STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065394	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bruce McCandless CO State Veterans Nursing Home	903 Moore Dr Florence, CO 81226

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to provide a safe environment and protect residents from resident-to-resident abuse, involving nine of ten residents reviewed (#15, #3, #68, #27, #70, #46, #6, #50 and #59) out of 33 sample residents. Record review and staff interviews revealed Resident #68, significantly cognitively impaired and with a history of trauma, was the victim of four incidents of resident-to-resident physical abuse (11/8/25, 11/25/25 (twice) and 12/3/26).The abusive incidents contributed to the resident being physically abused (shoved, pushed, grabbed, and hit in the face and head), and sustaining physical harm (abrasions, facial contusions) and psychosocial harm (fear, anxiety, agitation, distress (crying). Record review revealed additional incidents of resident-to-resident abuse (hitting, shoving, threats of harm) involving Residents #50, #3, #15, #59, #46 and #6. Record review revealed that facility staff and administration failed to put effective interventions in place to prevent repeated incidents of resident-to-resident abuse. Primary interventions - separating the residents and increasing levels of supervision - were known to be ineffective and not reassessed. New interventions, individual and systemic, were not considered to protect the residents from further abuse, although staff interviews and observations indicated staffing and lack of communication among staff were potential unaddressed factors in the repeated incidents. Record review further revealed that despite documentation in the facility investigations that described the resident-to-resident incidents as deliberate, and for Resident #68 harmful, the facility failed to substantiate the incidents as abusive, limiting its investigation and ability to correct the behavior to prevent further abuse. The facility's failures above created a situation for serious harm if not immediately corrected. I. IMMEDIATE JEOPARDY A. Findings of immediate jeopardy Record review and staff interviews revealed Resident #68, significantly cognitively impaired and with a history of post traumatic stress disorder (PTSD) from a prior long term abusive relationship, was the victim of four incidents of resident-to-resident physical abuse (11/8/25, 11/25/25 (twice) and 12/3/26).The abusive incidents contributed to the resident being physically abused (shoved, pushed, grabbed, and hit in the face and head), and sustaining physical harm (abrasions, facial contusions) and psychosocial harm (fear, anxiety, agitation, distress (crying). - Interviews and record review revealed that facility staff and administration did not ensure interventions put into place, such as one-on-one staff supervision for Resident #68, were put into place consistently to prevent repeated physical abuse, including two incidents within eight days involving Resident #68 and Resident #6. Record review further revealed additional incidents of resident-to-resident physical abuse (hitting, shoving, threats of harm) involving Residents #50, #3, #15, #59, #46 and #6. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review revealed that facility staff and administration failed to put effective interventions to prevent repeated incidents of resident-to-resident abuse in place. Primary interventions - separating the residents and increasing levels of supervision - were known to be ineffective and not reassessed. New interventions, individual and systemic, were not considered to protect the residents from further abuse. Observations and staff interview revealed line of sight observation was unmanageable by staff to prevent wandering and additional agitation that could have led to further physical abuse incidents. The facility's failures above created a situation for serious harm if not immediately corrected. On 1/28/26 at 2:08 p.m. the facility's nursing home administrator (NHA) was notified that the failure to recognize and protect residents from resident-to-resident abuse created an immediate jeopardy situation. B. Facility plan to remove immediate jeopardy On 1/28/26 at 4:00 p.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: Immediate Action: Identification of residents affected or likely to be affected: All residents who reside in the secured neighborhood were identified as being at risk of being affected by the deficient practice on 1/28/2026. The facility took the following actions to address the citation and prevent any additional Residents from suffering an adverse outcome: 1. Evaluated Staffing patterns a. Added a dedicated activities professional to support staff and residents seven days a week starting on 1/28/2026. b. Starting on 1/28/2026 during both shift changes, a nursing supervisor will be present as well as having one CNA specifically assigned to monitor the floor allowing the nurse and other certified nurse aides (CNA) to complete the shift report. c. Staff working in memory care may call for assistance at any time to the following in order: 1. Nursing shift supervisor 2. Assistant Director of Nursing 3. Director of Nursing 4. Nursing Home Administrator. d. Starting on 1/28/2026, staff education will be completed for all staff who work on the secured neighborhood prior to their next shift, and all other facility staff within the next seven days, on the following: 1. Relias training: Behavioral and Communication Approaches in Dementia Care, Dementia Care: Behavioral Challenges - Physically Abusive Residents, Dementia Care: Behavioral Challenges - A (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	leadership team member will be assigned to validate that these 4 trainings have been completed via the certificate of completion. Systemic Changes: 1. Memory Care Unmet Need assessment to be completed by CNA or nurse hourly on residents who have been involved in physical aggression towards other residents in the last 90 days. a. Results of these rounds will be reviewed by the social worker/interdisciplinary team to determine any trends and identify if new interventions need to be developed and care planned for the next 15 days. b. In person training for all staff to be conducted 2/5/2026 to include: Dementia Education, Activity Planning in Dementia Units , Secure Memory Care, updates to staffing (Dedicated Activity Staff in Four Seasons Trail), and process for completing Memory Care Unmet Need forms will be provided by social service staff where staff will receive a copy of the policies, be given the opportunity to ask questions for understanding and will sign and date a staff inservice record. c. Starting at the next new employee orientation on 2/2/2026, new hire staff will be provided the following education both in person and electronically prior to working the floor: Relias training: Behavioral and Communication Approaches in Dementia Care, Dementia Care: Behavioral Challenges - Physically Abusive Residents, Dementia Care: Behavioral Challenges. -A leadership team member will be assigned to validate that these four trainings have been completed via the certificate of completion. d. Dementia Education, Activity Planning in Dementia Units , Secure Memory Care will be provided by social service staff where staff will receive a copy of the policies, be given the opportunity to ask questions for understanding with the social service staff and will sign and date a staff inservice record. Monitoring: a. Social work staff will complete random rounds two times a day Monday - Friday and nursing supervisors will complete rounds two times a day on Saturday-Sunday to review effectiveness of interventions and determine if new interventions need to be implemented as well as provide staff support starting 1/29/2026. Social services will document findings on morning meeting agenda related to staff and Resident feedback and report out at the following morning meeting. b. The Administrator implemented a QAPI PIPs for Abuse prevention intervention and effectiveness and Staff Education monitoring. Findings will be reported at the monthly QAA meeting for a minimum of three months. C. Removal of immediate jeopardy On 1/28/26 at 6:00 p.m. the NHA was notified that based on review of the facility plan and observations, the immediate jeopardy situation had been abated. However, deficient practice remained at a G level, actual harm, isolated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	II. FAILURE TO PROTECT RESIDENTS #3, #50, #68, #15, #59, #70, #6, #27 and #46 FROM RESIDENT-TO-RESIDENT ABUSE I. Incident of physical abuse on 10/21/25 between Resident #50 and Resident #3 A. Facility investigation of physical abuse by Resident #3 toward Resident #50 Incident 10/21/25 Resident #50 entered the dining room to play an activity and Resident #3 was sitting in a spot Resident #50 believed to be her spot. Resident #50 tapped Resident #3 on the shoulder and said mister. Resident #3 did not hear her or respond. Resident #50 then tapped him on the arm twice more and Resident #3 then proceeded to smack her on the right side of her face with the back side of his hand. Resident #50 then smacked him on his right arm twice in defense and Resident #3 then smacked her again on the right side of her face with the back of his hand. Resident #50 left the dining room. Following the incident, the residents were separated and each assessed for injury with none being noted.Resident #50 went out to smoke. Resident #3 was directed to the nurses' station. The residents were interviewed and placed on 72 hour monitoring. Resident #50 was interviewed by staff and she reported that she had gone down to the dining room early to get her spot for the activity and the other resident was sitting there. She attempted to get his attention but was unsuccessful and then tapped his arm. The other resident then smacked her in the face with the back of his hand. The other resident was then moved to another table. Resident #3 was interviewed by staff and said he did not recall the event. Record review further revealed that despite documentation in the facility investigation that Resident #3 deliberately smacked Resident #50 twice in the face, the facility failed to substantiate the incident as abusive. In not substantiating the incident as resident-to-resident abuse, the facility limited its investigation and ability to correct the behavior to prevent further abuse. B. Residents 1. Resident #3 (assailant) Resident #3, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included Alzheimer's disease and cerebral infarction. Resident status: The 10/31/25 minimum data set (MDS) assessment documented the resident was never/rarely understood and had a memory problem. He required substantial/maximal assistance with bathing, dressing, hygiene and transfers. It was documented that Resident #3 had physical behavioral symptoms directed towards others one to three times weekly and he had verbal behavioral symptoms one to three times weekly. Resident #3's behavior care plan, initiated 5/7/25 and revised 11/6/25, documented that Resident #3 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	exhibited sun-[NAME] type of behaviors related to his diagnosis of Alzheimer dementia with agitation. These behaviors occurred regularly in the evenings around 4:00 p.m. Per family, advise staff that when Resident #3 verbalizes to be left alone to heed the warning. Interventions included administer antipsychotic medications, anticipate Resident #3's needs, explain all procedures to Resident #3 before starting, intervene as necessary to protect the rights and safety of others, offer tasks, monitor behavior episodes and determine underlying causes and provide activities. -The care plan was not updated following the 10/21/25 incident with Resident #50 until 11/6/25. Behavior, nurse and progress notes following the incident: A behavior note, dated 10/23/25, revealed that the resident was agitated through the evening, however, no aggression toward peers or staff. A nurse's note, dated 10/30/25, revealed that the resident attempted to hit the registered nurse (RN) when attempting to take his blood pressure. -Progress notes dated 10/21/25 to 10/30/25 failed to reveal what interventions were attempted and implemented to prevent a recurrence other than seven day monitoring. 2. Resident #50 (victim) Resident #50, age [AGE], was admitted on [DATE]. According to the January 2026 CPO, diagnoses included hemiplegia and hemiparesis (paralysis to one side of the body) following a cerebral infarction (restricted blood flow to the brain) affecting the right dominant side and muscle weakness. Resident status: The 1/2/26 MDS assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set up assistance for toileting, dressing and hygiene and was independent for transfers. Progress, follow up notes, and care plan: The nursing progress note from 10/21/25 at 2:34 p.m. documented that the resident stated she was going into the dining room to play pokerino and there was a man she didn't know sitting in her spot. She attempted to say Hi sir but he did not hear her or respond. She tapped him on his arm. The male resident proceeded to smack her on the right side of her face with the back side of his hand. She stated that she smacked him in the arm in defense and he smacked again on the right side of her face. She then left the situation to go have a cigarette. The residents were both removed from the dining room. Resident #50 was assessed and had no injury to the area at this time. She mentioned being scared of the male resident and stated she would avoid him. A 72 hour follow up note, dated 10/21/25, revealed that the resident had an altercation with another resident and she was assessed for injuries. The resident's behaviors would be monitored for the following seven days A nursing note from 10/22/25 at 6:13 a.m. documented that Resident #50 expressed, What happened to me today has me really upset. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing note from 10/23/25 at 2:13 p.m. documented that the resident reported she was fearful toward her neighbor (the assailant) and would avoid him. Resident #50's behavior care plan, initiated 10/24/25, documented that Resident #50 did not accept the concept of open seating during meals and activity programs and would demand that her peers move to another location despite there being an open seating policy. Interventions included assisting Resident #50 to develop more appropriate methods of coping and interacting with peers regarding open seating options, encouraging Resident #50 to seek staff assistance prior to approaching other residents, discuss Resident #50's behaviors and intervene as necessary to protect the rights and safety of others. C. Resident and Staff interviews Resident #50 was interviewed on 1/25/26 at 5:22 p.m. She said a couple months ago, she tapped another resident on the shoulder to get his attention and he turned around and smacked her across the face. She said she was still fearful of him and avoided him in the common areas. She said after the incident occurred, she was told that the resident who hit her was talked to. She said she was unsure of any other interventions in place to keep her safe. Registered nurse (RN) #1 was interviewed on 1/27/26 at 10:45 a.m. She said she was made aware of the incident between Resident #50 and Resident #3 and completed some of the follow-up monitoring. She said this included skin assessments to make sure Resident #50 did not have any bruising and completed the 72 hour monitoring for behaviors. She said she did not recall Resident #50 having any changes in her behaviors after the incident. Certified nurse aide (CNA) #3 was interviewed on 1/28/26 at 8:47 a.m. She said Resident #50 did not have any behaviors or make false accusations. She said she was aware of the physical altercation with Resident #50 and said that Resident #50 did not change her behavior after the incident. CNA #1 was interviewed on 1/28/26 at 9:00 a.m. She said Resident #3 had verbal and physical aggressive behaviors with staff. She said she had not seen him aggressive towards other residents. She said his behaviors were worse when he was woken up in the morning and in the evening. She said that when he had behaviors, she would offer him a soda and let him have space. RN #4 was interviewed on 1/28/26 at 9:15 a.m. She said Resident #3 had increased behaviors in the evening time. She said his behaviors were directed toward staff and she had never seen his behaviors directed toward residents. She said he was verbally aggressive. The social services director (SSD) was interviewed on 1/28/26 at 4:30 p.m. She said it was determined that Resident #50 was free from fear and mental anguish based on reviewing the progress notes, offering her counseling which she declined and updating her care plan with interventions to prevent it from occurring again. CNA #7 was interviewed on 1/27/26 at 1:31 p.m. She said she was present for but did not witness the occurrence on 10/21/25 between Resident #3 and Resident #50. She said that Resident #50 reported to her that Resident #3 hit her in the face and refused to move out of the chair she believed was hers. She said that Resident #50 did not express fear or distress. An activity aide (AA) was interviewed on 1/27/26 at 1:35 p.m. She said she had left the dining room (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	where the activity was taking place to put some dishes away and when she returned, Resident #50 said that Resident #3 had hit her. The AA said that Resident #50 did not express fear or distress but was instead angry. The NHA was interviewed with the social services director (SSD) and the social services assistant (SSA) on 1/27/26 at 1:58 p.m. She said regarding the incident on 10/21/25 between Resident #3 and Resident #50, it was determined through staff interviews that the root cause was that Resident #3 had been sitting in a spot that Resident #50 had unofficially decided was her spot and this made her upset. The NHA said the interventions put into place were to educate Resident #50 to ask for staff assistance and educate her that seating during activities is a first come and first serve designation. She said both residents were monitored for 72 hours, skin assessments were provided, Resident #3 was put on 15 minute checks and Resident #50's care plan was updated to include territorial behavior during activities. II. Incident of physical abuse on 11/8/25 between Resident #70, #68, #15, and #59. A. Facility investigation of physical abuse by Resident #70 toward Residents #68, #15, and #59 Incident 11/8/25 The incident between Resident #70 and Residents #68, #15, and #59 occurred in the resident rooms on the secure memory care unit where all four of the residents resided. Resident #70 had awoken at around 4 am and went into other residents' rooms and was waking them up to kick them out of his home. Resident #70 attacked three residents and two staff. He went into Resident #68's room and shoved her, making her cry. He then went into Resident #15's room and shoved him while he was standing up, causing him to fall back into his recliner. Resident #59 was standing in the doorway and told Resident #70 to leave the staff and other residents alone. Resident #70 then followed him and stated to him that he was going to kill Resident #59 and to kick him out of this place because this was his home. The nurse went to stand between the two males and then Resident #70 shoved the nurse into Resident #59. When Resident #59 tried to stand between Resident #70 and the nurse to protect her, Resident #70 shoved him. Following the incident, the residents were separated and each assessed for injury with none being noted. None of the residents were interviewable. Resident #70 was not redirectable and sent out to the hospital for evaluation. The facility failed to substantiate the abuse citing bodily injury/serious bodily injury had not met, and Resident #70 was suffering from terminal agitation. -However, the facility investigation, and behavior, follow up, and communication notes (see below) revealed documentation that Resident #70 deliberately shoved and threatened the residents and made them fearful. In not substantiating the incident as resident-to-resident abuse, the facility limited its investigation and ability to correct the behavior to prevent further abuse. B. Residents (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Resident #70 (assailant) Resident status: Resident #70, age [AGE], was admitted on [DATE]. According to the January 2026 CPO, diagnoses included unspecified dementia, post traumatic stress disorder (PTSD), and aphasia (brain damage causing significant communication challenges). The resident was residing in a secure memory care unit. The 11/7/25 MDS assessment documented the resident had significant cognitive impairments with a BIMS score of three out of 15. He required maximum staff assistance with bathing and moderate assistance with dressing, and transfers. The resident was independent in ambulation without an assistant device. He had behaviors of wandering, rejection of care, and physical aggression. Behavior care plan and notes: The behavior care plan, revised 11/10/25, revealed that the resident had made verbal and physical threats towards staff and other residents. Interventions, dated 11/11/25, included to intervene before agitation escalates, guide him away from source of distress, engage him calmly in conversation, if response is aggressive, staff to walk calmly away, and approach him later. Also, keep the resident in line of sight when in common areas with other residents. -However, the care plan did not identify that the altercation on 11/8/25 had occurred in resident rooms, not in a common area (see below notes). A behavior note, dated 11/6/25, revealed that the resident had made threats to kill a staff member after they entered his room to find food in the toilet and floor, clothing on the floor belonging to other residents, and a broken closet door. The staff gave him his breakfast and left the room. The resident then went into other rooms to make the beds and eventually took naps in four different rooms that were not his. A 72 hour follow up note, dated 11/7/25 at 2:43 a.m., revealed that the resident was irritable and roaming into other resident rooms and was argumentative with them. A communication note, dated 11/7/25 at 5:04 a.m., revealed that the resident was in his room slamming the door and then began slamming other residents' doors. He made demands that the staff kick the other residents out and then made threats to kill staff and residents. When staff did not follow his demands, he began going into other resident rooms and trying to kick them out of their beds. The physician was called and an antipsychotic medication was provided to the resident that was ineffective. A communication note, dated 11/7/25 at 11:30 a.m., revealed that the resident was sent out to the emergency room with the spouse's consent for evaluation and labs related to his behaviors. A nurse's note, dated 11/7/25 at 5:25 p.m., revealed that the resident had returned from the emergency room at 1:30 p.m. with all his labs coming back within normal limits and no behaviors displayed at the hospital. A communication note, dated 11/7/25 at 8:32 p.m., revealed that the resident returned from the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	include loud or startling noises. Interventions, initiated 1/18/26, included to intervene as necessary, approach/speak in a calm manner, divert attention, remove from the situation and take to an alternate location as needed. Also, identify and document potential triggers. The behavior care plan, initiated 12/18/25, revealed the resident had an intolerance to loud noises, which she exhibited as frustration in the form of verbal aggression. The resident also would be intrusive with other residents. Interventions, initiated 12/18/25, included to assist the resident to develop more appropriate methods of coping and interacting with others, encourage the resident to express feelings appropriately, anticipate and meet her needs, provide opportunity for positive interaction and attention, stop and talk to the resident when passing by, and provide a program of activities that are of interest and accommodates the resident's status. Also, the residents' triggers were loud, startling noises and to de-escalate, staff were to provide one-on-one engagement. The resident was to be provided one-on-one staff observation for safety. The aggression care plan, initiated 12/18/25, revealed the resident had the potential to be physically and verbally aggressive with staff and peers related to her progressing dementia. Interventions, initiated 12/18/25, included to assess and address contributing sensory deficits, provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage her to seek out of staff members when agitated. -None of the care plans above were updated after the incident on 11/8/25 until over a month later on 12/18/25, and after Resident #68 had sustained three additional incidents of resident-to-resident abuse, two on 11/25/25 and another on 12/3/25. Follow up note: A 72 hour follow up note, dated 11/8/25 at 5:01 a.m., revealed the nurse heard the CNA yelling for help. When the nurse arrived, Resident #70 was in Resident #68's room trying to kick her out. He then shoved Resident #68 and when the CNA tried to get in between them, he shoved the CNA into the corner. He then left the room and began to target other residents. -No social services follow up notes to monitor for psychosocial harm were located for the incident (see the psychiatrist assessment under above revealing history of abuse). See socal service director (SSD) below, stating social services reviews notes, reports, and alerts and residents are checked on for seven days; however, these checks are not documented. 3. Resident #15 (victim) Resident status: Resident #15, age [AGE], was admitted on [DATE]. According to the January 2026 CPO, diagnoses included unspecified dementia with severe agitation. The resident was residing in the secure memory care unit. The 12/6/25 MDS assessment documented the resident had been unable to complete the brief interview for mental status score (BIMS). A staff assessment revealed the resident had long and short term memory deficits, was only orientated to himself, and had severe deficits in judgement and decision making. He required maximum staff assistance with personal hygiene, toilet use, bathing, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	dressing, and transfers. The resident was independent in ambulation without an assistant device. The resident had behaviors of delusions, physical aggression, and rejected care. The behavior care plan, revised 10/1/24, identified that the resident had a diagnosis of dementia with behavioral disturbance and insomnia. The resident experienced difficulties with sleep and could become restless related to his poor cognition which had the potential to cause agitation. Interventions, initiated 3/31/24, included anticipate and met his needs, provide opportunity for positive interaction and attention, stop and talk to the resident when passing by, and provide a program of activities that is of interest and accommodates the resident's status. -The care plan had not been updated with new interventions following the 11/8/25 incident. Behavior note: A behavior note, dated 11/8/25 at 6:37 a.m., revealed the resident was the victim of an altercation with another male resident. Resident #15 was sitting in his recliner in his room as the other male resident was yelling at him. The nurse was in the room and asked the other male resident to leave and he refused. Resident #15 then stood up and the other resident shoved him back into his recliner. -No social services follow up notes to monitor for psychosocial harm were located for the incident. See SSD interview below: Social services reviews notes, reports, and alerts and residents are checked on for seven days; however, these checks are not documented. 3. Resident #59 (victim) Resident status: Resident #59, age [AGE], was admitted on [DATE]. According to the January 2026 CPO, diagnoses included unspecified dementia with psychotic features. The resident was residing in a secure memory care unit. The 12/6/25 MDS assessment documented the resident had been unable to complete the BIMS. A staff assessment revealed the resident had long and short term memory deficits, was orientated only to himself, and had severe deficits in judgment and decision making. He required maximum staff assistance w

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured and labeled in accordance with accepted professional standards for two of two medication storage rooms. Specifically, the facility failed to:-Ensure medications were labeled with the date they were opened; and, -Ensure expired medications were properly disposed of. Findings include:I. Facility policy and procedureThe Medication Storage policy, revised 1/9/26, was received from the nursing home administrator (NHA) on 1/29/26. The policy read in pertinent part, It is the policy of the facility to ensure that all medications housed on the premises should be stored in the pharmacy, medication rooms and/or carts according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. Medication storage areas should be routinely inspected by the designee for discontinued, outdated, defective, expired or deteriorated medications with worn, illegible or missing labels and destroyed per policy.II. Professional referenceAccording to PharMerica's (1/12/25) Abridged List of Medications with Shortened Expirations Dates, retrieved on 2/2/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://pharmerica.com/wp-contents/uploads/2025/01/F Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's Package Insert (PI) under the ?How Supplied/Storage & Handling' section. A drug product's Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening, whichever comes first. These In-Use medications should be labeled such that the ?date opened' is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration.According to Pharmcare USA's (4/9/23) Medication Disposal Practices in Assisted Living and Long Term Care, retrieved on 2/2/26 from https://pharmcareusa.com/education/medication-disposal-practices-in-assisted-living-ltc/#:-:text=As%20an%2(When medications are not disposed of correctly, they can pose serious threats to bother human health and the environment. Improper disposal can lead to accidental ingestions, overdose and even death.III. Observations On 1/27/26 at 2:15 p.m. the Big Horn Bluff hallway medication cart was observed with registered nurse (RN) #1. The following items were found:-An open inhaler of Serevent Diskus (inhaler medication used to treat chronic obstructive pulmonary disease (COPD) and asthma) 50 micrograms (mcg) was not labeled with an open date. -A bottle of Preparation H cream (medication used to treat hemorrhoids) with an expiration date of December 2025. On 1/27/26 at 3:15 p.m. the Columbine hallway medication cart was observed with RN #4. The following items were found: -A medication card of oxycodone (pain medication) 5 milligrams (mg) with an expiration date of 12/2/25. -Two medication cards of clonazepam (medication used to treat seizure and panic disorders) 0.5 mg had no expiration date on the label. -An open bottle of polyvinyl alcohol eye drops was not labeled with an open date. -An open bottle of Refresh tears eye drops was not labeled with an open date. -An open inhaler of Trelegy Ellipta (medication used to treat asthma and COPD) 100 mcg/62.5 mcg/25 mcg was not labeled with an open date. -Petrolatum 42% cream (medication used to treat dry, rough, scaly or irritated skin) had an expiration date of August 2025. -Liquid iodine (a topical medication used to treat and prevent infections) had an expiration date of October 2025. IV. Staff interviews RN #4 was interviewed on 1/27/26 at 3:15 p.m. RN #4 said she was unsure if eye drops and inhalers needed to be labeled with an open date. The director of nursing (DON) was interviewed on 1/28/26 at 9:45 a.m. The DON said the facility's pharmacy consultant audited the medication storage monthly and a staff member who did the medication ordering audited the medication storage weekly. She said the nurses (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be discarding expired medications and ensuring medications were stored properly. She said the importance of discarding expired medications was because the potency of the medication could not be guaranteed after the expiration date had passed and it was a resident safety issue. She said each eye drop and inhaler was good for a certain time frame after opening and should be labeled with an open date.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations and interviews, the facility failed to provide activities that meet the interest and needs of the residents on the secure memory care unit.Specifically, the facility failed to provide meaningful and person centered activities for residents residing in a secure memory care unit (cross-reference F600 for abuse). Findings include:I. Observations During an initial walk through of the facility on 1/25/26 at approximately 9:00 a.m., a facility activities calendar was observed on the non secure side of the facility. It did not indicate any specific activities for the secure memory care unit. On the secure memory care unit, there was no posted activities calendar observed. During a continuous observation on the secure memory care unit on 1/26/26 beginning at 8:08 a.m. and ending at 1:21 p.m. the following was observed:Resident #27 was observed at 8:08 a.m. until 11:03 a.m. wandering without purpose. Resident #27 frequently stood near the windows looking out or pacing back and forth without interjection from the staff. At 11:12 a.m., Resident #27 was taken to his room by staff to use the restroom and then he returned to the common area at 11:21 a.m. Resident #15 was observed at 8:38 a.m. to 10:58 a.m. watching other residents wander around the secure unit, while either sitting in a recliner in the common area or standing up in the common area. At 11:32 a.m., Resident #5 wandered to the back door to the secure courtyard and began pushing on the door until the alarm stopped going off and he was able to open the door. Facility staff did not intervene. Resident #5 was able to open the door and started to go outside before certified nursing assistant (CNA) #5 intercepted Resident #5 and was able to encourage him to come back into the secure unit. At 12:10 p.m., Resident #27 finished his lunch and left the dining room and began wandering in the hallway without purpose. At 12:48 a.m., Resident #27 stopped wandering and sat in a recliner in the common area with Resident #6. There was a musical channel playing on the television and both Resident #27 and Resident #6 were not provided with any meaningful activities.At 1:01 p.m. Resident #5 began pushing on the back door again and refused to allow the staff to prevent him from going outside. This awoke Resident #27, who was asleep in the common area recliner and he began to wander the unit again without purpose. At 1:07 p.m., both of the CNAs on the unit went outside to try to bring Resident #5 back inside and were finally able to convince him to come back in. At 1:08 p.m., Resident #27 and Resident #6 were both wandering from the common area to the dining room without purpose. At 1:14 p.m., Resident #6 went down the hallway to the resident's rooms without any interjection from staff. Resident #6 wandered in and out of six different resident rooms and if the doors were closed, he attempted to open them. At 1:21 p.m., CNA #5 saw him and redirected him to the common area. -During the continuous observation on the secure memory care unit, there were no individual or group activities observed or offered to the residents. During a continuous observation on 1/26/26 beginning at 2:30 p.m. and ended at 3:47 p.m. the following was observed:Resident #27 was observed at 2:30 p.m. to 3:40 p.m. wandering the common area without purpose. Resident #15 was observed on the secure memory care unit on 1/26/26 at 2:33 p.m. to 3:00 p.m. wandering the common area without purpose.At 2:33 p.m., Resident #5 began pushing on the back door again until it opened and he went outside and sat down At 2:34 p.m., Resident #59 took his wheelchair and used it as a walker to go outside to the secure courtyard. At 2:36 p.m., Resident #6 and Resident #53 walked into the common area and then wandered into the dining room. Inside the dining room, they wandered around the dining room without purpose. Resident #15 got up from a recliner and began wandering around the common area.At 2:38 p.m., Resident #6 came from the hallway where the resident rooms were to the common area and then wandered into the dining room without purpose. Resident #6 then returned to the common area at 2:40 p.m. and sat down in a recliner and fell asleep. At 2:41 p.m., Resident #22 also pushed the door to go outside into the secure courtyard and sat outside with the other two men out there, none of which were willing to wear coats despite the temperature being below 30 degrees fahrenheit. At 3:33 p.m., Resident #6 began wandering down the hall into other residents' rooms. The CNAs were finally able to bring Residents #5, #59, and #22 back inside of the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	building. The residents were asked to sit in the common area but were not offered any activities or stimulation by the staff. At 3:40 p.m., Resident #59 tried to wander into Resident #53's room who began to scream at him to leave and threatened him. The staff were on the other side of the unit and it took two minutes for them to get to the two residents and separate them. -During the continuous observation on the secure memory care unit, there were no individual or group activities observed or offered to the residents. II. Staff interviews Registered nurse (RN) #3 was interviewed on 1/26/26 at 9:12 a.m. He said the secure memory care unit did not have its own activities calendar. He said sometimes the activities staff would take Resident #59 to the other side of the building to join an activity but the staff did not take any of the other residents from the unit. Activities aide (AA) #1 was interviewed on 1/26/26 at 3:35 p.m. He said he conducted activities for the entire facility. He said he would do activities on the memory care unit if he was asked to, but usually the activity staff tried to take residents off of the unit to the other part of the building if they were capable of participating in activities. AA #1 was unable to say how often he went to the secure memory care unit to take residents to group activities. CNA #5 was interviewed on 1/27/26 at 9:37 a.m. CNA #5 said the activities department provided activities to the residents on the other side of the building but not on the secure memory care unit. She said AA #1 would come over to work on his laptop to chart but did not provide activities. CNA #5 said an activities program on the unit would help with behaviors by stimulating and distracting the residents.RN #3 was interviewed on 1/27/26 at 10:12 a.m. He said that the activities director would make suggestions to the staff but it was left up to the memory care staff to provide those activities and prevent altercations at the same time. He said sometimes the AA #1 would come over and do ball toss with the residents or turn music on. RN #3 said the activity staff come over daily with a packet with current events and papers for activity ideas but none of them were appropriate for the memory care population. He said more visits from activities would decrease the behaviors and slow down the progression of the disease process for many of the residents. Activity aide (AA) #2 was interviewed on 1/27/26 at 1:55 p.m. She said there were three activity aides and one activity director for a facility of 63 residents. She said that AA #1 said he went to the secure memory care unit five times a week but she was not sure what he did. AA #2 said she was not sure if he was dedicated to the unit but when he said he was going to the unit, she assumed that was where he was and she didn't see him on those days. She said the facility used to have an activity calendar for the secure unit but that went away before the holidays and she didn't know why. The nursing home administrator (NHA) was interviewed on 1/27/26 at 3:34 p.m. She said the activity staff were relatively new and they needed more training on dementia care. The NHA said the activities staff need to create more structured activities on the unit and the activity staff need more training on how to develop activities for a dementia population. The NHA could not say how she or the director of nursing (DON) were facilitating this training with the activities department.CNA #6 was interviewed on 1/28/26 at 9:48 a.m. and said she sometimes saw AA #1 walk a resident around the secure memory care unit for a little while but he did not come over and provide an activity program for the residents on any consistent basis. She said she had suggested specific activities and had reached out to the activities department for items the memory care staff thought would be helpful for the residents but the staff didn't get any feedback from activities or facility administration regarding their requests or suggestions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#11) of two residents who required respiratory care received care consistent with professional standards of practice out of 33 sample residents.Specifically, the facility failed to:-Follow physician's orders to maintain, clean, sanitize and store Resident #11's continuous positive airway pressure (CPAP) mask and machine; and, -Ensure a care plan was in place to include settings, cleaning, disinfecting and storage of the CPAP for Resident #11.Findings include:I. Facility policy and procedureThe Noninvasive Ventilation (CPAP) policy, revised 1/8/26, was provided by the nursing home administrator (NHA) on 1/27/26 at 3:05 p.m. The policy revealed in pertinent part, Noninvasive ventilation systems (CPAP, BiPAP) vary by manufacturer. Common equipment includes the machine, tubing, mask, headgear/straps, disposable/non-disposable filters, and humidifier chamber.The facility should follow the manufacturer's instructions for use of the machine. Dust the machine when needed, and wipe clean with a damp cloth and mild detergent. If humidification is required, distilled or sterile water will be used to fill the humidifier chamber. Empty the chamber completely after each use and wipe dry.Follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Only the supplier may service the machine.General guidelines to replace the equipment were to change the face mask and tubing every three months, headgear, non-disposable filters and humidifier chamber every six months and disposable filters twice monthly.II. Manufacturer's recommendationsThe Resmed Manufacturer guidelines were provided by the NHA on 1/28/26 at 10:33 a.m. It read in pertinent part, Nasal/mask cushion should be cleaned daily, the headgear and frame should be cleaned weekly. In a sink or tub, clean the cushion mask and headgear to remove any oils. Gently rub with mild liquid detergent and warm drinking quality water. Avoid using stronger cleaning products as they may damage the mask or leave harmful residue.The humidifier chamber should be cleaned daily. Empty the humidifier tub and wipe it thoroughly with a clean disposable cloth. Allow it to dry out of direct sunlight. Once a week, soak the humidifier tub in warm water using a mild dishwashing liquid or in a solution with a ratio of one part vinegar and nine parts water at room temperature. Place the humidifier tub on a flat surface, on top of a towel, to dry.III. Resident #11A. Resident statusResident #11, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included pneumoconiosis (chronic lung disease) due to asbestos and other mineral fibers, pulmonary fibrosis (scarring and stiffening of lung tissue), interstitial pulmonary disease (causing inflammation and scarring in the lung tissue), acute and chronic respiratory failure, chronic obstructive pulmonary disease and obstructed sleep apnea. The 11/28/25 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. He had no behaviors and did not reject care. He had shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. He received oxygen and used a non-invasive mechanical ventilator. B. Observations On 1/25/26 at 2:14 p.m. Resident #11's CPAP machine was observed on the resident's night stand next to the bed. The CPAP machine's nasal pillows were attached to the tubing and placed on top of the night stand laying across the top and the CPAP's headgear was hanging down towards the floor.On 1/26/26 the following was observed:At 8:20 a.m. Resident #11 was asleep in bed and the resident's CPAP machine headgear and tubing were draped across the CPAP machine. At 1:26 p.m. the resident was asleep in his recliner. The CPAP machine's headgear and tubing were wrapped up and stored behind the CPAP machine which was on the resident's nightstand.On 1/27/26 at 8:27 a.m. Resident #11 was asleep in bed and the CPAP machine's headgear and tubing were wrapped up and stored behind the CPAP machine.C. Record reviewReview of Resident #11's January 2026 treatment administration record (TAR) revealed the following physician's order:Clean CPAP mask with soap and water, or mask wipes upon rising. -The facility failed to have physician's orders related to the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaning of the CPAP machine's humidifier, the machine, the tubing and the storage of the CPAP equipment.-Review of Resident #11's comprehensive care plan revealed there was no CPAP machine care plan focus addressing the CPAP machines settings or the care and cleaning of the CPAP machine.IV. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 1/27/26 at 9:41 a.m. CNA #1 said she did not know who was responsible for cleaning Resident #11's CPAP mask, tubing and machine. She said she did not know how often the CPAP machine should be cleaned or how the machine should be cleaned and stored.Registered nurse (RN) #2 was interviewed on 1/27/26 at 9:48 a.m. RN #2 said she was the nurse supervisor and the nurses were responsible for cleaning Resident #11's CPAP mask every shift with the CPAP wipes that were stored in the nurses' cart. She said she did not know who was responsible for cleaning the CPAP machine's humidifier chamber, the machine and the tubing or how often the machine should be cleaned. She said the CPAP tubing should be changed according to the manufacturer's guidelines. However, she said she did not know what those guidelines were. She said the CPAP mask should be stored in a plastic bag to ensure no debris got into the mask for infection control purposes.The infection control preventionist (IP) was interviewed on 1/27/26 at 11:07 a.m. The IP said the nurses were responsible for cleaning Resident #11's CPAP mask daily and storing it in a plastic bag. She said she was not sure how often the CPAP machine's humidifier chamber and tubing needed to be cleaned or replaced. She said it was important to clean and store the CPAP machine correctly to prevent bacterial growth.The director of nursing (DON) was interviewed on 1/27/26 at 12:35 p.m. The DON said according to the facility policy, a CPAP machine's mask and tubing should be replaced every three months and the headgear and humidifier chamber should be replaced every six months. She said the CPAP machine's humidifier chamber should be emptied every day and dried out and the mask should be stored in a plastic bag. She said the mask/nasal pillows should be cleaned with soap and water and left to air dry on a towel. She said it was important to store and clean the CPAP equipment appropriately to prevent contamination with bacteria. She said it was important to keep it from touching the floor to prevent contamination and bacterial growth. She said she did not know what the manufacturer's guidelines were for the cleaning of Resident #11's CPAP machine at the time of the interview.The DON was interviewed a second time on 1/27/26 at 12:57 p.m. The DON said the manufacturer's guidelines were reviewed for Resident #11's CPAP machine and the humidifier chamber should be cleaned weekly with a mix of vinegar and water. She said she would immediately get physician's orders in place for the proper cleaning and storing of Resident #11's CPAP machine.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an infection control programdesigned to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection. Specifically, the facility failed to ensure Resident #24's catheter drainage bag was not stored on the floor to prevent potential contamination. Findings include:I. Facility policy and procedureThe Indwelling Catheter Care policy, revised 11/5/25, was provided by the nursing home administrator (NHA) on 1/27/26 at 3:05 p.m. The policy revealed in pertinent part, It is the policy of the facility to ensure residents with indwelling catheters receive appropriate catheter care to maintain their dignity, privacy and receive adequate care when indwelling catheters were in use. Catheter care should be performed every shift and as needed by nursing personnel. Privacy bags should be available and catheter drainage bags should be covered at all times while in use. Ensure the drainage bag is located below the level of the bladder to discourage backflow of urine.II. ObservationOn 1/25/26 at 2:11 p.m. Resident #24 was laying in bed. The resident's catheter drainage bag was not covered with a privacy bag and was laying on the floor next to the bed. III. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 1/27/26 at 9:41 a.m. CNA #1 said the catheter drainage bags should be in a privacy bag which was attached to the bed frame. She said the catheter drainage bag should not be stored on the floor for privacy issues. Registered nurse (RN) #2 was interviewed on 1/27/26 at 9:48 a.m. RN #2 said a resident's catheter drainage bag should be stored in a privacy bag that was attached to the bed frame or in a pan to keep it from touching the floor. She said the catheter drainage bag should not be stored on the floor related to infection control purposes and the integrity of the bag. The infection control preventionist (IP) was interviewed on 1/27/26 at 11:07 a.m. The IP said the catheter drainage bag should be kept below the bladder and hooked on the bottom of the bed frame. She said it should never be stored on the floor related to dignity and infection control purposes to keep it as clean as possible. The director of nursing (DON) was interviewed on 1/27/26 at 12:35 p.m. The DON said the catheter drainage bag should be stored below the bladder in a privacy bag so it did not touch the floor for dignity and infection control purposes. She said she would immediately ensure all residents' catheter drainage bags were in privacy bags and educate staff on ensuring catheter drainage bags did not touch the floor.