

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  08/07/2025
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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure five (#40, #28, #45, #5 and #43) of seven residents reviewed for abuse out of 27 sample residents were kept free from abuse. Specially, the facility failed to:-Protect Resident #40 from physical abuse by Resident #45;-Protect Resident #28 from physical abuse by Resident #45; -Protect Resident #28 and Resident #45 from physical abuse by each other;-Protect Resident #5 from physical abuse by Resident #28; and, -Protect Resident #43 from physical abuse by Resident #32. Findings include: I. Incident of physical abuse of Resident #40 by Resident #45 on 6/3/25A. Facility investigation The 6/3/25 facility investigation documented a nurse witnessed Resident #40 back his motorized wheelchair into the hallway. Resident #45 was ambulating down the hallway and came upon Resident #40 and hit him on the back of the head (near the base of the skull/top of neck) with the back of her open hand. The staff redirected Resident #45 away from the Resident #40. Resident #40 continued moving his wheelchair and did not acknowledge that anything had occurred.The two residents were separated by staff and assessed for injuries and no injuries were noted. When interviewed by staff, neither resident could recall the events due to their cognitive impairments. The residents resided on the same secured unit of the facility. Resident #45 was assigned one-on-one observation by staff and new interventions were added to offer a milkshake for distraction, redirect others from Resident #45 or step between her and other residents at times of increased agitation. The physician was notified and an increase of Resident #45's antipsychotic medication was requested. The facility substantiated the incident, but did not substantiate abuse as there was no injury and no fear.-However, abuse occurred due to Resident #45 being observed slapping Resident #40 in the head. B. Resident #45 (assailant)1. Resident statusResident #45, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included unspecified dementia and a traumatic brain injury (TBI). The 7/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to participate in the brief interview for mental status (BIMS) assessment. A staff assessment for mental status revealed the resident had short and long term memory impairments and had severe impairments to her daily decision-making skills. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), physical and verbal aggression, rejecting care, and wandering. The resident experienced delusions. 2. Record reviewResident #45's behavior care plan, revised 6/13/25, revealed the resident had behaviors of verbal aggression with other residents related to dementia and a history of TBI. The resident would pace and wander to the point of exhaustion and did not have awareness of others' space and would enter others' rooms. The resident could be paranoid and did not not get along with another female resident on the unit and would have altercations with her if in close proximity. The resident would strike others unprovoked and could become verbally aggressive if feeling threatened. Interventions, initiated 4/14/25, included redirecting the resident from others' space and to her room or common areas, allowing the resident to sit in chairs in the hallway, engaging with the resident when passing her in the hallway with smiles and greetings, if the resident felt she was being followed, offering reminders of where the other resident's rooms were and offering to walk away from them with her, offering sweet treats, assisting with turning on the resident's television in her room during times of frustration, allowing the resident independent visits with her male friend in the unit, offering the resident compliments on her appearance, and offering to paint her nails. Interventions, initiated 6/4/25, included offering the resident a milkshake when agitated, and staff were to create a space between her and others or stand between them if unable to redirect the resident away from others. Interventions, initiated 6/7/25, included providing one-on-one staff at times of increased agitation and with busy waking hours. Interventions, initiated 6/9/25, included encouraging a calm bedtime environment and relaxation to promote sleep, offering the resident a back rub, smoothing of the resident's hair, providing soft or calming music and encouraging the resident to take walks outside with staff daily to reduce [NAME] up energy and reduce the risk of agitation .Interventions, initiated 6/13/25, included for the facility to purchase an identical pillow for the resident as another resident had as Resident #45 frequently took the other resident's pillow, which caused conflict, redirecting the resident away from the female resident she did not get along with and redirecting her from going into others' rooms or taking their belongings. Interventions, initiated 6/30/25, included reducing one-on-one observation to afternoon hours or with times of agitation. A nursing progress note, dated 6/3/25</p>		

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<p>F 0603</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>(continued on next page)</p>

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<p>F 0603</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure that one (#42) of 10 residents reviewed for freedom from involuntary seclusion out of 27 sample residents was provided the least restrictive environment and was not placed on a secured locked unit without an evaluation, assessment, justification, or documentation. Resident #42 was cognitively intact and had no history of wandering. On 7/13/25, following an incident in which she attempted to leave the facility to walk to a nearby store, staff redirected Resident #42 to a room on the secured locked memory care unit. Facility documentation revealed no physician's order, no completed assessment justifying locked secured unit placement, no evidence the secured placement was the least restrictive alternative and no interdisciplinary team (IDT) review before or immediately after the move. Although initial notes reflected Resident #42's temporary agreement to remain on the secured unit for the night, progress notes and interviews revealed that the secured unit placement continued beyond that evening, with the resident not knowing the door code and requiring staff assistance to exit. The resident reported feeling awful about being in a place where the door would not open, said she could not communicate with peers on the secured unit and expressed fear of certain male residents who knocked on her door at night. Resident #42's representative said there was no written consent, no assessment and no evaluation of the resident's emotional reaction to secured unit placement. The representative reported the resident was more agitated since the move and was struggling mentally. Specifically, the facility failed to ensure Resident #42 was removed from the secured unit after she agreed to stay overnight on the unit, which led to fear for the resident. Findings include: I. Facility policy and procedure The Restraint Management policy, dated March 2023, was provided by the nursing home administrator (NHA) on 8/6/25 at 1:49 p.m. It revealed in pertinent part, Restraints are implemented in accordance with State and Federal regulations. If indicated, the least restrictive restraint is used for the least amount of time. Restraints are not used as a disciplinary action or for the convenience of the facility to control behavior. In cases where restraints are implemented based on the resident's assessment, the facility will make reasonable efforts to systematically and gradually reduce their use. II. Resident #42A. Resident status Resident #42, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and delusional disorder (false beliefs). The 6/5/25 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. She had behaviors of verbal aggression towards others. She did not have behaviors of physical aggression towards others. She did not have behaviors of wandering. She required setup and cleanup assistance with bathing. B. Resident representative interview Resident #42's representative was interviewed on 8/7/25 at 10:25 a.m. The representative said Resident #42 was doing well from a health perspective but she had been frustrated and struggling from a mental perspective at being in the facility. The representative said the resident had told her there was a situation where she left the facility and an employee led her back inside. She said Resident #42 was upset when redirected by the certified nurse aide (CNA) and she was frustrated because she could not go to the grocery store. The representative said the resident had told her that staff had been overly aggressive and she did not want to return to her normal room because the CNA was in that section of the facility. She said that ever since then, the resident did not want to leave the secured unit. The representative said staff had been trying to get her back to her room in the non-secured section of the building, but she refused. The representative said it was supposed to be a temporary placement in the memory care unit due to a transition to another state. The representative said no assessment or evaluation had been completed for the memory care unit placement and there was no written consent, only verbal. The representative said that since the secured unit placement, the resident had been fussier and more agitated. The representative said Resident #42 continued calling her to pick her up and get her out of the facility. C. Resident interview Resident #42 was interviewed on 8/5/25 at 11:47 a.m. Resident #42 said her daughter had brought her to the facility three years earlier and had told her to take a look inside and see if she liked it, but then had left her there and dumped her. She said she did not come to the facility out of her own free will and had felt people in the facility had hurt her emotionally. She said she had come to the secured unit after an incident when she wanted to be taken to the store before it closed at 7:00 p.m. to get hairspray. She said staff at the front desk had said someone would take her, but as it was getting closer to 7:00 p.m. she had become worried. She</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>(continued on next page)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure that one (#28) of ten residents out of 27 sample residents were free from chemical restraint and were receiving the least restrictive approach for their needs. Specifically, for Resident #28, the facility failed to provide adequate documentation to justify the addition of new psychotropic medications, the increase in dosage of psychotropic medications and/or the continued use of psychotropic medications. Findings include: I. Facility policy and procedure The Behavior Assessment, Intervention, and Monitoring policy, undated, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:01 p.m. It read in pertinent part, Interventions are individualized and part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent or relieve the residents distress or loss of abilities. Non pharmacologic approaches are used to the extent possible to avoid or reduce the use of psychotropic medications to manage behavioral symptoms. Psychotropic medications are prescribed for behavioral symptoms and documentation includes rationale for use, potential underlying causes of the behavior, non-pharmacological approaches and interventions tried prior to the use of the psychotropic medication, specific target behaviors and expected outcomes, monitoring for efficacy and adverse consequences, and plans (if applicable) for gradual dose reductions. II. Resident #28A. Resident status Resident #28, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with mood disturbance and major depressive disorder. The 6/18/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), wandering, delusions and physical aggression. B. Record review Resident #28's depression care plan, revised 7/10/25, revealed the resident took Sertraline (an antidepressant) related to depression with target behaviors of isolation and loss of interest in things she enjoyed. She additionally took Trazodone (an antidepressant) for insomnia. Interventions, revised 7/10/25, included to redirect, provide a quiet environment, take on a walk, reposition, offer music, offer activity of interest or provide snacks or beverages. Review of Resident #28's August 2025 CPO revealed the following physician's orders: Trazodone 50 milligrams (mg) tablet. Give one tablet in the evening for insomnia, ordered 4/15/25. Sertraline 50 mg tablet. Give one tablet a day for depression, ordered 6/16/25. Monitor for behaviors related to antidepressant medication Sertraline. 1-Isolation 2-Loss of interest in activities the resident is known to enjoy. Use non-pharmacological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/10/25. Review of Resident #28's electronic medical record (EMR), from 5/1/25 to 8/4/25, revealed the following progress notes: Between 5/1/25 to 5/30/25, there was no documentation to indicate Resident #28 exhibited any episodes of isolating or decreased interest in activities she was known to enjoy. Between 6/1/25 to 6/31/25, there was no documentation to indicate Resident #28 exhibited any episodes of isolating or decreased interest in activities she was known to enjoy. A system order note, dated 6/8/25, revealed Resident #28 was standing in her doorway when another resident walked past her and teased and laughed at her. The other resident then raised her fist at Resident #28, walked away, and then returned. At that time, the other resident hit Resident #28 in the arm and Resident #28 hit her back in the arm. Both residents were separated and redirected. Cross reference F600 for failure to protect residents from physical abuse. A depression screen evaluation note, dated 6/10/25, revealed Resident #28 participated in a depression screen and did not show any signs or symptoms of depression, with a score of zero out of nine. A system order note, dated 6/12/25, revealed another resident (same resident from 6/8/25) took a pillow out of Resident #28's room, upsetting Resident #28. Resident #28 then hit the other resident in the head and the other resident hit Resident #28 in the arm. Both residents were separated and redirected. A system order note, dated 6/16/25, revealed Resident #28 had been started on Sertraline for depression. -However, review of Resident #28's EMR failed to reveal documentation to justify the addition of the antidepressant medication or a physician's rationale for the medication. An at-risk review note, dated 6/18/25, revealed after the initiation of Sertraline, there were no noted change in behaviors. The staff were to continue to offer person-centered interventions and redirect Resident #28 from the resident she frequently had altercations with. An at-risk</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to provide residents who were unable to carry out activities of daily living (ADLs) the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (#1) of three residents reviewed out of 27 sample residents. Specifically the facility failed to -Offer repositioning to Resident #1, and;-Provide assistance with toileting for Resident #1. Findings include: I. Resident #1A. Resident status Resident #1, age [AGE], was admitted on [DATE] and readmitted [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included acute respiratory failure, irritable bowel syndrome, osteoarthritis and history of pneumonia. The 5/19/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 14 out of 15. She required substantial/maximal staff assistance with chair/bed to chair transfer with and substantial/maximal staff assistance with toileting transfers. B. Resident interview. Resident #1 was interviewed on 8/4/25 at 3:32 p.m. The resident said she was supposed to be checked every two hours because she needed help going to the bathroom. She said the nursing staff did not check on her. Resident #1 said she had to make sure she did not drink too much water so she did not go to the bathroom. C. Observations During a continuous observation on 8/5/25, beginning at 12:30 p.m. and ending at 4:12 p.m., the following was observed: At 12:33 p.m. Resident #1 was in bed eating her lunch and watching television. At 12:45 p.m. an unidentified staff member went into Resident #1's room. The staff member asked the resident if she was done with her meal and removed her lunch tray. At 12:55 p.m. Resident #1 was in bed lying on her back watching television. At 1:30 p.m. Resident #1 remained in bed lying on her back looking at a book with her television on. At 1:50 p.m. Resident #1 was in bed lying on her back watching television. At 2:15 p.m. the nursing home administrator (NHA) brought a vase of flowers into the resident's room. -However, the NHA did not ask the resident if she needed to be repositioned or use the restroom. At 3:30 p.m. Resident #1 was in her bed watching television. At 4:06 p.m. Resident #1 initiated her call light for assistance. At 4:12 p.m. certified nurse's aide (CNA) #1 and registered nurse (RN) #2 went into Resident #1's room to answer her call light. CNA #1 and RN #2 changed the resident's brief. The resident's brief was saturated with urine. There was a blue line on the outside of the brief that indicated the brief was wet. -The resident was not provided incontinence care from 12:30 p.m to 4:12 p.m. D. Record review The ADL care plan, initiated on 3/27/24 and revised on 5/28/25, revealed Resident #1 had a self-care performance deficit. Pertinent interventions included the resident required staff assistance for repositioning-However, observations revealed staff failed to offer or provide Resident #1 with repositioning for four hours (see observations above). E. Staff interviews CNA #1 was interviewed on 8/5/25 at 4:21 p.m. CNA #1 said the staff needed to check on Resident #1 every two hours. CNA #1 said he was busy and was unable to check on the resident. CNA #1 said it was important to check the residents every two hours because they may need assistance changing out of the wet brief. He said if a resident stayed in a wet brief for more than two hours, it can lead to urinary infections or skin breakdown. RN #2 was interviewed on 8/6/25 at 10:18 a.m. RN #2 said Resident #1 required staff assistance for toileting. RN #2 said it was the responsibility of the nursing staff to check on the resident every two hours to make sure she was not sitting for prolonged periods in a wet brief. The director of nursing (DON) and the NHA were interviewed together on 8/7/25 at 2:35 p.m. The DON said the nursing staff should be checking on residents who were dependent on staff for toileting assistance at a minimum of every two hours. The DON said if the staff did not stick with the two hour time frame for providing incontinence care, it could expose the resident to developing skin breakdown or urinary infections. The NHA said she would provide education to the nursing staff regarding providing the residents with according to their care plan. The NHA said adhering to the resident's care plan in regards to incontinent care to maintain skin integrity was important.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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Facility policy and procedure The CPAP/BiPAP (bilevel positive airway pressure) Support and Cleaning, Respiratory and Pulmonary Conditions policy and procedure, revised March 2015, was provided by the nursing home administrator (NHA) on 8/7/25 at 4:37 p.m. It read in pertinent part, Purpose: To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen; To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease; To promote resident comfort and safety. General Guidelines for Cleaning: These are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier of the PAP device. These guidelines are for single-resident use cleaning. Machines must be preprocessed for use between residents by the supplier of the device. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. Humidifier (if used): Use clean, distilled water only in the humidifier chamber. Clean humidifier weekly and air dry. To disinfect, place vinegar-water solution (one to three ratio) in a clean humidifier. Soak for 30 minutes and rinse thoroughly. Filter cleaning: Rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. Replace disposable filters monthly. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for five minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. Document the following in the resident's medical record: general assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure; time CPAP was started and duration of the therapy; mode and settings for the CPAP; oxygen concentration and flow, if used; how the resident tolerated the procedure; and oxygen saturation during therapy. II. Manufacturer's instructions The [NAME] Resprionics CPAP Machine cleaning instructions were provided by the NHA on 8/6/25 at 5:35 p.m. It read in pertinent part, - Daily Cleaning: Items to clean: Mask cushion, tubing (optional), and humidifier chamber (if used); Unplug the CPAP machine; Disassemble the mask - separate the cushion from the frame and headgear; Wash the mask cushion in warm water with mild, non-antibacterial soap. Rinse thoroughly. If desired, rinse the tubing with warm water (not necessary daily unless visibly soiled). Empty the humidifier chamber (if applicable), rinse with warm water, and let air dry. Air dry all parts on a clean towel - do not expose to direct sunlight. Wipe the CPAP unit exterior with a dry cloth - do not submerge or spray with water. Weekly Cleaning: Items to clean: Tubing, mask frame, headgear, humidifier chamber. Soak the tubing, mask frame, headgear, and humidifier chamber in warm, soapy water for 15-30 minutes. Rinse all items thoroughly to remove all soap residue. Hang tubing to air dry - make sure it dries completely before reconnecting. Wipe the outside of the CPAP device with a soft, damp cloth. Monthly Cleaning: Items to check/replace/clean: Air filter. Inspect the reusable pollen filter (gray foam) for dust or discoloration. Wash gently with water if reusable. Let dry completely before reinserting. If using a disposable fine filter (white), replace it monthly or as needed (do not wash). Check for signs of wear and tear on the mask, tubing, and chamber. Do Not Use: Bleach, alcohol, antibacterial soap, or harsh cleaners. Dishwasher (unless your model specifically states parts are dishwasher-safe). Direct sunlight to dry. Machine parts while wet. Replacement Schedule (General Guidelines): Mask cushion/pillows are replaced every two to four weeks; Tubing replaced every three months; Humidifier chamber replaced every six months; Filter (disposable) replace monthly; Filter (reusable foam) replace after six months (wash monthly). Full mask/headgear replaced every six months. III. Resident #8A. Resident status Resident #8, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on the right side), traumatic brain injury, cognitive communication deficit, status post fracture of right pubis (pelvis) and sleep apnea. The 5/29/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She was dependent with bed to chair transfers, toilet transfers and shower transfers. She required</p>		

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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)
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure that a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one (#42) of five residents with a documented history of trauma out of 27 sample residents. Specifically, the facility failed to identify and create a person-centered individualized care plan that addressed Resident #42's past history of trauma, and/or triggers which may cause re-traumatization and train staff on the residents trauma and triggers. Findings include: 1. Resident #42A. Resident status Resident #42, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and delusional disorder (false beliefs). The 6/5/25 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 health questionnaire (PHQ-9) assessment for depression scored zero out of 27 which indicated no depression. B. Resident representative interview Resident #42's representative was interviewed on 8/7/25 at 10:25 a.m. The representative said that Resident #42 became increasingly agitated and distressed due to staff interventions and the lack of trauma-informed care. The representative said that no assessment, evaluation or written consent had been completed to guide staff in supporting the resident's trauma history. She said that the resident refused to return to her previous room in the unsecured unit and was frustrated and upset with staff interactions. C. Resident interview Resident #42 was interviewed on 8/5/25 at 11:47 a.m. Resident #42 said her daughter had brought her to the facility three years earlier and had told her to take a look inside and see if she liked it, but then had left her there and dumped her. She said she did not come to the facility out of her own free will and had felt people in the facility had hurt her emotionally. She said she had come to the secured unit after an incident when she wanted to be taken to the store before it closed at 7:00 p.m. to get hairspray. She said staff at the front desk had said someone would take her, but as it was getting closer to 7:00 p.m., she had become worried. She said she realized the staff had no intention of taking her to the store and perceived they were laughing at her. She said she decided to walk to the store herself. She said she was not sure how it happened, but then several staff members tried to stop her and she became fearful. She said she had been told she was free to leave the facility whenever she wanted and then they would not let her. She said as a result of being fearful of staff, she asked to stay the night in an empty room and had been brought to the locked unit. Resident #42 said she felt awful about being in a place where the door would not open and she had been very unhappy in the unit. She said she had also been fearful of moving back to the other side of the building because she believed she had been physically attacked by staff when trying to go to the store. She said she was scared of some of the men on the secured unit and that they would knock on her door at night. She said there was a man who pushed on the exit door and set the alarm off all of the time. She said she could not talk to the other residents in the secured unit because they did not understand what she was saying. She said she had asked for the code to the door and had reiterated she was supposed to be able to leave whenever she wanted, but she did not know the code to the locked door. Cross reference F603 for failure to keep residents free from involuntary seclusion. D. Record review The Colorado preadmission screening and resident review (PASRR) Level II notice of determination for mental illness, dated 2/1/23, documented that Resident #42 had a PASRR condition of delusional disorder. The PASRR Level II evaluation indicated the resident had a known or suspected diagnosis of a major mental illness. The PASRR Level II identified that the resident had a history of trauma and recommended individual therapy as a specialized service. -However, Resident #42 did not have a care plan that addressed the trauma identified in the PASRR Level II, the triggers or person-centered individualized interventions to prevent re-traumatization. The social services director (SSD) updated Resident #42's care plan, during the survey on 8/5/25, and addressed the resident's preferences, triggers, and need for individualized trauma-informed approaches. New interventions included avoiding speaking with Resident #42 about her daughter unless Resident #42 brought her up, monitoring and reviewing with the resident regularly and obtaining the resident's and her representative's consent for the resident to remain in the secured memory unit as it made Resident #42 feel safe. -However, the care plan was not updated to include person-centered individualized interventions, personalized triggers or personalized signs and symptoms to prevent re-traumatization of Resident #42. The</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, and interviews, the facility failed to identify and address the behavioral health care needs of two (#45 and #32) of 10 residents out of 27 sample residents. Specifically, the facility failed to:-Develop individualized interventions related to psychotropic medications for Resident #45 and Resident #32; and,-Consistently document the non-pharmacological interventions that were attempted and/or effective for Resident #45 and Resident #32's behaviors. Findings include:I. Facility policy and procedureThe Behavior Assessment, Intervention, and Monitoring policy, undated, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:01 p.m. It read in pertinent part,Interventions are individualized and part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent or relieve the residents distress or loss of abilities.Non-pharmacological approaches are used to the extent possible to avoid or reduce the use of psychotropic medications to manage behavioral symptoms. Psychotropic medications are prescribed for behavioral symptoms and documentation includes; rationale for use, potential underlying causes of the behavior, non- pharmacological approaches and interventions tried prior to the use of the psychotropic medication, specific target behaviors and expected outcomes, monitoring for efficacy and adverse consequences, and plans (if applicable) for gradual dose reductions.II. Resident #45A. Resident statusResident #45, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included unspecified dementia and a traumatic brain injury (TBI). The 7/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to participate in the brief interview for mental status (BIMS) assessment. A staff interview for mental status revealed the resident had short and long term memory impairments and had severe impairments to her daily decision-making skills. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), physical and verbal aggression, rejecting care and wandering. The resident additionally experienced delusions. B. Resident observationDuring a continuous observation of Resident #45 on 8/5/25, beginning at 11:04 a.m. and ending at 1:24 p.m., the resident was observed pacing back and forth across the secure unit. No staff members attempted to offer any interventions to the resident to redirect her from her continuous pacing or engage with her while she paced. C. Record reviewResident #45's behavior care plan, revised 6/13/25, revealed the resident had behaviors of verbal aggression with other residents related to dementia and a history of TBI. The resident paced and wandered to the point of exhaustion, lacked awareness of others' space and would enter others' rooms, experienced paranoia, struck out at others unprovoked due to agitation, and did not get along with another female resident on the unit and would altercate with her if in close proximity. Interventions included redirecting the resident from others' space, allowing the resident to sit in chairs in the hallway, offering finger foods while pacing, engaging with the resident when passing her in the hallway, offering her sweet treats, offering the resident compliments on her appearance and offering to paint the resident's nails. Resident #45's mood care plan, revised 7/9/25, revealed the resident had a mood problem related to the disease process of dementia with behavioral disturbances. Interventions included observing for signs and symptoms of mania or hypomania, racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep and agitation or hyperactivity. Resident #45's psychosocial care plan, revised 7/22/25, revealed the resident took antipsychotic medications for agitation related to dementia with a target behavior of striking out at others. Interventions included consulting with the pharmacist and the physician to consider dosage reductions when clinically appropriate at least quarterly (initiated 1/16/25), monitoring and documenting occurrence of target behaviors symptoms and updating target behavior documentation as needed (initiated 1/16/25) and trying non-pharmacological interventions, such as one-on-one, redirect, offer food/fluids, toilet, remove from situation, activity, assess for pain, or massage/back rub (initiated 5/27/25). Review of Resident #45's August 2025 CPO revealed the following physician's orders:Rexulti (an antipsychotic medication) 1 milligram (mg) tablet. Give one 1 mg tablet one time a day for dementia with agitation, ordered 1/2/25 and increased 6/7/25.Rexulti 3 mg tablet. Give 0.5 tablet (1.5 mg) by mouth twice a day for Alzheimer's disease, ordered 6/7/25. Trazodone (antidepressant medication) 50 mg tablet. Give 75 mg at bedtime for insomnia, ordered 3/21/25. Monitor for behaviors of agitation due to dementia for Rexulti 1 Use non-pharmacological interventions 1 Refused 2</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of three units. Specifically, the facility failed to: -Ensure staff performed hand hygiene prior to providing wound care for Resident #19;-Ensure staff followed appropriate infection control guidelines for handling of wound care supplies for Resident #19; and,-Ensure staff wore the appropriate personal protective equipment (PPE) when providing incontinence care for Resident #6, who was on enhanced barrier precautions (EBP) for having an indwelling urinary catheter. Findings include: I. Failed to ensure staff performed hand hygiene prior to providing wound care and handled wound care supplies appropriately for Resident #19 A. Observations On 8/4/25 at 2:39 p.m. Resident #19's right foot was observed to be wrapped with wound dressings. On 8/6/25 at 10:26 a.m. registered nurse (RN) #4 entered Resident #19's room to complete wound care for the resident. RN #4 donned gloves and a gown prior to entering the room. -However, RN #4 failed to complete hand hygiene prior to donning the gown and gloves and before proceeding to perform the resident's wound care. On 8/6/25 at 10:27 a.m., after completing wound care for Resident #19, RN #4 dropped a partially opened package of medical gauze that was used for the resident's wound care bandages on the floor. The opened package of gauze landed upside down on the floor, with the exposed gauze touching the floor. RN #4 picked up the package of gauze and proceeded to place the package of gauze into a clean medical supply basket designated for Resident #19. -RN #4 placed contaminated medical wound dressing supplies into a clean basket of medical supplies. II. Failed to ensure staff wore the appropriate PPE when providing incontinence care for Resident #6, who was on EBP for having an indwelling urinary catheter. A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 8/10/25 from <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html</a>, It read in pertinent parts, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy, undated, was received from the nursing home administrator (NHA) on 8/6/25 at 1:49 p.m. The policy read in pertinent part, Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDRO) to residents. Enhanced barrier precautions refer to infection prevention and control interventions designed to reduce the transmission of multi drug resistant organisms during high contact resident care activities. EBP apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical device, and does not have secretions or excretions that are unable to be covered or contained. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include dressing, bathing or showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, prolonged, high contact with items in the residence room, with residents equipment, or with residents clothing or skin, device care or use including central lines urinary catheters feeding tubes tracheostomies or ventilators, and wound care. C. Observations On 8/4/25 at 2:25 p.m. there was a sign on Resident #6's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 8/4/25 at 2:39 p.m. Resident #6 was sitting on his bed. He had an indwelling urinary catheter draining yellow urine attached to his bed. On 8/7/25 at 11:12 a.m. certified nurse aid (CNA) #3 was providing</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance for one (#6) of two residents out of 27 sample residents. Specifically, the facility failed to ensure clinical signs and symptoms of an infection were identified and/or culture results were obtained prior to the administration of antibiotics for Resident #6. Findings include:</p> <p>I. Professional reference The Centers for Disease Control and Prevention's (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, dated 2019, was retrieved on 8/10/25 from <a href="https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html">https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html</a>. It read in pertinent part, Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections.</p> <p>II. Resident #6 A. Resident status Resident #6, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included congestive heart failure, anemia, hypertension (high blood pressure), benign prostate hyperplasia (BPH - an enlargement of the prostate), obstructive uropathy (a condition where urine flow is blocked, causing a backup of urine into the kidneys) and asthma. According to the 6/9/25 minimum data set (MDS) assessment, Resident #6 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required minimal assistance for showering/bathing, dressing and transferring. The MDS assessment revealed the resident was receiving an antibiotic medication.</p> <p>B. Resident interview Resident #6 was interviewed on 8/4/25 at 2:55 p.m. Resident #6 said he had a catheter because he retained urine. Resident #6 did not think he had any infections.</p> <p>C. Record review Review of Resident #6's August 2025 CPO revealed the following physician's order: Cefdinir (antibiotic) oral tablet 300 milligrams (mg). Give one tablet by mouth two times a day for urinary tract infection (UTI) for five days, ordered 8/1/25. The 7/30/25 nursing progress notes documented Resident #6 was admitted to the hospital for a urinary tract infection and discharged back to the facility the same day. Review of Resident #6's electronic medical record (EMR) revealed a urinalysis was completed during his hospital stay on 7/30/25 with results positive for a UTI and an indication for a culture and sensitivity (a two-part diagnostic procedure used to identify the cause of an infection and determine the most effective treatment). -There was no documentation in the resident's EMR to indicate the culture and sensitivity was completed, prior to the start of the resident's antibiotics.</p> <p>III. Staff interviews Registered nurse (RN) #1 was interviewed on 8/5/25 12:05 p.m. RN #1 said there was no specific monitoring or documentation that needed to be done for residents on antibiotics. RN #1 said the physician would order the antibiotic for a resident if the resident had an infection. RN #1 said the facility would send out a urine test to confirm the presence of a UTI in a resident. The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 8/6/25 at 2:00 p.m. The IP said she started in her role at the facility on 7/14/25. She said her role as IP involved monitoring infections and antibiotic use with mapping and monitoring trends. The IP said she used the McGreer's criteria when assessing a resident who may need an antibiotic. She said the McGreer's Criteria consisted of symptoms, such as burning with urination and cloudy urine, which would require a urinalysis and a culture and sensitivity to be completed before initiating antibiotic treatment. The IP said Resident #6 was the only resident who was being treated for a UTI. She said the resident was sent to the hospital and diagnosed with a UTI and started on antibiotics. The IP said the UTI was confirmed via urinalysis with a culture and sensitivity pending. The IP said she never followed up with the hospital for the culture results. The IP said because the facility did not have the culture results for Resident #6, it was possible the facility did not treat his UTI effectively. The DON said Resident #6 was started on an antibiotic in the hospital after the hospital conducted a urinalysis on the resident. The DON said the facility did not receive any documentation from the hospital regarding the results of a culture and sensitivity that was indicated. The DON said the facility should have followed up on the culture and sensitivity because the culture and sensitivity results would identify what antibiotic would most effectively treat the UTI.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for two (#19 and #7) of five residents reviewed for immunizations out of 27 sample residents. Specifically, the facility failed to offer the pneumonia vaccine to Resident #19 and Resident #7. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC), updated 2025, Recommended Immunization Schedule for Adults Aged 19 years or Older, retrieved on 8/11/25 from <a href="https://www.cdc.gov/vaccines/hcp/immz-schedules/downloads/adult/adult-combined-schedule.pdf">https://www.cdc.gov/vaccines/hcp/immz-schedules/downloads/adult/adult-combined-schedule.pdf</a>, Pneumococcal vaccination-Routine vaccination-Age 50 years or older who have not previously received a dose of PCV13 (pneumococcal conjugate vaccine), PCV15, PC20, OR PCV21 or whose previous vaccination history is unknown: one dose PCV15 or PCV20 or one dose PCV21. If PCV15 is used, administer one dose PPSV23 at least one year after the PCV15 dose (may use a minimum interval of eight weeks for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak). Previously received only PCV7: follow the recommendation above. Previously received only PCV13: one dose PCV20 or one dose PCV21 at least one year after the last PCV13 dose. Previously received only PPSV23: one dose PCV15 or one dose PCV20 or one dose PCV21, at least one year after the last PPSV23 dose. If PCV15 is used, no additional PPSV23 doses are recommended. Previously received both PCV13 and PPSV23 but no PPSV23 was received at age [AGE] years or older; one dose PCV20 or one dose PCV21 at least five years after the last pneumococcal vaccine dose. Previously received both PCV13 and PPSV23, and PPSV23 was received at age [AGE] years or older: Based on shared clinical decision making, one dose of PCV20 or one dose of PCV21 at least five years after the last pneumococcal vaccine dose. II. Facility policy and procedure The Pneumococcal Vaccine policy, revised March 2022, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:48 p.m. It read in pertinent part, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia or pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series unless medically contraindicated or the resident has completed the current recommended vaccine series. Before receiving a pneumococcal vaccine the resident or legal Representatives receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Residents have the right to refuse vaccination. If refused, appropriate information is documented in the residence medical record indicating the date of the refusal of the pneumococcal vaccination. For each resident who receives a vaccine, the date of the vaccination, Lot number, expiration date, person administering and site of the vaccinations are documented in the resident's medical record. III. Resident #19 A. Resident status Resident #19, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included atrial fibrillation (irregular heartbeat), lymphedema (swelling), hypertension (high blood pressure), dermatitis and open wound of the left lower leg. The 2/27/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required substantial/maximal assistance with toileting, personal hygiene. He required partial/moderate assistance with bed mobility and was independent with eating. The assessment did not indicate the resident was offered the pneumonia vaccine. B. Resident interview Resident #19 was interviewed on 8/4/25 at 4:07 p.m. Resident #19 said he received some vaccines years ago while living at home, but was not offered any vaccinations while living at the facility. C. Record review Review of Resident #19's electronic medical record (EMR) on 8/6/25 did not reveal documentation that the pneumonia vaccine was offered to the resident. The August 2025 CPO revealed a physician's orders for the pneumonia vaccine, ordered on 2/20/25. -However, review of the EMR failed to reveal documentation in the resident's EMR that the pneumonia vaccine was administered. IV. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic osteomyelitis (infection) in the right ankle, diabetes type 2, cirrhosis of the liver, anxiety and depression. The 7/17/25 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 10 out of 15. He was independent with toileting or personal hygiene. He required partial/moderate assistance with wound care and was independent with eating. The assessment did not indicate the resident had not been offered the pneumonia vaccine. B. Resident interview Resident #7 was interviewed on 8/4/25 at 4:18 p.m. Resident #7 said he had not received, nor was he offered any vaccines</p>		

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  08/07/2025
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)
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>(continued on next page)</p>

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  08/07/2025
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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to implement policies and procedures related to COVID-19 immunizations for two (#19 and #7) of five residents reviewed for immunizations out of 27 sample residents. Specifically, the facility failed to offer the COVID-19 vaccine was offered to Resident #19 and Resident #7. Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC), COVID-19 guidelines (revised 1/7/25), retrieved on 8/10/25 from <a href="https://www.cdc.gov/covid/vaccines/stay-up-to-date.html">https://www.cdc.gov/covid/vaccines/stay-up-to-date.html</a>. Everyone ages six months and older should get a 2024-2025 COVID-19 vaccine. The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death. It is especially important to get your 2024-2025 COVID-19 vaccine if you are age [AGE] and older, are at risk for severe COVID-19, or have never received a COVID-19 vaccine. Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine.II. Facility policy and procedureThe COVID vaccine policy, revised March 2022, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:48 p.m. It read in pertinent part,All residents will be offered COVID vaccines to aid in preventing COVID infections. Prior to or upon admission, residents are assessed for eligibility to receive the COVID vaccine series, and when indicated, are offered the vaccine series unless medically contraindicated or the resident has completed the current recommended vaccine series. Before receiving a COVID vaccine the resident or legal Representatives receive information and education regarding the benefits and potential side effects of the COVID vaccine. Residents have the right to refuse vaccination. If refused, appropriate information is documented in the residence medical record indicating the date of the refusal of the COVID vaccination. For each resident who receives a vaccine, the date of the vaccination, Lot number, expiration date, person administering and site of the vaccinations are documented in the resident's medical record.III. Resident #19 A. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included atrial fibrillation (irregular heartbeat), lymphedema (swelling), hypertension (high blood pressure), dermatitis and open wound of the left lower leg. The 2/27/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required substantial/maximal assistance with toileting, personal hygiene. He required partial/moderate assistance with bed mobility and was independent with eating.The assessment did not indicate that the resident was ever offered the covid vaccine. B. Resident interviewResident #19 was interviewed on 8/4/25 at 4:07 p.m. Resident #19 said he received some vaccines years ago while living at home, but was not offered any vaccinations while living at the facility.C. Record reviewReview of Resident #19's electronic medical record (EMR) on 8/6/25 did not reveal documentation that the COVID-19 vaccine was offered or administered to the resident. IV. Resident #7A. Resident statusResident #7, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic osteomyelitis (infection) in the right ankle, diabetes type 2, cirrhosis of the liver, anxiety and depression. The 7/17/25 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 10 out of 15. He was independent for toileting or personal hygiene. He required partial/moderate assistance with wound care and was independent with eating.The assessment did not indicate that the resident was offered the COVID-19 vaccine. B. Resident interviewResident #7 was interviewed on 8/4/25 at 4:18 p.m. Resident #7 said he did not receive, nor was he offered any vaccines while living at the facility. C. Record reviewReview of Resident #7's EMR on 8/6/25 did not reveal documentation that the COVID-19 vaccine was offered or administered to the resident. D. Staff interviewsThe director of nursing (DON) and the NHA were interviewed together on 8/7/25 at 2:35 p.m. The DON said it was the responsibility of the admitting nurse to offer, obtain consents and administer vaccinations to newly admitted residents to the facility. The DON said the facility utilized the immunization tab in the resident's EMR to document relevant historic vaccination information, such as refusals or administration of vaccinations. The DON said she remembered Resident #19 declined to receive any vaccine after it was offered to him from the facility.-However, documentation indicating Resident #19 declined the COVID-19 vaccination was not provided. The DON said she would look for additional information regarding Resident #7 vaccination status.-However, the facility did not provide additional information regarding Resident 37's vaccination status.</p>		