

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/14/2026
NAME OF PROVIDER OR SUPPLIER Paonia Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#4) of three residents reviewed for medication errors out of 11 sample residents. Resident #4, who had a diagnosis of seizures, was admitted to the facility from home on 4/27/26 for a five-day respite stay. The resident had physician's orders for levetiracetam (a medication used to treat seizures) to be administered two times per day related to her seizures. The resident was scheduled to receive the levetiracetam medication between 3:00 p.m. and 6:00 p.m., per her home medication regimen. However, the medication orders were not obtained until 4:00 p.m. (over five hours after the resident was admitted to the facility). When the medication orders were put into the resident's electronic medical record (EMR), the timeframe for the first medication dose to be administered was entered as being due the next day (4/28/26). As a result, Resident #4 missed her scheduled dose of levetiracetam on the evening of 4/27/26, between the hours of 3:00 p.m. and 6:00 p.m. Resident #4 experienced two seizures on the morning of 4/28/26. Specifically, the facility failed to ensure Resident #4 was administered her levetiracetam medication per physician's orders, which likely contributed to the resident suffering a seizure. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 7/13/26 to 7/14/26, resulting in the deficiency being cited as past noncompliance with a correction date of 4/30/26. I. Situation of [NAME] 4/27/26 Resident #4 did not receive her evening scheduled dose of anticonvulsant medication, levetiracetam. Due to the missed administration of the medication, Resident #4 experienced two seizures on the morning of 4/28/26, which likely resulted from the missed medication administration the evening prior. II. Facility plan of correction The corrective action plan the facility put in place in response to the incident with Resident #4 on 4/27/26 was provided by the nursing home administrator (NHA) on 7/14/26 at 12:25 p.m. The plan read as follows: The facility failed to ensure that medications ordered upon admission from the facility were entered and verified appropriately within the EMR system prior to the scheduled medication administration time. This resulted in the resident's evening anticonvulsive medication potentially contributing to seizure activity experienced by the resident on 4/28/26. A. Corrective action Corrective action was initiated immediately on 4/28/26 upon discovery of the missed medication administration. Resident #4 was immediately assessed following the seizure activity. Nursing staff initiated emergency response procedures, including seizure precautions, oxygen administration, neurological monitoring, and administration of ordered emergency medication. The director of nursing (DON) and the physician were immediately notified. The resident's responsible party was notified of the event and interventions performed. Medication orders were reviewed and corrected in the EMR to ensure all medications populated appropriately on the active electronic medication administration record (eMAR). Resident #4 resumed prescribed medication regimen immediately following stabilization. The resident remained (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 0760 Level of Harm - Actual harm Residents Affected - Few	under direct nursing observation through the postictal recovery phase (recovery period immediately following a seizure).The date completed was 4/28/26.B. Identification of other residentsBeginning 4/29/26, the DON and nurse managers completed an audit of all current admissions and readmissions within the previous 30 days, all newly entered medication orders, all high risk medications, including anticonvulsants, anticoagulants, insulin, narcotics, and cardiac medications and the medication administration record (MAR) verification processes related to EMR order entry timing. The audit specifically reviewed whether medications entered during active medication administration windows appropriately populated on the eMAR and whether first-dose administration was completed timely. Any discrepancies identified were corrected immediately. No other discrepancies were identified. The date completed was 4/30/26.C. Systematic changes Effective 4/29/26, the facility implemented the following systemic changes:A revised admission and readmission protocol was implemented requiring:-Verification that all physician medication orders were received prior to completion of admission whenever possible;-If verbal orders were accepted pending written documentation, nursing leadership must verify reconciliation against physician facility documentation before medication pass;-All medications entered into the EMR during an active administration window must undergo a secondary nurse verification to ensure medications populate appropriately on the eMAR; and, -First-dose verification documentation would be completed for all newly admitted residents. D. Monitoring The DON, staff development coordinator, or designee will conduct the following audits: Review of all admissions and readmissions for medication reconciliation accuracy, verification that medications populate correctly on the eMAR, verification of first-dose administration completion, and review of high- risk medication admissions. Audit five admissions and readmissions and add all admissions and readmissions to the morning meeting report and audit findings will be reviewed through the facility Quality Assurance and Performance improvement (QAPI) committee. Any identified concerns will result in immediate corrective action and additional staff education as necessary. E. EducationBeginning 4/29/26, all licensed nursing staff received education regarding: EMR medication order entry timing, eMAR verification procedures, admission and readmission medication reconciliation, high risk medication monitoring, escalation procedures for delayed physician orders and admission requirements.The facility's admission from the Community policy was reviewed and reinforced with nursing staff.The date implemented was 4/29/26.III. Professional referenceAccording to [NAME], P.A., [NAME], A.G et.al, Fundamentals of Nursing, 10th ed., (2023). Elsevier, St. Louis, Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications:1. The right medication;2. The right dose;3. The right patient;4. The right route;5. The right time;6. The right documentation; and,7. The right indication.IV. Facility policy and procedure The Adverse Consequences and Medication Errors policy, revised June 2025, was provided by the NHA on 7/14/26 at 12:10 p.m. It read in pertinent part, The interdisciplinary team (IDT) monitors medication usage to prevent and detect medication-related problems such as adverse drug reactions and side effects. A significant medication related-error is defined as: requiring hospitalization, or extending a hospitalization, resulting in disability; requiring treatment with a prescription medication; resulting in cognitive deterioration or impairment; life threatening; and or resulting in death. Review the residents medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis. Evaluate the resident for possible medication-related adverse consequences when the resident has clinically significant change in condition or status, including: unexplained decline in function, cognition, or behavior: and or worsening of an existing problem or condition. In the event of a significant medication-related error, (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	take action, as necessary, to protect the residents safety and welfare. Promptly notify the provider of any significant error.V. Resident #4A. Resident statusResident #4, age less than 65, was admitted on [DATE] and discharged on 4/28/26. According to the April 2026 computerized physician orders (CPO), diagnoses included cerebral palsy, neuralgia and neuritis (general nerve pain and nerve inflammation), unspecified and other seizures.The 4/28/26 minimum data set (MDS) assessment documented Resident #4 was moderately cognitively intact with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS assessment indicated the resident received anticonvulsant medications. B. Record reviewReview of Resident #4's April 2026 CPO revealed the following physician's orders:Levetiracetam 500 milligrams (mg), administer three tablets by mouth two times a day related to other seizures, ordered 4/27/26. Nayzilam nasal solution (a prescription nasal spray used to treat acute repetitive seizures) 5 mg/0.1 milliliters (ml), administer one spray to alternating nostrils one time a day as needed related to other seizures, ordered 4/27/26. The nurse progress note, dated 4/28/26 at 9:25 a.m. and written by the assistant director of nursing (ADON), revealed Resident #4 was admitted to the facility on [DATE] at approximately mid-morning. The resident's medication orders were not obtained until 4:00 p.m., and when the medication orders were put into the EMR system, the the timeframe for the first medication dose to be administered was entered as being due the next day (4/28/26). Resident #4 missed her scheduled dose of levetiracetam on the evening of 4/27/26, between the hours of 3:00 p.m. and 6:00 p.m. Resident #4 experienced two seizures on the morning of 4/28/26. The resident was now up in the wheelchair and doing well.The nurse progress note, dated 4/28/26 at 9:36 a.m. and written by registered nurse (RN) #3 revealed Resident #4 appeared to start having a seizure in the dining room. Another nurse was present and took the resident out of the dining room and into the resident's room, transferred her to the bed and turned her onto her side. The resident's first seizure was presumed to have started around 7:48 a.m. and lasted until 7:52 a.m. The resident's second seizure started at 7:54 a.m. Nayzilam nasal spray medication was administered by another nurse at 7:55 a.m. and the seizure stopped at 7:58 a.m. Resident #4's vital signs were obtained at the end of the seizure and oxygen was initiated. The progress note further revealed the postictal phase started at 8:03 a.m., and more vital signs were obtained every 15 minutes. The oxygen was removed with the resident's oxygen saturation level at room air (above 90 percent). The resident's lung sounds were clear throughout and the resident was resting comfortably at the time of the assessment. Staff remained with the resident until 8:49 a.m. Resident #4's representative was called at 8:50 a.m. Staff reported to the resident's representative when the first and second seizure began and ended and when the postictal phase started. The resident's representative stated, What do you mean she had a seizure, she only has seizures under certain circumstances. According to the note, Resident #4 awoke around 9:00 a.m. and said she wanted to get up. Staff promptly helped the resident up and levetiracetam medication was administered right away.Review of Resident #4's EMR revealed the resident's levetiracetam medication order was entered into the EMR at 4:42 p.m. on 4/27/26 and scheduled be administered two times a day, once in the morning, between 6:00 a.m and 10:00 a.m, and once in the evening, between 3:00 p.m. and 6:00 p.m. -However, review of Resident #4's April 2026 medication administration record (MAR) revealed no levetiracetam medication doses were administered to the resident on 4/27/26 between 3:00 p.m. and 6:00 p.m., and one dose of the levetiracetam medication was administered on 4/28/26 at 9:14 a.m., which was after the resident's seizures had already occurred. The nurse progress note, dated 4/28/26 at 10:36 a.m. and written by the ADON, revealed Resident #4 missed the evening dose of levetiracetam medication (on 4/27/26) and possibly could have assisted in the result of the resident sustaining a seizure on 4/28/26. The progress note documented Resident #4 presented with shaking, (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to revise and implement an effective discharge plan for one (#4) of one resident reviewed for discharge planning out of 11 sample residents. Specifically, the facility failed to complete a discharge summary for Resident #4. Findings include: I. Facility policy and procedure The Discharge Summary and Plan policy, revised March 2025, was provided by the nursing home administrator (NHA) on 7/14/26 at 12:10 p.m. It read in pertinent part, When a resident's discharge is anticipated, a discharge summary is created, and the discharge plan is finalized to assist the resident with plans for care after the discharge. The medical record contains a copy of the discharge summary with the identity of the recipient of the summary. A discharge summary includes: a recapitulation of the resident's stay at the facility, a final summary of the resident's status at the time of the discharge and a reconciliation of all pre-discharge medications with the resident's post discharge medications. II. Resident #4A. Resident status Resident #4, age less than 65, was admitted on [DATE] and discharged on 4/28/26. According to the April 2026 computerized physician orders (CPO), diagnoses included cerebral palsy, neuralgia and neuritis (general nerve pain and nerve inflammation) unspecified and other seizures. The 4/28/26 minimum data set (MDS) assessment documented Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS assessment indicated the resident received anticonvulsant medications. B. Record Review The progress note, dated 4/27/26 and written by registered nurse (RN) #3, revealed Resident #4 admitted to the facility at 10:20 a.m. in a wheelchair, with transportation provided by the resident's representative. The representative said she would be back to pick up the resident next Monday (6/1/26) after lunch sometime. The resident was admitted to the facility for a five-day respite stay. Review of Resident #4's electronic medical record (EMR) revealed no discharge progress note or discharge summary for the resident. III. Staff interviews The assistant director of nursing (ADON) was interviewed on 7/14/26 at 10:30 a.m. The ADON said Resident #4 was admitted to the facility for a five-day respite stay. She said the resident had been a prior resident several times. The ADON said on the morning of 4/28/26 Resident #4 appeared to be having a seizure and was laid down in the bed. Cross reference F760 for failure to ensure residents were free from significant medication errors. The ADON said a nasal spray medication was administered to stop the seizure and staff monitored the resident. She said once the seizure was over, the resident woke up and wanted to attend activities. The ADON said the resident's representative was notified and within an hour, the representative arrived at the facility to discharge Resident #4 from the facility. The ADON said the discharge summary was not completed for Resident #4 because the discharge happened so quickly. The director of nursing (DON) was interviewed on 7/14/26 at 10:40 a.m. The DON said a discharge summary was important to complete for every resident. The DON said the discharge summary provided information for the disposition of the residents and to finalize the records from the resident's admission to the facility. She said a discharge summary was not completed for Resident #4. The NHA was interviewed on 7/14/26 at 12:15 p.m. The NHA said the discharge summary was completed by nursing staff and uploaded to the residents' EMRs to show the disposition of the residents. He said Resident #4 discharged from the facility one day after admission and the discharge summary was overlooked. He said he would complete the discharge summary for Resident #4. -However, no discharge summary was provided by the facility prior to the survey exit date on 7/14/26.		