

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 03/10/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide reasonable accommodations for one (#2) of three residents out of seven sample residents. Specifically, the facility failed to provide timely accommodations for moving Resident #2's personal belongings during a room change. Findings include: I. Facility policy and procedure The Room Change policy, revised April 2025, was provided by the nursing home administrator (NHA) on 3/10/26 at 7:18 p.m. The policy read in pertinent part, A resident may request a room transfer at any time. The resident's request for transfer will be honored if there is an available bed on an appropriate unit and if the resident is able to comply financially with any potential private room differential. Environmental services staff or designee will assist the resident to pack their belongings prior to the room change. A nursing assistant or designee will bring the resident to the new room at the time of the room change and will introduce the resident to any new staff, as indicated. Nursing staff will assist the resident to unpack belongings and get settled into the new room. II. Resident #2A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included cerebral vascular accident (CVA - stroke), hemiparesis, spastic hemiplegia of the left side, coronary artery disease, hyperlipidemia, depression, attention-deficit hyperactivity disorder (ADHD), lower back pain and muscle weakness. The 3/4/26 minimum data set (MDS) assessment documented Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed Resident #2 exhibited verbal behavioral symptoms directed towards others including yelling and cursing. Resident #2 required set up and clean up assistance with eating. Resident #2 was independent with oral and personal hygiene, toileting, bathing and dressing. Resident #2 used a wheelchair for mobility. B. Resident interview Resident #2 was interviewed on 3/9/26 at 5:56 p.m. Resident #2 said she reported her concerns about witnessing a housekeeper mixing cleaning chemicals in her bathroom to the NHA. Resident #2 said the NHA offered her a room change, but she initially declined until the room was inspected for chloramine gas exposure (a hazardous gas caused by mixing bleach and ammonia based cleaning solutions). Resident #2 said on the night of 12/15/25, she reported irritation to her nose and eyes and refused to go back to her room. Resident #2 said the night staff offered her a new room and wheeled her into it. Resident #2 said she was told she needed to either return to her previous room or move into the new room, but the facility would not assist her with moving her personal items and told her she needed to move them herself or arrange for someone else to move them. Resident #2 said she could not move the items herself because she could not move her left side. Resident #2 said she felt like she should not have to pay to move her own items because the facility offered her the room change. Resident #2 said she was allowed to go back to her previous room when she was supervised by staff, but the majority of her personal items remained in her previous room until the facility hired a moving company on 1/27/26 to move her belongings to the new room. C. Record review The progress note, dated 12/16/25 at 4:13 a.m., documented Resident #2 complained of an increased smell of ammonia and bleach in her room on 12/15/25 at 9:00 p.m. The progress note documented Resident #2 said she was being poisoned and could no longer stay in her room due to the smell. The progress note documented Resident #2 declined a nursing assessment or (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
---	-------	-----------

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 03/10/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>transport to the local area emergency room. The progress note documented staff assisted Resident #2 into a new room so she could get some sleep. The progress note, dated 12/19/25 at 1:05 p.m., documented the floor nurse and a certified nurse aide (CNA) responded to Resident #2's call light. The progress note documented Resident #2 asked staff to bring her toiletries and a plant from her old room to her new room. The progress note documented the CNA told Resident #2 the staff were not allowed to move her items, they were only allowed to accompany Resident #2 to her previous room and accompany Resident #2 while she moved the items. The progress note documented Resident #2 agreed and was escorted to her previous room to acquire the aforementioned personal items. The progress note, dated 1/3/26 at 5:27 p.m., documented a nurse and a CNA entered Resident #2's room to administer her morning medications. The progress note documented Resident #2 requested staff to get socks from her room. The progress note documented the nurse explained to Resident #2 that staff were not allowed to go into her room, but could accompany Resident #2 into her room. The progress note documented Resident #2 agreed and was wheeled by staff to her previous room. The progress note documented Resident #2 gathered some of her own belongings, including a plant, and brought them to her new room. Resident #2's care plan, revised 2/27/26, revealed Resident #2 had a behavior care plan related to behaviors of yelling or lashing out at staff with inappropriate language. Interventions included following the resident's preference to communicate with Resident #2 via email instead of in-person, reminding Resident #2 her speech was inappropriate when Resident #2 yelled or cursed at staff and following up on Resident #2's concerns in a timely manner. On 3/10/26 at 11:36 a.m. the NHA provided copies of email communications between Resident #2 and the NHA. The emails revealed the following: The email, dated 12/11/25 at 4:01 p.m., revealed the NHA replied to Resident #2's concerns related to the facility inspection of Resident #2's reported concern of chemical exposure. The email revealed the NHA offered a room change to Resident #2 as an accommodation. The email, dated 12/12/25 at 9:33 a.m. revealed Resident #2 declined the offer to change rooms at this time. The email revealed Resident #2 did not want to transfer rooms because she filed a complaint and wanted to preserve the state of the room until the room was investigated for chemical exposure. The email revealed Resident #2 was willing to cooperate with a room transfer immediately after the investigation was complete. The email, dated 12/18/25 at 11:32 a.m. revealed the NHA contacted Resident #2 regarding occupying two rooms at the same time. The email documented the NHA informed Resident #2 that no permanent room change was approved. The email documented Resident #2 relocated to a new room on her own initiative; it was not authorized as a permanent assignment. The email documented the NHA had previously offered an alternative room as a potential accommodation, which Resident #2 declined. The email documented attempts to allow a plumber into Resident #2's initial room were also declined by Resident #2. The email documented a county examiner inspected her previous room on 12/18/25, based on the resident's reports of chemical exposure, and did not substantiate the complaint of a chemical exposure. The email documented Resident #2 needed to choose which room to occupy by 12/18/25. The email documented if Resident #2 chose to move to the new room permanently, the move needed to be completed by 12/22/25. The email, dated 12/18/25 at 1:12 p.m., documented the NHA contacted Resident #2 regarding the room change. The email documented Resident #2 chose to permanently move to the new room. The email documented that due to ongoing concerns raised by Resident #2 related to the handling of personal property and previous misunderstandings regarding staff involvement, Resident #2's personal belongings should be moved by a family member, authorized representative or a third-party mover of Resident #2's choice and expense. The email documented facility staff would be available to assist with coordination of access to the room, and overall safety during the room change; however, staff would not directly handle the resident's personal belongings unless otherwise agreed upon in advance and documented. The email documented the approach was intended to respect Resident #2's expressed concerns and to prevent further distress or misunderstandings. The email, dated 12/18/25 at 4:38 p.m., documented Resident #2 replied to the NHA. The email (continued on next page)</p>		

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 03/10/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>documented Resident #2 felt the initial room transfer was initiated by the facility and not Resident #2. The email documented Resident #2 was willing to oversee the transfer of her items on 12/19/25 at 6:00 p.m., requesting night shift staff oversee the process. The email, dated 12/19/25 at 9:58 a.m., documented the NHA responded to Resident #2. The email documented the facility's stance on the resident's room relocation was that the relocation was not facility-directed because there was no environmental hazard, which was confirmed by multiple outside sources. The email documented the facility was providing the room change as an accommodation to the resident. The email documented the facility was willing to provide access to Resident #2's old room and oversight for the relocation of Resident #2's personal belongings, however, the facility staff would not physically handle or move personal property. The email documented the NHA informed Resident #2 the packing, transport, and placement of belongings remained Resident #2's responsibility. The email, dated 12/22/25 at 3:17 p.m., documented the NHA provided Resident #2 with a notice of non-compliance with room assignments and personal property requirements. The email documented Resident #2 had previously informed the facility she planned to move her personal belongings on Friday, 12/19/25, shortly after 6:00 p.m. The email documented the move did not occur, and Resident #2's belongings remained in her previous room. The email documented the NHA reiterated to Resident #2 how the facility would be able to accommodate her request to move to a different room. However, the facility did not move or transport residents' personal property. The email documented Resident #2 was responsible for coordinating the relocation of her personal belongings to her new room. The email, dated 1/21/26 at 10:59 a.m., documented the NHA informed Resident #2 the facility had hired a moving company to complete the move of Resident #2's personal belongings to her new room on 1/27/26. However, the move to the new room did not occur until 39 days after Resident #2 agreed to the permanent transfer to her new room on 12/19/25. III. Staff interviews The social services director (SSD) was interviewed on 3/10/26 at 10:22 a.m. The SSD said Resident #2 was the only resident to have initiated a room change since he started in his position at the facility two years prior. The SSD said he was informed of Resident #2's room change, but was not directly involved in the room change. The SSD said Resident #2 had a history of contentious relationships with staff and attempts to manipulate situations. The SSD said almost all communication between Resident #2 and the facility's administration staff went through the NHA. The SSD said this was an intervention to reduce misunderstandings between the facility staff and Resident #2. The SSD said the records documented Resident #2's room was officially changed on 1/27/26. The SSD said he knew Resident #2 was occupying the room prior to 1/27/26, but he did not know why the room change was not officially changed when Resident #2 first occupied the new room. The SSD said the facility's room change policy indicated the environmental services staff would assist with the packing of residents' belongings and nursing staff would assist with unpacking the belongings. The SSD said the facility's policy did not specify who would physically move the personal belongings from one room to another, but he assumed environmental services staff or nursing staff would typically assist with moving; or the maintenance department might assist with moving furniture. The NHA was interviewed on 3/10/26 at 11:36 a.m. The NHA said Resident #2 had a long history of distrust toward the facility staff and behaviors of cursing, yelling and belittling staff members. The NHA said email communication was requested as an accommodation by Resident #2 and all communication between the NHA and Resident #2 occurred via email. The NHA said Resident #2 previously attempted to email multiple staff members, attempting to find different answers from different staff, so communication between facility administration and Resident #2 was primarily completed by the NHA to reduce misunderstandings between staff and Resident #2. The NHA said typically, when a resident wanted to change rooms or units due to a change in resident status, the facility requested family assistance with the room transfer. The NHA said the purpose of requesting family assistance was to reduce the incidence of items becoming lost or misplaced. The NHA said if the family was unable to assist, the facility staff would assist with transferring the resident's items, and the maintenance staff may (continued on next page)</p>		

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 03/10/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assist with transferring large items or furniture. The NHA said sometimes previous residents had to wait for a room to become available, but once the room was available, room move transfers took less than a week to coordinate. The NHA said she told Resident #2 the facility was not willing to transfer any of Resident #2's personal belongings because of previous accusations by Resident #2 of staff losing, stealing, or mishandling her items. The NHA said she offered ways to schedule a date to move Resident #2's items, and allowed Resident #2 into her previous room to retrieve her own belongings whenever she requested. The NHA said she did offer to accommodate Resident #2's concerns by offering a room change, but Resident #2 declined. The NHA said when Resident #2 refused to go back to her room during the night of 12/15/25, staff probably did assist her into the new room because they were wanting to provide good customer service. The NHA said despite staff assistance, she still considered the room change as initiated by Resident #2 and not by the facility. The director of nursing (DON) was interviewed on 3/10/26 at 4:12 p.m. The DON said the facility usually asked residents' families to assist with moving residents' items to reduce the odds of items going missing, but sometimes the family was not available or physically able to assist. The DON said Resident #2 had a long standing history of accusing different staff members of improper care, losing and mishandling her property. The DON said Resident #2 would email different staff members with questions and try to use the differing responses against the facility. The DON said the facility never expected Resident #2 would be physically able to move her personal belongings, but they were hoping Resident #2 would reach out to family or hire a company for assistance. The DON said she was not sure if the facility provided the resident with a list of moving companies or attempted to assist Resident #2 with finding assistance prior to the NHA hiring the moving company at the end of January 2026. The NHA was interviewed again on 3/10/26 at 5:01 p.m. The NHA said she never expected Resident #2 would be physically able to move her own items. The NHA said Resident #2 was young for their resident population and in a difficult situation. The NHA said she knew that Resident #2 was not frequently in contact with her family. The NHA said she did not remember if she ever provided Resident #2 with any informational resources on moving services. The NHA said she did not want to offend Resident #2's cognitive abilities to manage her items. The NHA said she knew Resident #2 was resourceful and was hoping she would reach out to someone for assistance. The NHA said when she saw no progress was made on Resident #2's behalf after several weeks, she contacted the moving company on 1/21/26 to move Resident #2's items on 1/27/26. The NHA said the facility covered the cost of the moving company.</p>		

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 03/10/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property for one (#2) of three residents out of seven sample residents. Specifically, the facility failed to report an allegation of verbal abuse towards Resident #2 by the director of nursing (DON) to the State Agency. Findings include: I. Facility policy and procedure The Occurrence Reporting-Vulnerable Adult policy, revised October 2022, was provided by the nursing home administrator (NHA) on 3/10/26 at 6:09 p.m. The policy read in pertinent part, Report all alleged violations and substantiated incidents immediately, but no later than 2 (two) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the state agency and all other agencies as required. II. Resident #2A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included cerebral vascular accident (CVA - stroke), hemiparesis, spastic hemiplegia of the left side, coronary artery disease, hyperlipidemia, depression, attention-deficit hyperactivity disorder (ADHD), lower back pain, muscle weakness. The 3/4/26 minimum data set (MDS) assessment documented Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed Resident #2 exhibited verbal behavioral symptoms directed towards others including yelling and cursing. Resident #2 required set up and clean up assistance with eating. Resident #2 was independent with oral and personal hygiene, toileting, bathing and dressing. Resident #2 used a wheelchair for mobility. B. Resident interview Resident #2 was interviewed on 3/9/26 at 2:26 p.m. Resident #2 said the DON was sent by the NHA on the evening of 12/19/25 to oversee the moving of her (Resident #2) belongings into a new room. She said when the DON came to her room, the DON stood between Resident #2 and the door with her hands on her hips. Resident #2 said the DON told her she would move the facility provided furniture but Resident #2 needed to move her own personal belongings. Resident #2 said she felt that asking her to move her own items despite knowing her left side was paralyzed was asking her to perform impossible tasks. Resident #2 said she felt cornered in her room and the facility staff were attempting to provoke an emotional response from her. Resident #2 said when she told the DON she was not able to move her items, the DON argued with her and the facility told her it was not their problem. Resident #2 said she began to argue with the DON that the facility needed to provide accommodations for her. Resident #2 said she and the DON each began to talk over each other until the DON and Resident #2 were yelling. Resident #2 said she asked the DON to stop yelling at her and instead communicate with her in writing. Resident #2 said the DON asked her over and over if she was going to move her stuff and when she asked the DON to follow her accommodations, the DON mocked her, asking Resident #2 if she was unable to hear. Resident #2 said she felt the DON's tone was demeaning and the DON mocked her disabilities. Resident #2 became tearful and said she felt the facility was trying to blame her for the problems because they wanted to find a way to evict her from the facility. Resident #2 was interviewed again on 3/9/26 at 5:56 p.m. Resident #2 said registered nurse (RN) #3 witnessed the argument between her and the DON. Resident #2 said she sent an email with the recording of the argument and a written statement to the NHA the evening of 12/19/25. Resident #2 said she told the NHA in her email that she felt mocked and provoked by the DON. Resident #2 said no facility staff members followed up with her regarding the argument, and she did not know if anyone ever investigated her concerns regarding the DON. Cross-reference F610 for failure to investigate an alleged violation. C. Record review Resident #2's careplan, revised 2/27/26, revealed Resident #2 had a behavior care plan related to behaviors of yelling or lashing out at staff (continued on next page)</p>		

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 03/10/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>with inappropriate language. Interventions included following the resident's preference to communicate with Resident #2 via email instead of in-person, reminding Resident #2 her speech was inappropriate when Resident #2 yelled or cursed at staff, and following up on Resident #2's concerns in a timely manner. Resident #2's abuse prevention care plan revealed Resident #2 was at risk for abuse or neglect related to Resident #2's physical impairment, history of disruptive behavior, misinterpreting information and verbally lashing out at staff. The care plan documented Resident #2 was alert and oriented and would be able to report suspected abuse. Interventions included conducting supportive rounds as needed, abuse prevention observations completed by the social services director (SSD) on admission, annually and with significant changes; and staff observations for signs and symptoms of abuse such as fear or resistance to allowing a staff person, family or visitor to assist them. On 3/10/26 at 11:36 a.m. the NHA provided copies of email communications between Resident #2 and the NHA. The emails revealed the following: The DON's email, dated 12/19/25 at 7:48 p.m., revealed the DON contacted the NHA about the argument with Resident #2. The email documented the DON claimed she was at the facility at 5:50 p.m. per the NHA's request to assist with overseeing the transfer of Resident #2's belongings to her new room. The email documented the DON told staff they were not to move any of Resident #2's personal belongings. The email documented the DON waited in the common area for Resident #2. The email documented the nurse went into Resident #2's room to administer medication and Resident #2 did not mention moving to the nurse. The email documented the DON received a text message from the NHA stating Resident #2 emailed the NHA indicating no staff members were at the facility to coordinate the move. The email documented Resident #2 claimed she also needed the facility provided furniture moved to her new room. The email documented the DON went to obtain a cart. The DON's email documented the DON and RN #3 entered the room together, and the DON told Resident #2 that she heard the resident needed assistance moving some furniture. The email documented the DON told Resident #2 she would only move the furniture items and per the previous email sent by the NHA, Resident #2 needed to move her own personal belongings. The email documented Resident #2 became angry and told the DON she was not able to move her belongings and talked about her disability. The email documented Resident #2 asked the DON why she did not come to her room when she arrived. The email documented the DON asked if Resident #2 was going to move her items and Resident #2 told the DON her questions needed to be in writing. The email documented the DON asked Resident #2 why she wanted the DON to come to her room if she was not allowed to talk to her. The email documented the DON asked Resident #2 several times if she was going to move tonight (12/19/25), during which Resident #2 kept talking over the DON, repeating that the DON had to communicate with Resident #2 in writing. The email documented the DON claimed she repeated the question louder so Resident #2 could hear her. The email documented Resident #2 told the DON she was shouting and the DON told Resident #2 she was talking loudly, but not screaming. The email documented Resident #2 continued to repeat she wanted communication in writing until the DON and RN #3 left the room. Resident #2's email, dated 12/19/25 at 8:46 p.m., revealed Resident #2 contacted the NHA about the argument with the DON. The email documented Resident #2 claimed the DON addressed Resident #2 in an infantilizing and confrontational manner, standing with her hands on her hips and repeatedly demanding to know whether or not Resident #2 was moving her items, despite Resident #2's documented physical and cognitive CVA-related disabilities. The email documented Resident #2 claimed the DON repeatedly mocked Resident #2's request for written communication and Resident #2 claimed the mockery appeared intended to provoke a reaction. Resident #2's email, dated 12/20/25 at 10:09 a.m., documented Resident #2 contacted the NHA again regarding the argument. The email documented Resident #2 requested she no longer speak with facility administration without the ombudsman or a dedicated representative present due to the argument with the DON. The email documented Resident #2 told the NHA she felt the DON's behavior was verbally abusive. -However, despite Resident #2 indicating that she felt the DON had been verbally abusive, the facility did not (continued on next page)</p>		

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 03/10/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>report the resident's allegation to the State Agency.III. Staff interviewsThe NHA was interviewed on 3/10/26 at 11:36 a.m.The NHA said Resident #2 had a long history of distrust toward the facility staff and behaviors of cursing, yelling, and belittling staff members. The NHA said she received an email from Resident #2 and the DON later that night (12/29/25) about the argument that occurred between them. The NHA said she listened to the audio recording of the conversation provided by Resident #2 as well as reviewing the written statements by Resident #2 and the DON. The NHA said she additionally spoke with RN #3 to see if he agreed with the written statement completed by the DON. The NHA said she had the regional corporate director and the corporate compliance officer review the written statements and the audio recording. The NHA said the regional corporate director and the corporate compliance officer felt both the DON and Resident #2 were arguing with each other, and the DON's speech was loud and direct, however the three of them (the NHA, the regional corporate director and the corporate compliance officer) decided the verbal abuse was not substantiated. The NHA said after speaking with the corporate compliance officer and the regional corporate director, she asked the DON to listen to the audio recording and then provided education to the DON. The NHA said she did not report Resident #2's allegation of abuse to the State Agency because she had already investigated the situation and decided it was not substantiated, so she did not need to report it.</p>		

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 03/10/2026
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for one (#2) of three residents out of seven sample residents. Specifically, the facility failed to maintain documentation to indicate a thorough investigation was completed after an allegation of verbal abuse towards Resident #2 by the director of nursing (DON). Findings include: I. Facility policy and procedure The Occurrence Reporting-Vulnerable Adult policy, revised October 2022, was provided by the nursing home administrator (NHA) on 3/10/26 at 6:09 p.m. The policy read in pertinent part, All reports of suspected/alleged resident abuse, neglect, exploitation of residents, mistreatment, injury of unknown source and/or misappropriation of resident property shall be promptly and thoroughly investigated. All interviews related to the investigation shall be conducted in private. The investigation may include, but is not limited to: physical examination of the resident and environment; examination of the resident by a licensed nurse or physician (If sexual abuse is suspected, call the police immediately. Do not bathe/wash the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred.); interview the person(s) reporting the incident; interview the alleged victim; interview any potential witnesses to the incident. Interview the alleged perpetrator; interview other residents to whom the alleged perpetrator provides care or services; review the completed documentation. If witness reports are obtained, they may be in writing; witnesses should sign and date such reports; document the results of the investigation; log the incident on the event summary or other log; use the event summary or other log for ongoing review and analysis of abuse incidents and the implementation of changes to prevent future occurrences of abuse. The results of all investigations must be reported to the administrator (or his or her designated representative) and state agency and to other officials in accordance with state law within 5 (five) working days of the incident. If the alleged violation is verified appropriate corrective action must be taken. If an employee is found to have perpetrated the incident, follow the employee handbook. II. Resident #2A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included cerebral vascular accident (CVA - stroke), hemiparesis, spastic hemiplegia of the left side, coronary artery disease, hyperlipidemia, depression, attention-deficit hyperactivity disorder (ADHD), lower back pain and muscle weakness. The 3/4/26 minimum data set (MDS) assessment documented Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed Resident #2 exhibited verbal behavioral symptoms directed towards others including yelling and cursing. Resident #2 required set up and clean up assistance with eating. Resident #2 was independent with oral and personal hygiene, toileting, bathing and dressing. Resident #2 used a wheelchair for mobility. B. Resident interview Resident #2 was interviewed on 3/9/26 at 2:26 p.m. Resident #2 said she communicated with the NHA regarding moving her personal belongings to her new room on 12/19/25 at 6:00 p.m. Resident #2 said in her email, she told the staff she was not physically able to move her items and needed assistance. Resident #2 said this was an accommodation because she was told by the NHA that she misinterpreted or misunderstood previous in-person conversations. Cross-reference F558 for failure to provide reasonable accommodations of needs. Resident #2 said nobody came to her room on 12/19/25 to let her know they were ready at 6:00 p.m. Resident #2 said she emailed the NHA to let her know no staff members had arrived. Resident #2 said she found out the DON was waiting in the hallway and Resident #2 said she was upset nobody told her they were ready to start moving. Resident #2 said she felt the DON was worked up the moment she entered Resident #2's room. Resident #2 said she recorded the argument between her and the DON. Resident #2 said the DON stood between Resident #2 and the door with her hands on her hips. Resident #2 said the DON told her she would move the facility provided furniture but Resident #2 needed to move her own personal belongings. Resident #2 said she felt that asking her to move her (continued on next page)</p>		

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 03/10/2026
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>own items despite knowing her left side was paralyzed was asking her to perform impossible tasks. Resident #2 said she felt cornered in her room and the facility staff were attempting to provoke an emotional response from her. Resident #2 said when she told the DON she was not able to move her items, the DON argued with her and the facility told her it was not their problem. Resident #2 said she began to argue with the DON that the facility needed to provide accommodations for her. Resident #2 said she and the DON each began to talk over each other until the DON and Resident #2 were yelling. Resident #2 said she asked the DON to stop yelling at her and instead communicate with her in writing. Resident #2 said the DON asked her over and over if she was going to move her stuff and when she asked the DON to follow her accommodations, the DON mocked her, asking Resident #2 if she was unable to hear. Resident #2 said she felt the DON's tone was demeaning and the DON mocked her disabilities. Resident #2 became tearful and said she felt the facility was trying to blame her for the problems because they wanted to find a way to evict her from the facility. Resident #2 was interviewed again on 3/9/26 at 5:56 p.m. Resident #2 said registered nurse (RN) #3 witnessed the argument between her and the DON. Resident #2 said she sent an email with the recording of the argument and a written statement to the NHA the evening of 12/19/25. Resident #2 said she told the NHA in her email that she felt mocked and provoked by the DON. Resident #2 said no facility staff members followed up with her regarding the argument, and she did not know if anyone ever investigated her concerns regarding the DON. C. Record review Resident #2's behavior care plan, revised 2/27/26, revealed Resident #2 had a behavior care plan related to behaviors of yelling or lashing out at staff with inappropriate language. Interventions included following the resident's preference to communicate with Resident #2 via email instead of in-person, reminding resident #2 her speech was inappropriate when Resident #2 yelled or cursed at staff, and following up on Resident #2's concerns in a timely manner. Resident #2's abuse prevention care plan, revised 2/27/26, revealed Resident #2 was at risk for abuse or neglect related to Resident #2's physical impairment, history of disruptive behavior, misinterpreting information and verbally lashing out at staff. The care plan documented Resident #2 was alert and oriented and would be able to report suspected abuse. Interventions included conducting supportive rounds as needed, abuse prevention observations completed by the social services director (SSD) on admission, annually and with significant changes; and staff observations for signs and symptoms of abuse such as fear or resistance to allowing a staff person, family or visitor to assist them. On 3/10/26 at 11:36 a.m. the NHA provided copies of email communications between Resident #2 and the NHA. The emails revealed the following: The DON's email, dated 12/19/25 at 7:48 p.m., revealed the DON contacted the NHA about the argument with Resident #2. The email documented the DON claimed she was at the facility at 5:50 p.m. per the NHA's request to assist with overseeing the transfer of Resident #2's belongings to her new room. The email documented the DON told staff they were not to move any of Resident #2's personal belongings. The email documented the DON waited in the common area for Resident #2. The email documented the nurse went into Resident #2's room to administer medication and Resident #2 did not mention moving to the nurse. The email documented the DON received a text message from the NHA stating Resident #2 emailed the NHA indicating no staff members were at the facility to coordinate the move. The email documented Resident #2 claimed she also needed the facility provided furniture moved to her new room. The email documented the DON went to obtain a cart. The DON's email documented the DON and RN #3 entered Resident #2's room together, and the DON told Resident #2 that she heard the resident needed assistance moving some furniture. The email documented the DON told Resident #2 she would only move the furniture items and, per the previous email sent by the NHA, Resident #2 needed to move her own personal belongings. The email documented Resident #2 became angry and told the DON she was not able to move her belongings and talked about her disability. The email documented Resident #2 asked the DON why she did not come to her room when she arrived. The email documented the DON asked if Resident #2 was going to move her items and Resident #2 told the DON her questions needed to be in writing. The email documented the DON asked Resident #2 (continued on next page)</p>		

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 03/10/2026
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>why she wanted the DON to come to her room if she was not allowed to talk to her. The email documented the DON asked Resident #2 several times if she was going to move tonight (12/19/25), during which Resident #2 kept talking over the DON, repeating that the DON had to communicate with Resident #2 in writing. The email documented the DON claimed she repeated the question louder so Resident #2 could hear her. The email documented Resident #2 told the DON she was shouting and the DON told Resident #2 she was talking loudly, but not screaming. The email documented Resident #2 continued to repeat she wanted communication in writing until the DON and RN #3 left the room. Resident #2's email, dated 12/19/25 at 8:46 p.m., revealed Resident #2 contacted the NHA about the argument with the DON. The email documented Resident #2 claimed the DON addressed Resident #2 in an infantilizing and confrontational manner, standing with her hands on her hips and repeatedly demanding to know whether or not Resident #2 was moving her items, despite Resident #2's documented physical and cognitive CVA-related disabilities. The email documented Resident #2 claimed the DON repeatedly mocked Resident #2's request for written communication and Resident #2 claimed the mockery appeared intended to provoke a reaction. Resident #2's email, dated 12/20/25 at 10:09 a.m., documented Resident #2 contacted the NHA again regarding the argument. The email documented Resident #2 requested she no longer speak with facility administration without the ombudsman or a dedicated representative present due to the argument with the DON. The email documented Resident #2 told the NHA she felt the DON's behavior was verbally abusive.-However, despite Resident #2 indicating that she felt the DON had been verbally abusive, the facility did not report the resident's allegation to the State Agency. Cross-reference F609 for failure to report an alleged violation. A written statement, dated 12/20/25, was provided by the NHA on 3/10/26 at 11:36 a.m. The written statement revealed the NHA interviewed RN #3. The written statement documented RN #3 confirmed he was present during a conversation that occurred on 12/19/25 between The DON and Resident #2. The written statement documented there was an email summary written by the DON in regards to that conversation and RN #3 was included on the summary. The written statement documented RN #3 had nothing further to add.-However, there was no documentation provided by the facility regarding what specific questions RN #3 was asked in the interview related to what occurred between the DON and Resident #2.-Review of Resident #2's electronic medical record (EMR) and the email correspondence between the NHA and Resident #2 revealed no additional documentation of an investigation or further communication between the NHA and Resident #2 regarding Resident #2's claim of possible verbal abuse.-The facility was unable to provide documentation to indicate a thorough investigation of the incident between the DON and Resident #2 was completed, to include an interview with Resident #2 about the incident, interviews with other residents regarding their interactions with the DON, interviews with other staff members to see if they overheard the incident on 12/19/25, or documentation of the NHA's review of the audio recording sent to him by Resident #2 and discussion of the recording and the written statements with the regional corporate director and the corporate compliance officer (see NHA interview below). III. Staff interviews The SSD was interviewed on 3/10/26 at 10:22 a.m. The SSD said he did not communicate directly with Resident #2 in most situations. The SSD said Resident #2 had a history of contentious relationships with staff and attempts to manipulate situations. The SSD said almost all communication between Resident #2 and the facility's administration went through the NHA. The SSD said this was an intervention to reduce misunderstandings between the facility staff and Resident #2. The NHA was interviewed on 3/10/26 at 11:36 a.m. The NHA said Resident #2 had a long history of distrust toward the facility staff and behaviors of cursing, yelling, and belittling staff members. The NHA said email communication was requested as an accommodation by Resident #2, and all communication between the NHA and Resident #2 occurred via email. The NHA said Resident #2 previously attempted to email multiple staff members, attempting to find different answers from different staff, so communication between the facility's administration and Resident #2 was primarily completed by the NHA to reduce misunderstandings between staff and Resident #2. The NHA said she asked the DON to stay and (continued on next page)</p>		

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 03/10/2026
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>oversee the transfer of Resident #2's personal belongings on 12/19/25. The NHA said she received an email from Resident #2 indicating no staff members had arrived to assist with the relocation of the resident's belongings to her new room. The NHA said she messaged the DON to confirm she was available to assist with oversight of the move. The NHA said she received an email from Resident #2 and the DON later that night (12/19/25) about the argument that occurred between them. The NHA said she listened to the audio recording of the conversation provided by Resident #2, as well as reviewing the written statements by Resident #2 and the DON. The NHA said she additionally spoke with RN #3 to see if he agreed with the written statement completed by the DON. The NHA said she had the regional corporate director and the corporate compliance officer review the written statements from the DON and Resident #2 and the audio recording of the argument. The NHA said the regional corporate director and the corporate compliance officer felt both the DON and Resident #2 were arguing with each other, and the DON's speech was loud and direct, however the three of them (the NHA, the regional corporate director and the corporate compliance officer) decided the verbal abuse was not substantiated. The NHA said after speaking with the corporate compliance officer and the regional corporate director, she asked the DON to listen to the audio recording and then provided education to the DON. -However, there was no documentation provided of the steps that the NHA indicated were taken in response to the allegation of verbal abuse made by Resident #2. The DON was interviewed on 3/10/26 at 4:12 p.m. The DON said she was asked by the NHA to oversee the relocation of Resident #2's personal belongings to her new room on 12/19/25. The DON said she was in the dining area of the facility at approximately 5:45 p.m., talking with another resident and waiting for Resident #2. The DON said at some point, she received a text message from the NHA asking if she was on the unit. The DON said the NHA told her Resident #2 claimed no staff members were available and Resident #2 needed assistance with moving furniture. The DON said she got the cart to move furniture from storage, then the DON and RN #3 entered Resident #2's room with the cart. The DON said she did not remember her exact words, but she said she told Resident #2 she was there to oversee the move. The DON said Resident #2 asked why the DON did not meet with Resident #2 when she arrived. The DON said she did not remember exactly how, but at some point Resident #2 stated to her that the Americans with Disability Act (ADA) requirements required staff to communicate with Resident #2 in writing. The DON said at first she was confused by what Resident #2 said because she thought she was referring to her hemiparesis and told Resident #2 that it was not related to her hearing. The DON said she then understood it was not related to her hearing, and once she understood, she said she asked Resident #2 if she planned to move her items tonight (12/19/25). The DON said Resident #2 continued to tell her she (the DON) needed to make her requests in writing. The DON said she and Resident #2 continued to go back and forth repeating themselves, getting progressively louder until the DON and RN #3 left the room. The DON said after the conversation with Resident #2, she documented her recollection of the events and sent them in an email to the NHA with RN # 3 carbon copied (cc) in the email. The DON said within the next day or two, she met with the NHA in her office. The DON said she listened to the audio recording from Resident #2 with the NHA. The DON said she did not remember the specifics in the audio recording, but she remembered she felt bad about how the conversation went. The DON said she should not have kept repeating herself and she should not have allowed Resident #2 to escalate her feelings. The DON said she had participated in unrelated abuse investigations with the NHA. The DON said the facility had a checklist to ensure they completed a thorough investigation of abuse allegations. The DON said a thorough investigation typically included interviews with additional staff or residents to gather evidence, ensure other residents were not affected, and rule out a possible pattern or additional allegations. The DON said phrases that would prompt additional investigation when interviewing staff or residents would include fear of retaliation or lack of care for reporting and staff members unwilling to discuss situations. The DON said residents using words, such as intimidated or provoked, when referring to staff would also prompt additional investigation questions. The NHA was interviewed again on 3/10/26 at 5:01 p.m. (continued on next page)</p>		

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 03/10/2026
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA said she felt she adequately investigated Resident #2's allegation of verbal abuse. The NHA said when she reviewed the written statements and audio recording, she said if she were in the same situation as the DON, she probably would have left the resident's room earlier. The NHA said she did not interview Resident #2 in person because her written statement served as the interview. The NHA said when she spoke with RN #3, she asked him if he saw the email from the DON and if he had anything to add, which he said he did not. The NHA said she did not ask RN #3 additional questions about the event. The NHA said she did not complete the additional steps of the facility's abuse investigation checklist, including interviews of additional staff members and residents because after reviewing the initial information with her regional corporate director and corporate compliance officer, they did not substantiate the event as verbal abuse. IV. Facility follow-up On 3/11/26 at 9:20 a.m., the NHA sent an email to communicate the facility's decision to re-initiate the investigation of Resident #2's allegation of verbal abuse on 12/19/25. -However, the facility failed to thoroughly investigate the allegation of abuse at the time it occurred.</p>		

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 03/10/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and observations, the facility failed to ensure residents were free from accidents or hazards for one (#1) of four residents reviewed for accidents hazards out of seven sample residents. Specifically, the facility failed to ensure Resident #1 was provided a hot beverage without injury. Resident #1, was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, unspecified cataract, unspecified macular degeneration (loss in central vision of the eyes), disorientation, unspecified, and restlessness and agitation. On 11/12/25 Resident #1 was provided a hot beverage dispensed from the facility's coffee machine and then heated in the microwave for an additional 30 seconds, per the resident's request, by a staff member. Resident #1 was visually impaired and could not find the opening on the lid to drink the hot beverage. The resident attempted to remove the lid, causing the beverage to spill on her arm and leg, which resulted in second degree burns to the resident's skin. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 3/9/26 to 3/10/26, resulting in the deficiency being cited as past non-compliance with a correction date of 12/11/25. I. Incident on 11/12/25 On 11/12/25 Resident #1 requested a physical therapy assistant (PTA) to make her tea, which was dispensed from the hot water out of the coffee machine, very hot. The PTA heated up the tea in the microwave for an extra 30 seconds. The PTA secured a lid on the coffee cup and placed the cup on on Resident #1's bedside table. Resident #1 attempted to remove the lid but had difficulty finding the opening to drink out of due to her macular degeneration. Resident #1 spilled the hot tea on herself, resulting in a burn. Resident #1 was assessed and it was determined that she received second degree partial thickness burns to her arm and leg. The nurse practitioner determined the burns from the hot tea covered a 6% (percent) total body surface area. II. Facility plan of correction The plan of correction the facility implemented in response to Resident #1's burn incident on 11/12/25 was provided by the NHA on 3/10/26 at 5:40 p.m. The plan of correction documented the following: A. Immediate action to correct the deficient practice Resident #1's hot liquid burn sites were measured, the nurse practitioner was notified, assessed the injuries and treatment orders were written on 11/12/25. Staff interviews were conducted beginning on 11/12/25 regarding residents' physical and visual needs when consuming hot beverages independently for further evaluation for adaptive equipment. An audit was completed revealing no other residents were in need of an occupational therapy (OT) evaluation for adaptive equipment. Staff were informed to notify leadership if any new identified evaluations were needed. Multiple forms of education were provided to staff related to the incident beginning on 11/12/25. The hot liquid dispensers in the facility were reviewed to ensure temperatures were within acceptable ranges on 11/12/25. Signs were placed near the microwaves and in the kitchen to remind staff not to use microwaves to heat liquids beginning on 11/12/25. The Hot Beverage policy was reviewed by the interdisciplinary team (IDT) at the quality assurance performance and improvement meeting on 11/13/25. B. Systematic changes The home office clinical team, the regional director of nutrition and the regional director for the facility were notified of the incident and assisted the facility to identify the root cause of the incident and create a follow-up plan. Resident #1 was evaluated by OT on 11/17/25 to determine the type of adaptive equipment for safe consumption of hot/warm liquids with her visual impairment. Resident #1 was provided with a specialized hot beverage cup to promote independence and safety when consuming hot beverages on 11/17/25. The facility identified other residents at potential risk related to hot beverages and vision impairment. The identified residents were assessed by OT for the need for adaptive equipment on 12/11/25. One other resident was determined to benefit from adaptive equipment during hot beverage consumption. Education was added to the new hire orientation to include contract staff and the therapy department on 2/25/26. C. (continued on next page)</p>		

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 03/10/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>MonitoringA monthly audit of the hot liquid dispensers in the kitchen and the kitchenettes was conducted by the dietary manager beginning on 11/12/25 and completed on 2/27/26.III. Facility policy and procedureThe Hot Beverage policy, revised 1/10/25, was provided by the dietary manager (DM) on 3/10/26 at 4:35 p.m. The policy read, Hot beverages will be served at a palatable, safe temperature. All hot beverage machines will be set to manufacturer's established temperature recommendations to enhance quality, palatability, and safety of beverages served. Hot beverage machines will be serviced as needed and, established temperature settings per manufacturer's recommendations will be verified. (The facility) must maintain the set temperature of the machine and may not request the manufacturer to increase for any reason due to safety of the residents. If the temperature of hot beverages is not considered palatable for any reason, pour another fresh cup and do not use the microwave to reheat. Report concerns with safety/decline managing hot beverages to director of food and nutrition/IDT (interdisciplinary team)/therapy for review and any possible intervention/updates to plan of care. IV. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] discharged home on [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, unspecified cataract, unspecified macular degeneration, disorientation, unspecified, restlessness and agitation.The 10/7/25 minimum data set (MDS) assessment documented Resident #1 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS assessment indicated the resident was independent with eating and drinking. According to the MDS assessment, Resident #1 had adequate vision and did not use glasses or other corrective lenses. B. Record reviewThe activities of daily living (ADL) care plan , initiated 9/27/25, documented Resident #1 could feed herself independently but required set up assistance. The care plan interventions, initiated on 11/12/25, directed staff to encourage her to leave the lid on cups/mugs containing hot liquids, use the call light to request staff assistance for removing/replacing lids on hot liquids and provide her education on the risk for burns when reheating liquids in the microwave. According to the care plan, staff were to offer to provide the resident a hot beverage of her choice by use of the kitchen dispensing equipment.The skin integrity care plan, initiated 9/27/25, identified Resident #1 was at risk for alterations in her skin integrity related to incontinence of bladder and bowel, decreased activity, immobility, cognitive impairment, hip fracture and need for assistance with ADLs. The care plan documented Resident #1 had a burn to her right forearm and right thigh related to hot liquids (11/12/25). The care plan directed staff to provide treatment orders per her physician (11/13/25), change the dressing daily and provide the resident with a spill proof cup (11/17/25). The vision care plan, initiated 11/13/25, documented Resident #1 had a vision impairment related to cataracts, macular degeneration and diplopia (double vision). According to the care plan, Resident #1 wore an eye patch and glasses. The 11/12/25 skin assessment documented Resident #1 sustained a burn to her right lower arm and right posterior thigh when she removed the lid from a coffee container. The burn on her arm measured 8 centimeters (cm) by 5 cm. The burn to her thigh measured 12 cm by 22 cm. The burns were described as bright red and blanchable (a red or discolored area of skin that turns pale or white when pressed before quickly returning to its red color when pressure is removed). The assessment documented the resident had a burn related broken blister on her arm. The 11/12/25 nurse practitioner (NP) note documented Resident #1 was seen by the NP due to a partial thickness burn from spilling hot tea on her right forearm and right thigh. According to the note, the resident rated her level of pain as 3 out of 10 and denied numbness, tingling, fevers or chills.The 11/12/25 skin progress note documented OT notified the registered nurse (RN) that Resident #1 had spilled hot water on her right arm and right posterior thigh. The RN assessed the resident's skin. At the time of the assessment, the resident's skin was bright red without blistering. The RN applied an ice pack with a barrier to both affected areas. The RN retrieved wound orders from the NP and a broken blister to the resident's arm was noted during the wound care. The 11/13/25 nursing note identified staff (continued on next page)</p>		

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 03/10/2026
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>apologized for the burn incident to Resident #1 and reviewed a plan with the resident and her representative. According to the note, the resident and the resident's representative were informed that liquids could not be heated more than the set temperature on the coffee machine. The note documented a spill resistant cup had been ordered for the resident to help prevent a future occurrence. The 11/17/25 nursing note documented communication from OT to the nursing department related to the new cup for Resident #1. The note directed staff to provide Resident #1 with new blue insulated mugs for hot liquids, adding the milk prior to bringing the beverage to the resident so she did not need to remove the lid herself and placing the handle on the right side of her, per her preference. The 11/27/25 nursing note documented Resident #1's burn wound on her right forearm measured 3.5 cm by 2.5 cm and the right thigh burn wound measured 2.5 cm by 1 cm. The note identified both wounds presented with scabbing and the presence of epithelial tissue (tissue that appears pink or pearly white and wrinkles when touched; occurs in the final stages of healing) without infection.V. Staff interviewsRN #4 was interviewed on 3/9/26 at 5:09 p.m. RN #4 said she was newer to the facility but had learned during the facility's on boarding orientation that nothing was reheated. She said if the resident needed something warmed up, the item would go back to the kitchen. RN #1 was interviewed on 3/9/26 at 5:10 p.m. RN #1 said the facility did an performance improvement plan and an education with all staff to ensure they knew not to reheat items in the microwave. RN #5 was interviewed on 3/9/26. RN #5 said all staff knew not to reheat items for the residents. RN #1 and the director of nursing (DON) were interviewed together on 3/10/26 at 1:05 p.m. RN #1 said Resident #1 was assessed by the wound care nurse on 11/12/25. She said she assessed Resident #1's skin after the resident spilled a hot beverage on herself. She said the top layer of Resident #1's skin was red and partially removed from the burn initially and then blisters formed and broke. RN #1 said she investigated the 11/12/25 incident. She said Resident #1 wanted her tea hotter than the hot water dispensed from the kitchenette's coffee machine and requested the PTA to heat her tea. She said the PTA heated up the tea in the microwave without checking the temperature of the beverage and served it to Resident #1. She said the resident spilled the tea on herself, resulting in burns. She said the NP identified the burns as covering 6% of Resident #1's body with partial thickness. RN #1 said all the staff were educated not to reheat drinks or soups provided by the facility, in the microwave. She said the dietary manager (DM) made sure the coffee machines were set at 160 degrees fahrenheit (F). RN #1 said the facility determined the root causes of the 11/12/25 incident. She said the tea was heated up hotter than it was originally dispensed from the coffee machine. She said Resident #1 had impaired vision and removed the lid on accident trying to find the hole on top of the lid to sip out of. She said the hot tea spilled on the resident when she attempted to take the lid off. RN #1 said the facility ordered and provided Resident #1 with specialized cups with lids that she would not be able to easily remove the lid. She said the facility continued to monitor and treat the resident until she discharged home a couple weeks later. She said Resident #1's burns were scabbed over and almost healed when she was discharged . The DM was interviewed on 3/10/26 at 3:26 p.m. The DM said the facility followed manufacturer's recommendations of setting the coffee machine temperature at 160 degrees F. He said the coffee machine vendors set the temperatures of the coffee machines. He said coffee and tea were served out of the kitchenettes on the first and second floor. The DM said drinks and soups should not be reheated. He said staff should dispense new coffee or hot water for tea instead of reheating the drinks in the microwave if the coffee or tea was not warm enough when it was served. He said the facility used a lid over their hot beverages because it looked nicer and was harder to spill on the residents. The DM was interviewed a second time on 3/10/26 at 4:35 p.m. The DM said the review of manufacturer's recommendations identified the manufacturer recommended the brewing and dispensing temperature of the hot liquid to be 180 degrees F, but the facility had chosen to not set the machine brewing/dispensing temperature above 160 degrees F for safety of the residents. The NHA was interviewed on 3/10/26 at 6:38 p.m. The NHA said the facility had safety measures in place to decrease the risk of resident burns. She said the facility special ordered cups for Resident #1 (continued on next page)</p>		

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 03/10/2026
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>and other residents who were assessed for the new cups with safety lids after the 11/12/25 incident. The NHA said the facility preferred to have the coffee machine settings to dispense liquids at 160 degrees F. RN #1 and the DON were interviewed together a second time on 3/15/26 at 7:00 p.m. RN #1 said the facility audited all residents who had visual impairments to determine if those residents would be appropriate for specialized cups with handles and lids that could not be easily removed. She said the residents that were determined to be at risk for spills related to the visual impairments were provided the cups if deemed necessary and their care plans were updated to help prevent a similar occurrence. The DON said there were not set guidelines for how hot beverages should be served but the facility strived for beverages to be at 160 degrees F or below. RN #1 said staff was not allowed to reheat any food or drink that had been provided by the facility. She said if a family member brought in an item, the staff could reheat the item but staff needed to use their best judgement to ensure the item was not too hot.</p>		