STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065251	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paonia Care and Rehabilitation Center	1625 Meadowbrook Blvd Paonia, CO 81428

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 40467 Based on observations, record review and interviews, the facility failed to ensure two (#2 and #3) out of 10 residents reviewed for abuse were free from sexual abuse out of 13 sample residents. Specifically, the facility failed to protect Resident #2 and Resident #3 from sexual abuse by Resident #1. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, dated September 2022, was provided by the nursing home administrator (NHA) on 3/24/25 at approximately 1:30 p.m. The policy read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. All findings of all investigations are documented and reported. II. Incident of sexual abuse of Resident #2 by Resident #1 on 12/20/24 A. Facility investigation The 12/20/24 investigation file of the incident involving Resident #2 and Resident #1 was provided by the corporate consultant (CC) on 3/20/25 at 5:33 p.m. The investigation included an investigation report under sexual abuse, an interview note with two staff witnesses, interviews with other staff members and residents and notification of the incident to the appropriate parties. The investigation report documented dietary aide (DA) #1 observed Resident #1 in the activity room with his hand inside the shirt of Resident #2. DA #1, alerted certified nurse aide (CNA) #1 about Resident #1's behavior. The behavior was immediately stopped and the assistant director of nursing (ADON) was alerted. The residents were separated and Resident #1 was placed on a one-to-one observation/supervision with an employee. Resident #2 was assessed and no injuries or signs of distress/discomfort were identified. The investigation report documented Resident #2 was non-verbal, had no signs of emotional/mental distress and was behaving and reacting at her baseline. The investigation report identified Resident #1 was interviewed and had no memory of the incident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER: Paonia Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1625 Meadowbrook Blvd Paonia, CO 81428	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation report documented the facility concluded physical contact was made between Resident #1 and Resident # 2. Immediate action was taken to protect Resident #2 and all other residents. The investigation report indicated the facility placed Resident #1 on one-to-one supervision after the 12/20/24 incident to help prevent a recurrence. According to the report, Resident #2 did not have a change in her regimen or care plan following the incident, but she was assessed for signs of emotional/mental distress. A handwritten and undated witness interview note documented DA #1 said Resident #1 was sitting next to Resident #2 in the activity room. Resident #1 had his hand inside Resident #2's shirt for an undetermined amount of time. According to the interview of DA #1, she said Resident #2 did not appear in distress and CNA #1 immediately removed Resident #1. The witness interview note indicated CNA #1 said Resident #1 was witnessed reaching over to Resident #2 and placing his hand under her shirt and over her breast. The investigation identified four other residents and four staff members who were interviewed on 12/20/24 did not have concerns regarding abuse. B. Resident #2 (victim) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included unspecified dementia unspecified severity, without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety, generalized muscle weakness, lack in coordination, psychomotor deficit and Alzheimer's disease. The 1/22/25 minimum data set (MDS) assessment identified Resident #2 had severe cognitive impairment, per a staff assessment for mental status. Resident #2 had short and long term deficits. She was dependent on staff for all of her activities of daily living (ADL) care and used a wheelchair for mobility. The MDS assessment indicated she had inattention, disorganized thinking and altered level of consciousness. 2. Record review Review of the March 2025 care plan for Resident #2 identified the resident had a communication and memory problem related to dementia, decreased vision, decreased mobility and difficulty expressing needs and wants. -The care plan did not identify Resident #2 was at risk for abuse. -The care plan did not identify new interventions were put in place for Resident #2 to prevent her from sustaining future occurrences of potential sexual abuse following the 12/20/24 incident with Resident #1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's progress notes between 12/20/24 and 3/24/25, did not reveal documentation of the 12/20/24 incident between Resident #1 and Resident #2 or what interventions for Resident #2 were put in place to prevent potential sexual abuse from reoccurring. -Review of the progress notes did not identify Resident #2 was monitored for changes in her behavior after the 12/20/24 incident with Resident #1. C. Resident #1 (assailant) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unsteadiness on feet, generalized muscle weakness, lack of coordination, Alzheimer's disease and cognitive communication deficit. The 2/6/25 MDS assessment identified Resident #1 had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. He used a wheelchair for mobility and needed partial to moderate assistance with most of his ADLs. According the MDS assessment, Resident #1 did not have physical, verbal or other behavioral symptoms directed towards others. 2. Observations On 3/20/25 at 12:25 p.m. Resident #1 was in the secured unit dining room eating his lunch at the dining room table with female residents. A CNA sat between him and one of the female residents. The other female resident sat across the table from Resident #1. CNA #2 stood in the dining room facing Resident #1. On 3/20/25 at 2:05 p.m. Resident #1 was sleeping in bed in his room in the secured unit. CNA #2 sat in the hallway near the room of Resident #1. On 3/24/25 at 11:38 a.m. Resident #1 was asleep in his room while a staff member sat inside the room near the doorway. 3. Record review Review of Resident #1's behavior care plan, revised 2/27/25, revealed the resident had inappropriate social/sexual behaviors (verbal/physical) related to dementia and he exhibited poor safety awareness and had a lack of spatial awareness and awareness of others' personal space. Interventions initiated on 8/4/23, included allowing Resident #1 to express anger within social parameters, approaching the resident in a calm but firm manner, assisting the resident to a quieter calmer area of the living environment, if reasonable, discussing with Resident #1 the behaviors identified and explaining/reinforcing why the behavior is inappropriate and/or unacceptable to the resident, notifying the family and physician of increased behavioral concerns, redirecting and assisting Resident #1 away from confrontational situations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The intervention initiated on 2/26/24 directed staff to notify hospice of any changes in the resident's behaviors. The behavior care plan interventions, initiated 2/27/25, directed staff to offer Resident #1 activity of choice, sensory activities, food/fluid or one-to-one engagement, redirecting from other residents' personal space and providing line of sight supervision when Resident #1 was in common areas. According to the 2/27/25 interventions, Resident #1 would benefit from the smaller, structured environment of the secure unit. -The facility failed to initiate new care plan interventions following the 12/20/24 incident where Resident #1 placed his hand inside the shirt of Resident #2. -The facility failed to implement new interventions for Resident #1's sexually inappropriate behaviors until 2/26/25, over two months later, after the resident was involved in a second sexual abuse incident with Resident #3 (see incident involving Resident #3 below). -The behavior care plan did not identify Resident #1 was on one-to-one supervision or line of sight supervision after the 12/20/24 incident with Resident #2, as had been identified in the 12/20/24 investigation report (see investigation report above). Review of Resident #1's March 2025 CPO revealed the following physician's orders: Frequent checks/monitoring for inappropriate sexual behaviors, ordered 10/26/23 and discontinued 3/24/25, during the survey. -The physician's order indicated Resident #1 should have been frequently monitored for inappropriate sexual behaviors between 10/26/23 and 3/24/25. Non-pharmacological behavior monitoring interventions for inappropriate sexual behaviors to include one-to-one's, ordered 10/26/23. -The physician's order did not specify whether the one-to-one's were visits made by staff members or if the resident was to be on consistent one-to-one supervision. Line of sight when out of room order, ordered 2/25/25. -Review of Resident #1's physician's order history failed to reveal a physician's order for the resident to be on one-to-one supervision or line of sight monitoring from 12/20/24 through 2/25/25, following the sexual abuse incident with Resident #2 (see investigation above). Review of Resident #1's progress notes from 7/26/24 through 2/6/25 revealed the following progress notes: A 7/26/24 interdisciplinary team (IDT) psychotropic committee note identified Resident #1 had a physician's order for finasteride for support in management of inappropriate sexual behaviors. An 8/8/24 IDT note identified Resident #1 had an increase in sexual behaviors towards a hospice staff member. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 10/11/24 nursing note identified Resident #1 was observed kissing another resident in the dining room. The 10/15/24 nursing note identified Resident #1 was found licking another resident's hair. A 10/18/24 IDT psychotropic committee note indicated occupational therapy (OT) monitored/observed Resident #1 due to his increase in sexual behaviors. According to the note, OT felt the resident would benefit from a sensory related program based on his oral fixations to help decrease these types of behaviors. The note identified the IDT agreed to the sensory programming with OT. -There was no progress note documented on 12/20/24 regarding the incident with Resident #2 where Resident #1 was found by staff with his hand on Resident #2's breast inside her shirt (see investigation above). A 1/2/25 IDT (which was documented as a late entry note with the effective date of 12/20/24) indicated Resident #1 was placed on one-on-one supervision due to recent sexual behaviors. The note identified the physician and all reporting parties were notified on 12/20/24. Both residents involved (Resident #1 and Resident #2) were safe and neither resident recalled the incident. According to the note, staff education completed by the director of nursing (DON) regarding safety and emotional monitoring, was completed. -However, review of Resident #1's physician orders history revealed there was no physician's order for the resident to be on one-to-one supervision following the 12/20/24 incident (see physician's orders above). The 1/16/25 at risk review note documented Resident #1 was without behaviors for several weeks and it recommended to discontinue the of line of sight physician's order and move to frequent roundings and checks and redirection for inappropriate behaviors. -However, review of Resident #1's physician orders history revealed there was no physician's order for the resident to be on line of sight monitoring following the 12/20/24 incident (see physician's orders above). The 2/6/25 at risk note for quarterly review documented Resident #1's behavior monitoring was still in place for inappropriate sexual behaviors and there had been no significant changes at the time. -However, review of Resident #1's behavior tracking records revealed staff were not consistently documenting the resident's one-to-one supervision or line of sight monitoring (see below). The December 2024 behavior tracking record for monitoring inappropriate sexual behaviors did not identify Resident #1 had behaviors on 12/20/24. The behavior tracking record identified the resident was provided redirection and one-to-one supervision on 12/1/24, 12/2/24, 12/3/24, 12/15/24, 12/16/24, 12/17/24 and 12/28/24. -The December 2024 behavior tracking record for monitoring inappropriate sexual behaviors did not identify Resident #1 was provided consistent one-to-one or line of sight supervision after he placed his hand in the shirt of a female resident on 12/20/24. The resident was only documented as receiving one-to-one supervision on 12/28/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The January 2025 behavior tracking record for monitoring inappropriate sexual behaviors did not identify Resident #1 was provided one-to-one or line of sight supervision. The February 2025 behavior tracking record for monitoring inappropriate sexual behaviors identified Resident #1 had one incident of inappropriate sexual behaviors and was provided one-to-one supervision on 2/25/25 (see incident with Resident #3 below). -The behavior tracking record for inappropriate sexual behavior did not identify the resident was on a one-to-one supervision for any of the rest of the days in February 2025. III. Incident of sexual abuse of Resident #3 by Resident #1 on 2/25/25 A. Facility investigation The 2/25/25 investigation file was provided by the CC on 3/20/25 at 5:29 p.m. The investigation file included the suspected abuse initial investigation record, Resident #1's care plan for behaviors, an investigation report under sexual abuse, the abuse allegation incident report and resident and staff member interviews. The suspected abuse initial investigation record identified Resident #1 approached Resident #3, touched her on her knee and told her she had nice legs. The staff removed Resident #1 from the area and staff redirected him to an alternate space. According to the investigation, there were interventions identified to potentially reduce the risk of the incident prior to the event. -However, the facility failed to implement effective interventions prior to the event with Resident #3 (see incident with Resident #2 above). The investigation referred to Resident #1's care plan. The investigation record noted that new interventions were added to his care plan. The investigation record identified Resident #1 had a new 2/25/25 intervention of a line of sight observation when the resident was not in his room and a 2/26/25 intervention to move the resident to the secured unit. Resident #1's behavior care plan, initiated 8/4/23, that was included in the the facility's investigation file, identified Resident #1 displayed inappropriate social/sexual behaviors, both physical and verbal. The interventions documented in the care plan included staff to discuss with the resident the identified behaviors and explaining/reinforcing why the behavior was inappropriate, initiated 8/4/23; redirecting and assisting the resident away from confrontational situations, initiated 8/4/23; assisting the resident to calmer areas of the living environment, initiated 8/4/23; staff to observe and redirect the resident in public areas as needed and offering reminders to not touch others as appropriate, revised 1/16/25. The 2/25/25 investigation report under sexual abuse, documented Resident #1's behaviors were wandering, inappropriate social/sexual behaviors, lack of spatial awareness and he was not aware of others' personal space. The report identified the resident was involved in another sexual allegation on 12/20/24 (see incident above). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation report indicated Resident #1 was placed on a one-to-one line of sight observation when he was out of his room. The report identified the incident made Resident #3 uncomfortable. She was not injured or in pain. She denied Resident #1 touched her leg in a rough manner. She denied she was touched anywhere else on her body. The investigation report identified the incident was witnessed by an activity assistant (AA). According to the investigation report, Resident #3 did not have behavioral changes but said she felt uneasy around Resident #1 since the incident. The investigation report documented Resident #1 had a history of behaviors with a recent increase in wandering in the facility and entering others' personal space. The investigation report concluded the facility was able to substantiate the incident occurred, but was not able to determine motives or intent of the alleged assailant (Resident #1) due to his cognitive deficit. The abuse allegation incident report documented there were no injuries to either Resident #1 or Resident #3 identified after Resident #1 touched Resident #3's leg and made an inappropriate comment. The report documented Resident #3 did not like Resident #1 touching her leg and did not want to be around him. The staff member and resident interviews identified one staff member, Resident #1, Resident #3, and six other residents were interviewed after the 2/25/25 incident. The staff member interviewed was the AA who said she witnessed the incident. According to the AA's interview, she heard Resident #1 tell Resident #3 she had nice legs and witnessed him touch her. The interview did not identify where he touched her. The provided interviews identified Resident #3 was interviewed three times on 2/25/25. The social services director (SSD) interview documented Resident #3 told the SSD another resident (Resident #1) wheeled his wheelchair over to her and said she had nice legs and then he felt them with his hands. Resident #3 motioned that Resident #1 touched her down the front of her thigh. The interview indicated Resident #3 denied feeling scared, felt safe, but looked visibly upset. The DON interview documented Resident #3 did not like when Resident #1 touched her and did not want to be around him. She said she felt safe and did not think he could get to her now. Resident #3 requested for the DON to keep Resident #1 away from her. Resident #3 was interviewed again, later on the evening of 2/25/25. Resident #3 said she was okay but did not want Resident #1 to touch her again. When the resident was asked if she felt scared, Resident #3 said she knew he could not get her now because he was in bed. She said she just did not want to be around him anymore. The interview documented Resident #3 was more relaxed once in her own space and was assured that the staff were actively monitoring his behaviors and the location to keep her safe. The 2/25/25 interview with Resident #1, conducted by the DON, identified when questioned about the 2/25/25 incident with Resident #3, he was not able to recall the incident or indicate he understood the questions asked. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review of the six other residents' interviews did not identify the interviewed residents felt upset, uncomfortable, fearful, or were physically harmed by another resident. According to the interviews, the residents felt they were treated with respect and dignity from other residents at the facility. B. Resident #3 - victim 1. Resident status Resident #3, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included Huntington's disease, major depressive disorder, recurrent and partial remission, unsteadiness on feet, generalized muscle weakness and lack of coordination. The MDS assessment identified Resident #3 was cognitively intact with a BIMS score of 15 out of 15. The resident did not have inattention or disorganized thinking behaviors. According the the MDS assessment, Resident #3 was independent in her mobility and ADL care. 2. Resident interview Resident #3 was interviewed on 3/20/25 at 3:35 p.m. Resident #3 said Resident #1 touched her leg during an activity. She said she told him not to touch her and she reported the incident to staff. Resident #3 said she felt scared and worried because she thought Resident #1 might touch her again. She said Resident #1 was moved into the secured unit and she had not had any more concerns. 3. Record review The trauma care plan, initiated 2/27/25, identified Resident #3 was a victim of a traumatic experience and experienced anxiety and feelings of being scared and upset. The 2/27/25 goal for the resident was to feel safe and less anxious throughout the period of post trauma. The 2/27/25 interventions directed staff to complete wellness checks as needed and offer one-to-one activities when Resident #3 felt overwhelmed. The 2/25/25 system note documented Resident #3 was touched on the back of the leg below her knee by another resident (Resident #1) who told her she had nice legs. The note identified the registered nurse (RN) did not witness the encounter but spoke to the resident. According to the note, Resident #3 said she was okay but she wanted to stay away from him (Resident #1). The 2/25/25 social services note documented Resident #3 notified the SSD that she was touched on the leg by another resident. The note indicated Resident #3 appeared uncomfortable but said she was not scared and felt safe. According to the note, the SSD immediately notified the DON, the charge nurse and the NHA to let them know the aggressor (Resident #1) needed to be on line of sight monitoring. The 2/25/25 nursing note identified a nurse had a wellness visit with Resident #3. The note documented the resident was not scared but did not like (Resident #1) touching her and did not want to be around him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/26/25 IDT note documented Resident #3 was a victim in the 2/25/25 event that made her feel uncomfortable. According to the note, all immediate safety/wellness checks were completed on 2/25/25, 72-hour wellness checks were put in place and interventions were initiated for Resident #1 to keep the two residents separated. C. Resident #1 - assailant The 2/25/25 behavior note documented the DON visited with Resident #1 after he had inappropriate behaviors with another resident (Resident #3). According to the note, the resident was in good spirits and was happy to be at the dinner table. There was no emotional/physical distress noted/reported and Resident #1 reported no recollection of the events earlier in the evening. The 2/26/25 at risk review note documented Resident #1 had behaviors affecting others. Resident #1 had increased wandering and poor safety awareness/awareness of other residents' personal space. He was unable to retain information/education related to his actions but was easily redirectable with identification of behaviors. The intervention identified in the at risk note was to transfer Resident #1 to a secure unit for safety due to increased wandering and for increased staff observation. The note indicated Resident #1 would be maintained on a line-of-sight observation while in common areas or with wandering. The 2/27/25 at risk review note documented the summary of the IDT discussion included Resident #1's inappropriate touching of a female resident's leg (Resident #3) and commenting on her legs. The intervention was to immediately separate Resident #1 from Resident #3, implement a line of sight order and conduct wellness checks for both residents involved. According to the at risk note, Resident #1 had been evaluated as appropriate for the dementia unit, as the increased structure provided would help with redirection and sensory needs and the physician and the resident's responsible party were made aware. A physician's order, revised 2/26/25, identified Resident #1 was admitted to the secured unit due to the risk of wandering away from the facility and placing himself at risk of harm due to inability to find a way back to the facility and a history of behavioral disturbances that seriously disrupted the rights of others. According to the physician's order, a less restrictive alternative would be unsuccessful and a smaller focused environment would be beneficial. Review of the February 2025 behavior tracking record for monitoring inappropriate sexual behaviors identified Resident #1 had one incident of inappropriate sexual behaviors on 2/25/25. The behavior marked the resident was provided one-to-one supervision on 2/25/25. -The behavior tracking for inappropriate sexual behavior did not identify the resident was on one-to-one supervision or line of sight monitoring following the incident with Resident #3 on 2/25/25. IV. Staff education A 12/10/24 all staff in-service (conducted 10 days prior to the incident between Resident #1 and Resident #2) was provided by the facility on 3/24/25. The provided training materials identified abuse was reviewed with the staff. According to the abuse training materials, anything that caused fear in a resident's home was considered abuse and it was the facility's responsibility to provide a safe place for the residents to live. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/10/24 all staff in-service training materials identified the difference between and the purpose of a line of sight observation and a one-to-one observation. According to the training material, line of sight observation meant a staff member could see the resident at all times. The purpose of a line of sight observation was to ensure the resident's safety and prevent potential harm or incidents. A specific staff member was assigned to maintain a line of site observation, and this was done in person, and not through video monitoring. The staff should document and assess the resident's condition at regular intervals, such as every 15 minutes. The 12/10/24 all staff in-service training materials identified a one-to-one observation meant a staff member was consistently with the resident within arm's reach. The purpose of a one-to-one observation was to provide the highest level of observation and immediate intervention if needed. The staff member remained with the resident at all times and the resident never left the staff member's immediate presence. Staff should document the resident's condition and any interventions at regular intervals, such as every 15 minutes. The 12/10/24 all staff in-service participation sheet documented 17 staff members attended the training, however, only two staff members were nursing staff members. The 1/10/25 staff inservice staff for one-to-one observation due to inappropriate behavior education was provided by the DON on 3/20/25 at 5:27 p.m. The education documented one-to-one supervision of a resident was set in place for the safety of their respective environment, including but not limited to themselves, other residents, staff, guests, or any other person in the facility. According to the education, when the resident was not alone in their room, the resident must be in line of sight, at arm's length at all times. The DON, the hall nurse, or the NHA would assign the one-on-one attendee. One-to-one staff members must always follow one-to-one guidelines, no exceptions. For breaks, shift change or any other need, one-to-one staff members must wait for another staff member to take their one-to-one position with the resident. The education indicated any actions from a resident that was placed on a one-to-one that put others at risk must be immediately reported to the NHA and the DON. -The 1/10/25 education was provided three weeks after the 12/20/24 incident between Resident #1 and Resident #2. A 3/10/25 staff in-service was provided by the CC on 3/20/25 at 5:33 p.m. The in-service identified abuse prevention was reviewed with 22 staff members, including some nursing staff. V. Staff interviews CNA #2 was interviewed on 3/20/25 at 2:05 p.m. CNA #2 said he had been watching Resident #1 for falls and behaviors the past two to three months, four days a week from 5:30 a.m. to 6:30 p.m. He said other available staff would be responsible for watching the resident the rest of the time. He said he needed to make sure Resident #1 was in line of sight, kept away from female residents and exhibited appropriate behaviors. CNA #2 said since Resident #1 had been in the secured unit, there was also a sensor by the door that identified when the resident was out of bed. He said he was not aware of Resident #1's behaviors toward female residents other than touching people's hands, but nothing more serious. He said Resident #1 was easy to redirect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER: Paonia Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1625 Meadowbrook Blvd Paonia, CO 81428	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 3/20/25 at 2:10 p.m. LPN #1 identified herself as the nurse for the secured unit. She said precautions to watch for for Resident #1 was inappropriate sexual behaviors. She said Resident #1 needed to be kept in the line of sight of staff. She said that she had not observed any inappropriate sexual behaviors since the resident had been on the secured unit. Registered nurse (RN) #1 was interviewed on 3/20/25 at 3:44 p.m. RN #1 said she had worked on the non-secured hall since January 2025, before Resident #1 was on the secured unit. She said she never saw Resident #1 with inappropriate behaviors. She said she was not aware of extra monitoring or supervision for Resident #1. She said the staff were responsible for keeping an eye on all of the residents. The DON and the CC were interviewed together on 3/20/25 at 3:49 p.m. The DON said Resident #1 was discontinued from one-to-one staff supervision on 2/26/25 and then placed on line of sight supervision on 2/26/25. The DON said Resident #1 was placed on one-to-one supervision after Resident #1 had inappropriate sexual behaviors towards Resident #2 on 12/20/24. -However, there was no documentation or a physician's order in Resident #1's EMR to indicate he had been placed on one-to-one supervision following the 12/20/24 incident (see record review above). The CC said other interventions for Resident #1 included the timing of the medication finasteride and since the change of the medication's administration timing from day to night, staff had seen improvement in his behaviors. She said after the incident with Resident #3 on 2/25/25, Resident #1 was moved to the secured unit for more line of sight monitoring and engagement. The SSD was interviewed on 3/20/25 at 4:05 p.m. The SSD said Resident #1 was kept in line of sight supervision since 12/20/24, after the incident with Resident #2. -However, according to the facility's investigation of the 12/20/24 incident, Resident #1 was supposed to be on one-to-one supervision (see above). The SSD said other interventions for Resident #1 were to offer individual activities that required his hands to help prevent him from touching other residents. He said Resident #1 loved activities. He said there were evening activities but not activities later at night. The SSD said one-to-one supervision was when an assigned staff member would stay with and make sure the supervised resident was not within an arm's length of another resident. He said staff received an education in December 2024 regarding one-to-one supervision (see education above). The CC was interviewed again on 3/20/25 at 4:46 p.m. The CC said Resident #1's one-to-one supervision should have been documented in the behavior tracking record. The CC reviewed the December 2024 behavior tracking record and said the behavior tracking for Resident #1 after the 12/20/24 incident was inconsistent. The CC reviewed the behavior care plan for Resident #1. She said no new interventions were identified on the care plan after the 12/20/24 incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER: Paonia Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1625 Meadowbrook Blvd Paonia, CO 81428	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 3/24/25 at 11:40 a.m. She said the staff education completed on 12/10/24 (prior to the 12/20/24 incident) was not conducted for a specific resident, but had been part of an all-staf[TRUNCATED]