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	02/26/2026

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 - 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 record review and interviews, the facility failed to ensure residents were kept free from physical abuse for two (#33 and #20) of three residents reviewed for abuse out of 37 sample residents.Resident #42 was admitted to the facility on [DATE] with diagnoses of a traumatic brain injury (TBI), altered mental status, other specified disorders of the brain, unspecified dementia of unspecified severity with other behavioral disturbance, alcohol-induced persisting dementia and delirium due to known physiological condition.On 11/15/25 the facility initiated an aggression care plan for Resident #42 which identified that the resident was physically and/or verbally aggressive with staff and residents at times due to poor impulse control, dementia and history of TBI. Pertinent interventions, (initiated 11/15/26) directed staff to maintain a safe environment for Resident #42 and others, observing and evaluating the times of day, places, circumstances, potential triggers and what helped redirect his behavior and monitoring, documenting and reporting the danger to self and others. On 2/7/26 a certified nurse aide (CNA) reported that Resident #42 entered the room of Resident #33 and shouldered him to the floor, which resulted in a pelvic fracture for Resident #33.The facility revised Resident #42's aggression care plan after the altercation on 2/7/26 and directed staff to intervene before Resident #42 agitation escalated by redirecting him from sources of distress and calmly engaging him in conversation. According to the intervention, staff should walk away if his response was aggressive and reapproach later.On 2/13/26, just six days after the altercation involving Resident #42 and Resident #33, Resident #42 and Resident #20 were observed wandering in the same hallway of the memory care unit. Resident #42 began to verbally accuse Resident #20 of stealing his shoes. A CNA heard raised voices and shouting and observed Resident #42 holding Resident #20 by the shirt and Resident #20 had his hand on Resident #42's left shoulder. The CNA stepped between the residents to separate them and de-escalated the situation. Resident #20 said Resident #42 had hit him. The altercation resulted in a split lip and an abrasion to the chin for Resident #20. Specifically, the facility failed to protect Resident #33 and Resident #20 from physical abuse by Resident #42, which resulted in a pelvic fracture for Resident #33 and a lip laceration and chin abrasion for Resident #20.Findings include: I. Facility policy and procedureThe Resident Abuse Prevention policy, undated, was provided by the nursing home administrator (NHA) on 2/23/26 at 2:28 p.m. The policy read in pertinent part, (The facility) will not tolerate any form of abuse, neglect or exploitation of our residents This policy is to ensure that allegations of abuse, neglect or exploitation are identified, investigated, reported, documented and followed up with interventions to prevent recurrence and assure protection. Each resident has the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and physical or chemical restraints.II. Incident of physical abuse of Resident #33 by Resident #42 on 2/7/26A. Facility investigationThe facility investigation of the abuse incident between Resident #33 and Resident #42 was provided by the NHA on 2/25/26 at 5:56 p.m. The facility investigation documented Resident #42 attempted to enter the room of Resident #33 on 2/7/26 at 12:15 a.m. and said he needed to perform electrical work in the room. The investigation documented Resident #33 had placed a chair up against (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	the door from inside the room as part of a nightly routine, which made the door difficult to open. According to the investigation, CNA #1 attempted to redirect Resident #42 but Resident #42 continued to attempt to open Resident #33's room door, prompting CNA #1 to hold the door knob closed. Resident #42 entered the room after opening the door by pushing CNA #1 into the door frame when she attempted to step in front of him. CNA #1 witnessed Resident #33 get out of bed and walk towards Resident #42. The investigation documented Resident #42 used his right shoulder and upper arm to make physical contact with Resident #33, causing Resident #33 to fall backward and land on the floor. The investigation indicated Resident #42 proceeded to enter Resident #33's bathroom and attempt to exit out the window. Review of the investigation identified the facility substantiated abuse. B. Resident #33 (victim)1. Resident statusResident #33, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included dementia, unspecified severity, with other behavior disturbances, cognitive communication deficit and unspecified fracture of unspecified pubis. The 2/12/26 minimum data set (MDS) assessment identified Resident #33 had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. According to the MDS assessment, Resident #33 did not exhibit hallucinations or delusional thinking. He did not have behaviors directed towards himself or others.The MDS assessment indicated Resident #33 was independent with most of his activities of daily living (ADLs). 2. Record reviewThe fall care plan, revised 11/15/25, identified Resident #33 was at risk for falls. Interventions directed staff to anticipate and meet his needs (initiated 8/20/25).The risk for intrusion care plan, initiated 2/7/26, identified Resident #33 had anxiety related to unwanted entry into his room. The care plan goal, revised 2/21/26, was to ensure the resident remained free from distress or injury related to unwanted room entry from others, as evidenced by decreased agitation and the ability to rest safely in his room. Interventions, initiated 2/7/26 directed staff to allow the resident to place a chair on the inside of the room as a visual and physical cue to discourage other residents from entering his room, monitoring chair placement each shift to ensure continued safety and appropriateness, ensuring chair placement did not obstruct the resident's ability to exit the room and did not pose a fall risk, providing frequent checks and supervision, reassessing the need for intervention with any change in the resident's behavior or condition, redirecting other residents away from Resident #33's room as needed and reinforcing the resident's right to privacy and personal space. According to the care plan, staff were educated that Resident #33's chair placement was a protective measure, not a restraint, and was initiated based on the resident's preference.The 2/7/26 change of condition assessment documented Resident #33 had a fall and needed more assistance with ADLs due to decreased mobility related to a fall. According to the assessment, Resident #33 landed on the floor at 12:00 a.m. (on 2/7/26) and complained of pain in his neck, back and hips six hours later. The assessment identified he was sent to the hospital for an Xray and evaluation. The 2/7/26 admission progress note documented a CNA found Resident #33 sitting on the floor in his room and the resident (Resident #42) who shouldered Resident #33 was standing in the resident's room. The 2/7/26 nursing progress note documented Resident #33 went to the hospital on 2/7/26 at approximately 7:45 a.m. for evaluation after an altercation with another resident (Resident #42) overnight and returned to the facility at 11:30 a.m. According to the progress note, Resident #33 had a right sided inferior pubic rami fracture (pelvic fracture). The resident was evaluated by occupational therapy and was provided with a walker. C. Resident #42 (assailant) 1. Resident statusResident #42, age less than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included personal history of traumatic brain injury, Wernicke's encephalopathy (neurological disorder), altered mental status, other specified disorders of the brain, unspecified dementia of unspecified severity with other behavioral disturbance, alcohol-induced persisting dementia, delirium due to known physiological condition, and generalize epilepsy and epileptic syndromes.The 1/30/26 MDS assessment documented Resident #42 had severe cognitive impairment with a BIMS score of zero out of 15. According to the MDS assessment, Resident #42 had behaviors (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	of physical aggression directed at others, wandering, rejections of care and other behavioral symptoms not directed at others. He was independent with mobility and did not require a mobility device.2. Record reviewResident #42's behavior care, initiated 11/15/25, identified Resident #42 had a potential for impaired behavioral patterns related to alcohol induced persisting dementia, delirium, delusions, history of TBI and altered mental status. Interventions, initiated 11/15/25, included anticipating and meeting Resident #42's needs, engaging him in activities for distraction, maintaining consistency in timing of ADLs, caregivers, and routines as much as possible, providing medications as ordered and monitoring and documenting the medications for effectiveness and side effects.The aggression care plan, initiated 11/15/25, indicated Resident #42 was physically and/or verbally aggressive with staff and residents at times due to poor impulse control, dementia and history of TBI. Pertinent interventions, (initiated 11/15/25) included maintaining a safe environment for Resident #42 and others, observing and evaluating the times of day, places, circumstances, potential triggers and what helped redirect his behavior and monitoring, documenting and reporting the danger to self and others. The intervention, revised 2/7/26, directed staff to intervene before Resident #42 agitation escalated by redirecting him from sources of distress and calmly engaging him in conversation. According to the revised intervention, staff should walk away if his response was aggressive and reapproach later. The 2/7/26 behavior note documented a CNA reported that Resident #42 entered the room of Resident #33 and shouldered Resident #33 to the floor. Resident #33 denied pain or discomfort and was assisted back to bed. Resident #42 was escorted out of the room and into the hallway. According to the progress note, staff continued the redirection of Resident #42, provided 15-minute checks and kept him in line of sight. The 2/7/26 change of condition assessment documented Resident #42 had physical aggression and shouldered another resident (Resident #33) to the ground. III. Incident of physical abuse of Resident #20 by Resident #42 on 2/13/26A. Facility investigationThe facility investigation of the abuse incident between Resident #20 and Resident #42 was provided by the NHA on 2/25/26 at 5:56 p.m. The physical abuse facility investigation documented Resident #42 and Resident #20 were involved in a physical altercation on 2/13/26 at 6:22 p.m. The investigation documented Resident #42 and Resident #20 were observed wandering in the same hallway of the memory care unit. Resident #42 had removed his shoes and placed them under the key pad near the unit entrance. According to the facility investigation, Resident #42 began to verbally accuse Resident #20 of stealing his shoes. A CNA heard raised voices and shouting and observed Resident #42 holding Resident #20 by the shirt and Resident #20 had his hand on Resident #42's left shoulder. The CNA stepped between the residents to separate them and de-escalated the situation. Resident #20 had a split lip as a result of the altercation and Resident #42 had no visible injuries. The investigation documented Resident #42 was redirected to his room with constant monitoring to ensure Resident #42 was not in close proximity to any other residents to ensure safety before being transferred to the emergency department for stabilization. Resident #20 was interviewed after the incident and said he was hit by Resident #42. Resident #20 denied feeling unsafe or fearful. Review of the investigation identified the facility substantiated abuse. The investigation documented physical contact occurred between both residents. The strike to Resident #20's face was not directly witnessed, but the presence of the abrasion and split lip on the resident's face was consistent with Resident #20's report and supported the accuracy of his statement that Resident #42 hit him. According to the investigation, the simultaneous presence of both residents in the same area, combined with Resident #20's tendency to approach others closely, may have contributed to triggering the altercation.The facility provided education to the memory care unit staff regarding the importance of recognizing seemingly normal activities that could represent behaviors capable of triggering negative responses from other residents. The staff were instructed to remain observant, intervene early, and utilize proactive strategies to minimize potential behavioral escalations.B. Resident #20 (victim)1. Resident statusResident #20, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included Alzheimer's disease unspecified, dementia (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	with other diseases classified elsewhere, moderate with other behavioral disturbance, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits (stroke), unspecified mood disorder and generalized muscle weakness. The 12/8/25 MDS assessment identified Resident #20 had severe cognitive impairment, per the staff assessment for mental status. The MDS assessment documented he had long and short term memory loss, disoriented thinking, inattention and an altered level of consciousness. The assessment identified Resident #20 required set up and supervision for most of his ADLs. He did not require a mobility device. According to the MDS assessment, Resident #20 had physical behaviors directed towards others.2. Resident's representative interview Resident #20's representative was interviewed on 2/26/26 at 2:39 p.m. The representative said Resident #42 had verbal altercations with Resident #20 and would frequently go in his room. She said the altercation on 2/13/26 was the first time Resident #42 was physical with Resident #20. She said after that incident, Resident #20 preferred not to be around Resident #42 and told her that he did not like Resident #42.3. Record reviewThe aggression care plan, initiated 8/4/25, indicated Resident #20 was physically and/or verbally aggressive with staff and residents at times due to poor impulse control and dementia. Interventions, initiated 8/4/25, included administering medications as ordered, assessing his comfort needs and sensory deficits, offering choices and activities, providing physical and verbal cues to alleviate anxiety, giving him positive feedback, assisting him with verbalization of the source of agitation, assisting him to set goals for more pleasant behavior and encouraging him to seek out staff members when agitated. According to the care plan, Resident #20 needed one-to-one redirection when he entered other residents' physical space and opened and closed their doors. If he became agitated, staff should intervene before he escalated through calm conversation, keeping him safe and walking away if needed to reapproach later (initiated 8/19/25). The care plan identified Resident #20 was verbally and physically triggered when other residents were disruptive (initiated 10/24/25). The elopement and wandering care plan (revised 11/19/25) identified Resident #20 had wandering behaviors. Interventions included providing him reorientation strategies (initiated 12/10/24), identifying his pattern of wandering and intervening as appropriate, monitoring his location throughout the shift and documenting his wandering behavior and attempting diversional interventions (initiated 11/15/25). The 2/13/26 nursing progress note documented Resident #20 was involved in a physical altercation with another resident (Resident #42) and the residents were separated and kept in line of sight of staff. According to the note, Resident #20 said he was not fearful and told the staff he was fine and not to worry about him. The 2/14/26 change of condition assessment documented Resident #20 had a split in his right upper lip and a small abrasion to his chin. C. Resident #42 (assailant) 1. Record review The 2/13/26 nursing progress note documented the on-call nurse was contacted at approximately 7:22 p.m. and was notified Resident #42 was involved in a physical altercation with another resident (Resident #20). The on-call nurse arrived at the facility and saw Resident #42 in his room with staff standing at his doorway, providing one-to-one supervision. According to the note, the primary registered nurse (RN) had contacted the police. Resident #42 proceeded to go in and out of his room and paced the halls with the all on-call nurse. The note indicated the resident had to be redirected from areas with other residents. The physician was notified and gave orders at 10:00 p.m. to transfer Resident #42 to the hospital's emergency room for medication management and uncontrolled behaviors.IV. Staff interviewsThe NHA was interviewed on 2/26/26 at 1:51 p.m. The NHA said abuse was substantiated related to the 2/7/26 incident between Resident #33 and Resident #42. The NHA said Resident #42 said he had to do electrical work in Resident #33's room. She said CNA #1 attempted to stop Resident #42 from going into Resident #33's room by holding the door shut, but the resident forced his way into the room. The NHA said Resident #33 got out of bed and Resident #42 and Resident #33's paths crossed and Resident #33 fell on his buttocks. The NHA said she substantiated abuse because Resident #33 was injured. She said Resident #33 was taken to the hospital after he expressed he was in pain. The NHA said the hospital determined Resident #33 sustained a pelvic fracture as a result of the altercation (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	with Resident #42 that was nonoperable.The NHA said staff was provided additional education related to interventions with memory care residents and CNA #1 was educated on what to do in the future regarding the incident between Resident #42 and Resident #33. The NHA said holding the door shut and physically attempting to prevent Resident #42 from entering Resident #33's room probably escalated his behavior. She said staff should continue to look for escalating behaviors of residents before they attempted to enter a resident's room. The NHA said to prevent Resident #42 from additional altercations, staff continued to look for escalating behaviors, perform 15-minute checks on him and tried to redirect him before he went into anyone's room. She said his prior interventions were effective but the situations involving Resident #33 and Resident #20 were two different scenarios.The NHA said the 2/13/26 incident between resident #42 and Resident #20 was the first time Resident #20 and Resident #42 had a physical altercation. She said both residents had the anxious behavior of wandering up and down the hallway. She said Resident #20 tended to get into other peoples' personal space and Resident #42 would go into other residents'rooms. The NHA said Resident #42 had removed his shoes on 2/13/26 and placed them under the keypad by the front entrance door and next to the entryway of Resident #20's room. She said both residents were wandering and intersected in the same location. The NHA said CNA #2 was helping another resident when she heard Resident #42 yelling at Resident #20 that he stole his shoes. She said both residents were using profanities towards each other. The NHA said CNA #2 turned towards Resident #42 and Resident #20 and witnessed Resident #42's hand on the shirt collar of Resident #20 and Resident #20 had his hand on the left shoulder of Resident #42. The NHA said CNA #2 and CNA #9 ran towards the residents and CNA #2 stepped between the two residents to separate them. The NHA said Resident #20 said Resident #42 had hit him. The NHA said no one saw the punch, but Resident #20 had a split in his lip and an abrasion to his chin. She said Resident #20 reported that he was mad but not fearful of Resident #42. The NHA said she substantiated the allegations of physical abuse because Resident #20 had injuries related to the altercation. The NHA said Resident #42 was taken to the hospital for medication adjustment and a neurological consult after the incident with Resident #20. She said Resident #42 was on a medication dose reduction and also had a seizure. She said he was already on 15minute checks at the time of the incident with Resident #20, but a lot could happen in 15 minutes. She said to prevent the recurrence of altercations, Resident #42's medications were readjusted, staff were educated on what to look for with resident triggers and the resident was on close monitoring with staff and 15-minute checks of his whereabouts. The NHA said Resident #42 had been more in the line of sight of staff since the altercations. CNA #2 was interviewed on 2/26/26 at 2:44 p.m. CNA #2 said Resident #33 was afraid of other residents entering his room while he was in there so he placed a chair in front of his door to help prevent other residents from going into his room. CNA #2 said Resident #42 was fixated on going into Resident #33's room. She said to prevent more altercations with Resident #42 and Resident #33, staff continued to watch where he was located.CNA #2 said Resident #42 had aggressive behaviors. She said the 2/13/26 incident with Resident #20 happened during shift change when she was giving report to CNA #9 who was new to the memory care unit. She said she heard yelling and observed Resident #42's hand was holding onto Resident #20's shirt collar and Resident #20 had his arm stretched out towards Resident #42 in an attempt to push Resident #42 away from him. CNA #2 said she and other staff members helped de-escalate Resident #42 and took him to a quieter location to calm down.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#5) of two residents received treatment and care in accordance with professional standards or practice out of 37 sample residents.Resident #5 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (total paralysis on one side of the body) and hemiparesis (weakness affecting one side of the body) affecting the left side.On 2/2/26 Resident #5 was being transferred by licensed practical nurse (LPN) #1 and certified nurse aide (CNA) #3 using the sit-to-stand lift. The resident let go of the handle of the lift, resulting in her left arm getting hung up in the lift sling in an awkward position. Resident #5 was lowered back to her bed and was found to have no bruising at the time to her left arm. According to staff, the resident did not express pain, but typically had difficulties expressing pain, so the nurse administered acetaminophen (Tylenol) to the resident for pain after the incident. The facility failed to notify the resident's representative at the time of the incident (see representative interview below).On 2/5/26 new bruising was noted to Resident #5's left upper arm and the resident was assessed to have a pain level of 7 out of 10. The physician was notified and recommended an Xray be obtained of the resident's left shoulder area. However, the Xray was not obtained until 2/13/26, 11 days after the incident occurred (see record review below). The 2/13/26 Xray results revealed Resident #5 had an acute displaced fracture of the left humerus at the surgical neck. On 2/16/26 Resident #5's hospice nurse recommended a sling for the resident's left arm and a physician's order for a sling was obtained from the hospice physician on 2/17/26. However, a sling was not provided to the resident until 2/23/26, 21 days after the incident occurred and 10 days after the Xray results revealed the resident's left humerus fracture (see record review below).Specifically, the facility failed to: -Complete a timely Xray for Resident #5 after a change in condition; and,-Provide a sling for Resident #5, based on the hospice provider's recommendation, in a timely manner.Findings include:I. Facility policy and procedureThe Change In A Resident's Condition or Status policy, revised February 2021, was provided by the regional corporate resource on 2/27/26 at 2:45 p.m. It revealed in pertinent part, The nurse will notify the resident's attending physician or physician on call when there has been a(an): accident or incident involving the resident; b. discovery of injuries of an unknown source; adverse reaction to medication; significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; refusal of treatment or medications two (2) or more consecutive times; need to transfer the resident to a hospital/treatment center; discharge without proper medical authority; and/or specific instruction to notify the physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting); impacts more than one area of the resident's health status; requires interdisciplinary review and/or revision to the care plan; and ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument.II. Resident #5A. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included hyperlipidemia, hypertension, depression, anxiety, hemiplegia and hemiparesis affecting the left side following cerebrovascular disease, dementia with agitation, chronic obstructive pulmonary disease (COPD), diabetes, atrial fibrillation, heart failure and displaced fracture of the left humerus. The 2/19/26 minimum data set (MDS) assessment revealed Resident #5 had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The assessment revealed Resident #5 had difficulty expressing and understanding verbal communication. Resident #5 was dependent on staff for repositioning in bed, transfers, bathing, toileting, hygiene, upper and lower body dressing and footwear. Resident #5 required substantial assistance with eating. B. Resident's representative interviewResident #5's representative was interviewed on 2/24/26 at (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	9:24 a.m. Resident #5's representative said the facility never notified her of an accident occurring during a transfer using a lift at the beginning of February 2026. Resident #5's representative said she was informed of the incident by the hospice nurse over the phone, days after the incident occurred. Resident #5's representative said she was told Resident #5 broke her left arm when the lift the facility staff were using to transfer Resident #5 tipped over. Resident #5's representative said she visited Resident #5 and Resident #5 winced in pain with movement to her left arm. Resident #5's representative said she felt unhappy and worried for Resident #5 when she found out it took the facility over 10 days to complete an Xray of Resident #5's arm and another 10 days to provide Resident #5 with a sling (see record review below). Resident #5's representative said she remembered a weekend nurse was trying to push things through to get her seen for an Xray, but she did not know why the facility did not contact her the day it occurred or why the resident's care was delayed. Cross reference F580 for failure to notify of changes (injury).C. Record reviewThe progress note, dated 2/10/26 at 1:15 p.m., documented a late entry progress note describing events which occurred on 2/2/26. The progress note documented Resident #5 let go of the handle during a transfer using the sit-to-stand lift. The progress note documented her arm was held up only by the sit-to-stand lift sling and in an awkward position. The progress note documented the resident was lowered in the lift and assisted back on to the bed. The progress note documented the resident was then transferred to her wheelchair using a hoyer lift (full body mechanical lift). The progress note documented Resident #5 expressed no pain, but frequently was unable to express pain verbally; therefore Resident #5 was administered as needed (PRN) acetaminophen for pain. The progress note documented Resident #5 did not have bruising upon assessment.The skin alteration note, dated 2/5/26 at 1:00 p.m., revealed an unidentified CNA reported new bruising on Resident #5's forehead to registered nurse (RN) #2 on 2/4/26 and new bruising to Resident #5's left arm to RN #2 on 2/5/26. The skin alteration note documented RN #2 contacted her supervisor and was asked to take pictures of both areas of bruising, in addition to completing skin assessments. The skin alteration note documented pain to Resident #5's left arm and shoulder during the assessment with a Pain Assessment in Advanced Dementia (PAINAD) assessment score of seven out of 10. The skin assessment, dated 2/5/26 at 1:00 p.m., documented an area of bruising to Resident #5's left temple and an area of bruising to Resident #5's left shoulder and arm. The area of bruising on the left arm and shoulder measured 8.7 centimeters (cm) in length and 8.25 cm in width.The change in condition progress note, dated 2/5/26 at 1:00 p.m., documented new bruising was found on Resident #5's shoulder, bicep, and forehead. The progress note documented Resident #5's physician was contacted and the physician recommended an Xray of Resident #5's left shoulder. The physician's follow-up note, dated 2/6/26 at 6:24 p.m., documented Resident #5 experienced a recent fall resulting in bruising to the left arm with pain when staff provided care. The progress note documented an Xray was indicated. The progress note revealed physician's orders for a 2 view Xray of Resident #5's left humerus were given.-However, the Xray ordered on 2/6/26 was never obtained (see interviews below).The hospice nurse note, dated 2/6/26 at 10:45 a.m., revealed the facility's medical director placed a physician's order to Xray Resident #5's left arm for new bruising found on 2/5/26. The progress note documented Resident #5 appeared with nonverbal signs of pain, including fidgeting, frowning and appearing weary during the assessment. The progress note documented Resident #5 requested the nurse not touch her left arm during the assessment.The progress note documented the hospice nurse contacted Resident #5's representative, informing her of the new bruising and reported the incident with the sit-to-stand lift. The progress note documented the hospice nurse reinforced with the facility staff to contact the hospice provider in a timely manner, on the same day incidents occurred. The progress note, dated 2/12/26 at 6:42 p.m., revealed the bruising to Resident #5's forehead was resolved. The progress note documented the bruising on Resident #5's shoulder was improving, however Resident #5 continued to complain of shoulder pain.The radiology results, dated 2/13/26, revealed a 2 view Xray was ordered by Resident #5's hospice provider. The results revealed Resident #5 had an acute displaced fracture (continued on next page)

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	065249	A. Building B. Wing	02/26/2026

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	of the left humerus at the surgical neck.The facility progress note, dated 2/15/26 at 1:24 p.m., revealed the facility received new physician's orders from the hospice provider on 2/13/26. The progress note documented a new order for a 2 view Xray of Resident #5's left shoulder. If the Xray was unable to visualize the entire humerus, an X-ray of the resident's left humerus was additionally to be completed.The progress note, dated 2/16/26 at 10:40 a.m., documented the hospice nurse spoke with the facility's floor nurse regarding a sling recommendation for Resident #5's left arm. The progress note documented the hospice nurse was supposed to call back with further instructions.The hospice nurse note, dated 2/17/26 at 12:45 p.m., documented a physician's order from the hospice provider for a sling to be applied to Resident #5's left arm for support and comfort for six weeks.-However, the sling for the resident's left arm was not obtained until 2/23/26 (see interviews below). The physician's order note, dated 2/23/26 at 9:44 a.m. (six days after the initial order for a sling), documented a physician's order completed by the medical director for a sling to support Resident #5's left arm.III. Staff interviewsThe hospice nurse was interviewed on 2/25/26 at 2:36 p.m. The hospice nurse said her hospice CNA informed her on 2/4/26 of new bruising and pain to Resident #5's left arm while providing a bath. The hospice nurse said she visited the resident on 2/6/26 for her routine visit. The hospice nurse said she spoke with the facility's nursing staff and found out Resident #5 had sustained an accident of some kind during a transfer with the sit-to-stand lift. The hospice nurse said she spoke with the director of nursing (DON) during her visit on 2/6/26 and the DON told her she was already getting an Xray order for Resident #5 and the hospice nurse did not need to do anything at the time. The hospice nurse said she spoke with Resident #5's representative over the phone to inform her of the resident's new pain and bruising. The hospice nurse said Resident #5's representative was not aware of the incident or bruising until she was informed by the hospice nurse. The hospice nurse said Resident #5's representative called her back to report Resident #5 appeared to have pain when she visited Resident #5 in person. The hospice nurse said after Resident #5's representative called back, she followed up with the DON and found out the Xray ordered on 2/6/26 was never completed. The hospice nurse said she then contacted the hospice physician and obtained another physician's order for an Xray, which was completed on 2/13/26 and revealed Resident #5 had sustained a left humerus fracture. The hospice nurse said once they received the results of the Xray, the hospice physician gave a physician's order for a sling for Resident #5's left arm for comfort, but the physician did not want to pursue more invasive interventions since the fracture occurred almost two weeks before the Xray was eventually completed. The hospice nurse said she checked on the status of the resident's left arm sling during her next visit to the facility on 2/20/26 and the DON told her she was ordering one.-However, the physician's order had been obtained on 2/17/26, three days prior.RN #2 was interviewed on 2/25/26 at 5:22 p.m. RN #2 said she was the nurse who completed the assessments for the bruising on Resident #5's left arm and forehead on 2/4/26 and 2/5/26. RN #2 said the bruising looked a few days old when she assessed them. RN #2 said she contacted the assistant director of nursing (ADON) and the DON on 2/4/26. RN #2 said the DON instructed her to take pictures of the bruises and additionally told her that LPN #1 reported that Resident #5 slipped during a sit-to-stand transfer on 2/2/26. RN #2 said she spoke with the medical director after his follow up visit on 2/6/26. RN #2 said the medical director told her he was going to enter a physician's order for an Xray for Resident #5's left arm and shoulder. RN #2 said Resident #5 reported pain and displayed non-verbal signs of pain with movement. RN #2 said Resident #5 was not always able to report pain verbally, so she also completed the PAINAD assessment and provided PRN Tylenol for pain. RN #2 said she did not know why, but the 2/6/26 Xray had not been completed when she returned to work on 2/12/26. RN #2 said she called the hospice nurse on 2/13/26 to inform her no Xray had been completed. RN #2 said the hospice nurse contacted the hospice physician, obtained a new order and Resident #5's Xray was completed on 2/13/26. RN #2 said she heard of the recommendation from the hospice physician to provide Resident #5 with a sling, but Resident #5 did not have a sling during her shifts from 2/19/26 through 2/21/26.The director of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	rehabilitation (DOR) was interviewed on 2/26/26 at 9:26 a.m. The DOR said she was not made aware of Resident #5's injury until 2/23/26. She said when she was informed of the injury,she spoke with the floor nurse right away. The DOR said she heard Resident #5 did not receive an Xray to confirm the fracture for almost two weeks. She said she was told the hospice physician recommended a sling for comfort, but Resident #5 did not have one when she spoke to the floor nurse on 2/23/26. The DOR said she provided a sling for Resident #5 on 2/23/26. The DON and the nursing home administrator (NHA) were interviewed together on 2/26/26 at 4:01 p.m. The DON said LPN #1 contacted her over the phone on 2/2/26, reporting Resident #5 slipped while using the sit-to-stand lift with LPN #1 and CNA #3. The DON said LPN #1 told her Resident #5 let go of the handle of the sit-to-stand lift and Resident #5's arm became compromised in the sling, but LPN #1 said Resident #5 did not fall. The DON said LPN #1 reported Resident #5 had no signs of injury and did not report pain, but because of the way Resident #5's arm was positioned, LPN #1 administered PRN Tylenol for pain. The DON said she called CNA #3 who also said Resident #5 did not fall during the incident. The DON said she did not investigate the incident further because both staff members reported Resident #5 did not fall and there was no apparent sign of injury when they contacted her. The DON said she remembered the medical director completed a follow up and wanted to order an Xray of Resident #5's left arm. The DON said she did not know how Resident #5 acquired bruising to her forehead if she did not fall, but since the bruising appeared to be the same age as the bruising on her arm, she attributed both areas of bruising to the incident on 2/2/26. The DON said she thought the radiologist was still waiting for the Xray order when she checked before taking leave from work on 2/11/26 to 2/16/26. The NHA said the facility completed an investigation as to why the delay of care happened for Resident #5 once they found out the physician's order for the Xray was never completed and had to be re-ordered by the hospice nurse on 2/13/26. The NHA said the facility found out the physician's office forgot to fax the physician's order to the radiologist. The NHA said she heard the radiologist's office only accepted physician's orders from the physician's office. The NHA said she contacted the director of the local area radiologist's office and established communication with him so the facility could follow up with him directly and allow the facility to resend an order for Xrays if a physician's office forgot in the future. The DON said she was first made aware of the recommendation for a sling for Resident #5 during the meeting with the hospice nurse on 2/20/26. The DON said she was not aware the DOR provided the sling on 2/23/26, since she was not sure if the facility or hospice needed to cover the cost of the sling.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions in the main kitchen, main dining room and secured memory unit. Specifically, the facility failed to ensure staff followed accepted hand hygiene practices during the meal service.Findings include:I. Professional referenceAccording to The Colorado Retail Food Regulations (3/16/24), retrieved on 3/9/26, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands.II. Facility policy and procedureThe Food Preparation and Service policy, November 2022, was provided by the regional corporate resource on 2/26/26 at 4:55 p.m. The policy read in pertinent part, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Cross-contamination can occur when harmful substances (chemical or disease-causing microorganisms) are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Cross-contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods. The Handwashing/Hand Hygiene policy, October 2023, was provided by the regional corporate resource on 2/26/26 at 4:55 p.m. The policy read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infectionsAll personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.III. Observations During a continuous observation of the dinner meal service in the kitchen on 2/25/26, beginning at 4:20 p.m. and ending at 5:36 p.m., the following was observed:At 4:41 p.m. [NAME] (CK) #2 began plating residents' meals for dinner. CK #2 retrieved the plates from the plate warmer with a suction device. CK #2 held the plates with his hand under the plate with his thumb on top of the surface of each plate to hold the plate steady as he dished the ready-to-eat food on top of the plates. He switched between the right and the left hand and right and left thumb holding the plate in place as he dished the food. At 5:15 p.m. CK #2 unwrapped alcohol wipes and took the final temperatures of the food in the steam table. At 5:20 p.m. CK #2 collected a pile of alcohol wipe wrappers from the counter, dropping one on the floor. He picked the wrapper up with his bare hands and threw it in the trash can. -CK #2 did not wash his hands after picking up the item off the floor. At 5:21 p.m. CK #2 proceeded to plate the food, putting his thumbs on top of each plate without performing hand hygiene. At 5:28 p.m. the dietary consultant entered the kitchen and observed the plating process of [NAME] #2. She instructed him to hold the plates from the side and not to place his thumb on top of resident plates. IV. Staff interviewsThe infection preventionist (IP) was interviewed on 2/26/26 at 1:41 p.m. The IP said she provided staff hand hygiene education twice a year. She said the last hand hygiene education was conducted in January 2026. She said education was conducted with small groups of staff reviewing soap and water hand hygiene with a return competency evaluation. She said she provided education on alcohol based hand rub (AHBR) when appropriate. The dietary consultant was interviewed on 2/26/26 at 3:16 p.m. The dietary consultant said she was currently coming to the facility twice a week for the past two weeks since the former dietary manager was gone. She said she would come to the facility once and a while and was at the facility in January 2026 to help the dietary department prepare for an upcoming survey. She said she reviewed sanitation with the dietary staff during her visits.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete a performance review of certified nurse aides at least once every 12 months and to provide regular in-service education based on the outcome of these reviews for three of three certified nurse aides (CNAs).Specifically, the facility failed to complete annual performance reviews and/or provide regular in-service education based on the outcome of the reviews for CNA #3, CNA #6 and CNA #7.Findings include:I. Facility policy and procedureThe All Staff In-Service Training policy and procedure, undated, was provided by the regional corporate resource on 2/27/26 at 10:22 a.m. It read in pertinent part, All staff are required to participate in regular in-service education, including all new and existing personnel, individuals providing services under contractual agreements, and volunteers. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the residents' quality of life and quality of care and can demonstrate competency in the topic areas of the training. The required training topics include resident rights and responsibilities, preventing abuse, neglect, exploitation, and misappropriation of resident property.II. Record reviewAnnual performance reviews were requested on 2/25/26 at 10:22 a.m. from the nursing home administrator (NHA).The facility was unable to provide annual performance evaluations for 2025 for CNA #3 (hired on 8/1/21), CNA #6 (hired on 8/1/21) and CNA #7 (hired on 8/30/23).-CNA #3, CNA #6, and CNA #7 did not have an annual performance review completed and did not have an in-service education plan based on the outcome of the review.III. Staff interviewsThe staff development coordinator was interviewed on 2/26/26 at 2:40 p.m. The staff development coordinator said she was responsible for training all new hires and existing personnel. The staff development coordinator said annual performance reviews and in-service education were important and required to be completed at least once a year. However, she said she had only been in her current role for a few months and was not sure if the annual performance reviews had been completed for 2025. The NHA was interviewed on 2/26/26 at 3:30 p.m. The NHA said performance reviews should be completed annually based on the CNAs date of hire. The NHA said performance reviews were not completed for CNA #3, CNA #6 and CNA #7. The NHA said she was not sure why the training was not completed. She said most of the department managers were recent hires, including herself. The NHA said she would immediately establish a system to provide annual performance evaluations and in-service training for all CNAs.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable, attractive and at an appetizing temperature. Specifically, the facility failed to ensure residents were served warm food that was appetizing.Findings include:I. Resident interviewsResident #2 was interviewed on 2/23/26 at 11:36 a.m. Resident #2 said the food was always cold when it got to his room. He said a lot of the food the facility served was tasteless.Resident #2 was interviewed again on 2/23/26 at 1:03 p.m., after he was provided his lunch on a room tray. He said the meal was cold. He said most of the meals were cold. He said he had complained to the nurses, the certified nurse aides (CNA), the dietary staff and the registered dietitian (RD) but the food continued to be cold. Resident #45 was interviewed on 2/23/26 at 2:40 p.m. Resident #45 said her food was frequently cold.Resident #18 was interviewed on 2/23/26 at 1:14 p.m. Resident #18 said her lunch today (2/23/26) was tasteless because it lacked seasoning. She said it tasted like institutional food.Resident #22 was interviewed on 2/24/26 at 9:45 a.m. Resident #22 said her food was consistently cold. She said she knew the facility had just hired a new person and they hoped things improved. She said yesterday (2/22/26) during lunch, her soup and her vegetables were cold. Resident #4 was interviewed on 2/24/26 at 10:13 a.m. Resident #4 said the food was frequently cold. She said her eggs were cold almost every single morning and her soup was always cold. She said her breakfast yesterday (2/23/26) was tough and overcooked. She said she had to ask another resident to help her cut it up because it was so tough.II. Record reviewThe December 2025 and the January 2026 resident council minutes were provided by the nursing home administrator (NHA) on 2/25/26 at 9:32 a.m. The December 2025 resident council minutes documented residents reported concerns of cold food served. According to the minutes, the dietary manager (DM) acknowledged the concerns of cold food and said she would review food temperature monitoring practices with the dietary staff. The January 2026 resident council minutes documented residents had concerns regarding the food being served at inadequate temperatures. According to the minutes, the DM acknowledged the concerns and said she would monitor the food temperatures. III. ObservationsOn 2/25/26 at 4:41 p.m. [NAME] (CK) #2 was observed preparing to serve food in the kitchen. CK #2 removed the lids covering the food in the steam table and started plating the food. He retrieved a plate from the plate warmer and placed the plate on a plastic plate base with a pellet. The ready-to-eat food was then covered with a lid and placed in a cart for delivery. CK #2 dished up the broccoli and pork and beans into separate bowls that were not covered to maintain heat and directly placed the bowls of food on a tray in the mobile cart.At 5:34 p.m. the dietary consultant instructed dietary aide (DA) #1 to cover the bowls of pork and beans and broccoli before they were put in the cart for delivery.At 5:38 p.m. the last meal cart left the kitchen with resident room trays and a sample test tray of barbeque chicken breast, cooked broccoli and pork and beans. IV. Test trayOn 2/25/26 at 5:55 p.m. the dinner test tray was retrieved from the hall cart, immediately after the last room tray was delivered. At 5:56 p.m. the temperature and taste of the tray, consisting of barbeque chicken breast, cooked broccoli and pork and beans was evaluated by three surveyors. The following was observed:Each of the food items was placed all on one plate and covered. -The internal temperature of the pork and beans registered at 113 degrees Fahrenheit (F) and tasted lukewarm. -The broccoli tasted bland and was watery and very soft in texture. Resident #30 and Resident #12 were observed eating the dinner meal on 2/25/26 at approximately 6:07 p.m. in the dining room. Both residents said the broccoli was mushy and tasted watery. V. Staff interviewsCertified nurse aide (CNA) #8 was interviewed on 2/25/26 at 5:40 p.m. CNA #8 said she often had to serve the residents' room trays by herself on two of the halls. She said she wished other staff would be available to help her so the residents would receive their meals faster and hotter. The dietary consultant and the registered dietitian (RD) were interviewed together on 2/26/26 at 3:16 p.m. The dietary consultant said she had been coming to the facility twice a week for the past two weeks since the former dietary manager was gone. She said she had reviewed food (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperatures with the dietary staff. The dietary consultant said the former dietary manager had called her and told her that the steam table was not holding food temperatures. The dietary consultant said she instructed the former dietary manager to contact a kitchen service vendor. She said the vendor came to the facility and determined the oven required calibration because the temperature in the oven was not registering correctly by 15 degrees F. She said the vendor identified the dietary staff was not using the proper switch on the steamer and educated the staff. The vendor identified the steam table needed a new part to make the repairs. She said the facility was still waiting on the part and it was scheduled to arrive at the facility on 2/27/26 and the vendor would then make the repairs on the steam table. The dietary consultant said residents did not share food concerns at the February 2026 resident council meeting. She said she did not know if the residents brought up food concerns in prior resident council meetings. She said the former dietary manager thought room trays were not delivered fast enough by staff and the plastic pellet inserts to keep the plate warm were not holding their temperature. She said after the vendor looked at the kitchen equipment on 2/16/26, it was determined that the food temperature problem was primarily related to the equipment failing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection. Specifically, the facility failed to:-Ensure staff performed appropriate hand hygiene when assisting residents with eating; and,-Ensure residents were offered the opportunity for hand hygiene prior to eating.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers, retrieved on 3/9/26 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, It read in pertinent part, CDC provides the following recommendations for hand hygiene in healthcare settings. Know when to clean your hands: immediately before touching a patient; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or patient surroundings; after contact with blood, body fluids, or contaminated surfaces; immediately after glove removal. When to use an alcohol-based hand sanitizer (ABHS): Unless hands are visibly soiled, ABHS is preferred over soap and water in most clinical situations because: it is more effective at killing germs on hands than soap; easier to use when providing care, especially when moving from soiled to clean activities on the same patient or when moving between care of patients in shared rooms; results in improved skin condition with less irritation and dryness than soap and water; improves hand hygiene adherence. When to wash with soap and water: when hands are visibly soiled; before eating; after using the restroom; during the care of patients with suspected or confirmed infection during outbreaks of C. difficile and norovirus.II. Facility policy and procedureThe Handwashing/Hand Hygiene policy, dated October 2023, was provided by the regional corporate resource on 2/26/26 at 4:55 p.m. The policy read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Residents, family members and/or visitors are encouraged to practice hand hygiene. Fact sheets, pamphlets and/or other written materials promoting hand hygiene practices are provided at the time of admission and/or posted throughout the facility.III. ObservationsDuring a continuous observation of the lunch meal in the main dining room on 2/23/26, beginning at 12:02 p.m. and ending at 1:08 p.m., the following was observed:Between 12:02 p.m. and 12:47 p.m. hand hygiene was not offered or available to the residents in the dining room. Observations did not identify that hand cleansing wipes or alcohol based hand rub (AHBR) were offered to residents by staff nor were they within reach of the residents at the tables and in the dining room. Several of the residents were observed holding on to their walkers to walk into the dining room or self-propelling themselves in a wheelchair to the dining room by use of their hands. At 12:26 p.m. staff began to serve residents their meals. The residents were not offered hand hygiene in the dining room prior to meal service. Observations identified many of the residents who were served rolls and cake, used their hands to eat the rolls. One resident used her hands to eat her cake, At 12:45 p.m. a resident blew her nose at the table with other residents and then continued eating. The resident was not provided hand hygiene after she blew her nose. At 12:47 p.m. hand hygiene wipes were offered by an unidentified staff member to the residents in the dining room. The unidentified staff member opened packages of hand hygiene wipes and told residents that the wipes were for after they were finished eating. At 12:48 p.m. a second unidentified staff member started to offer hand hygiene wipes to the residents and stocked the tables with wipes. During a continuous observation of the lunch meal in the secured memory care unit dining room on 2/23/26, beginning at 11:50 a.m. and ending at 12:30 p.m., the following was observed: At 12:05 p.m. the meal cart arrived on the secured unit and the staff proceeded to pass out the meal trays to the residents in the dining room. The residents were not offered hand hygiene in the dining room before they were (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served their meals. The staff wore gloves to pass out the meal trays. At 12:10 p.m. registered nurse (RN) #1 cut up a resident's food for him and served him a bite of the food, using the same gloves she wore to pass trays out to the other residents. At 12:14 p.m. RN #1 adjusted the napkin of another resident and then went back to the first resident and positioned his fork so he could grab it. The resident used the fork to take a bite of his food and then he put the fork down. -RN #1 did not change her gloves between the two residents.At 12:15 p.m. RN #1 doffed (took off) her gloves and wiped her hands with hand hygiene wipes. At 12:24 p.m. activity assistant (AA) #1 attempted to encourage the first resident to eat. The resident was coughing and sneezing. With her gloved hand, AA #1 picked up the resident's fork and then placed a small bite-sized piece of chocolate cake on his fork for him to eat. At 12:26 p.m. AA #1 got up from the resident's table, used her gloved hand to press the code on a key pad and turned the door knob to unlock and open the nurse office door. AA #1 entered the office and collected napkins with the same gloved hands she assisted the resident with his cake who was coughing and squeezing. She provided the resident napkin and set the other napkins down at another resident's table before she removed her gloves.IV. Staff interviewsThe infection preventionist (IP) was interviewed on 2/26/26 at 1:41 p.m. The IP said she provided staff hand hygiene education twice a year. She said the last hand hygiene education was conducted in January 2026. She said education was conducted with small groups of staff reviewing soap and water hand hygiene with a return competency evaluation. She said education alcohol based hand rub (AHBR) when appropriate. The IP said staff offered hand hygiene wipes at meals for residents. She said some residents were able to wash their hands in their rooms prior to going to the dining room. She said staff needed to educate residents to use the hand hygiene wipes before and after meals. She said staff should educate residents that if they were feeling ill, they were to be encouraged to use masks or spend time in their room when symptomatic. The IP said residents in their wheelchairs were at particular risk for an infection control issue because they touched the wheel base when self-propelling their wheelchairs.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to inform the resident's representative when a change in condition occurred for one (#5) of two residents reviewed out of 37 sample residents.Specifically, the facility failed to notify Resident #5's representative when the resident experienced a significant change in physical condition after bruising appeared to her left temple, as well as bruising and new pain to her left arm and shoulder following an incident that occurred during a sit-to-stand lift transfer.Findings include:I. Facility policy and procedureThe Change In A Resident's Condition or Status policy, revised February 2021, was provided by the regional corporate resource on 2/27/26 at 2:45 p.m. It revealed in pertinent part, Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status; there is a need to change the resident's room assignment; a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital/treatment center.II. Resident #5A. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included hyperlipidemia, hypertension, depression, anxiety, hemiplegia and hemiparesis (weakness and immobility affecting one side of the body) affecting the left side following cerebrovascular disease, dementia with agitation, chronic obstructive pulmonary disease (COPD), diabetes, atrial fibrillation, heart failure and displaced fracture of the left humerus. The 2/19/26 minimum data set (MDS) assessment revealed Resident #5 had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The assessment revealed Resident #5 had difficulty expressing and understanding verbal communication. Resident #5 was dependent on staff for repositioning in bed, transfers, bathing, toileting, hygiene, upper and lower body dressing and footwear. Resident #5 required substantial assistance with eating. B. Resident representative interviewResident #5's representative was interviewed on 2/24/26 at 9:24 a.m. Resident #5's representative said the facility never notified her of an accident occurring during a transfer using a lift at the beginning of February 2026. She said the facility additionally never notified her when new bruising was found on Resident #5's left arm and left temple. Resident #5's representative said she was informed of the incident by the hospice nurse over the phone, days after the incident occurred. Resident #5's representative said she visited Resident #5 and Resident #5 winced in pain with movement to her left arm. Resident #5's representative said she felt unhappy and worried for Resident #5 when she found out it took the facility over 10 days to complete an Xray of Resident #5's arm and another 10 days to provide Resident #5 with a sling. Resident #5's representative said she remembered a weekend nurse was trying to push things through to get her seen for an Xray, but she did not know why the facility did not contact her the day it occurred or why the resident's care was delayed. Cross reference F684 for failure to provide treatment in accordance with professional standards.C. Record reviewThe change in condition progress note, dated 2/5/26 at 1:00 p.m., documented new bruising was found on Resident #5's shoulder, bicep and forehead. The progress note documented Resident #5's physician was contacted and the physician recommended an Xray of Resident #5's left shoulder.-However, review of the progress note revealed no documentation notifying Resident #5's representative of the change in condition and no documentation notifying the representative that Resident #5 slipped while using the sit-to-stand lift on 2/2/26.III. Staff interviewsThe hospice nurse was interviewed on 2/25/26 at 2:36 p.m. The hospice nurse said her hospice certified nurse aide (CNA) informed her on 2/4/26 of new bruising and pain to Resident #5's left arm while providing a bath. The hospice nurse said she visited the resident on 2/6/26 for her routine visit. The hospice nurse said she spoke with the facility's nursing staff and found out (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 had sustained an accident of some kind during a transfer with the sit-to-stand lift. The hospice nurse said she spoke with Resident #5's representative over the phone to inform her of the resident's new pain and bruising. The hospice nurse said Resident #5's representative was not aware of the incident or bruising until she was informed by the hospice nurse.Registered nurse (RN) #2 was interviewed on 2/25/26 at 5:22 p.m. RN #2 said she was the nurse who completed the assessments for the bruising on Resident #5's left arm and forehead on 2/4/26 and 2/5/26. RN #2 said the bruising looked a few days old when she assessed them. RN #2 said she contacted the assistant director of nursing (ADON) and the director of nursing (DON) on 2/4/26. RN #2 said the DON instructed her to take pictures of the bruises and additionally told her that licensed practical nurse (LPN) #1 reported Resident #5 slipped during a sit-to-stand transfer on 2/2/26. RN #2 said she did not contact Resident #5's representative because when she was told about Resident #5 slipping out of the sit-to-stand lift, she assumed Resident #5's representative was notified of the incident on the day it occurred. RN #2 said she did not remember if the DON or the ADON instructed her to contact Resident #5's representative.The DON and the nursing home administrator (NHA) were interviewed together on 2/26/26 at 4:01 p.m. The DON said LPN #1 contacted her over the phone on 2/2/26, reporting Resident #5 slipped while using the sit-to-stand lift with LPN #1 and CNA #3. The NHA said she informally investigated the incident due to the delay in obtaining Resident #5's Xray. The NHA said LPN #1 told her she did not call Resident #5's representative on the day of the incident (2/2/26) because Resident #5 did not appear to have any injuries and did not fall. The NHA said she did not remember speaking with the resident's representative, but did remember speaking with another family member approved for medical information on 2/18/26 (16 days after the incident and five days after the Xray results indicated the resident had a fractured humerus). The DON said a staff member should have contacted Resident #5's representative when the extensive bruising was found, but she could see how RN #2 might have thought the family was already aware of the situation. The DON said she educated staff that if the incident was significant enough to contact the physician, staff should also notify the resident's representative.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents received notification of changes in eligibility for Medicare or Medicaid covered services, what the resident's financial responsibility may be, and their appeal rights for three (#59, #60 and #61) of four residents out of 37 sample residents.Specifically, the facility failed to ensure Resident #59, Resident #60 and Resident #61 were provided with notices of Medicare Non-Coverage when their skilled nursing benefits ended. Findings include:I. Facility policy and procedureThe Notice of Medicare Non-Coverage form was provided by the nursing home administrator (NHA) on 3/3/26 at 9:58 a.m. via email. According to the NHA, the facility did not have a policy for beneficiary notices, but used the regulations as their guidance. The notice of Medicare Non-Coverage form read in pertinent part, Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current services after the effective date (indicated date). You may have to pay for any services you receive after (indicated date). II. Resident #59A. Resident statusResident #59, age greater than 65, was admitted on [DATE] and discharged on 8/20/25. According to the 9/5/25 MDS assessment, diagnoses included obstructive pulmonary disease (COPD), unspecified hepatic failure (liver disease), unspecified with coma, and chronic respiratory failure with hypoxia. The MDS assessment documented Resident #59's discharge was planned. B. Record review The notice of Medicare Non-Coverage for Resident #59 was requested from the facility but not provided. III. Resident #60 A. Resident statusResident #60, age greater than 65, was admitted on [DATE] and discharged on 1/27/26. According to the 1/31/26 MDS assessment, diagnoses included cerebral infarction due to unspecified occlusion or stenosis of the right middle cerebral artery, diabetes mellitus and anxiety disorder. The MDS assessment documented Resident #60's discharge was planned. B. Record review The notice of Medicare Non-Coverage for Resident #60 was requested from the facility but not provided.IV. Resident #61 A. Resident statusResident #61, age greater than 65, was admitted on [DATE] and discharged on 2/5/26. According to the 2/11/26 MDS assessment, diagnoses included acute chronic systolic congestive heart failure, methicillin resistant staphylococcus aureus (MRSA) and anxiety. The MDS assessment documented Resident #61's discharge was planned. B. Record review The notice of Medicare Non-Coverage for Resident #61 was requested from the facility but not provided.V. Staff interviewsThe social services director (SSD) was interviewed on 2/26/26 at 11:24 a.m. The SSD said she could not find the Notice of Medicare Non-Coverage forms for Resident #59, Resident #60 and Resident #61. The SSD was interviewed again on 2/26/26 at 11:28 a.m. The SSD said it was important for residents to be given the Notices of Medicare Non-Coverage form so they were fully aware of their financial responsibility if they chose to stay at the facility when their skilled services ended. She said she missed sending out the notices for Resident #59, Resident #60 and Resident #61. She said she added an updated check list to make sure she did not miss any residents going forward. The regional corporate resource was interviewed on 2/26/26 at 6:17 p.m. The regional corporate resource said the facility was looking at additional methods to streamline the discharge process and improve communication so the Notices of Medicare Non-Coverage forms could be sent out to residents timely.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent misappropriation of property for three (#7, #22 and #57) of eight residents reviewed for personal property out of 37 sample residents.Specifically, the facility failed to prevent the loss of property for Resident #7, Resident #22, and Resident #57 from their rooms.Findings include:I. Facility policy and procedureIdentifying Exploitation, Theft and Misappropriation of Resident Property policy and procedure, revised April 2021, was provided by the regional corporate resource on 2/27/26 at 12:14 p.m. It read in pertinent part, As part of the Abuse Prevention Strategy, volunteers, employees and contractors hired by the facility are expected to be able to recognize exploitation of residents and misappropriation of resident property. Exploitation, theft and misappropriation of resident property are strictly prohibited. It is understood by the leadership in this facility that preventing these occurrences requires staff education and training. The quality assurance and performance improvement (QAPI) committee reviews and creates plans of action to address quality deficiencies that may lead to exploitation, theft or misappropriation of resident property.II. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included pressure ulcer of the right heel, chronic kidney disease and chronic obstructive pulmonary disease (COPD)The 12/10/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident's behavior of rejection of care occurred 1 to 3 days during the assessment look-back period.B. Resident interviewResident #7 was interviewed on 2/23/26 at 4:28 p.m. Resident #7 said he went to the bank to withdraw $200.00 from his account and spent $50.00. The resident said he could not locate the remaining $150.00 from his wallet in his room. Resident #7 said he reported the incident to the activity department and the social services director (SSD). He said he believed the facility completed an investigation, but there was no restitution made to him for his loss of the money. Resident #7 said he refused to sign the grievance form because he did not receive his money back. Resident #7 said he was not offered a lockbox until his money went missing. The resident said he had not lost any money since he was offered a lockbox.C. Record reviewThe facility's loss of property investigation for Resident #7, dated 12/16/25, was provided by the nursing home administrator (NHA) on 2/25/26 at 11:38 a.m. It documented Resident #7 reported to an unidentified staff member that he was missing $150.00 of his $200.00. The investigation revealed that Resident #7, in a conversation with NHA on 12/19/26, mentioned that his money might have been stolen or thrown away with his old wallet. The resident's financial advisor was contacted by the facility and confirmed Resident #7 withdrew $200.00 from his account on 12/11/25.The police were notified and Resident #7 was provided with a lockbox for valuables. Resident #7's care plan was updated to reflect the resident's agreement to keep money in a lockbox and not visible to others. The facility's admission procedure was updated to include notification upon admission of the availability of a lockbox for residents' personal use.The facility concluded the incident of loss of property was unsubstantiated.-However, the resident could not find $150.00 of the $200.00 that his financial advisor confirmed the resident withdrew from his account on 12/11/25.-The facility updated its admission procedure to include notification upon admission of the availability of a lockbox for residents after the incident of missing money was reported (see above).-A grievance form for Resident #7, dated 12/15/25, was provided by the SSD on 2/25/26 at 1:25 p.m. It revealed that Resident #7 stated that on 12/11/25, he withdrew $200.00 from his bank accounts. The resident reported that later the same evening around 9:00 p.m., he requested that an unidentified nurse DoorDash him a McDonald's food order. Resident #7 confirmed receipt of the food and stated that he gave the nurse $50.00 out of his $200.00 to cover the cost of the food and delivery. The next day, 12/13/25, Resident #7 reported switching to use a new wallet and disposing of the old one. Resident #7 reported on 12/15/25 that he was missing $150.00. The (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolution listed on the grievance form was that the incident was reported to the State Agency.-However, both the interview with Resident #7 and the facility's investigation revealed the resident's financial advisor confirmed a withdrawal of $200.00 on 12/11/25 (see above).A review of Resident #7's progress notes and electronic medical record (EMR) documented that Resident #7 was yelling at a certified nurse aide (CNA) on 12/10/25 at 8:00 a.m. that he needed to go to the bank. The EMR did not reveal any other information regarding Resident #7's missing money.-The safety and security care plan revealed that it was not initiated until 12/27/25, 12 days after the resident's allegation of missing money. Interventions included staff were to ensure Resident #7 had a lockbox available and accessible, and to educate the resident on safe use and proper storage of personal belongings.III. Resident #22A. Resident statusResident #22, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included muscle weakness, anxiety disorder and insomnia. The 11/19/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #22 was dependent and required substantial assistance with personal hygiene, toileting, and set assistance with eating.B. Resident interviewResident #22 was interviewed on 2/24/26 at 9:42 a.m. Resident #22 said some time last year (2025), her daughter had brought her $50.00 for spending money. Resident #22 said she had kept the money in an envelope in the back of the top drawer of her dresser. The resident said she recalled being out of her room, likely at activities, when the incident of her missing money occurred. She said upon returning to her room, she discovered her top dresser drawer was open and $30.00 was missing from the envelope. Resident #22 said she reported the theft to the facility, and an investigation was conducted, which included a search of her room; however, they were unable to locate the missing money. Resident #22 said she had begun keeping her money hidden in a different location and felt it was now secure.C. Record reviewThe facility's misappropriation investigation for Resident #22, dated 1/30/26, was provided by the NHA on 2/25/26 at 11:38 a.m. It documented Resident #22 reported to a CNA that she was missing money from her wallet. An investigation was started and the resident's wallet was found to have $28.00 in cash. Resident #22 said her daughter gave her $50.00, not $28.00 and said she was missing the rest of her money. The resident's daughter confirmed she gave her mother $50.00, in addition to $8.00 that her mother already had. Resident #22 said she had not participated in any outing that would require her to spend money. The resident stated that she used a debit card for all online purchases and had not spent any physical cash.The investigation revealed there had been a pattern of misappropriation of Resident #22's property.Description of the misappropriation of Resident #22's property included an incident reported on 12/4/25 of a missing $40.00 on A-hall, an incident reported on 12/15/25 of $150.00 on A-hall, and the current incident involving Resident #22 additionally occurred on A-hall.Based on interviews and a review of documentation, the facility concluded there was possible misappropriation of some source, but the source was not identified. The interventions implemented were communication to residents and residents' families and utilization of visible stain theft detection powder was ordered and a process was in place.-However, the interventions failed to include staff and resident education for the prevention of misappropriation of residents' property.-A review of Resident #22's care plan did not reveal any updates, including interventions to prevent further misappropriation of property for the resident.-A review of Resident #22's progress notes and electronic medical record (EMR) did not reveal any information regarding the property misappropriation incident.A grievance form for Resident #22, dated 1/30/26, was provided by the SSD on 2/25/26 at 1:25 p.m. It was documented on 1/30/26 at approximately 9:15 a.m. that the director of nursing (DON) reported to the SSD that Resident #22 informed her that she was missing $30.00. The resolution listed on the grievance form was that the incident was escalated to the grievance official, the NHA for review and it was reported to the State Agency. There was no documentation included on the grievance form indicating restitution for the missing money was made to Resident #22.-However, the interview with Resident #22 and the facility's investigation revealed the resident's daughter confirmed giving the resident $50.00, together with her additional $8.00, totalling $58.00, which (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulted in $30.00 being unaccounted for.IV. Resident #57A. Resident statusResident #57, age greater than 65, was admitted on [DATE] and discharged on 2/9/26. According to the February 2026 CPO, diagnoses included COPD, chronic respiratory failure, chronic kidney disease and muscle weakness.The 10/24/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15.B. Record reviewThe facility's misappropriation investigation for Resident #57, dated 12/4/25, was provided by the SSD on 2/25/26 at 1:25 p.m. It documented Resident #57 reported to the SSD that she was missing $64.00. The report revealed that an immediate investigation of staff, family, and the resident's roommate occurred. During the course of the investigation, the facility conducted interviews and a search with the resident's permission. The investigation documented Resident #57 and her family gave varying information related to the amount of cash missing. The facility did not identify any alleged assailants or a pattern of missing items. The investigation could not determine whether the money was lost or stolen.The resident did not want law enforcement notified; however, the police were notified.The facility provided a lockbox for the resident and the allegation of missing money was not substantiated; however, there were several incidents of misappropriation of residents' property during the same period and the facility failed to provide education for staff on the prevention of misappropriation of residents property (see above investigation).A grievance form for Resident #57, dated 12/4/25, was provided by the SSD on 2/25/26 at 1:25 p.m. It revealed Resident #57 reported to the SSD that she was missing $64.00 given to her by a friend. The resident's representative was interviewed by the facility, and she confirmed that Resident #57 received $40.00 from a friend.A review of Resident #57's progress note and EMR did not reveal any other information related to the incident of misappropriation of the resident's property.V. Staff interviewsCNA #3 was interviewed on 2/25/26 at 1:45 p.m. CNA #3 said she had not heard or witnessed any residents having property go missing in her unit. CNA #3 said she had not been trained by anyone in the facility on the prevention of the misappropriation of property for Resident #7, Resident #22 and Resident #57. CNA #3 said she was not involved in addressing the incidents; therefore, she did not receive any training.CNA #3 said she was familiar with the facility's grievance process. She said she would assist residents who needed help writing a formal grievance and report the incident to the SSD, the NHA, and possibly the DON.Registered nurse (RN) #3 was interviewed on 2/25/26 at 1:55 p.m. RN #3 said he had not had any incident of misappropriation of residents' property on his shift. RN #3 said he heard a few months ago of an incident of misappropriation of property on other units. He said he was not aware of the details, whether it was substantiated or not. RN #3 said he was not involved in the investigation and had not received any training related to misappropriation of residents' property. RN #3 said he understood and followed the facility's grievance process by reporting all incidents of misappropriation of residents' property immediately to the SSD.The SSD was interviewed on 2/26/26 at 1:51 p.m. The SSD said when a missing item of property was reported, she conducted a search for the property with the resident's permission. She said that if the property could not be located, a grievance form would be completed, and investigations would begin immediately. The SSD said if she was not able to reach a resolution with the resident involved, she would escalate the incident to the NHA, the grievance official. The SSD said she conducted the investigation for the incidents of misappropriation of residents' property for Resident #7, Resident #22 and Resident #57. She said she was unable to locate the three residents' property. The SSD said she escalated the incidents to the NHA. The SSD said she did not know whether the three incidents were substantiated. The SSD said the residents did not receive restitution for the missing property.The NHA and the DON were interviewed together on 2/26/26 at 3:30 p.m. The DON said she was involved in investigating allegations of misappropriation of residents' property. She said that incidents of misappropriation of property for Resident #7, Resident #22 and Resident #57 were confirmed by their families and representatives.The NHA said she was the grievance official and reported all three incidents of misappropriation of property for Resident #7, Resident #22 and Resident #57 to the police and the State Agency. The NHA said the facility had (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acquired a visible-stain theft-detection powder to help eliminate such occurrences. The NHA said the three residents did not receive restitution for the loss of their properties. She said she did not know the reason for several incidents of the misappropriation of residents' funds at the facility. The NHA said she did not know the facility's policy on restitution and had to verify and get back with an answer. The NHA said the facility was currently working on hiring a business office manager who would be in charge of securing residents' property. She said the facility was now offering lockboxes for residents who required them for storing valuables.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to incorporate recommendations from the preadmission screening and resident review (PASRR) level I screening from the State Mental Health Agency in the case of residents without serious mental illness or a related condition for one (#7) of three residents reviewed for PASRR out of 37 sample residents.Specifically, the facility failed to follow the recommendation to re-evaluate Resident #7's PASRR level I screening if the resident's symptoms or behavior did not improve or resolve within 60 days of the screening.Findings include:I. Facility policy and procedureThe Admissions policy, revised March 2019, was provided by the nursing home administrator (NHA) on 3/2/26 at 12:28 p.m. It read in pertinent part, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.II. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included unspecified mood disorder, other psychoactive substance use, unspecified psychoactive substance-induced disorder, chronic kidney disease, heart failure and restlessness and agitation.The 12/10/25 minimum data set (MDS) assessment revealed Resident #7 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment revealed Resident #7 declined to answer the patient health questionnaire (PHQ - a standardized, nine-question tool used by physicians to screen for, diagnose, and monitor the severity of depression). The assessment revealed Resident #7 had behaviors of threatening or cursing at others and refusing care. Resident #7 required partial assistance with dressing, bathing, and toileting.B. Resident interview and observationResident #7 was interviewed on 2/23/26 at 5:19 p.m. Resident #7 said he was refusing to eat. Resident #7 said he occasionally ate a prepackaged snack in his room or had food delivered, but he refused to eat food provided by the facility. Resident #7 said he initially stopped eating out of protest related to inferior services provided by the local urologists and lies the occupational therapist made claiming Resident #7 required assistance with dressing and going to the bathroom. Resident #7 said he was not concerned about losing weight, because he was 84 and did not want to live much longer.On 2/24/26 at 10:36 a.m. Resident #7 was observed arguing with and yelling at staff in the hallway outside of his room. Resident #7 said staff were violating his rights and to leave him alone.C. Record reviewResident #7's PASRR level I screening, dated 11/20/25, indicated that a PASRR qualifying disability (serious mental illness or intellectual disability) was not present. The assessment recommendations revealed low level behavioral health symptoms were present. However, those behavior symptoms appeared to be situational. The assessment revealed if Resident #7's symptoms/behaviors did not improve or resolve within 30 to 60 days of the initial PASRR level I screening, then the nursing facility must submit an updated status change PASRR level I screen to reevaluate the need for a PASRR level II behavioral health evaluation.Resident #7's care plan, revised 1/29/26, revealed a care plan documenting Resident #7 had a level I PASRR determination. Interventions included staff monitoring of Resident #7's mood, social engagement, and emotional status during daily interactions and reporting any changes or concerns to social services or the physician as indicated.-However, Resident #7's care plan failed to include recommendations to submit for re-evaluation of the PASRR level I screening if the resident's behaviors did not improve or resolve. The progress note, dated 2/10/26 at 10:01 p.m., revealed during wound care with the wound clinic nurse, Resident #7 said he was not going to live anymore so he was no longer going to eat. The progress note documented Resident #7 was offered hospice services, but Resident #7 declined, saying he did not want to be like his neighbor, referring to another resident. The progress note (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented Resident #7 did not want interventions at the time of the note. The physician communication note, dated 2/10/26, documented the director of nursing (DON) communicated a concern regarding Resident #7 to the medical director. The communication note documented Resident #7 was not eating. The communication note documented Resident #7 said he was choosing not to eat or drink because he no longer wanted to live. The communication note documented Resident #7 had lost 15 pounds since 1/6/26. The communication note documented the facility offered a hospice consultation to the resident, but Resident #7 declined. The communication note documented observations of Resident #7 eating minimal amounts of food, including popcorn and potato chips, and an observation of Resident #7 eating one slice of pizza on 2/8/26. The communication note documented the communication was noted and to transition Resident #7 to comfort measures care. The communication note documented the physician asked if Resident #7's family was aware of the situation. The progress note, dated 2/16/26 at 10:22 a.m., revealed Resident #7 continued to refuse all food offered in 24 hours. The progress note documented Resident #7 told staff he was doing this on purpose and that he was reporting it to the newspaper.The weight change alert note, dated 2/23/26 at 3:15 p.m. documented Resident #7 had continued weight loss. The progress note documented Resident #7 said he was ready to die and he was not eating. The progress note documented Resident #7 declined hospice services, but received comfort-focused care, per the medical director. The progress note, dated 2/24/26 at 1:54 p.m. documented Resident #7 continued his pattern of protest by not eating.Review of Resident #7's intake documentation from 1/26/26 through 2/24/26 documented Resident #7 ate any percentage of a meal only 11 times in 29 days.III. Staff interviewsThe registered dietitian (RD) was interviewed on 2/26/26 at 10:26 a.m., The RD said the facility discussed Resident #7's significant weight loss and behaviors during the interdisciplinary team (IDT) meetings. The RD said Resident #7 refused all interventions for supplemental food when offered. The RD said she could not force Resident #7 to eat, and she did not know what other interventions she could offer him. The RD said she knew Resident #7 ordered food delivery through his phone. The RD said the documentation in the certified nurse aide (CNA) documentation was probably not accurately capturing meals Resident #7 ate but did not tell the staff about. The RD said she knew the social services director (SSD) was in the IDT meetings reviewing Resident #7. The RD said she was not sure if the SSD had offered any mental health services to the resident. The SSD was interviewed on 2/26/26 at 10:38 a.m. The SSD said she heard reports from floor nurses about Resident #7's behaviors and refusals to eat. The SSD said she heard multiple claims of Resident #7 refusing to eat because he was dissatisfied with the services provided by the facility. The SSD said she attempted to complete the PHQ-9 screening, but Resident #7 refused to answer questions. The SSD said she offered tele-health talk therapy sessions to Resident #7 shortly after his admission to the facility but he declined. The SSD said Resident #7 refused to talk to the SSD ever since she had to present him with a grievance from another resident about Resident #7's yelling. The SSD said the facility had reviewed Resident #7's behavior and refusals to eat in IDT meetings, but she said she was not informed of Resident #7 making statements to staff about wanting to die. The SSD said she felt Resident #7's behaviors and mood had not improved since his admission. The SSD said she was not previously aware of the recommendation on the PASRR level I screen to reassess Resident #7 if his symptoms did not improve. The SSD said all staff should report statements about a resident wanting to die to a supervisor so the SSD was aware and could offer interventions or ensure the resident was safe.The NHA was interviewed on 2/26/26 at 10:47 a.m. the NHA said the facility frequently discuss Resident #7's significant weight loss and behavior in at-risk IDT meetings. The NHA said it was difficult to determine if Resident #7's behavior had improved or worsened since his admission to the facility. The NHA said Resident #7 was unpredictable, and would yell at staff members one day and get along well with the same staff members later in the same day. The NHA said Resident #7 spoke with the DON earlier today (2/26/26) about ending his hunger strike if the facility followed his recommendations. The NHA said the facility was aware Resident #7 ordered food (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for delivery and the documentation of his meals was likely not accurate. Registered nurse (RN) #2 was interviewed on 2/26/26 at 2:49 p.m. RN #2 said floor staff offer Resident #7 a tray at every meal but Resident #7 always refused to eat. RN #2 said she could not recall if Resident #7 ever told her directly that he wanted to die, but she did hear he made a statement about it to the DON. RN #2 said she observed Resident #7 eat the prepackaged snacks in his room and order food delivery, but she was not sure if the floors CNA documented those foods in Resident #7's intake records.CNA #4 was interviewed on 2/26/26 at 2:52 p.m. CNA #4 said Resident #7 told her to get out of his room frequently when she offered him meals. CNA #4 said Resident #7 said he did not want to do anything or receive care until things got solved. CNA #4 said the resident made various complaints, including the restorative services by the facility and his shoes. CNA #4 said the resident ordered food delivery probably a couple times every month. CNA #4 said Resident #7 made no statements to her about wanting to die. CNA #4 said she was not sure if his behavior improved, but Resident #7 did seem to scream at others less often compared to when Resident #7 first admitted to the facility CNA #4 said any time any resident made a statement about wanting to die, she would immediately report it to the charge nurse and the DON. The DON and the NHA were interviewed together on 2/26/26 at 4:01 p.m. The DON said the SSD typically reviewed PASRR recommendations prior to admission, but she also completed reviews of any PASRR level II recommendations. The DON said she had not seen the recommendation to reevaluate in 60 days on Resident #7's PASRR level I screening. The DON said Resident #7's mood and behavior was very situational. The DON said Resident #7 could have one behavior toward someone and have totally different behavior for the next person in the room. The NHA said Resident #7 could be egocentric or perseverate on the same topic. The DON said she could not say for certain if Resident #7's behaviors had resolved or improved since his admission to the facility. The DON said some of the behaviors were related to dementia and she would not expect those behaviors to improve. The DON said the conversation about the resident wanting to die happened during a wound care visit with the wound care nurse. The DON said when he made a statement about wanting to die, she asked him about a plan. The DON said Resident #7 did not have a plan and Resident #7 instead began to perseverate about his veteran's benefits. The DON asked Resident #7 why he would not want to live if he had this benefit and Resident #7 did not answer. The DON said she asked Resident #7 if he wanted hospice services but Resident #7 declined. The DON said Resident #7 frequently told staff he would end his hunger strike if they did these things but later changed his mind. The DON said said when she sent the communication with the physician regarding Resident #7's weight loss and refusal for hospice referral, she was hoping the physician would consider something like a psychiatric consult instead of only approving comfort measures orders.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to to ensure residents received treatment and care in accordance with professional standards of practice for one (#4) of three residents out of 37 sample residents.Specifically, the facility failed to follow the physician ordered parameters for the administration of Resident #4's pain medication.Findings include:I. Professional referenceAccording to Fundamentals of Nursing 10th edition by [NAME] and [NAME] et. al, 2021 pp. 672,1063-1064, Responsibilities of medication administration include knowing medication therapeutics, assessing a patient before administration, calculating doses, administering medications using the seven rights, monitoring and evaluating medication effects, and assessing a patient's ability to self-administer medications. The seven rights of medication administration include the right medication, right dose, right patient, right route, right time, right documentation, and right indication. Studies of nurses' attitudes regarding pain management show that a nurse's personal opinion about a patient's self-report of pain affects pain assessment and titration of medication doses. It has been shown that nurses' assessment of pain intensity often underestimates patients' pain reports. Also, nurses may infer cues on pain severity solely from how pain is treated and then use the cues when making symptom judgments, often leading to underestimationand overestimation of pain. Patients with a high self-report of pain, even when nurses are aware of their pain experience and analgesic treatment, are vulnerable to underestimation and hence to pain undertreatment. Also, patients with a low self-report of pain are subject to overestimation and thus are exposed to overtreatment with potential treatment hazards.II. Facility policy and procedureThe Documentation policy, revised November 2022, was provided by the regional corporate resource on 2/27/26 at 2:45 p.m. It revealed in pertinent part, Documentation of medication administration includes, as a minimum: the resident's name; name and strength of the drug; dosage; route of administration; date and time of administration; reason(s) why a medication was withheld, not administered, or refused (as applicable); initials, signature and title of the person administering the medication; resident response to the medication, if applicable (PRN -as needed, pain medication); and the condition of the venipuncture or vascular access device site before and after medication administration (if administered intravenously).III. Resident #4A. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included lymphedema, chronic kidney disease, atrial fibrillation, hypertension, venous insufficiency, heart failure, osteoarthritis, stiffness of the right and left shoulder, muscle weakness, chronic pain syndrome and depression.The 11/26/25 minimum data set (MDS) assessment revealed Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #4 was dependent on staff for repositioning in bed, transfers, bathing, toileting, upper and lower body dressing and footwear. Resident #4 required substantial assistance with oral and personal hygiene. Resident #4 required set up assistance with eating.The assessment revealed Resident #4 had constant pain with moderate pain as the worst rating of pain during the assessment look back period. B. Resident interviewResident #4 was interviewed on 2/24/26 10:18 a.m. Resident #4 said she had constant pain in her shoulders. Resident #4 said the facility's therapy staff told her they wanted her to participate in physical therapy with the goal of being able to propel herself in her wheelchair with her arms. Resident #4 said it was currently too painful for her to use her arms when propelling her wheelchair. Resident #4 said the facility's nurses gave her a couple of medications for pain including a pain patch, a topical gel, and as needed norco (hydrocodone/acetaminophen 7.5 milligrams (mg)/325 mg) tablets for pain. Resident #4 said she felt the facility was trying to manage her pain, but she still had constant pain despite the current interventions.C. Record reviewReview of Resident #4's February 2026 CPO revealed the following physician's order:Hydrocodone-acetaminophen 7.5-325 mg. Give one tablet by mouth every six hours for a pain level of 5-10, ordered 2/12/26 at 5:00 p.m.Review of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's February 2026 medication administration record (MAR) revealed administrations of hydrocodone-acetaminophen with no pain assessment at the time of administration for the following administrations: 2/12/26 at 5:00 p.m., 2/13/26 at 11:00 a.m., 2/13/26 at 5:00 p.m., 2/19/26 at 11:00 a.m., 2/19/26 at 5:00 p.m., 2/20/26 at 11:00 a.m., 2/20/26 at 5:00 p.m., 2/21/26 at 11:00 a.m., 2/21/26 at 5:00 p.m., 2/22/26 at 11:00 a.m., 2/22/26 at 5:00 p.m. and 2/25/26 at 11:00 a.m.Review of Resident #4's February 2026 MAR revealed administrations of hydrocodone-acetaminophen with a pain assessment below five out of 10 (various pain ratings between 0 and 5) at the time of administration for the following administrations: 2/14/26 at 11:00 a.m., 2/14/26 at 5:00 p.m., 2/15/26 at 11:00 a.m., 2/15/26 at 5:00 p.m., 2/15/26 at 9:00 p.m., 2/17/26 at 11:00 a.m., 2/17/26 at 5:00 p.m., 2/17/26 at 9:00 p.m., 2/18/26 at 5:00 a.m., 2/18/26 at 11:00 a.m., 2/18/26 at 5:00 p.m., 2/22/26 at 9:00 p.m., 2/23/26 at 5:00 a.m., 2/23/26 at 11:00 a.m., 2/23/26 at 5:00 p.m., 2/24/26 at 11:00 a.m., 2/24/26 at 5:00 p.m., 2/24/26 at 9:00 p.m. and 2/25/26 at 5:00 a.m.IV. Staff interviewsRegistered nurse (RN) #2 was interviewed on 2/26/26 at 9:15 a.m. RN #2 said Resident #4 had constant pain and several interventions for pain. RN #2 said she assessed Resident #4 for pain every shift, but did not assess Resident #4's pain with each administration of hydrocodone-acetaminophen 7.5-325 mg because the physician's order was scheduled and not as needed (PRN). RN #2 said she was not previously aware of the additional instructions to administer for pain rated 5 through 10. RN #2 said scheduled medication orders for pain medication did not usually include an order to assess pain at the time of administration. RN #2 said Resident #4 almost always rated her pain at a 5 or 6 out of 10 any time RN #2 completed a pain assessment. RN #2 said she felt Resident #4's pain was well managed, but not following the physician's order to assess pain could affect the physician's ability to determine how well Resident #4's pain was managed. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 2/26/26 at 4:01 p.m. The DON said Resident #4's physician's order for hydrocodone-acetaminophen 7.5-325 mg as written would indicate the need for a pain assessment at the time of the medication's administration. The DON said normally instructions to complete a pain assessment with the medication order would not be added to scheduled medications. The DON said the facility completed a recent audit of all pain medications for all residents in the facility. The DON said she thought what happened was they received a lot of recommendations from physicians and Resident #4's physician's order was possibly not updated correctly.The DON said it appeared Resident #4 had too many pain assessments for staff to complete, so staff did not document pain assessments with the administration of the medication because they had already completed a previous pain assessment. The DON said she was not sure if the physician's order should have been written as a PRN order or if the pain assessment should be removed from the order. The DON said she planned to clarify the order with the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from accidents or hazards for one (#42) of six residents reviewed for accident hazards out of 37 sample residents. Specifically, the facility failed to prevent an elopement for Resident #42 on 1/15/26. Findings include:I. Facility policy and procedureThe Wandering and Elopement policy, revised March 2019, was provided by the nursing home administrator (NHA) on 2/26/26 at 1:00 p.m. It read in pertinent part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. II. Facility investigationThe facility's investigation was provided by the NHA on 2/24/26 at 5:18 p.m. The facility's investigation identified Resident #42, who resided on the secured memory unit, was seen sleeping in his bed on 1/15/26 at 5:30 a.m. Resident #42 was not located when staff checked on him at 6:02 a.m. and was determined to be missing from the facility at 6:05 a.m. The staff initiated a search inside and outside the facility and contacted the police. The police located the resident off premises at 7:06 a.m. The resident was returned to the facility by a police officer. The investigation documented Resident #42 was missing for approximately an hour to an hour and a half.Resident #42's vital signs were taken when he returned to the facility. His oxygen saturation level was at 85 percent (%) and his temperature registered at 96.4 degree Fahrenheit (F). According to the investigation, the resident appeared at baseline cognitively and physically but was transported to the emergency department at the hospital at 7:22 a.m., via non-emergent transport for an evaluation due to an abrasion to his right elbow and his history of seizures. The investigation documented Resident #42 was treated at the hospital with warm intravenous (IV) fluids to increase his body temperature and then returned to the facility approximately an hour and a half to two hours later. The investigation documented the facility implemented 15-minute safety checks for 72 hours to ensure Resident #42 remained in the secure unit. His care plan was reviewed and redirection techniques were increased. Tactile busy boards were moved to more prominent locations on the secured unit for a higher visual awareness and access.The investigation indicated Resident #42 eloped from the secured unit and the facility by going out a window in the secured unit. According to the facility investigation, all door alarms were operable and working appropriately at the time of the elopement and no alarm had sounded. Upon perimeter checks, an open window was found with the screen replaced except for the bottom which was not secured to the window frame. A safety stop on the window was found to be broken. The investigation documented Resident #42 opened the window in another resident's empty room and broke the safety stop. The resident then exited through the window, replaced the screen except for the very bottom and climbed over the fence to exit the secure courtyard.The facility's investigation documented additional measures were taken to prevent a recurrence of elopement to include all the windows were assessed and windows with the small plastic safety stops were disabled with metal screws to ensure that the windows could not be opened to full capacity, leaving one window operable with stronger safety stops for egress. III. Resident #42 A. Resident status Resident #42, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included personal history of traumatic brain injury (TBI), Wernicke's encephalopathy (neurological disorder), altered mental status, other specified disorders of the brain, unspecified dementia of unspecified severity with other behavioral disturbance, alcohol-induced persisting dementia, delirium due to known physiological condition and generalized epilepsy and epileptic syndromes.The 1/30/26 minimum data set (MDS) assessment documented Resident #42 had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The MDS (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment identified he was independent with mobility and did not require a mobility device. According to the MDS assessment, Resident #42 had wandering behaviors. B. Observation and staff interviewsOn 2/23/26 at 2:50 p.m. Resident #42 came out of his room and into the dining room. The certified nurse aide (CNA) offered him a snack and put on a western show for him. After a few minutes, Resident #42 told registered nurse (RN) #1 that he had to be somewhere else and she needed to let him go. RN #1 told him he did not need to be anywhere else right now. At 3:42 p.m. Resident #42 was by the back door of the memory care unit. He was repeatedly pushing on the emergency push bars in an attempt to open the door.At 3:43 p.m. RN #1 came up to Resident #42 and showed him the red light above the door and told him when the red light was on, the door was locked. He looked at the red light on the door, touched the light and then continued to push on the emergency bars of the door. At 3:45 p.m. activity assistant (AA) #1 told Resident #42 that she would take him for a walk after she was done playing a game with the other residents. At 3:47 p.m. the CNA tried to redirect Resident #42 from the back door but he continued to try to open the door so the CNA sat down in a chair by the door.At 3:48 p.m. Resident #42 walked down the hallway and attempted to open the main entrance door to the secured unit by pushing buttons on the keypad. The resident then entered a resident's room next to the entrance door. At 3:50 p.m. the resident walked back up the hallway and sat on the couch in a small lounge and closed his eyes. On 2/24/26 at 3:40 p.m. a sign was on the outside door of the memory care unit. The sign directed staff not to force the door closed. On 2/26/26 at 10:18 a.m. the secured courtyard was observed with the maintenance director (MTD). Observation of the secured unit courtyard identified the courtyard was surrounded by a six foot fence with a latching device on the outside of the fence. The MTD said a resident would not have been able to open the gate from inside the courtyard. He said he was told that Resident #42 could have used the tree to climb over the fence. He motioned to a tree in the corner of the courtyard that was approximately four feet away from the fence. He said the facility determined the tree was used in the resident's elopement because some of the resident's personal items were found on the backside of the fence near the tree. The MTD said after Resident #42's elopement, additional measures were put in place with the windows so residents could not get out to the courtyard by using the windows. He said he reviewed the doors on the secured unit and reminded the staff to allow the entrance door on the secured unit to fully shut on its own while making sure residents were not near the door. He said the door should not be forced closed or it would not lock properly. C. Record reviewThe mood and behavior care plan, revised 2/7/26, identified Resident #42 had a pattern of elopement attempts.The care plan identified Resident #42 had a history of kicking out window screens, slamming windows in an attempt to open them and going into other residents' rooms and bathrooms due to a traumatic brain injury (TBI), dementia, delirium and other disorders of the brain. The care plan interventions, initiated 11/15/25, included assisting and encouraging the resident in developing the most appropriate methods of coping, interacting and expressing his feelings appropriately, and offering opportunities for positive interaction and attention by talking to him and providing activities. According to the care plan, staff should discuss the resident's behavior with them, when reasonable, and explain/reinforce why the behavior was inappropriate and/or unacceptable. The staff should intervene when necessary to protect the rights and safety of others, to include approaching/speaking in a calm and controlled manner, offering redirection and removing him from a situation to alternate location as needed and administering medications as ordered with monitoring and documentation of side effects and effectiveness. The care plan intervention, revised 2/7/26, directed staff to anticipate and meet Resident #42's needs.The elopement/wandering care plan, revised 10/16/25, identified Resident #42 was an elopement risk. According to the care plan, Resident #42 had a history of leaving his home unattended and had an impaired awareness of safety. Interventions included placing the resident on a secured unit and personalization of his room with familiar objects (initiated 7/2/26), ensuring a staff awareness of his elopement risk and identifying his pattern of wandering and need to intervene when appropriate (initiated 8/4/25), encouraging the resident to maintain his own personal space (initiated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/2/25) and providing redirection for his wandering behavior by offering pleasant diversions and structured activities (revised 10/16/25). The 1/15/26 at 7:00 a.m. change of condition evaluation documented Resident #42 had a change in skin condition or skin color. The evaluation documented Resident #42 had an abrasion to his right elbow and reddened skin to both hands. According to the evaluation, the resident was transported to the hospital.The 1/15/26 at 10:54 a.m. nursing progress note documented the resident returned from the hospital to the facility. The note identified Resident #42 was treated for acute hypothermia. According to the note, his laboratory (lab) work was normal, and there were no broken bones or internal bleeding. The note indicated he had scratches on his hands and knees. The resident was provided breakfast and his morning medication and then helped to bed where he was sleeping soundly. The note indicated the facility initiated 15-minute checks to monitor his whereabouts. -Review of the progress notes did not identify Resident #42's 1/15/26 elopement from the facility. IV. Staff interviewsRN #1 was interviewed on 2/24/26 at 3:45 p.m. RN #1 said Resident #42 was at risk for elopement and had eloped in the past. She said she was not on shift at the facility when the resident eloped on 1/15/26, but said she was told that he went out a window, put the screen back in place and then jumped over the fence of the secured courtyard to get out. She said he was found south of the facility. RN #1 said Resident #42 was now on 15-minute checks which were logged on a form. She said the staff needed to continue to ensure his location. The MTD was interviewed on 2/24/26 at 3:50 p.m. The MTD said each window on the secured memory unit had a plastic stopping device put in place to prevent the windows from fully opening. The MTD said he was not told which window Resident #42 was believed to have eloped from. He said he noticed in November 2025 that one of the window screws was coming loose from a plastic stopper, so he tightened the device and started a weekly check to ensure all the window stopping devices were secured. The MTD said in December 2025 he installed a top panel to the windows for extra securement so the window could not be easily removed. He said in January 2026, after Resident #42's elopement, he installed self-tapping screws on the left side of each double window in the secured memory unit to prevent the removal of the windows. The NHA, the director of nursing (DON) and the staff development coordinator were interviewed together on 2/26/26 at 12:03 p.m. The DON said CNA #10 went outside to take trash out to the dumpster in the early morning of 1/15/26. The DON said CNA #10 noticed a picture and a magazine on the back side of the fence that she recognized belonged to Resident #42. CNA #10 re-entered the facility through the courtyard and reported that Resident #42 was gone. The NHA said staff did a full search and contacted the police. The NHA said Resident #42 was last seen at 5:30 a.m. The NHA said CNA #10 found the resident's belongings at approximately 5:50 a.m. and he was determined to be not in or around the facility shortly after 6:00 a.m. The NHA said the resident was located by the police on the other side of the highway near the railroad tracks. She said he would have had to cross the highway to get to the railroad tracks. The DON said Resident #42 was cold when he was found. She said he left without a coat so his body temperature was 96.4 degrees F. She said his oxygen saturation level was at 85%. The DON said his oxygen saturation levels were low (by use of a pulse oximeter on his finger) but his fingers were cold, so the results may not have been completely accurate. She said he went to the hospital for an evaluation and was brought back two to three hours later. She said Resident #42 was placed on 15-minute checks for ongoing monitoring and supervision after the elopement and he would remain on 15-minute checks. The DON said she interviewed the staff who were working at the time of Resident #42's elopement. She said the staff did not report that they did not hear an exit door alarm sounding, which she felt ruled out that the resident did not exit through a door to leave the facility. The NHA said the staff found a broken window stopper on the window ledge of a wide open window in room [ROOM NUMBER] and the window screen was not fully secured to the window frame. The NHA said the facility did a complete check of all the windows in the facility and additional screws in the seals were inserted in the windows to ensure the windows were all secured. She said the facility conducted two hour perimeter checks until the window in room [ROOM NUMBER] was fixed and all residents were (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accounted for. The NHA said the MTD made sure all the door alarms were in proper working order and the courtyard was secured. The DON said the facility added a sign to the outside of the secured unit doors that reminded visitors to make sure no one was near the door when they entered the secured unit and not to push the automatic doors to the unit closed because it could cause the doors not to properly lock. The NHA said verbal education with staff was conducted with the memory care staff on 1/15/26. The staff development coordinator said she conducted education with all staff on 1/21/26 which focused on elopement risk and ensuring all windows and doors were secure. The staff development coordinator said the memory care unit staff received dementia care education on 2/18/26 and the facility would have an all-staff dementia training in March 2026.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review and interviews, the facility failed to ensure proper storage of medications for two of four medication storage carts. Specifically, the facility failed to:-Date residents' insulin pens with the date they were opened; and,-Discard expired medications in a timely manner.Findings include:I. Professional referenceAccording to the manufacturer, Sanofi-Aventis, Prescribing and Safety information, revised May 2025, retrieved on 3/4/26 from https://products.sanofi.us/Lantus/Lantus.pdf. The 3 milliliter (ml) single-patient use SoloStar prefilled pen can be stored unopened in a refrigerator until the expiration date, stored unopened at room temperature for 28 days and used for 28 days after opened at room temperature.According to the manufacturer, Sanofi-Aventis, Prescribing and Safety information, September 2025, retrieved on 3/4/26 from https://www.novolog.com/taking-novolog.html, Store unused NovoLog pens, PenFill cartridges, and vials at room temperature up to 86 degrees Fahrenheit (F) for up to 28 days. Store unused NovoLog pens and vials in the refrigerator at 36 degrees F to 46 degrees F until expiration. Storage after use: keep at room temperature (below 86 degrees F) or refrigerate for up to 28 days; keep away from direct heat and light. Dispose after 28 days, even if there is insulin left in the pen or vial.II. Facility policy and procedureThe Medication Labeling and Storage policy, revised February 2023, was provided by the regional corporate resource on 2/27/26 at 2:45 p.m. It revealed in pertinent part, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: medication name (generic and/or brand); prescribed dose; strength; expiration date, when applicable; resident's name; route of administration; and appropriate instructions and precautions. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.III. Observations and interviewsOn 2/25/26 at 9:03 a.m., the #1 medication administration cart was observed with registered nurse (RN) #3. The following medications were found:-An opened Lantus SoloStar 100 units per ml injectable insulin pen for Resident #43 which expired on 1/13/26.-An opened Lantus SoloStar 100 units per ml injectable insulin pen for Resident #14, which had smeared marker on the pen. The opened date on the pen was no longer legible.-An opened Lantus SoloStar 100 units per ml injectable insulin pen for Resident #30, which expired on 2/20/26.RN #3 said each insulin pen should have been checked prior to administration. RN #3 said any insulin pen found to be expired should have been removed from the resident's individual plastic container and replaced. RN #3 said the smeared marker showed a previous staff member attempted to write the open date on the insulin pen and it became illegible during use. RN #3 said since he could no longer confirm the opened date of the pen, it should have been replaced. RN #3 said he normally checked each of his insulin pens, but he did not notice the expired and mislabeled Lantus pens because they were only administered at bedtime by night shift. RN #3 notified the staff development coordinator who replaced each insulin pen.On 2/25/26 at 9:55 a.m., the #2 medication administration cart was observed with RN #2. The following medications were found:-An opened Novolog 100 units per ml injectable insulin pen for Resident #1, which did not have a cap and was not labeled with the date it was opened.RN #2 said without the cap for the pen, the nurse would have to clean it really well prior to each use. RN #2 said the open date was probably written on the cap which was lost. RN #2 said without an open date, she could not ensure if the insulin was safe to administer and the insulin pen should be replaced. IV. Additional staff interviewsThe director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 2/26/26 at 4:01 p.m. The DON said the staff development coordinator informed her of the mislabeled and expired insulin pens found in medication cart #1. The DON said RN #2 informed her of the insulin pen without a cap or open date in medication cart #2 and she ensured (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the insulin pen was replaced. The DON said each nurse should be checking the insulin pen's expiration and open dates prior to each administration. The DON said she planned to review the other medication carts in the facility to ensure no other residents were affected by mislabeled or expired medications.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and record review, the facility failed to ensure certified nurse aides (CNA) received at least 12 hours of annual in-service training that also included dementia management training and resident abuse prevention training to ensure continued competence for two out of five certified nurse aides (CNA) reviewed.Specifically, the facility failed to ensure CNA #3 and CNA #4 received 12 hours of continuing education annually.Findings include:I. Facility policy and procedureThe All Staff In-Service Training policy and procedure, undated, was provided by the regional corporate resource on 2/27/26 at 10:22 a.m. It read in pertinent part, All staff are required to participate in regular in-service education, including all new and existing personnel, individuals providing services under contractual agreements, and volunteers. Training requirements will be met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. Based on the outcome of the assessment, additional training may be required.Completed training will be documented by the staff development coordinator, or his or her designee, which will include the date and time of training, the topic of the training, the method used for the training, a summary of the competency assessment, and the hours of training completed.The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the residents' quality of life and quality of care and can demonstrate competency in the topic areas of the training. The required training topics include resident rights and responsibilities, preventing abuse, neglect, exploitation, and misappropriation of resident property.II. Training record review and staff interviewsFive randomly selected CNA training records were reviewed on 2/25/26 at 5:18 p.m. Of the five CNAs reviewed, CNA #3 and CNA #4's training records did not include 12 hours of annual training. The staff development coordinator said she would review the employee's files and provide the required training records if found. The nursing home administrator (NHA) said CNA #3's (hired 8/1/21) employee file did not have 12 hours of training and CNA #4's (hired 4/25/25) employee file did not have records of the initial required training for dementia care, abuse, neglect and exploitation of residents.III. Additional staff interviewsThe staff development coordinator was interviewed on 2/26/26 at 2:40 p.m. The staff development coordinator said she was responsible for ensuring employees received the required hours of training before having contact with residents. The staff development coordinator said she was required to collaborate with the unit managers and the director of nursing (DON) to ensure CNAs completed the mandatory 12 hours of in-service training. The staff development coordinator said she would immediately begin checking regularly to ensure each staff member complied with the policy.The NHA was interviewed on 2/26/26 at 3:30 p.m. The NHA said performance reviews should be completed annually based on the CNAs date of hire. The NHA said performance reviews were not completed for CNA #3 and CNA #4. The NHA said she was not sure why the CNAs training was not completed. She said most of the department managers were recent hires, including herself. The NHA said she would immediately establish a system to ensure the mandatory 12-hour CNA annual training and in-service training were provided for all CNAs.