STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Received treatment and care in accordance with professional standards or practice out of eight sample residents. Specifically, the facility failed to:-Complete a wander risk assessment after Resident #1 had a change of condition and left the building;-Obtain physician's orders for the use of Resident #1's wanderguard; and, -Ensure Resident #1's care plan was updated with the use of a wander guard. Findings include:I. Facility policy and procedureThe Wandering and Elopement policy, revised March 2019, was provided by the director of nursing (DON) on 9/30/25 at 3:26 p.m. It revealed in pertinent part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.II. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included diabetes type I, epilepsy (seizure disorder), history of infection of the central nervous system, unspecified mood disorder, Parkinson's disease (causes tremors) and abnormal gait and movement.The 8/11/25 minimum data set (MDS) assessment revealed Resident #1 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #1 required moderate assistance with bathing and required set up assistance with lower body dressing, oral hygiene, personal hygiene and toileting. Resident #1 was able to ambulate independently. B. Facility investigationThe DON provided the facility investigation of the 9/14/25 elopement event on 9/29/25 at approximately 2:50 p.m. It revealed in pertinent part,The investigation summary documented on 9/14/25 at approximately 2:40 p.m. Resident #1 was found on the sidewalk approximately 0.5 miles from the facility by licensed practical nurse (LPN) #3, who was on break when she spotted Resident #1 outside of the facility. LPN #3 drove back to the facility to confirm Resident #1 was missing. The facility staff searched the premises to confirm that Resident #1 had eloped from the facility when they found his empty wheelchair in the front lobby. The facility was not aware Resident #1 eloped from the facility until altered by LPN #3. LPN #3 and another staff member drove back to the street where LPN #3 saw Resident #1. When attempting to assist Resident #1 into a vehicle, Resident #1 collapsed. The facility contacted emergency medical services (EMS). Per the EMS report, Resident #1 had altered mental status and a blood glucose reading of 129 milligrams per deciliter (mg/dL). EMS transported Resident #1 to the local hospital for additional evaluation. Resident #1 returned to baseline cognition in the emergency room and was transported back to the facility on 9/14/25. Upon return to the facility, Resident #1 agreed to wear a wanderguard to prevent further elopements. The investigation documented the wanderguard was applied to the resident.The investigation documented a written statement by LPN #3 on 9/14/25. LPN #3 wrote she last saw Resident #1 at 1:30 p.m. to administer a scheduled medication. LPN #3 wrote she went on break and saw Resident #1 walking down the street. LPN #3 wrote she drove back to the facility to get another staff member to help her. LPN #3 wrote they drove back to where she saw Resident #1. LPN #3 documented she attempted to assist Resident #1 to stand, but Resident #1 lost consciousness. LPN #3 documented she lowered him safely back to the ground. LPN #3 wrote she then called 911 and the assistant director of nursing (ADON). LPN #3 wrote she stayed with Resident #1 until the ambulance arrived within 10 minutes from the time she called. C. Resident interview and observationsResident #1 was interviewed on 9/29/25 at 1:50 p.m. Resident #1 said he remembered the events around his elopement from the facility a few weeks prior to the interview. He said he could not remember why, but that he got up from his chair and began walking. He said he did not know why he was confused at the time and did not know why he decided to leave the facility. He said he did not remember how, but he was found by a staff member from the facility sitting next to a post down the street. Resident #1 said he remembered the facility staff shaking him to get him to wake up. Resident #1 said the staff member tried to help him stand up but he was too weak. Resident #1 said an ambulance arrived to help him up and he went to the hospital. Resident #1 said when he was first found and aroused by the staff member he was not able to answer any questions but he was able to speak normally in the emergency room. He said the emergency room doctor told Resident #1 it appeared he had a seizure. Resident #1 said since returning to the facility, the facility put a wanderguard bracelet in case he became confused and began to wander again. Resident #1 said he approved of the intervention since he still did not know what caused the change in behavior and did not want to get injured if he was confused. Resident #1 said he thought staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from accidents or hazards for three (#2, #5 and #3) of eight residents reviewed out of eight sample residents. Specifically, the facility failed to:-Implement interventions to prevent an elopement for Resident #2 and;-Implement fall interventions for Resident #5 and Resident #3.Finding include: I. Elopement failures A. Facility policy and procedure The Wandering and Elopement policy, revised March 2019, was provided by the director of nursing (DON) on 9/30/25 at 3:26 p.m. It revealed in pertinent part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. B. Resident #2 1. Resident status Resident #2, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician's orders (CPO), diagnoses included unspecified sequelae of cerebral infarction (complications from a stoke), epilepsy, type 2 diabetes mellitus without complication, unspecified dementia with unspecified severity, major depression depressive disorder, lack of coordination, abnormalities of the gait and mobility, personal history of a transient ischemic attack (TIA) and cerebral infarction (stoke) without residual deficit. The 8/4/25 minimum data set (MDS) assessment identified Resident #2 had a short and long term memory problem with a staff assessment for mental status and had some difficulty with new situations per staff assessment. The MDS assessment indicated Resident #2 had wandering behaviors and verbal behavioral symptoms directed at others. According to the assessment, Resident #2 was independent in mobility with use of his wheelchair. 2. Resident observations and interview Resident #2 was smoking in the outside courtyard on 2/29/25 at 2:35 p.m. Resident #2 did not have a wanderguard attached to his wheelchair or wore a wanderguard bracelet. He said he had no concerns with the facility and was not planning on leaving. 3. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's comprehensive care plan did not identify he was at high risk for elopement and had an actual elopement. The care plan did not include interventions to prevent a recurrence of an elopement. The cognition care plan, revised 5/2/25, documented Resident #2 had impaired cognitive function or impaired thought processes related to dementia. The smoking care plan, revised 8/11/25, documented Resident #2 was an unsupervised smoker. The intervention, revised 5/8/25, directed staff to supervise the resident when smoking. -The smoking care plan documented the resident was both an unsupervised and a supervised smoker. The care plan did not clearly identify the level of supervision needed after smoking supervision was identified as a safety intervention due to the resident's 7/8/25 elopement. The 6/10/25 quarterly risk for elopement/wandering assessment documented Resident #2 was a low risk for elopement. The 7/8/25 missing person report documented Resident #2 had poor safety awareness, had difficulty making his needs known, a diagnosis of dementia and mobilized wheelchair independently. The report documented Resident #2 was missing from the facility for 45 minutes. He left the facility out the front door and wheeled himself to his representative's place of employment, three blocks away. The report indicated the wanderguard bracelet was placed on the resident wheelchair and he was put on supervised smoking. The 7/8/25 behavior note documented Resident #2 left the facility without staff knowledge and went to his representative's business. The resident was brought back to the facility by the POA. According to the behavior note, the resident was assessed and had no injuries as a result of the elopement. The note identified he was using inappropriate language and striking out at the representative and staff when he was returned to the facility. The resident's physician was notified and placed an order for Hadol (antipsychotic medication) to calm Resident #2. The note documented a wanderguard was put in place for his safety. The facility investigation for Resident #2's 7/8/25 elopement was provided by the DON on 9/29/25 at approximately 2:50 p.m. The investigation documented Resident #2 was last seen at the facility on 7/8/25 at 11:00 a.m. and brought back to the facility by his representative at 11:45 a.m. The representative informed the facility that Resident #2 had self propelled himself to her place of business and she had to assist him back to the facility in his wheelchair. The investigation documented Resident #2 said he went out the front door because he was upset at his representative and wanted the representative to take him home. Review of the July 2025 CPO revealed a wanderguard/alert device for underneath Resident #2's wheelchair, start date 7/8/25, identified the resident's wanderguard was discontinued on 7/25/25. The September 2025 treatment administration record (TAR) did not identify Resident #3 was monitored for behaviors of elopement, exit seeking or wandering. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/10/25 quarterly risk for elopement/wandering assessment documented Resident #2 was at a high risk for elopement related to leaving the facility unsupervised, cognition, diagnosis, impaired vision, hearing and/or communication, an expressed desire to go home, and the responsible party expressed concern of the resident leaving the facility. Review of the 9/10/25 quarterly assessment identified Resident #2 had an increased risk for elopement compared to the June 2025 elopement assessment indicating the resident was at a low risk for elopement. 4. Staff interviews Certified nurse aide (CNA) #4 was interviewed 10/30/25 at approximately 10:10 a.m. She said for residents with a wanderguard who were too close to the door, she would encourage them to move away from the door. She said if the residents left the facility, she would follow them. She said she usually worked on another unit and was not aware of who had elopement precautions off the memory care unit. CNA #3 was interviewed on 9/30/25 at 10:20 a.m. CNA #3 said if Resident #2 was seen by the front door, she would redirect him. She said Resident #2 did not have a wanderguard. CNA #1 was interviewed on 9/30/25 at 10:25 a.m. She said she had residents that were at risk for elopement wore a wanderguard on their ankle or wheelchair. She said if a wanderguard triggered the door alarm, she would check the door and redirect the resident. She said there were a few residents that would say they want to go home but they were not a risk for elopement but checked in on them. Licensed practical nurse (LPN) #2 was interviewed on 9/30/25 at 10:34 a.m. LPN #2 said when residents were expressing an interest to leave the facility, she would make sure their needs were met and try to decrease their escalated behaviors. She said residents' interventions were identified in the care plan and tracked in the treatment administration record. She said residents that were at risk for elopement wore a wanderguard. She said she was not concerned about any other residents attempting to elope that did not have a wanderguard. LPN #2 said she did not Resident #2 would try to elope again because he has been happy. She said she had heard Resident #3 wanted to leave the facility but she did not think he had the physical ability. She said the staff tried to make him comfortable and de-escalate his behavior. The DON was interviewed on 9/30/25 at approximately 11:00 a.m. She said when residents were admitted to the facility they were assessed for elopement risk. She said residents were reassessed when they start showing signs of exiting seeking, packing or other related behaviors. She said the facility then evaluates if the resident needs to be placed on the secured memory unit or have a wanderguard. She said a wanderguard was often placed resident when the resident was exiting seeking and not redirectable and/or eloped. The DON said Resident #2 no longer has a wanderguard because the staff spoke to him and his representative. The DON said Resident #2 agreed to not leave the facility again. She said he has not attempted to leave the facility again since his July 2025 elopement. She said in the past when he was upset he tended to go to the front door and was difficult to redirect. She said he used to have a wanderguard around the time he first admitted when he had prior elopement attempts. She said just before the 7/8/25 elopement, he seemed to be more calm in his behavior. The DON said he still would get angry but he was not going to the door like he did before. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said after his 7/8/25 elopement, the facility had not made changes to his care plan other than unsupervised smoking. She said the staff have not recently noticed him exit seeking when he was upset. The DON said Resident #2 was not exit seeking just before his elopement but would spend time near the front door. The DON said they would start him on 15-minute checks to make sure the situation did not happen again. She said a couple years back he had a wanderguard in place for a while because he was very angry and had difficulty adjusting to the facility. She said prior to his elopement in July 2025, he was calm but then became upset with his representative and went to her work. CNA #2 was interviewed on 9/30/24 at 4:32 p.m. CNA #2 said Resident #2 was independent with smoking and does not require supervision outside. She said he had left the facility a couple times. She said Resident #2 did not tell anyone he was planning on leaving but just left. CNA #2 said he was upset with his POA because she had not brought his snacks to him. She said it was routine for him to become upset with his POA and staff. She said he had not left the facility since July 2025 but will still get angry. She said so she tries to watch him closer when he is upset so he does not go out the door CNA #2 said he had a wanderguard after he elopement in July 2025. She said the wander guard was temporary and she did not know why it was discontinued. LPN #1 was interviewed on 9/30/25 at 4:26 p.m. LPN #1 said Resident #2 had a temporary wanderguard but had since been discontinued because he had a verbal agreement with the facility not to elope again. He said the staff monitors where he was but not with formal documentation. The activity director (AD) was interviewed on 9/30/25 at 4:42 p.m. The AD said Resident #2 was an unsupervised smoker. The social service director (SSD) was interviewed on 9/30/25 at 4:04 p.m. She said she was aware that Resident #2 was not on a wanderguard because he verbally agreed not to leave the facility again. She said she was not involved with the details of the verbal agreement. She said she was more involved with the team on trialing him with unsupervised smoking in the courtyard. She said Resident #2 and his representative have been informed that if Resident #2 tried to leave the facility again without staff acknowledgement, then he would be placed on supervised smoking. She said she was not concerned that he would try to leave the courtyard because he left out the front door in July 2025 and the courtyard had a lock on the gate that he could not reach. II. Fall prevention failures A. Facility policy and procedure The Falls - Clinical Protocol policy, revised September 2012, was provided by the DON on 9/30/25 at 3:26 p. m. It revealed in pertinent part, The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). B. Resident #5 1. Resident status Resident #5, age greater than 65, was admitted on [DATE] and discharged [DATE]. According to the September 2025 CPO, diagnoses included end stage heart failure, schizophrenia, chronic obstructive pulmonary disorder (COPD), pulmonary embolism and generalized muscle weakness. Resident #5's referral document, completed 9/22/25 documented Resident #5 had intermittent and increasing confusion, increased weakness and falls at home prior to admission to the facility. The referral documented the resident had baseline supplemental oxygen needs of 1-2 liters per minute via nasal cannula for air hunger. The referral documented the resident was a high fall risk. 2. Resident representative interview Resident #5's representative was interviewed on 9/30/25 at 9:09 a.m. The representative said Resident #5 was admitted to the facility because he fell multiple times at home and needed more supervision. She said she visited him most days he was at the facility and she felt he was not checked on frequently for safety even though he was a high fall risk. She said Resident #5 was confused, impulsive and did not use his call light for help. The representative said she received a phone call from the facility nursing home administrator (NHA) sometime in the afternoon on 9/24/25. She said she was told Resident #5 pulled out his own foley catheter and hit his head on the nightstand. She said she went to visit him and a staff member told her Resident #5 fell after he slipped in his urine when he pulled his foley catheter out. The representative said she also found Resident #5 on the floor on 9/26/25 at approximately 10:00 p.m. She said she went to visit him and had to alert staff that he fell again and was on the floor. The representative said after the second fall on Friday she asked the facility to put the fall mat in place, however the fall mat was leaning against the wall the next morning on 9/27/25. She said on the morning of 9/27/25, Resident #5 was no longer responding to her voice and was rocking back and forth. The representative said she requested Resident #5 go to the hospital. She said Resident #5 passed away in the hospital on 9/28/25. 3. Record review The progress note, dated 9/23/25 at 9:35 p.m., documented Resident #5 had impulsive behavior and dizziness. The progress note documented Resident #5 insisted on leaving or getting up but was unable to state why or where he was going. The progress note documented Resident #5 was at high risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress note, dated 9/24/25 at 6:00 p.m., documented the resident was admitted under comfort care and the facility was still completing baseline assessment. The progress note documented Resident #5 was not cooperative in keeping the nasal cannula in his nose for proper oxygenation and did not use the call light. The progress note documented if Resident #5 did not receive his as needed (PRN) morphine, then Resident #5 experienced air hunger and increased anxiety which caused him to try and ambulate unassisted, increasing the risk of falls. The progress note documented earlier in the afternoon, the day nurse reported Resident #5 was very agitated and ripped out his own Foley catheter because he needed to pee. The progress note documented a catheter was placed, PRN medication was administered and seemed to be effective on the follow up assessment. The progress note documented the nurse spoke to the resident representative about giving the morphine more consistently, but the resident representative did not want it given unless absolutely necessary because she wants him more alert so he's able to eat more and socialize. On 9/30/25 at approximately 10:00 a.m., two internal fall reports regarding Resident #5 were provided by the DON. They revealed in pertinent part, The fall report, dated 9/24/25 at 12:30 p.m., documented Resident #5 was found in bed with a new skin tear to his forehead. The fall report documented the resident was alert and oriented to person, place and situation, but disoriented to time. The fall report documented Resident #5 told staff he got up to go somewhere but could not recall where and fell backward onto the bed, hitting his head on the footboard of the bed. The fall report documented multiple predisposing factors contributing to the fall including confusion, gait imbalance, changes in cognition, recent illness and changes in medication. The fall report documented if Resident #5 did not receive PRN Morphine, then Resident #5 would have increased air hunger and anxiety causing Resident #5 to ambulate without assistance. -However, the fall report did not document if Resident #5 was wearing supplemental oxygen at the time of the fall, and review of vital signs and neurological checks completed after the fall do not include documentation of oxygen saturation. The fall report, dated 9/26/25 at 8:00 p.m., documented Resident #5 was found on the floor of his room by his resident representative. The fall report documented Resident #5 was unable to recall how the fall occurred. The fall report documented Resident #5 had no new injuries on assessment, but appeared anxious and confused. The fall report documented the resident was lethargic, disoriented to time, place, and situation. -However, the fall report did not document if Resident #5 was wearing supplemental oxygen at the time of the fall and review of vital signs, and neurological checks completed after the fall do not include documentation of oxygen saturation. Review of Resident #5's care plan, initiated 9/23/25 and revised on 9/24/25, revealed Resident #5 had a focus on risk for falls due to his decreased mobility and terminal illness. Interventions included anticipating resident needs, ensuring the resident was wearing appropriate footwear when ambulating, education to resident, family, and caregivers about safety reminders, ensuring the call light was within reach and providing a safe environment free from spills or clutter with personal items within reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's September 2025 CPO revealed no orders for supplemental oxygen. Additionally, review of daily vital signs for Resident #5 revealed missing documentation of oxygen saturation on 9/26/25. 4. Staff interviews CNA #1 was interviewed on 9/30/25 at 2:05 p.m. CNA #1 said she took care of Resident #5 while he resided at the facility, but could not recall the dates. CNA #1 said Resident #5 was confused, agitated and unable to follow directions. CNA #1 said she knew Resident #5 was on hospice, but was not aware Resident #5 had multiple falls in the facility and did not remember any specific fall interventions for Resident #5. CNA #1 said she was not aware Resident #3 expressed any desire to leave the facility and she was not aware Resident #3 was at risk for elopement. LPN #1 was interviewed on 9/30/25 at 1:57 p.m. LPN #1 said he took care of Resident #5 the night shift of 9/24/25. LPN #1 said he was aware Resident #5 fell earlier in the day but did not remember if Resident #5 had any injuries from the fall or from pulling out his own catheter. LPN #1 said he did remember Resident #5 wore supplemental oxygen via nasal cannula, but LPN #1 said he did not remember how much oxygen and he did not remember if Resident #5 had orders for oxygen. LPN #2 was interviewed on 9/30/25 at 3:37 p.m. in Resident #3's room. LPN #2 confirmed no sign to remind Resident #3 to call for assistance was hanging in Resident #3's room. LPN #2 said she remembered seeing the sign in his room previously. LPN #2 said Resident #3 changed rooms recently and she thought the sign was not put back up in the new room. LPN #2 said she planned to print out and hang a new sign for Resident #3. The DON was interviewed on 9/30/25 at 2:26 p.m. The DON said she met with Resident #5's representative almost daily while Resident #5 was at the facility. The DON said they rushed the referral process for Resident #5. She said Resident #5 wanted to leave the hospital and return home despite multiple falls and hospitalizations when he lived at home. The DON said Resident #5 was confused and agitated upon admission. The DON said Resident #5 required convincing to stay in the facility on the first day. The DON said they had a fall mat in place for small period of time after the first fall, but during IDT review on 9/25/30, they felt it was not a good intervention since Resident #5 refused to wear shoes or non slip socks. She said the floor mat would be an obstacle. The DON said she thought Resident #5 wore 3 L of supplemental oxygen, but she did not know why no oxygen order was entered into the CPO. The DON said air hunger increased Resident #5's anxiety and restlessness. The DON said she was not sure why there was no documentation of oxygen saturation on 9/26/25, the day the second fall occurred. The DON confirmed that the paper documentation of vital signs and neurological checks completed after each of his falls did not include a space to document oxygen saturation. The DON said she planned to change the paper form to include documentation of all vital signs. The DON was interviewed again on 9/30/25 at 5:15 p.m. The DON said Resident #3's ability to transfer independently fluctuated daily and most days he was able to transfer himself safely. The DON said the reminder sign placed in Resident #3's room in March 2025 was probably lost when he moved closer to the nurses' station. The DON said she planned to review with risk for falls care plan and ensure all of the interventions were in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #3 1. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included Huntington's disease (a progressive disorder that causes involuntary movements, cognitive decline, and psychiatric symptoms), major depressive disorder, shortness of breath, chronic obstructive pulmonary disease with acute exacerbation, generalized muscle weakness, lack of coordination, unspecified abnormalities of the gait and mobility, essential tremor and unspecified dementia with unspecified severity. The 7/24/25 MDS assessment revealed Resident #3 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. According to the MDS assessment, Resident #3 used a wheelchair for mobility and required partial to moderate assistance to transfer from surface to surface. The MDS assessment identified the resident has had multiple falls since his admission to the facility. The assessment did not identify he had rejections of care behaviors. 2. Observations and resident interview On 9/30/25 at 9:05 a.m. Resident #3 propelled his wheelchair with his feet to his room from the dining room. -Resident #3 was not escorted to his room as indicated in his care plan (see below). At 9:13 a.m. Resident #3 self-transferred himself from his wheelchair to his bed. Resident #3 did not push his call light on to request for help or lock his wheelchair breaks before he transferred. He said he usually transferred himself to bed. -Resident #3 was not escorted to his room as indicated in his care plan. At 11:56 a.m. Resident #3's room was observed and there was not a sign in his room reminding him to call staff for assistance prior to self-transferring. 3. Record review The fall care plan, revised 3/27/25, identified Resident #3 was at risk for falls related to Huntington's disease, weakness and decreased mobility. According the care plan, Resident #3 had a history of falls. The care plan revealed he had four unwitnessed falls between January 2025 and March 2025. Pertinent interventions included staff to anticipate and meet Resident #3's needs (7/23/19), staff was educated to provide Resident #3 contact guard during ambulation and transferring into chairs (5/2/19), Resident #3 used a wheelchair and directed staff to escort Resident #3 to and from meals for safety related to his unsteadiness and Huntington's disease for his safety (9/23/24); directed staff to place a sign in his room to remind him to call for staff assistance with increased unsteadiness (10/2/24) and staff to replace a visual cue/sign in the resident's room to help remind him to call for assistance (initiated 1/13/25 and revised 3/27/25). -There was no evidence indicating the facility reviewed the resident's fall care plan to ensure current interventions remained appropriate after Resident #3's 8/14/25 fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandrock Ridge Care & Rehabilitation	943 W 8th Dr Craig, CO 81625

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/15/25 health status note documented Resident #3 fell on the previous shift (8/14/25) without injury. The 8/14/25 fall investigation was provided by the director of nursing (DON) on 9/30/25 at approximately 10:00 a.m. The investigation identified Resident #3 had an unwitnessed fall on 8/14/25 at 4:15 p.m. He was found in his room sitting on the wet floor. The investigation indicated Resident #3 said he was incontinent and sat down on the floor to change. The investigation identified incontinence and self ambulating without assistance were factors of the fall. According to the investigation, Resident #3 did not use his call light when he tried to ambulate to the bathroom. -Review of the provided fall documentation did not identify the resident's fall interventions were reviewed to ensure the interventions remained appropriate after Resident #3's 8/14/25 fall. 4. Staff interviews The DON was interviewed on 9/30/25 at approximately 11:00 a.m. The DON said Resident #3 last fall was related to urine on the floor. She said he should be monitored for taking himself to the bathroom. She said staff were now going into his room to check on him which had decreased his fall risk.