STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065249	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Tree Care Center	2050 S Main St Delta, CO 81416

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure four (#3, #4, #7 and #8) of eight residents out of 10 sample residents were free from abuse.Specifically, the facility failed to:-Prevent physical abuse between Resident #3 and Resident #4;- Protect Resident #7 from physical abuse by Resident #9; and, - Protect Resident #8 from physical abuse by Resident #4. Findings include: I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention policy, last revised April 2021, was provided by the director of nursing (DON) on 7/23/25 at 5:12 p.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to: facility staff; other residents; develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents; and, ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates.II. Incident of physical abuse between Resident #4 and Resident #3 on 5/8/25A. Facility investigationThe facility investigation was provided by the nursing home administrator (NHA) on 7/23/25 at 9:28 a.m. The investigation documented on 5/8/25 at 4:05 p.m. Resident #3 leaned over Resident #4's wheelchair, held the arms of the wheelchair and shook it. Resident #4 grabbed Resident #3's forearm and caused a small abrasion. The event was witnessed by staff and the two residents were separated immediately. Resident #3 was assessed by licensed practical nurse (LPN) #1 and was found to have a small open area on her forearm with a small amount of bleeding requiring a bandage. The investigation documented both residents had severe cognitive impairments and could not recall the incident. The investigation documented increased supervision of residents to keep residents safe since Resident #3 wandered around the unit. The facility investigation indicated the facility substantiated that abuse occurred. B. Resident #3 (assailant and victim)1. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included generalized anxiety and disorder dementia and unspecified severity with other behavioral disturbances.The 5/16/25 minimum data set (MDS) assessment identified Resident #3 had severe cognitive impairments with short-term and long-term memory deficits, per staff assessment. The resident had behaviors of yelling, refusal of care, grabbing and pushing. She required assistance with dressing, bathing and incontinence care. The MDS assessment indicated the resident wandered frequently and had other behavioral symptoms not directed toward others, including throwing or smearing food or bodily waste.2. Record review-Review of Resident #3's electronic medical record (EMR) did not reveal documentation regarding the physical abuse incident on 5/8/25.C. Resident #4 (assailant and victim) 1. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included anxiety, restlessness and agitation and dementia with other behavioral disturbances.The 5/20/25 MDS assessment documented Resident #4 had severe cognitive impairments with short-term and long-term memory deficits and had communication deficits, per staff assessment. Resident #4's speech was rarely or never understood by others and he had severely impaired vision. Resident #4 was dependent on staff for bathing, dressing, eating and toileting. The MDS assessment indicated the resident exhibited verbal behaviors (yelling, cursing, or threats) and physical behaviors (hitting, kicking, pushing, or grabbing) towards others. The resident had other behavioral symptoms not directed toward others of disruptive sounds or screaming not directed at others.2. Resident #4's representative interviewResident #4's representative was interviewed on 7/23/25 at 11:03 a.m. The representative said Resident #4 frequently grabbed at other people and did not understand how hard he was squeezing. She said she had observed the behavior and was informed one time he scratched another resident. She said she did not think the behavior was aggressive, but instead it was related to his dementia, anxiety and impaired vision. 3. Record reviewResident #4's behavior care plan, initiated 12/2/24 and revised 6/22/25, indicated Resident #4 had behaviors that included tapping his legs and reaching out to hold the staff or resident's arm for comfort if he was anxious. The care plan documented the resident had aggressive behaviors that included exit seeking, pacing and grabbing others. Pertinent interventions included identifying

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for one (#4) of seven residents out of 10 sample residents.Specifically, the facility failed to thoroughly investigate two allegations of physical abuse by Resident #4. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation-Investigating and Reporting policy, revised September 2022, was provided by the director of nursing (DON) on 7/23/25 at 5:12 p.m. The policy read in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. All allegations are thoroughly investigated. The administrator initiates investigations.Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. The individual conducting the investigation as a minimum: reviews the documentation and evidence; reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; interviews the person(s) reporting the incident; interviews any witnesses to the incident; interviews the resident (as medically appropriate) or the resident's representative; interviews the resident's attending physician as needed to determine the resident's condition; interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interviews the resident's roommate, family members, and visitors; interviews other residents to whom the accused employee provides care or services; reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly.II. Resident #4 1. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician's orders (CPO), diagnoses included anxiety, restlessness and agitation and dementia with other behavioral disturbances.The 5/20/25 minimum data set (MDS) assessment documented Resident #4 had severe cognitive impairments with short-term and long-term memory deficits and had communication deficits per staff assessment. Resident #4's speech was rarely or never understood by others and he had severely impaired vision. The assessment documented Resident #4 was dependent on staff for bathing, dressing, eating and toileting.The assessment indicated the resident exhibited verbal behaviors (yelling, cursing, or threats) and physical behaviors (hitting, kicking, pushing, or grabbing) towards others. The assessment indicated the resident had other behavioral symptoms not directed toward others of disruptive sounds or screaming not directed at others. 2. Record reviewThe progress noted, dated 6/6/25 at 4:50 p.m., documented Resident #4 reached out and firmly grabbed and held three residents within an hour. The other unidentified residents tried to get him to let go and each time Resident #4's hand had to be pried off of the other resident by staff. The action resulted in return aggression from one of the unidentified residents. The note documented no injuries were sustained.The progress note, dated 6/20/25 at 10:25 a.m., documented Resident #4 walked up behind an unidentified resident in their wheelchair, grabbed the resident by the shoulders and squeezed them. Licensed practical nurse (LPN) #1 documented the unidentified resident was irritated by this behavior.A request was made on 7/23/25 for an investigation into the abuse allegations in the resident's electronic medical record (EMR). -The facility was unable to provide documentation to indicate an investigation was conducted related to the 6/6/25 and the 6/20/25 progress notes regarding Resident #4's physically aggressive behaviors. V. Staff interviewsLPN # 1 was interviewed on 7/23/25 at 3:15 p.m. LPN #1 said Resident #4 used to ambulate more often and used to walk up to people and grab them. LPN #1 said she remembered that Resident #4 grabbed other residents on both 6/6/25 and 6/20/25. She said she did not remember which residents he grabbed and she did not remember which residents became upset due to Resident #4's behavior. LPN #1 said she did not recall speaking with the DON about either altercation. LPN #1 said Resident #4 frequently grabbed out at people near him and the behavior did not appear targeted to anyone. She said residents who wandered should be directed away from Resident #4 to prevent them from being grabbed.The nursing home administrator (NHA) was interviewed on 7/23/25 at 5:12 p.m. The NHA said he recently began as the abuse coordinator in July 2025. He said anytime a resident made an allegation of hitting, kicking, slapping, or grabbing residents without consent it should be investigated. He said physical abuse could have occurred any time a resident expressed they did not feel safe and staff should report all

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure a resident diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for two (#4 and #6) of seven residents reviewed out of 10 sample residents.Specifically, the facility failed to:-Effectively implement person-centered approaches for dementia care to prevent resident-to-resident altercations for Resident #4; and, -Effectively implement person-centered approaches for dementia care to prevent verbal and physical aggressive behavior as well as wandering/elopement behavior for Resident #6.Findings include: I. Facility policy and procedureThe Dementia Clinical Protocol policy and procedure, revised November 2018, was provided by the director of nursing (DON) on 7/23/25 at 5:12 p.m. The policy read in pertinent part, For the individual with confirmed dementia, the IDT (interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life.The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools). Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT.The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician.The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.II. ObservationsDuring a continuous observation of the secured unit on 7/22/25, beginning at 3:43 p.m. and ending at 5:19 p.m. the following was observed:At 4:40 p.m. Resident #4 returned to the secured unit after visiting with his spouse. At that time, Resident #4 began to bang his hands on the table. Certified nurse assistant (CNA) #2 asked Resident #4 if he was hungry and assisted Resident #4 with putting on a clothing protector before dinner. At 4:44 p.m. Resident #4 resumed banging his hands on the table. CNA #2 attempted to redirect Resident #4 again, this time with a sensory fidget blanket. Resident #4 called out, but could not be understood by others. At 4:50 p. m. Resident #4 grabbed Resident #8 by the left arm and activities assistant (AS) #1 separated the two residents. After completing the assessment of the left arm of Resident #8, licensed practical nurse (LPN) #2 asked Resident #4 about his needs including pain, hunger, thirst and toileting. Resident #4 responded but could not be understood due to his impaired speech. At 5:02 p.m. Resident #4 grabbed Resident #6. Facility staff separated the two residents again and no injuries were present.At 5:09 p.m. Resident #6 told LPN #2 that he wanted to leave. LPN #2 attempted to redirect Resident #6 by telling him he could not go anywhere without eating dinner. Resident #6 remained upset and walked down the hallway. LPN #2 attempted to walk and talk with Resident #6 until Resident #6 stopped walking and stood by the entrance doors to the unit. At 5:19 p.m. an unidentified staff member walked through the entrance doors to the unit. Resident #6 attempted to push past the staff member and leave the unit.III. Resident #4A. Resident statusResident #4, age greater than 65, was admitted [DATE]. According to the July 2025 computerized physician's orders (CPO), diagnoses included anxiety, restlessness and agitation and dementia with other behavioral disturbances.The 5/20/25 minimum data set (MDS) assessment documented Resident #4 had severe cognitive impairments with short-term and long-term memory deficit and had communication deficits per staff assessment. Resident #4's speech was rarely or never understood by others and he had severely impaired vision. The assessment indicated the resident exhibited verbal behaviors (yelling, cursing, or threats) and physical behaviors (hitting, kicking, pushing, or grabbing) towards others. The assessment indicated the resident had other behavioral symptoms not directed toward others of disruptive sounds or screaming not directed at others.The assessment documented Resident #4 was dependent on staff for bathing, dressing, eating, and toileting.B. Record reviewResident #4's care plan, initiated on 12/2/24 and last revised on 6/22/25, indicated Resident #4 displayed behaviors of tapping his legs and reaching out to hold the staff or resident's arm for comfort if he was anxious. The care plan also documented Resident #4 was at risk for being the victim of resident-to-resident altercations due to his impaired speech and inability to recognize the personal space of other people. Pertinent The interventions included documented in the care plan was to speaking softly and gently to Resident #4 in order to redirect Resident #4 to more desirable activities or location. -Review of the