

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Castle Peak Senior Life and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 195 Freestone Rd Eagle, CO 81631	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**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 physical restraints for one (#1) of three residents out of five sample residents.</p> <p>Specifically the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #1 had physician's orders for the placement of a wanderguard; and, -Obtain consent to move Resident #1 to the secured unit, which prevented the resident from activities that met his interests. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Physical Restraint policy, revised 10/14/22, was provided by the director of nursing (DON) on 6/16/25 at 4:05 p.m. The policy read in pertinent part, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the residence body that the individual cannot remove easily and which restrict freedom of movement or normal access to one's body.</p> <p>It is the policy of the facility to use restraints only under the following conditions; as a last resort after a trial period where less restrictive measures have been undertaken and proven unsuccessful; with a physician's order and only when necessary to prevent injury to the resident or others, based on a physical, functional, emotional, and medication assessment; with the consent of the resident and his or her representative; when benefits of the restraint outweigh the risks.</p> <p>The Wandering Resident policy, revised 3/10/25, was provided by the DON on 6/16/25 at 4:05 p.m. The policy read in pertinent part, The facility ensures that residents who exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered care plan which addresses the unique factors contributing to their wandering behavior or elopement risk. Residents with a signaling device on will be escorted by staff, volunteers or another responsible person when they leave their unit/neighborhood.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Dementia Care policy, revised 3/10/25, was provided by the DON on 6/16/25 at 4:05 p.m. The policy read in pertinent part, A systematic process will be used including input from interdisciplinary team (IDT) members to provide holistic care for residents with dementia.</p> <p>Gather information on resident's past and current physical, functional and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related to complications and functional impairments.</p> <p>Monitor for safety including wandering and need for electronic monitoring.</p> <p>Create individualized approaches in the care plan with measurable goals and specific interventions for management of behavioral symptoms/ behavioral expressions.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease without dyskinesia (movement disorder), without mention of fluctuations, unspecified dementia, specified severity, with mood disturbance and other behavioral disturbances, Alzheimer's disease, anxiety disorder, abnormal involuntary movements, tremors, abnormalities of the gait and mobility, difficulty in walking and generalized muscle weakness.</p> <p>The 3/31/25 minimum data set (MDS) assessment identified Resident #1 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. He did not use a mobility device for ambulation but needed supervision with most of his activities of living (ADL).</p> <p>The MDS assessment documented Resident #1 did not have inattention or disorganized thinking.</p> <p>The MDS assessment indicated it was very important to Resident #1 to go outside to get fresh air and participate in his favorite activities was very important to him.</p> <p>According to the MDS assessment Resident #1 did not have wandering behavior, a physical restraint or alarm.</p> <p>B. Resident representative interview</p> <p>Resident #1's representative was interviewed on 6/17/25 at 10:34 a.m. The representative said he Resident #1 left the facility to hitch hike out of state to see his spouse. She said the facility placed a wanderguard on him and had him go to the memory care secured unit during the day. She said he was not assessed for the memory care unit. She said he was now permanently on the secured unit. The representative said she and the resident's power of attorney (POA) wanted Resident #1 to have the least restrictive environment possible. She said he was used to being very independent when he was at home.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The representative said she did not think the facility was providing personalized activities for Resident #1. She said walking was very important to him but the staff was not taking him on walks routinely. She said the staff were letting the resident go on the patio and not taking him for walks.</p> <p>Resident #1's POA was interviewed on 6/17/25 at 11:00 a.m. The POA said after Resident #1 tried to hitch-hike, the facility placed a wanderguard on Resident #1 and put him in the secured unit during the day. She said she did not agree to having Resident #1 on the secured unit and away from him from his room and personal items during the day. She said his communication skills were impaired due to aphasia (difficulty with language communication) and she was worried that he would not be able to fully communicate when he would want to go back to his room outside of the secured unit. She said the facility said they were going to have him go to the secure unit during the day without her consent.</p> <p>The POA said she was notified on the evening of 4/12/25 that the facility put a wanderguard on Resident #1 after his elopement on 4/12/25. She said she felt the facility should have educated him and assessed him before using a wanderguard. The POA said walks were very important to Resident #1. She said when he walked, he still felt some independence. She said he loved doing anything outside.</p> <p>C. Observations</p> <p>Resident #1 was in the secured memory care unit on 6/16/25, between 5:30 p.m. and 6:00 p.m., watching television.</p> <p>On 6/17/25 at 10:05 a.m. Resident #1 was in a lounge chair in the day room sleeping on the secured unit.</p> <p>At 11:35 a.m. he was independently drawing in the day room while a certified nurse aide (CNA) visited with him on the secured unit.</p> <p>At 11:58 a.m. the CNA read the newspaper to him on the secured unit.</p> <p>At 1:15 p.m. the resident was in his room resting on the secured unit.</p> <p>D. Record review</p> <p>The wander/elopement risk care plan, initiated 4/14/25, identified Resident #1 was at risk for elopement due to history of leaving the facility to travel out of state. The 4/17/25 interventions directed staff to monitor his calls with his spouse that could trigger his behaviors to travel out of state and ensure the resident's wanderguard was in place and functioning appropriately.</p> <p>Review of nursing progress notes identified Resident #1 eloped from the facility on 4/12/25. The facility placed a wanderguard on the resident and placed him on the secured unit during the day for memory care programming.</p> <p>The April 2025 CPO for a wanderguard was provided by the DON on 6/18/25 at 5:37 p.m. a A physician's order directed staff to place a wanderguard on Resident #1 one time between 6:30 p.m. and 10:00 p.m., ordered and discontinued on 4/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The April 2025 CPO identified the resident did not have physician's orders for the wanderguard after 4/12/25, however, the resident wore a wanderguard until he was placed on the memory care unit full time on 6/9/25 (see interviews below).</p> <p>The June 2025 CPO revealed a physician's order that directed staff to verify placement of the wanderguard device on Resident #1 every shift and check the device daily to confirm that it was working, ordered on 6/9/25 and discontinued on 6/17/25 (during the survey).</p> <p>-The 6/9/25 wanderguard physician's order for verification of the placement and confirmation that it was operational were added to the physician's orders after the resident was moved to the secured memory care unit and after the wanderguard was taken off of the resident (see interviews below).</p> <p>The June 2025 medication administration record (MAR) documented on 6/9/25 through the day shift on 6/17/25, the staff checked Resident #1's wanderguard daily to confirm that it was in working order and verify placement of the wanderguard device on the resident every shift.</p> <p>-However, according to the DON, the resident did not have a wanderguard after he was moved to the secured memory care unit on 6/9/25 (see interview below).</p> <p>The 3/27/25 activity assessment documented Resident #1's preferred program style was one-to-one, independent leisure and small groups. The assessment identified his past interests as walking to the store, biking, fishing, rafting, watching specific television shows and going to church. According to the activity assessment, the resident felt health, walks and church provided him life enjoyment, a meaningful daily routine and were very important to him.</p> <p>-The March 2025 activity participation record did not identify Resident #1 was offered or participated in group or individual leisure activities from the time of his admission on [DATE] to 3/31/25.</p> <p>The 4/11/25 progress note documented Resident #1 went for a walk on 4/11/25 and fell outside. According to the note, the resident was reminded to just walk around the facility.</p> <p>Review of the April 2025 progress notes identified Resident #1 eloped from the facility on 4/12/25. Review of participation records and progress notes between the time he admitted (3/26/25) and the time he eloped on 4/12/25, revealed he went on one walk and attended one activity.</p> <p>The April 2025 activity participation record documented Resident #1 was offered and participated in bingo on 4/2/25 prior to his 4/12/25 elopement. The participation record identified the resident was offered and participated in a walk and live music on 4/16/25, a drumming activity on 4/22/25, an afternoon stroll on 4/23/25 and watched a documentary and went on a walk on 4/28/25. The April 2025 participation record indicated the resident was offered and participated in seven activities in April 2025, which included three walks for the month, after he eloped.</p> <p>The May 2025 activity participation record documented Resident #1 was offered and participated in one or more walks on 5/6/25, 5/13/25, 5/16/25, 5/21/25, 5/22/25, 5/23/25, 5/29/25 and 5/31/25. The participation record identified the resident had eight days out 31 days that he received a walk. The participation recorded identified the resident was offered seven bingo or card games, one social on the patio and live music twice.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the May 2025 progress notes identified the resident wanted more opportunities for walks outside and attempted to take himself outside.</p> <p>The 5/17/25 nursing note documented Resident #1 triggered the wanderguard alarm when he went out the front door. The note documented that the resident said he only wanted to walk outside.</p> <p>-The note did not identify that the resident was provided a walk outside.</p> <p>The 5/21/25 nursing note documented Resident #1 triggered the wanderguard when he attempted to get on the facility elevator. The nurse reminded Resident #1 that he needed supervision to go for a walk off the unit. According to the note, the resident was told no one was available to take him on a walk. The resident then returned to his room.</p> <p>The 5/26/25 nursing note documented Resident #1 attempted to walk out of the facility. The note identified the resident said he just wanted to have a walk outside. According to the note, the nurse and three other staff members convinced Resident #1 to go to the memory care unit. The resident went to the memory care unit for 30 minutes, watched television and had a snack. The resident then said he wanted to go back to his room to sleep.</p> <p>-The note did not identify the resident was later provided a walk outside.</p> <p>The physician communication log identified Resident #1 had a written physician's order for placement on the secured unit on 6/9/25.</p> <p>The 6/10/25 activity progress note identified the activity director (AD) walked with Resident #1 outside for 30 minutes on 6/10/25. According to the note, the resident enjoyed the walk and the company.</p> <p>The 6/11/25 activity progress note identified Resident #1 received two walks on 6/11/25 and watered the flowers.</p> <p>According to the note, the resident was in a good mood and enjoyed the walks.</p> <p>III. Staff interviews</p> <p>The social services director (SSD) was interviewed on 6/17/25 at 12:20 p.m. The SSD said the nursing staff requested the physician's order for a wanderguard. He said the wanderguard was usually tried as an intervention before the resident was placed on the secured memory unit. The SSD said Resident #1 had a wanderguard and the nursing staff would try to have him go to the memory care unit for activities. He said if Resident #1 wanted to go back to his room on the non-secured side of the facility, the staff would assist him back to his room.</p> <p>The DON was interviewed on 6/17/25 at 12:33 p.m. The DON said a wanderguard would be implemented on a resident if the resident attempted to leave the facility and would not be able to find their way back. She said if the facility felt a resident needed a wanderguard, the facility would notify the family and the physician and get orders. The DON said the staff would make sure the wanderguard was in place and in good working order. She said Resident #1 no longer had a wanderguard on.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said Resident #1 was allowed to go outside of the facility on walks independently and with staff. The DON said he was just asked to let staff know when he was leaving. She said the resident did not have any restrictions before he attempted to hitchhike out of state on 4/12/25. The DON said after the elopement, the staff was very concerned about his safety. The DON said a wanderguard was placed on the resident and he was placed on the memory care unit during the day and offered supervised walks. The DON said the resident was brought to the secured memory care unit during the day and ultimately moved to the secured due to his wander risk and benefit for more activity programming.</p> <p>The activity assistant (AA) was interviewed on 6/17/25 at 3:22 p.m. The AA said Resident #1 liked games like bingo, cards and balloon bat and going on walks. She said the facility had religious services but not the denomination he preferred. She said the facility might be able to find someone to minister to him from his church.</p> <p>The DON was interviewed again on 6/18/25 at 1:18 p.m. The DON said sometimes a wanderguard would be placed on a resident in an emergency without a physician's order but the facility would then get an order.</p> <p>The DON was interviewed a third time on 6/18/25 at 3:46 p.m. The DON said a wanderguard was placed on Resident #1 after he eloped (on 4/12/25). She said he was provided day programming on the secured memory care unit from 4/13/25 to 5/30/25. The DON said starting on 5/30/25, he remained on the non-secured side of the facility. She said he continued to wear his wanderguard until he was moved to the secure memory care unit full time on 6/9/25. She said when a resident moved to the secured unit, the wanderguard would come off. The DON reviewed the wanderguard orders and said she did not know why Resident #1 had wanderguards orders for just one day on 4/12/25 or had orders to verify placement of the wanderguard when he was placed on the secured unit on 6/9/25. She said she would have to follow up.</p> <p>The AD was interviewed on 6/18/25 at 4:25 p.m. The AD said there was limited record of Resident #1's activity participation and walks in March 2025, April 2025 and May 2025. She said he may have engaged in and been offered more walks and activities but she could not say for sure because it was not documented. The AD said she knew he walked and watched television before he eloped on 4/12/25 but she did not know how often.</p> <p>The DON was interviewed a fourth time on 6/18/25 at 5:37 p.m. The DON said the nurse manager entered the wanderguard physician's orders incorrectly and it should not have been just for one day. She said the nurse manager must have misunderstood what the physician ordered. The DON said Resident #1 should have had active orders for the duration of use. The DON said the nurse manager should have additionally entered in the orders to verify placement and working condition of the wanderguard. She said the nurse manager must have not understood the full process of putting in a wanderguard order.</p> <p>The DON said she would provide education to the nurse manager. The DON said on 6/9/25 she noticed Resident #1 did not have complete orders for the wanderguard so she added the 6/9/25 physician's orders and discontinued the orders on 6/17/25.</p>		