3:12 p.m. Another resident approached the nursing staff to tell them Resident #13 was outside walking away from the facility with his walker. The nursing staff went outside and approached the resident. Resident #13 said everyone wanted to kill him, and said he was not sure if he could trust the staff member. On his arrival back to the facility, Resident #13 was assessed and found to not have any injuries.A progress note, dated 11/1/25 at 5:35 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety and behaviors.An elopement risk evaluation, dated 11/1/25 at 8:23 p.m., revealed Resident #13 was at a high risk of elopement. The assessment documented that Resident #13 was cognitively impaired, had dementia, had verbalized wanting to leave the facility, and had memory and decision-making impairments. Resident #13 was known to wander inside the facility with and without his walker. The assessment documented that verbal redirection was ineffective, and Resident #13 could not find his room without hands-on assistance from staff. The assessment documented that the resident had a score of 11 (high risk).-However, no elopement care plan was developed with effective, nonpharmacologic interventions that informed staff of the level of supervision the resident consistently required for his safety.A progress note, dated 11/1/25 at 9:00 p.m., revealed Resident #13 was observed wandering in the hallway. Resident #13 said he was going to the curb to catch a cab. When the nursing staff attempted redirection, Resident #13 was resistant to changing his plan. One-to-one supervision was implemented to observe Resident #13's whereabouts (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for the next several hours until he went to sleep.A progress note, dated 11/1/25 at 9:35 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam, as he was agitated, wandering, exit-seeking, and said he wanted to go to the police station to report a bad dinner. Resident #13 was making verbal threats of harm to staff.A progress note, dated 11/2/25 at 8:48 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation and anxiety. Relaxation techniques including deep breathing and redirection were used with minimal results.A progress note, dated 11/3/25 at 12:02 a.m., revealed the resident was having increased agitation and aggression. Resident #13 was pacing in his room and pulling on several layers of clothing. Resident #13 resisted assistance and cares from staff.A progress note, dated 11/3/25 at 1:19 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation, anxiety and aggression. Resident #13 was resisting all cares and assistance from staff. Resident #13 was pacing in his room and going through his drawers.A progress note, dated 11/3/25 at 4:17 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to his anxiety. Resident #13 was pacing and determined to go home.A progress note, dated 11/4/25 at 7:44 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation and anxiety. Resident #13 was expressing frustration with not being able to leave the facility.An IDT note, dated 11/4/25 at 10:00 a.m., revealed Resident #13 was reviewed by the IDT team for his elopement on 11/1/25. Resident #13 was walking with his walker and had started to cross the street at a stoplight, stopped and asked drivers to call the police, and was redirected back to the facility. The root cause of the incident was determined to be confusion and paranoia. New interventions included initiating 15-minute checks.-However, the note did not indicate the duration of the 15-minute checks or that the intervention was placed on the resident's care plan for consistent implementation. Further, there were no new non-pharmacologic interventions on his care plans to address his confusion and paranoia.A progress note, dated 11/7/25 at 7:44 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. Resident #13 was fixated on disliking his roommate and was pacing, rummaging through his belongings and displaying anger.A physician's note, dated 11/11/25 at 5:23 p.m., revealed Resident #13 was seen by his physician for a follow-up. Resident #13's hospice provider wanted to begin prescribing the resident donepezil (a medication used to improve cognitive function, used for people with dementia).-However, the physician did not address Resident #13's wandering, packing or pacing behaviors or his elopement on 11/1/25 or suggest nonpharmacologic interventions.A progress note, dated 11/13/25 at 1:12 p.m, revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. Resident #13 was pacing, questioning who the staff were and questioning why they were doing things, and indicating suspicions of hidden actions by the staff.A progress note, dated 11/16/25 at 9:16 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety, restlessness and exit-seeking.A progress note, dated 11/17/25 at 7:43 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. Resident #13 was pacing and fixated on the idea he was in a hotel and needed to check out.A progress note, dated 11/18/25 at 10:26 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. Resident #13 was fixated on the idea his sister was stuck in the facility and he needed to get her out.A progress note, dated 11/23/25 at 7:37 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. Resident #13 was paranoid, confused as to why he was in the facility and was pacing.A progress note, dated 11/24/25 8:43 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation and anxiety. Resident #13 was pacing, had increased tremors and was mumbling his speech.A (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	progress note, dated 11/25/25 at 7:30 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety and agitation. Resident #13 was pacing and exit-seeking.A progress note, dated 11/25/25 at 5:48 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety, pacing and tremors.A progress note, dated 11/26/25 at 9:44 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation and exit-seeking.A progress note, dated 11/27/25 at 5:32 p.m, revealed Resident #13 was administered an as-needed dose of lorazepam due to his anxiety. Resident #13 was displaying signs of high anxiety, including hallucinations, increased tremor and pacing.A progress note, dated 11/28/25 at 5:16 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety. Resident #13 was wandering and making suspicious statements and was difficult to redirect. Staff encouraged Resident #13 to stay in his room for dinner.A progress note, dated 11/29/25 at 5:52 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam. Resident #13 was talking about suspicious people and was mumbling his speech.A progress note, dated 11/29/25 at 11:31 p.m., revealed Resident #13 had an unwitnessed fall and was found on the floor. Resident #13 was unable to tell the nursing staff what had happened.A progress note, dated 12/2/25 at 8:02 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to physical signs of anxiety. Resident #13 had an increased tremor and was hyper-fixated on leaving. A progress note, dated 12/3/25 at 9:07 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased agitation. Resident #13 had an increased tremor, mumbled speech and darting eyes.A progress note, dated 12/5/25 at 3:38 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam. Resident #13 was showing signs of a suspicious attitude toward staff, and had a history of sundowning with agitation and anxiety.A progress note, dated 12/7/25 at 4:45 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam. Resident #13 was showing signs of agitation, including increased tremor, mumbled speech and pacing.A progress note, dated 12/10/25 at 4:55 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety and agitation. Redirection, distraction and relaxation with breathing techniques were used with minimal effectA progress note, dated 12/10/25 at 5:40 a.m., revealed Resident #13 was anxious and agitated multiple times overnight. Resident #13 was pacing in his room, packing and unpacking his belongings. The nursing staff attempted relaxation techniques including speaking to Resident #13 in a calm soothing voice and distracting him with minimal effect. Resident #13's lorazepam was administered, and Resident #13 became calm and returned to bed. Frequent checks were made on Resident #13 to ensure his safety and his needs were met.A progress note, dated 12/10/25 at 12:49 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety. Resident #13 was pacing, rummaging through his belongings and mumbling his speech.A progress note, dated 12/10/25 at 4:51 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam due to increased anxiety. Resident #13 was pacing, rummaging through his belongings and mumbling his speech.A progress note, dated 12/13/25 at 8:07 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam. Resident #13 was showing signs of wandering and restlessness before breakfast.A progress note, dated 12/13/25 at 8:11 a.m., revealed Resident #13 left the facility without his walker between 12:30 a.m. and 1:00 a.m. on 12/13/25. Staff observed Resident #13 on the facility grounds at the back door attempting to reenter the building through the back door, which was locked. Resident #13 was escorted back into the building, assessed and found to have no injuries. 15-minute checks were implemented for him, and line-of-sight observations were made for the remainder of the night. Resident #13 attempted to leave several more times throughout the night but was redirected. The DON, hospice provider and Resident #13's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	representative were notified.-Despite repeated documentation in late November and early December of exit-seeking behaviors (wandering, packing, pacing, hyper-fixated on leaving, and his second elopement on 12/13/25, the facility failed to develop an elopement care plan with effective, nonpharmacologic interventions that informed staff of the level of supervision the resident consistently required for his safety.A progress note, dated 12/13/25 at 10:07 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam as he was anxious and restless.A physician note, dated 12/19/25 at 3:05 p.m., revealed Resident #13 was seen for a routine visit. The nursing staff did not report any acute concerns, and the physician documented Resident #13 seemed to have some improvements since his hospice provider started prescribing a low dose of Seroquel.-However, the physician did not address Resident #13's wandering, packing or pacing behaviors, his elopements on 11/1/25 and 12/13/25, or suggest any nonpharmacologic interventions. A progress note, dated 1/15/26 at 7:23 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam as Resident #13 had a new roommate and was walking frequently.A physician note, dated 1/16/25 at 9:17 p.m., revealed Resident #13 was seen to address a concern with his vision.The physician documented Resident #13 was doing well and his behaviors were stable.A progress note, dated 1/18/26 at 8:04 a.m., revealed Resident #13 was administered an as-needed dose of lorazepam for increased anxiety. Resident #13 was pacing, had wide eyes and was monitoring the hallway from his doorway.A progress note, dated 1/18/26 at 4:33 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam. Resident #13 was pacing and had a paranoid affect, and said he felt anxious.A progress note, dated 1/20/26 at 1:37 p.m., revealed Resident #13 was administered an as-needed dose of lorazepam for anxiety. Resident #13 was pacing, had an increased tremor and was exit-seeking.An elopement risk evaluation, dated 1/20/26 at 12:46 p.m., revealed R

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were free from any significant medication errors, affecting one (#11) of five residents out of 24 sample residents.Resident #11 was admitted on [DATE] with diagnoses of epilepsy (seizure disorder) and acute kidney failure that required dialysis three days a week.Resident #11 was prescribed phenobarbital (anti-seizure medication), valproic acid (anti-seizure medication), clobazam (anti-seizure medication) and Depakote (anti-seizure medication). From [DATE] to [DATE] the resident was hospitalized due to seizure activity. Within 24 hours the resident was sent back to the hospital for more seizure activity. While at the hospital, it was recommended to increase the clobazam to twice a day. The facility failed to administer the resident's anti-seizure medications consistently. On [DATE] the resident was hospitalized again due to seizure activity. Review of the medication administration record (MAR), revealed the facility failed to administer multiple doses of the resident;s seizure management regimen. During the hospitalization, it was recommended to add Tegretol (anti-seizure medication) three times a day. The hospital documented the resident's medication levels were below therapeutic levels.Upon return, the facility failed to administer multiple doses of the Tegretol medication. The resident was hospitalized again due to seizure activity on [DATE]. On [DATE] the resident elected palliative care and expired due to breakthrough seizures and seizure disorder.The director of nursing (DON) was aware that some seizure medications were not administered, and some were held on the dialysis days per facility practice, but did not complete a full audit of residents' medication administration records (MAR) for November and [DATE]. The facility did not conduct an audit to determine the extent of missed medications. In addition, the resident's neurologist and primary care physician (PCP) were not notified about missed medications. Specifically, the facility failed to ensure Resident #11 was administered his seizure medications per physician's orders. Findings include:I. Immediate jeopardyA. Situation of immediate jeopardy Resident #11 was prescribed four different seizure medications upon admission. In [DATE] resident was started on hemodialysis due to kidney failure. Between [DATE] and [DATE], some of the seizure medications were tapered, all four were not administered on dialysis days, and a new seizure medication (Tegretol) was started. In addition, the resident had a PRN order for Lacosamide in [DATE] and Phenobarbital in [DATE] to be given on dialysis days as he was experiencing an increase in seizure activity. The resident was hospitalized on [DATE] for seizures, where subtherapeutic levels (below the recommended level) of his seizure medications were detected. The resident returned to the facility and was started on Tegretol.The new order for Tegretol was supposed to start on [DATE]. However, the medication was not administered for a total of four doses as nurses were not able to locate the medication that was stored in a separate area. The nurses were unaware that medication was available and did not administer it. The resident was hospitalized again due to increased seizure activity, was placed on palliative care and passed away on [DATE].Due to the facility's failures, a serious adverse outcome occurred that required hospitalization. The resident continued to have seizures requiring hospitalization. B. Facility notice of immediate jeopardyOn [DATE] at 1:55 p.m., the nursing home administrator (NHA) was notified of the facility's failure to prevent a significant medication error by not ensuring Resident #11 received his seizure medication as prescribed created a situation of immediate jeopardy for serious harm. C. Facility plan to remove immediate jeopardyOn [DATE] at 4:48 p.m, the NHA presented the following plan to address the immediate jeopardy situation. It read in pertinent part,Identification of other residents affected or likely to be affected: the facility took the following actions to identify other residents that may be at risk on [DATE]The DON and ADON completed an audit to ensure all residents (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	are getting medications as ordered. This audit included a review of each resident's medication administration record for the last 24 hours, and an audit of the medication carts to ensure the medications were available.The DON and regional clinical resource #1 audited all residents currently on dialysis to ensure administration of medications, per physician order, on dialysis days, for the last week.Actions to prevent occurrence/reoccurence:On [DATE] The Medication Administration policies were reviewed by NHA, the DON, regional clinical resource #1Beginning on [DATE] the DON educated all licensed nursing staff on the Medication Administration policy, properly following physician's orders and the process of notifying of medication errors. The education included the process of notifying providers when medications conflict with scheduled dialysis days. This education will be provided to all nursing staff prior to their next scheduled shift.The DON or designee will educate all new hire licensed nurses on medication administration and physician notification guidelines during orientation.The DON or designee will review MAR reports for all residents to ensure medications are administered as ordered, or the physician was notified appropriately if a medication was held. This audit will be completed daily for four weeks, then five times a week for four weeks.Beginning [DATE], all licensed nurses will be observed by the DON or designee administering medications to ensure competency. Observations will occur five times per week for four weeks, then weekly for eight weeks. Observations will occur across shifts and with various staff members. D. Removal of immediate jeopardyOn [DATE] at 5:45 p.m., the NHA was notified that, based on the plan for removal of immediate jeopardy, the plan was accepted and the immediate jeopardy situation removed. However, deficient practice remained at a G level, actual harm, isolated, that is not immediate. II. Facility policy and proceduresThe Medication Administration policy, revised on [DATE], was received from the NHA on [DATE] at 2:15 p.m. It read in pertinent part, The facility shall ensure that the medication will be administered according to the physician's orders. Errors in medication administration include medication omission. If an error has occurred, the nurse assesses the resident's condition and notifies the physician or health care practitioner as soon as possible. The Hemodialysis policy, dated [DATE] with no revision date, was received from the NHA on [DATE] at 2:15 p.m. It read as follows, The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatment. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.III. Resident #11A. Resident statusResident #11, age less than 65, was admitted on [DATE], discharged to the hospital multiple times and passed away on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included epilepsy, acute kidney failure (requiring dialysis), chronic gout, major depressive disorder, muscle weakness, bipolar disorder, and hypertension. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) assessment score of 15 out of 15. The resident was dependent on staff for all activities of daily living due to weakness, medication and disease process.B. Record reviewThe seizure care plan, dated [DATE], revealed Resident #11 had seizure disorder related to epilepsy. Interventions included to give medications as ordered and monitor for effectiveness. According to the medication administration record (MAR) for [DATE] and [DATE], Resident #11 was on the following seizure medications that were scheduled daily:-Phenobarbital oral tablet 48.6 milligrams (mg) to be given in the morning and 97.2 mg to be given in the evening; -Lacosamide oral tablet 100 milligrams (mg), given 200 mg by mouth in the morning and 250 mg by mouth in the evening; On [DATE], Lacosamide 100mg was increased to three times a day; -Clobazam oral tablet 15 mg twice a day; and,-Depakote oral tablet, delayed release 1125 mg given twice a day. In addition, the resident had as needed (PRN) order for seizures to be given after dialysis.-Phenobarbital oral tablet 32.4 mg as needed after dialysis (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	between [DATE] and [DATE]. -Review of the MAR revealed this medication was not administered even though the resident continued to have seizures after dialysis, and -Lacosamide oral tablet 100 mg as needed, to be given immediately after hemodialysis, from 11/2 25 to [DATE]. This medication was not administered even though residents continued to have seizures after dialysis. B. Failure to administer seizure medications and multiple hospitalizations for Resident #11Review of the [DATE] MAR revealed:On [DATE] the resident was not administered Lacosomide 100 mg at noon and Depakote extended release 1000 mg in the evening per physician's orders. -Review of Resident #11's EMR did not reveal documentation indicating the resident's neurologist or PCP were notified of the missed doses of anti-seizure medication. The [DATE] emergency room progress note documented the resident presented for evaluation of increased frequency of breakthrough seizures. The note documented the resident had several seizures today in the emergency department. Intravenous ativan (anti-anxiety medication) was administered. The note documented the resident was prescribed Phenobarbital in the morning and evening, Vimpat (lacosamide) in the morning, afternoon and evening, and Depakote twice a day. The resident was on a complex dosage and scheduling because the resident received dialysis on Tuesday, Thursday and Saturdays. The note documented the resident often had a seizure after dialysis. The [DATE] hospital history and physical documented phenobarbital and valproic acid levels were subtherapeutic on admission . The note documented the plan was to request the MAR from the nursing facility to verify appropriate dosing of seizure medications. The note documented the resident also experienced acute encephalopathy (brain dysfunction) that was likely secondary to seizures.The [DATE] nursing progress note documented at 4:20 p.m. revealed the resident was discharged back to the nursing facility.The [DATE] nursing progress note documented at 2:23 p.m. (less than 24 hours since returning to the facility) the resident was admitted back to the emergency room due to a seizure during dialysis. Review of [DATE] MAR revealed: On [DATE] the resident did not receive the morning dose of all of his four seizure medications: Phenobarbital 48. 6 mg morning dose, clabazam 10 mg morning dose, Depakote extended release 1125 mg morning dose and lacosamide 100 mg morning dose. Additionally, the resident did not receive the evening doses of Depakote ER 1000 mg evening dose and lacosamide 100 mg evening dose. -Review of Resident #11's EMR did not reveal documentation indicating the resident's neurologist or PCP were notified of the missed doses of anti-seizure medication. The [DATE] hospital discharge summary documented the resident was stabilized in the hospital and discharged back to the nursing facility the same day ([DATE]) at 5:00 p.m. The note documented the clobazam medication was increased to 15 mg twice a day. The [DATE] at 12:23 p.m. emergency room note documented the resident presented to the hospital for evaluation after experiencing a possible seizure or whole body tremor episode lasting about an hour. The note documented there were unclear details regarding the duration or continuity of the seizure. The note documented differential diagnoses included breakthrough seizure and subtherapeutic medication usage. Review of the [DATE] and [DATE] MAR revealed that prior to hospitalization on [DATE] and before the hospitalization on [DATE] the following medications were not administered: On [DATE] the lacosamide 100 mg morning and evening dose;On [DATE] the lacosamide 100 mg morning and evening dose;On 11/16 the clobazam 10 mg morning dose;On [DATE] the lacosamide 100 mg noon dose;On [DATE] the clobazam 15 mg evening dose; On [DATE] the lacosamide 100 mg noon dose, On [DATE] the lacosamide 100 mg noon dose; and, On [DATE] lacosamide 100 mg noon dose.Further review of the [DATE] MAR revealed on the morning of [DATE] prior to the resident's hospitalization the resident did not receive his morning medications that included:Lacosamide 100 mg, clobazam 15 mg, and Depakote ER 1125 mg.-Review of Resident #11's EMR did not reveal documentation indicating the resident's neurologist or PCP were notified of the missed doses of anti-seizure medication. The [DATE] hospital note (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented the resident was prescribed Tegretol 200 mg three times a day. The [DATE] nursing progress note documented the resident returned to the facility on [DATE] at 6:00 p.m.Review of the [DATE] MAR after the resident returned from the hospital on [DATE] revealed Tegretol was not administered on the following days:-[DATE] evening dose;-[DATE] all three doses;-[DATE] noon dose, and-[DATE] noon dose.-Review of Resident #11's EMR did not reveal documentation indicating the resident's neurologist or PCP were notified of the missed doses of anti-seizure medication. The [DATE] at 12:30 p.m. progress note documented resident was found with tremors and unresponsive, the provider was contacted and gave an order for Lorazepam administration. After the dose of Lorazepam, the resident became responsive and he was transferred to bed. The resident was assessed by the physician and sent to the emergency room due to intermittent partial seizures. The hospital admission records, dated [DATE], revealed the resident was admitted to the hospital at 3:46 p.m. due to unspecified convulsions. The record documented the resident presented after experiencing multiple seizures throughout the day despite adherence to his antiepileptic medications. He had received two doses of intravenous lorazepam.-However, review of the resident's EMR did not reveal the resident received the antiepileptic medications as ordered.The [DATE] hospital summary documented the resident's hospitalization was complicated by seizures, encephalopathy and severe weakness. He additionally experienced multiple episodes of hypotension and unresponsiveness. The resident transitioned to palliative care on [DATE] and passed away due to breakthrough seizures and seizure disorder. 3. ObservationsOn [DATE] at 10:00 a.m. registered nurse(RN) #2 was administering medications for Resident #25, in the 400 hallway. RN #2 was unable to locate Resident #25's Symbicort inhaler. RN #2 said the inhaler needed to be ordered and she did not have the medication to administer to the resident. The RN did not call the physician or write a progress note regarding the missed dose.IV. Staff interviewsRN #2 was interviewed on [DATE] at 11:39 a.m. She said on [DATE] around noon a certified nurse aide (CNA) reported that Resident #11 was having a seizure. RN #2 said she assessed the resident and implemented seizure precautions. She said she made sure he did not hit his head or injure himself. She said she timed the seizure activity. She said Resident #11 had a second seizure. She said the physician was in the building. She said the physician gave an order for Ativan and to transfer the resident to the hospital. She said she was unaware of any missed doses of medication. She said she did not do a change of condition form or get vital signs.LPN #1 was interviewed on [DATE] at 9:25 a.m. She said she worked with Resident #11 on [DATE] when he was hospitalized . She said CNAs told her that Resident #11 was not his usual self. She said she did not work with Resident #11 before and did not know what his baseline was. She said he appeared to be having a seizure and he was unresponsive. She said the resident's physician was in the building and sent the resident to the emergency room. LPN #1 said it was facility practice to hold medications when a resident was at dialysis as it was not physically possible to administer them when the resident was not in the building. The DON was interviewed on [DATE] at 10:30 a.m. She said on the days when the resident was out for dialysis, the EMR indicated the seizure medications and other medications were marked as not administered. She said it was a facility practice to hold medications when a resident was at the dialysis clinic. She said the orders for medications scheduled on the dialysis days were not clarified with the PCP or neurologist because both physicians already knew that the resident was in dialysis three times a week. The DON said she was aware four doses of Tegretol were not administered upon readmission on [DATE]. She said the facility educated nurses on the location of medications. She said she did not complete a full audit of resident's seizure medications and was not aware of any additional missed doses beside dialysis days. The DON said the PRN orders for lacosamide in [DATE] and phenobarbital in [DATE] that read to be administered after dialysis (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for breakthrough seizures. She said it was up to the dialysis clinic to decide and administer the medication. She said she did not clarify the order with the primary care physician or neurology as it was up to the dialysis clinic. The medical director (MD) was interviewed on [DATE] at 11:00 a.m. She said all seizure medications were managed by Resident #11's neurologist. She said she could not comment on any specifics about seizure medications. She said it was communicated to her that some seizure medications were missed for Resident #11. She said seizure medications should be given as ordered to prevent seizures. Resident #11's PCP was interviewed on [DATE] at 11:50 a.m. She said all seizure medications were managed by Resident #11's neurologist. She said since the resident started dialysis his seizure activity increased and the goal was to find a proper seizure medication that would not be removed (dialysed) during dialysis. She said for that reason the phenobarbital was titrated and resident was started on Tegretol.She said she did not know medications were not being administered on the days that the resident went to dialysis. She said she thought all of the scheduled seizure medications were administered except for one incident on [DATE] when four doses of Tegretol were not given. She said when nurses reported to her that Tegretol was not available on [DATE] and [DATE] her response to missed doses was a discussion with the IDT team. She did not give any new orders. Resident #11's PCP said said the PRN orders for lacosamide in [DATE] and phenobarbital in [DATE] read to be administered after dialysis for breakthrough seizures. She said it was up to the dialysis clinic to decide and administer the medication. She said she was aware that this resident had multiple seizure medications and was having an increase in seizure activity but it was not her role to manage, adjust or clarify any of seizure medications. She said the seizure medications were managed by the neurologist. On [DATE] at 1:02 p.m. an attempt was made to interview the neurologist. However, the neurologist was no longer working with the facility and was not available for an interview. A triage nurse at the dialysis clinic was interviewed on [DATE] at 2:15 p.m. She said the dialysis clinic did not administer any medications that were part of the nursing facility's orders. She said some residents who were able to administer their own medications were able to take them during or after dialysis. She said the residents who were not able to administer their own medications did not bring medications. She said if the resident was unable to administer their own medications, they were administered at the nursing facility before or after dialysis. The nephrology physician was interviewed on [DATE] at 3:30 p.m. He said he was a nephrology physician who worked with a dialysis clinic that Resident #11 visited three times a week in [DATE] and [DATE]. He said he was not aware that the dialysis clinic was expected to administer any medications to this resident. He said it was an unusual expectation from a nursing facility. He said the physician who signed orders in the nursing facility for Resident #11 was responsible for administration and clarification of the orders. The pharmacy consultant was interviewed on [DATE] at 4:40 p.m. She said she reviewed the residents' records monthly and submitted suggestions to the DON She said she did not identify any concerns with Resident #11's physician's orders. She said her suggestions were to check Depakote level in [DATE]. She said she was aware that the resident did not receive four doses of Tegretol on [DATE]. The pharmacy consultant said the dialysis clinic was responsible for administering the as needed lacosamide and the phenobarbital.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure three (#4, #22, and #23) of six residents of 24 sample residents received food prepared in the form designed to meet their individual needs. Resident #4 diagnoses of dysphagia, oropharyngeal phase (difficulty swallowing), cerebral infarction (stroke), cognitive communication deficit, and unspecified dementia was admitted on [DATE]. Resident #4 had a physician's order for minced and moist diet texture (cannot bite off pieces of food but does have basic chewing ability). Resident #22 had diagnoses of dysphagia oropharyngeal phase, cognitive communication deficit, and other symptoms and signs involving cognitive functions and awareness was admitted on [DATE]. Resident #22 had a physician's order for soft and bite-sized texture (not able to bite off pieces of food safely but able to chew bite-sized pieces down into little pieces that are safe to swallow). Resident #23 had diagnoses of gastroesophageal reflux disease (GERD) without esophagitis, dysphagia, oral phase (difficulty chewing, manipulating, or transporting food from the mouth to the throat) was admitted on [DATE]. Resident #23 had a physician's diet order of soft & bite-sized texture. On 1/13/26 Resident #4 was served regular textured soft tacos on a tortilla, which was not altered to the correct diet consistency. The resident began choking on a piece of tortilla, which got stuck in his throat. A registered nurse (RN) attempted the Heimlich maneuver several times and was unsuccessful. The resident was able to clear the piece of tortilla by coughing and then required high-flow supplemental oxygen given by a mask. Observations during the survey revealed the facility continued to provide residents the incorrect modified textured diets. Resident #22 received a regular texture hamburger and a cookie. Resident #23 received a regular texture cookie. Specifically, the facility failed to ensure Resident #4, Resident #22 and Resident #23 received the correct modified food per physcian's orders. The facility's failure to ensure residents received the physician's ordered diet texture placed residents at risk for serious harm or death if not corrected immediately. Findings include:I. Immediate jeopardyA. Situation of immediate jeopardyThe facility failed to ensure Resident #4 was served the correct diet texture as ordered by the physician. Resident #4, who was diagnosed with dysphagia. Resident #4 had a physician's diet order for minced and moist texture. He required supervision and hands-on assistance for meals. On 1/13/26 Resident #4 was served a regular texture meal of soft tacos instead of the minced and moist texture as ordered by the physician. Resident #4 began choking and a nurse performed the Heimlich maneuver. After several attempts she was unable to dislodge the tortilla. The resident was moving air during the episode. After a few minutes, the resident was able to cough up the tortilla and supplemental oxygen was applied. Observations of the dinner meal service on 2/3/26 at 5:40 p.m., revealed two residents who were prescribed a soft and bite-sized diet texture received regular diet food items. Specifically, Resident #22 received a hamburger bun with a whole lettuce leaf and a whole cookie and Resident #23 received a cookie. The facility's failure to ensure residents received the physician ordered diet texture placed residents at risk for serious harm or death if not corrected immediately. B. Facility notice of immediate jeopardyOn 2/4/26 at 1:29 p.m., the NHA and the director of nursing (DON) were notified of the immediate jeopardy situation created by the facility's failure to ensure Resident #4, Resident #22 and Resident #23 received the physician's ordered diet texture. C. Facility plan to remove immediate jeopardyOn 2/4/26 at 5:05 p.m., the facility submitted a plan for immediate jeopardy. The plan read:1. Action planAll staff involved in meal preparation or service including the interdisciplinary team (IDT), nursing, dietary, activities received re-education on diet modifications and following physician orders using the International Dysphagia Diet Standardization Initiative (IDDSI) (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	standards prior to their next scheduled shift. This education included a post-test to demonstrate understanding. All new IDT members, nursing, dietary and activities staff will receive this education during orientation. Education started on 2/4/26 and will continue until all staff are educated. Education provided by the DON or designee. All dietary staff received re-education on food preparation utilizing diet extensions and recipes to adhere to each resident's diet order prior to their next scheduled shift. All new dietary staff will receive this education during orientation. Education started 2/4/26 and will continue until all staff are educatedThe registered dietitian (RD) conducted an audit on 2/4/26 to ensure all dietary orders, recommendations, and documentation were accurate in the medical record and matched the dietary department's tray ticket information for each resident. 2. Systemic changesThe facility's pertinent menu and therapeutic diet policies were reviewed and revised on 2/4/26. The IDT received education on 2/4/26 on conducting root cause analysis of serious events, including choking incidents and to ensure appropriate actions are taken to prevent recurrence. The dietary manager (DM), the DON or designee will audit new admissions daily for three months to ensure the dietary orders/recommendations/documentation are accurate in the medical record and match the dietary department's meal ticket information for that resident and will document findings on an audit form. The DON or designee will review all new orders daily for four weeks then five times a week for four weeks then weekly for one month to monitor for changes to diet orders. Any changed orders will be communicated to the dietary department through a diet change communication form.3. MonitoringThe DON or designee will monitor food service at all three meals for all residents, and compare the meal being served to the physician order/documentation for that resident's dietary needs. Monitoring/auditing will continue daily for four weeks, then five times a week for four weeks, then weekly for one month and will document findings on an audit form.C. Removal of the immediate jeopardyOn 2/5/26 at 2:00 p.m., the NHA was notified that the facility's plan to remove immediate jeopardy was accepted based on the facility's plan to implement the measures above. However, the deficient practice remained at a D level, no actual harm with potential for more than minimal harm.II. Professional referencesThe IDDSI Patient Handout (January 2019), was retrieved on 2/10/26, from https://iddsi.org/Resources/Patient-Handouts It read in pertinent part, Level five minced and moist food may be used if you are not able to bite off pieces of food safely but have some basic chewing ability. Some people may be able to bite off a large piece of food, but are not able to chew it down into little pieces that are safe to swallow. Minced and moist only need a small amount of chewing and for the tongue to collect the food into a ball and bring it to the back of the mouth for swallowing. It is important that minced and moist foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. These foods are eaten using a spoon or fork. Level five minced and moist, for safety avoid these food textures that pose a choking risk for adults who need level five minced and moist food: Bread: no regular dry bread due to high choking risk.Level six soft and bite-sized textures are used if you are not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow. Soft and bite-sized foods need a moderate amount of chewing, for the tongue to collect the food into a ball and bring it to the back of the mouth for swallowing. The pieces are bite-sized to reduce choking risk. Soft and bite-sized foods are eaten using a fork, spoon or chopsticks. An example of of level six soft and bite-sized: Meat cooked tender and chopped, so pieces are no bigger than 1.5 centimeter (cm) by 1.5cm lump size. If food cannot serve soft and tender, serve as minced and moist.Level six soft and bite-sized, for safety avoid these food textures that pose a choking risk for adults who need level six soft and bite-sized food:Bread (no regular dry bread, sandwiches or toast of any kind). Use IDDSI (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	level five minced and moist sandwich recipe to prepare bread; use pre-gelled 'soaked' breads that are very moist and gelled through the entire thickness; Hard or dry food include nuts, raw vegetables, dry cakes, bread, dry cereal; Crumbly bits include dry cake crumble, dry biscuits (add sauce to make these suitable; ‘Floppy foods' include lettuce, cucumber, baby spinach leaves; Large or hard lumps of food include casserole pieces larger than 1.5cm x 1.5cm, fruit, vegetable, meat, pasta or other food pieces larger than 1.5cm x 1.5cm.III. Facility policy and proceduresThe Therapeutic Diet Orders policy and procedure, implemented 4/11/25, was provided by the NHA on 2/9/26 at 9:15 a.m. It revealed in pertinent part, The facility provides all residents with food in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or addressed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat and thickened liquids. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to: inadequate nutrition; nutritional deficits; weight loss; medical conditions such as diabetes; renal disease;or heart disease; swallowing difficulty. The reason for a therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures.IV. ObservationsV. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician's orders (CPO), diagnoses included dysphagia, oropharyngeal phase, cerebral infarction, cognitive communication deficit and unspecified dementia.The 11/8/25 minimum data set (MDS) assessment documented the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. The resident required supervision or touching assistance for eating and was moderate to maximum assist with all his activities of daily living (ADL).The MDS assessment documented the resident was on a mechanically altered diet, which required a change in the texture of foods or liquids. B. Record reviewThe nutrition care plan, initiated 8/8/24 revised 1/16/26, documented Resident #4 had nutritional problems related to dementia, recent stroke, bipolar and was on hospice services. Pertinent interventions included ensuring food, utensils and liquids were kept on his right side visual field due to left sided vision deficit and providing and serving the diet as ordered. The care plan indicated the resident was to receive a level five minced and moist texture.The February 2026 CPO revealed the following physician's order:-Large portion diet level 5-minced and moist texture, regular consistency, ordered 11/26/25.A progress note, dated 1/13/26 at 5:46 p.m., documented the nurse was notified, by a certified nurse aide (CNA) that Resident #4 was choking from being served a soft taco. The note documented the resident was on a level five minced and moist diet. The nurse performed the Heimlich several times. The resident was moving air, but was unable to dislodge the tortilla. The note documented eventually, the resident was able to cough up the tortilla and oxygen was applied. Emergency medical services (EMS) were called but the resident declined to go to the hospital. The 1/14/26 at 9:11 a.m., event note, identified the risk factors and root cause as Resident #4 having dysphagia with cognitive decline and poor safety awareness and insight. The resident was served a regular texture meal for dinner, which included a whole tortilla. The note documented Resident #4 lacked the insight into safety regarding food intake. The preventative measure in place prior to the incident included confirming Resident #4 had an order level five minced and moist. The new interventions included the description of the event and reeducation to the CNA who (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	served the meal despite the physician order of mince and moist texture.VI. Resident #221. Resident status Resident #22, age less than 65, was admitted on [DATE]. According to the February 2026 CPO diagnoses included dysphagia oropharyngeal phase, cognitive communication deficit, hemiplegia and hemiparesis following a cerebrovascular disease affecting the right dominant side, and other symptoms and signs involving cognitive functions and awareness.The 12/11/25 MDS assessment documented the resident was moderately cognitively impaired with a BIMS score of 10 out of 15. The resident required set-up assistance for eating and was substantial to touching assistance with ADLs. The MDS assessment documented Resident #22 was on a regular not on a therapeutic diet or mechanically altered diet at the time of the assessment. 2. Record reviewThe February 2026 CPO revealed the following physician's order:Level six soft and bite-sized texture, ordered on 1/12/26.The dietary care plan, initiated 6/10/25 and revised 1/14/26, documented Resident #22 had a potential for or presence of altered nutrition needs related to depression, diabetes, hemiplegia and hemiparesis. Pertinent interventions included downgrading the texture of diet per speech therapy and providing diet and food texture as tolerated regular diet, soft and bite-sized.VII. Resident #23A. Resident statusResident #23, age less than 65, was admitted on [DATE]. According to the February 2025 CPO diagnoses included gastroesophageal reflux disease without esophagitis, dysphagia, oral phase, cognitive communication deficit, cognitive social or emotional deficit following nontraumatic subarachnoid hemorrhage (brain bleed). The 12/26/25 MDS assessment documented Resident #23 was cognitively intact with a BIMS score of 14 out of 15. The resident required set-up assistance with all ADLs. The MDS assessment documented Resident #23 was on a mechanically altered diet which required a change in texture of food or liquids. B. Record review The nutrition care plan, initiated on 10/2/25, documented Resident #23 had a potential for altered nutritional needs related to anxiety, bipolar, GERD and heart disease Pertinent interventions included providing diet and food texture as tolerated soft and bite-sized texture (revised 2/9/26 -during the survey).The February 2026 CPO revealed the following physciain's orders:Level six, soft and bite sized, however the resident may have regular sandwiches and hamburgers, ordered on 11/17/25.-However, observations revealed Resident #23 was served a whole cookie which was not appropriate for the soft and bite sized diet.VIII. ObservationsOn 2/3/26 at 5:50 p.m. Resident #22 was served a regular textured hamburger on a bun with a whole lettuce leaf and a cookie. Resident #23 was served a whole cookie.-However, Resident #22 and Resident #23 were prescribed a level 6, soft and bite-sized diet.F. Staff interviews and observationsLicensed practical nurse (LPN) #2 was interviewed 2/3/26 at 6:03 p.m. LPN #2 said she received training on diet textures upon hire and every few months. LPN #2 said Resident #22 was on a soft and bite-sized diet. She said the resident was recently downgraded for his diet texture as he was recently hospitalized with a stroke and had dysphagia. LPN #2 entered Resident #22's room and looked at the resident's plate, which contained one whole lettuce leaf and a few 1 cm sliced onion pieces. LPN #2 asked Resident #2 what he had for dinner and the resident replied he had a hamburger. LPN #2 verified the resident's ticket said soft and bite-sized and said the resident should not have had lettuce or the lettuce leaf should have at least been cut up. LPN #2 was interviewed again at 6:10 p.m. LPN #2 said Resident #23 was on a soft and bite-sized diet texture because he had dysphagia. LPN #2 entered the resident's room and opened the resident's room tray lid and revealed three scoops of rice, small chunks of chicken in gravy and vegetable medley. The meal tray also contained a whole cookie. LPN #2 said the resident should not have a cookie with his diet texture. LPN #2 encouraged the resident to eat his meal, removed the cookie from the tray and asked if he wanted pudding or ice cream for dessert.CNA #7 was interviewed on 2/4/26 at 9:25 a.m. CNA #7, who was working on the secured unit at the time, said most of the residents on the secured unit eat (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	their meals in the dining room. She said the CNA assisted residents with physical or verbal assistance when needed. CNA #7 said she read the meal ticket from the tray to match it with the meal on the tray before she served the meal. She said she had been provided education through their training site and again recently by the DON on diet textures. Registered nurse (RN) #2 was interviewed on 2/4/26 at 9:30 a.m. RN #2 said she received training on diet textures upon hire and as needed. RN #2 said she had received training on diet textures two weeks ago when they switched to the IDDSI diet textures. RN #2 said their training included what to look for for each diet texture and what each diet texture could and could not have. CNA #1 was interviewed on 2/4/26 at 9:40 a.m. CNA #1 said he received training upon hire for diet textures by the CNA who trained him. CNA #1 said the CNA who was training a new CNA would give them pointers on what to look for when passing trays. CNA #1 said the DON would occasionally quiz them on diet textures and they received reminders during staff meetings. CNA #1 said for soft and bite-sized the residents could have bread, and could potentially have cookies depending on how soft they were. CNA #1 said MM5 residents' food was usually pretty blended up and had sauce or gravy to make it easier to eat. CNA #1 said the CNAs passed trays and would check the resident's meal ticket and ensure the meal they were served matched the diet texture on the ticket. CNA #1 said if he noticed any issues he would take the meal to the kitchen and have them serve the appropriate diet texture.RN #1 was interviewed on 2/4/26 at 10:12 a.m. RN #1 said she was working on 1/13/26, but was not working on the secured unit where Resident #4 resided. She said on 1/13/26 a CNA came out of the secure unit looking for a nurse because Resident #4 was choking. She said the nurse assigned to the secured unit was not on the unit at the time of the incident.RN #1 said she entered the unit and saw Resident #4 in the dining room struggling to breathe. She said she performed the Heimlich maneuver several times without success. She said she continued to coach the resident to cough in order to remove the object. RN #1 said Resident #4 was eventually able to cough up the object, which was a piece of tortilla. RN #1 said as the resident was coughing up the object EMS arrived but the resident declined to go to the hospital. The DM was interviewed on 2/4/26 at 10:55 a.m. The DM said he was unaware of dietary extensions (document that indicates how to alter food items to the correct texture) prior to the choking incident on 1/13/26. He said he was new to the position and was still learning the responsibilities of the position. The DM said after the choking incident he had placed dietary extensions in the kitchen so the staff had access to them. The DM said he was not sure if the dietary staff had education on diet textures and extensions. He said a dietary aide plated the food using the resident's diet ticket. The DM said the ticket had the diet order and the food to be served for each meal. The DM said the staff member who served the food, which was typically the CNA but could be any staff member, should also check the diet ticket and the meal to make sure they match up prior to serving the meal. The DM said he did not know if all staff had been educated on the different diet textures prior to 1/13/26. The DM said he has been providing one-to-one verbal education to the dietary staff and the DON had provided training on the IDDSI textures since 1/13/26. The DM said the education was not documented.The RD was interviewed on 2/4/26 at 11:40 a.m. The RD said the residents' diets orders were put in the electronic medical record (EMR) and the kitchen was able to print out dietary tickets. The RD said the diet tickets matched the diet order. She said the ticket also included the resident's likes and dislikes, allergies, extensions and the specific food that should be plated for each meal. The RD said the dietary aides received education and visual tools to use while serving. -However, observations revealed the visual aide was posted on a bulletin board behind the serving station (see observations above). The RD said the staff member serving the meal, which could be any staff member, was also responsible for checking the meal against the diet (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Creekside Village Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 E Stuart St Fort Collins, CO 80525	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ticket. The RD said education on the IDDSI diet textures was provided to all staff recently by the DON. The RD said Resident #22 should not have received the hamburger bun or piece of lettuce. The RD said Resident #22 and Resident #23 should not have received the cookies because those food items were not recommended on their ordered diets. The NHA and the DON were interviewed together on 2/4/26 at 11:56 a.m. The DON said she was present during the choking incident on 1/13/26. She said immediately after the incident she provided education to the secured unit staff regarding meal tickets matching the meal being served with the proper ordered diet. The DON said the education given that evening was not documented. The DON said she and the NHA had been providing education to all staff on the IDDSI diet textures. The DON said Resident #23 had received the right diet texture for his meal, but got the cookie. She said the cookie should have been cut up on 2/3/26 (see observations above). The DON said she did not know that Resident #22 received a regular textured hamburger and a cookie on 2/3/26 for dinner. The NHA said they had an issue with the tickets because the ticket said whole cookie rather than the soft and bite-sized cookie. He said there was a glitch with the computer program the evening of 2/3/26. The NHA said the root cause of the incident was a glitch with the ticket. He said the RD audited all the tickets and they match the physician's diet order and specifically went through the meal tickets for 2/4/26 to verify the menu items matched the tickets and diet orders. The NHA and the DON were interviewed again on 2/4/26 at 1:12 p.m. The DON said there were approximately 18 residents in the building on altered diets. The DON said the assistant director of nursing (ADON) audited the meals once a week. The DON said the ADON included three residents in her audit per week to ensure their diets were correct. The DON said three residents per week was not enough. The DON said the ADON did complete an audit form, however, the audit form did not include which meals were being audited. The DON said after the 1/13/26 incident she educated the staff on the IDDSI diet textures and conducted audits following the choking incident. The DON said their education was ongoing as some of their staff were out due to the recent gastrointestinal (GI) outbreak at the facility. The DON said the ADON had not found any concerns with the meal textures. The DON said she was not sure what meals had been audited. The DON said she would expect the ADON to audit different meals throughout the day. The DON said she had done multiple training sessions. She said she started with the staff who were involved with the choking incident. She said then another training on the 1/29/26 to capture more staff members. The DON said they had been educating the staff members as they returned to work prior to their next shift. The NHA said they spoke with the dietary aide (DA) #2, who plated the meals for 1/13/26 and 2/3/26. The NHA said DA #2 said he was flustered during the meal service on 1/13/26, because there was so much going on in the kitchen. The NHA said he had met with the DM and the dietary aides last night (2/3/26) and discussed the meal service. The NHA said there would be further education with DA #2 when his shift started.The DON and the NHA provided signed education sheets with no dates. The NHA said he should have a date on the education but all the education has been rolled out since the 1/13/26 incident.-However, the wrong texture meal was served to Resident #22 and Resident #23 after the education had been provided to all staff after the 1/13/26 choking incident (see observations above). CNA #11 was interviewed 2/5/26 at 10:59 a.m. CNA #11 said she had received education on diet textures this morning before her shift. CNA #11 said she checked the resident's meal tray against their diet texture on their meal ticket and looked at what they should have on their meal ticket versus what they were served. CNA #11 said she was educated on what the different diet textures should look like, the fork tine test and how level five minced and moist should look. CNA #4 was interviewed on 2/5/26 at 11:05 a.m. CNA #4 said she had received more education on diet textures on 2/4/26. She said she was educated to review the meal ticket against the plate to confirm (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the meal and ticket matched and the meal was the correct diet texture. She said she would get a new plate if the diet did not match. CNA #5 was interviewed on 2/5/26 at 11:10 a.m. CNA #5 said he had received more education on meal service on 2/4/26. He said he was to double check the meal ticket with the meal. He said if the meal ticket and meal were different, he would take the meal back to the kitchen. He said he had been educated on the different textures and to not rely only on the meal listed on the ticket but to check the diet order as well. RN #1 was interviewed on 2/5/26, at 11:26 a.m. RN #1 said she had received education regarding diet textures last night (2/4/26). RN #1 said the education reviewed what to look for with each diet texture, the staff should check each resident's meal to their meal tray ticket to verify it matched their physician ordered diet, and if the meal item did not match what was ordered to remove the item and bring it back to the kitchen to get the proper diet texture.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety.Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care. Findings include:I. Cross-referenced citationsCross-reference F 805: The facility failed to serve correct altered diet texture per physician order, resulting in an actual choking incident. The facility failed to ensure appropriate texture meals were served to multiple residents. Resident #4 was served a regular meal instead of a minced and moist diet on 1/13/26. He experienced a choking episode that required multiple attempts of Heimlich maneuver to dislodge the food from the airway. In addition, Resident #22 and #23 were served incorrect texture diets at the time of the survey. The facility's failure to serve an appropriate texture diet created an immediate jeopardy (IJ) situation with actual serious harm. Cross-reference F 689: The facility failed to prevent two elopement incidents for a resident who exhibited wandering behaviors. Resident #13 eloped from the facility on two different occasions. After the first incident, the facility did not implement interventions to prevent a second elopement. During the second incident, the resident left the facility without staff knowledge and was locked out outside. He was only noticed by staff when he was struggling to get through the locked door back into the facility. The facility's failure to ensure residents safety created an IJ situation with actual serious harm.Cross-reference F 760: The facility failed to ensure all medications were administered as ordered. Resident #11 was not administered his seizure medications on multiple occasions, and his seizure medication was not administered at all on days he went to dialysis. He experienced increased seizures and required multiple hospitalizations. The facility's failure to ensure residents were free from significant medication errors created an IJ situation with actual serious harm. II. Facility policy and procedureThe Quality Assurance and Performance Improvement policy and procedure, dated 4/11/25, was received from the nursing home administrator (NHA) on 2/9/26 at 3:12 p.m. It read in pertinent part, It is a policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides.III. Repeat deficienciesReview of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies.F600 Abuse prevention: The facility failed to prevent multiple physical abuse situations on the secure unit. This deficiency was consistently cited on previous complaints on 2/25/25, 5/13/25, and 9/4/25. F760 Significant mediation error: The facility failed to be free from significant medication errors. This deficiency was cited on 5/13/25 and 6/11/24 at a D level scope and severity, potential for more than minimal harm, isolated.On 7/8/25 this deficiency was cited at a G level scope and severity, isolated, actual harm.IV. Staff interviewsThe medical director (MD) was interviewed on 2/4/26 at 92:57 p.m. The MD said she was notified about seizure medication error and she expressed her concern to staff. She said her concern was that seizure medications should be administered as ordered to prevent seizure activity. She said all seizure medications were managed by a neurologist and staff should have contacted the neurologist for clarification. The nursing home administrator (NHA) was interviewed on 2/9/26 at 3:10 p.m. The NHA said all cases of abuse allegations were reviewed during QAPI. Several interventions were in place such as one to one monitoring for residents who displayed aggressive behaviors. He said the goal was to increase the number of staff on the secure unit who will provide additional activities for residents.The NHA said (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	he was aware of the significant medication error of the seizure medication. He said the facility completed the investigation, however he was not sure if any performance improvement plans were started.The NHA said he was not aware the kitchen was serving inappropriate diets even though he was aware of the choking incident on 1/13/26. The NHA said the facility was actively looking for a secured unit placement for Resident #13.