

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#11) of six residents were provided the care and services necessary to ensure a safe discharge from the facility to the community out of 22 sample residents. Specifically, the facility failed to coordinate a safe discharge for Resident #11. On 4/12/26, the facility issued Resident #11 a one hour notice to pack her belongings and leave the facility due to an uninvestigated allegation that Resident #11 was providing other residents with opioids (a class of powerful drugs that carry a high risk of dependence and overdose). The facility failed to coordinate services needed to meet her medical needs, failed to ensure the resident was discharged with her prescribed medications, and failed to ensure the resident was discharged to a safe location. Resident #11 did not have a safe place to discharge and ended up homeless after the facility discharged the resident. The facility's failure to ensure Resident #11 was discharged to a safe location, had services to meet the resident's medical needs arranged, and had access to her prescribed medications created the likelihood for serious harm. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy On 4/12/26 Resident #16 alleged that that Resident #11 gave Resident #16 a narcotic medication. The facility did not investigate the allegation and instead told Resident #11 she could wait for the police to do an investigation or she could leave the facility immediately. The resident was provided an immediate discharge notice on 4/12/26. The discharge notice revealed Resident #11 was being discharged because the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident and the health of individuals in the facility would otherwise be endangered. The notice documented a 30-day notice was not provided to Resident #11 because she posed an immediate danger to the health and safety of other individuals in the facility. The notice documented Resident #11 discharge to her son's home. -However, Resident #11 did not discharge with her son and did not have a location to discharge too. The resident slept in her friend's truck for a few days and then was homeless. She went to the emergency department on the evening of 4/12/26 for her medications. However, when the hospital (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reached out to the facility to confirm the physician's orders for medication, there was no answer and the resident was not provided with her medications. She returned to the emergency department twice the next day (4/13/26) and still was unable to get her medications. -Review of Resident #11's electronic medical record (EMR) did not reveal any physician's orders indicating the resident was safe to discharge from the facility, physician's orders for the resident to discharge with her medications, a reconciliation of the resident's medications and medication list, or a discharge summary. The facilities failures to ensure Resident #11 was discharged to a safe location, had services arranged to meet the resident's medical needs, and had access to her prescribed medications created the likelihood for serious harm. B. Imposition of immediate jeopardy On 7/27/26 at 2:16 p.m. the nursing home administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failure to ensure a safe discharge for Resident #11. C. Facility plan to remove immediate jeopardy On 7/27/26 at 6:45 p.m. the facility submitted a plan to remove the immediate jeopardy. The removal plan read: 1. Corrective action On 7/27/26 an audit of all discharge documentation for the past 90 days was completed by the director of nursing (DON) or designee in order to determine if any other residents were discharged without physician ordered medications, coordinated services to meet the resident's needs, and a safe discharge location. On 7/27/26 an audit of all involuntary and immediate discharges over the past 90 days was conducted by the DON or designee to ensure all requirements were met. All discharge plans within the following 72 hours were reviewed on 7/27/26 by the NHA, the DON, the social services director (SSD) and the director or rehabilitation to ensure that the resident will have ordered medications, services coordinated to meet the resident's needs and a safe discharge location. 2. Systemic changes Beginning on 7/27/26 the SSD will coordinate care plan meetings with residents and families for all residents preparing to discharge. Resident's goals, barriers to discharge, safety concerns, and all other issues will be discussed with the resident and/or their responsible party. The SSD will ensure that the resident will have proper access to a safe discharge location by confirming the location of discharge with the resident and the family. Residents will not be discharged without participating in a meeting and all discussion will be documented in the resident's medical record by the SSD. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 7/27/26, the NHA revised the Discharge Planning Process policy to include that no involuntary/immediate discharges may occur without documented interdisciplinary team (IDT) review, medical director review, and the NHA's approval. The revision of the policy was communicated to the facility's IDT. Beginning on 7/27/26, the DON or designee will oversee resident and family orientation on medical conditions and medication administration. Resident and family orientation, as well as discharge planning, will occur at least three days prior to the resident's discharge home in a manner in which the resident and the responsible party can understand. Beginning on 7/27/26, the director of rehabilitation or designee will conduct home evaluations prior to discharge as deemed necessary, to ensure the resident's home is safe and hazard free. Each resident will receive individualized preparation, orientation, and education based on the findings from the home visit. 4. Monitoring Beginning on 7/27/26 the regional director of clinical services provided education to all department heads and licensed nurses on regulations surrounding the discharge planning process, including involuntary and immediate discharges, ensuring safe discharges are adequately coordinated, and transfer discharge including the Involuntary Discharge and the Discharge Planning Process policies. This education will become part of new hire education for all department heads and will also be conducted annually. Beginning on 7/27/26 the SSD or designee will audit all discharges for three months to ensure that residents will be discharged with physician ordered medications, as well as prescriptions for medications that are not ordered to be discharged with the resident, services are coordinated to meet the resident's needs and that the resident will be discharged to a safe location. Beginning on 7/27/26 the SSD or designee will review any resident who has had a notice of involuntary/immediate discharge issued to ensure proper discharge planning has been completed, including provision of physician ordered medications and/or prescriptions for medications that are not ordered to be discharged with the resident, services are coordinated to meet resident's needs and that the resident will be discharged to a safe location by confirming the location of discharge with the resident and family. D. Removal of the immediate jeopardy Based on the facility's plan above, the immediate jeopardy was removed on 7/27/26 at 6:45 p.m. However, deficient practice remained at a D level, no actual harm with potential for more than minimal harm. II. Facility policy and procedure The Transfer and Discharge policy and procedure, revised 4/11/25, was received from regional nurse (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	consultant #2 on 7/9/26 at 3:57 p.m. It read in pertinent part, The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs. In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding the reason for transfer or discharge will be provided by a physician. Orientation for transfer will be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner the resident can understand. III. Resident #11 A. Resident status Resident #11, age less than 65, was admitted on [DATE] and discharged on 4/12/26. According to the April 2026 computerized physician orders (CPO), diagnoses included major depressive disorder, systemic lupus erythematosus (an autoimmune disease where the body attacks healthy tissues), rheumatoid arthritis, and viral hepatitis. The 4/12/26 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented the resident did not have any physical or verbal behavioral symptoms directed towards others. The assessment documented the resident required setup or cleanup assistance from staff for all activities of daily living (ADL) and most mobility tasks. The resident required supervision or touching assistance for car transfers and walking ten feet. The assessment documented the resident was taking high-risk medications, including opioids, anti-depressants and an antibiotic. B. Resident #11 interview Resident #11 was interviewed on 7/27/26 at 10:10 a.m. via telephone. Resident #11 said on 4/12/26, the NHA told her she had one hour to get packed and be gone from the facility. She said on the morning of the discharge, a resident made an allegation that she (Resident #11) was giving the other resident her pills. Resident #11 said that was not true, since the nurse watched her take her medications. She said her male friend picked her up from the facility and she slept in his truck for a couple of days. She said she then lived on the streets. She said she went to the emergency department the evening of the discharge (4/12/26) for her medications as she thought they would be able to give her her medications. She said when the hospital reached out to the facility to confirm the physician's orders for her medications, there was no answer and she was not provided with her medications. She said she returned to the emergency department twice the next day (4/13/26), but the hospital refused to give her her prescribed medications. C. Frequent visitor interviews (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Frequent visitor #1 was interviewed on 7/6/26 at 9:45 a.m. Frequent visitor #1 said Resident #11 was going through the process of appealing her discharge from the facility. Frequent visitor #1 said Resident #11 was homeless at the time of the interview and was going from couch to couch in her friends' homes. Frequent visitor #2 was interviewed on 7/9/26 at 10:09 a.m. Frequent visitor #2 said the facility accused Resident #11 of taking drugs and sharing pain medication, and when the resident asked for a drug test, the facility initiated a discharge, citing the safety of others. Frequent visitor #2 said another resident accused Resident #11 of giving her medications and Resident #11 was discharged without an investigation. Frequent visitor #2 said Resident #11 denied sharing pain medications. Frequent visitor #2 said Resident #11 had been rehospitalized after her discharge because one of the medications she needed to take, prednisone, had not been provided to her at the time of the discharge. C. Record review The discharge care plan, initiated 2/27/26, documented Resident #11 would remain at the facility for long-term care due to her inability to care for herself outside of this setting. The substance use care plan, initiated 2/8/26, revealed Resident #11 was at risk for complications related to potential substance and alcohol use. Resident #11 was observed with a bag of methamphetamine. Pertinent interventions included notifying Resident #11's physician and monitoring her if there was suspicion of intoxication, referring the resident to mental health services for substance use treatment, and searching the resident's room if there was reasonable suspicion of substance use. Resident #11 was educated on the facility's drug and alcohol policy and expressed understanding. A progress note, dated 2/8/26 at 9:06 a.m., revealed an unidentified certified nurse aide (CNA) found a small bag of a crystal substance in Resident #11's room. The CNA was moving Resident #11's laundry and the bag fell out of the resident's sock. Resident #11 denied all knowledge of the substance and said it must have been her friend's. She said she would tell her friend not to come back. The substance was locked in the narcotic box and the charge nurse was notified. A progress note, dated 2/8/26 at 1:02 p.m., revealed the police department confirmed the substance in the bag tested positive for methamphetamines. Resident #11's physician was notified, a urine toxicology sample was collected, and her physician's orders for narcotics were held. -However, a review of the laboratory (lab) results in the resident's EMR revealed the resident's toxicology screen was negative for all substances. An IDT progress note, dated 2/10/26 at 9:52 a.m., revealed the IDT met to discuss Resident #11 having been found with methamphetamines in her room. Risk factors included Resident #11's arthritis pain, depression and lupus. Preventative measures put in place prior to the incident included monitoring the resident for any signs or symptoms of substance abuse. New interventions included providing Resident #11 with education on the facility's drug and alcohol policies. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 2/23/26 at 5:02 p.m., revealed Resident #11 met with the SSD to discuss the transitions program (a program which specializes in assisting residents when moving from a nursing facility back to the community). Resident #11 said she was comfortable at the facility. Resident #11 had not talked about moving in with her daughter recently. A progress note, dated 4/12/26 at 9:40 p.m., revealed Resident #11 had been discharged home with her family. A discharge notice, dated 4/12/26, revealed Resident #11 was being discharged on 4/12/26. The notice documented Resident #11 was being discharged because the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident and the health of individuals in the facility would otherwise be endangered. The notice documented a 30-day notice was not provided to the resident because she posed an immediate danger to the health and safety of other individuals in the facility. The notice documented Resident #11 would be living with her son, and was signed by the resident and the operations manager on 4/12/26. -The notice did not provide the electronic or physical mailing address of the facility personnel who handled appeal notices. -Review of Resident #11's EMR did not reveal any physician's orders indicating the resident was safe to discharge from the facility, physician's orders for the resident to discharge with her medications, a reconciliation of the resident's medications and medication list, or any discharge summary. III. Staff interviews The operations manager was interviewed on 7/8/26 at 1:48 p.m. The operations manager said he was working at the facility on 4/12/26 when a resident (Resident #16) approached him and told him she had gotten oxycodone from Resident #11. The operations manager said he found out Resident #11 had given the other resident the oxycodone. The operations manager said Resident #11 had a history of drug possession and suspected drug use, so the facility issued an immediate discharge because her behaviors were then involving other residents and their safety. The operations manager said initially he threatened Resident #11 with an immediate discharge, but said he would drop the discharge notice if the resident consented to the police coming in to investigate the situation. He said Resident #11 elected to leave the facility. The operations manager said Resident #11 was discharged from the facility to her son's home a few hours after the incident was discovered. The operations manager said he did not want to kick Resident #11 out, but the resident did not want the police to be involved. The operations manager said Resident #11 had since appealed her discharge, but her appeal had been denied. The operations manager said he thought Resident #11 was telling on herself by not wanting to be involved in a police investigation. The operations manager said Resident #11 had previously been found to have illicit substances on her person and said he knew she had a history of issues with substances. The operations manager said the facility was not able to verify/unable to prove if Resident #16 had actually received oxycodone, but substantiated the allegation of Resident #11 providing her with the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medication based on Resident #11's history of substance possession within the facility. The operations manager said the facility staff suspected Resident #11's son was supplying her with the medication. The operations manager said he had also offered to have Resident #11 submit for a urine toxicology screening to prove her innocence, but the resident declined that. The operations manager said Resident #16 had a physician's order for oxycodone so they could not test her to see if she had any of the medication in her system. He said the resident did not exhibit any signs or symptoms of having received an extra dose of oxycodone. Registered nurse (RN) #1 was interviewed on 7/9/26 at 1:04 p.m. RN #1 said Resident #11 had a history of substance abuse but mostly kept to herself and stayed in her room. RN #1 said a lot of the other residents liked to hang out in Resident #11's room. RN #1 said Resident #16 accused Resident #11 of giving her drugs at one point. RN #1 said Resident #16 liked to stir the pot and make accusations. The SSD was interviewed on 7/9/26 at 1:26 p.m. The SSD said Resident #11 kept to herself and was in the transitions program. The SSD said Resident #11 had admitted to the facility from the community and had pain and arthritis. The SSD said she could not recall much about Resident #11 other than that she rested a lot due to her rheumatoid arthritis and other diagnoses, and she was out of the facility a lot. The SSD reviewed Resident #11's EMR and found a consent for the resident to receive mental health services, but said she could not find any referrals for the resident for mental health or substance use services. The SSD said for residents with substance use disorders, she would offer the resident a packet of information regarding alcoholics anonymous and offer them behavioral health services. The SSD said the facility had only created one behavioral contract with one resident. The SSD said the IDT met to discuss what options the facility had tried for the resident, including non-pharmacologic interventions and therapeutic passes, and initiated behavioral contracts as a last resort. The SSD said she did not like the idea of discharging a resident and not knowing they had a safe place to go to. The SSD said after Resident #11 discharged , she tried to find another placement for the resident and sent an emergency referral. The DON, the NHA, the operations manager and regional nurse consultant #1 were interviewed together on 7/9/26 at 1:56 p.m. The DON said Resident #11 was found to have given a narcotic medication to another resident. The DON said the facility staff offered to start an investigation or let Resident #11 leave against medical advice. The DON said the nursing staff had previously found illicit substances in Resident #11's room but the resident claimed it was not hers. The operations manager said Resident #11 told him on the day of her discharge (4/12/26) that she had a history of substance use but was trying to remain clean and sober. The operations manager said the facility was aware of her history of substance use prior to 4/12/26. The DON said she had provided Resident #11 with education about the facility's drug and alcohol policies after the resident was found with illicit substances. The DON said usually whenever the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility was aware of a resident's history of substance use or drug abuse, the facility would refer the resident to behavioral health providers. The DON said Resident #11 was alert and oriented, and received anti-inflammatory medications for her arthritis and opioid medications for her pain. The DON said Resident #11 was able to manage her own medications. The DON said Resident #11 left the facility on 4/12/26 without her medications. The DON said she could not recall when Resident #11 received her medications after her discharge, but thought it was the next day or maybe a few days after 4/12/26 when Resident #11 came back to the facility to ask for her medications. The DON said Resident #11's physician said it was okay for the resident to have all of her medications besides her narcotic medications. The DON and regional nurse consultant #1 reviewed Resident #11's EMR and said they did not see any progress notes or physician's orders indicating Resident #11 could discharge with her medications. The DON and regional nurse consultant #1 both said residents needed a physician's order to discharge with their medications. The DON said generally when a resident was going to be discharged from the facility, the IDT would meet and open a discharge evaluation and each department would fill out a section of the discharge summary. The DON said the physician needed to write an order for discharge which described where the resident would be discharging to and indicated whether the resident would discharge with their medications. The operations manager said the facility did conduct an investigation following Resident #16's allegation. The operations manager said Resident #16 already had a physician's order for oxycodone so they could not do a urine toxicology screening for Resident #16. He said Resident #11 had already left the facility before the facility's administration staff could search her belongings to see if the resident had any other illicit substances in her possession. The operations manager said the facility did notify the police department, but the police department did not come to the facility and said there was no further investigation needed since Resident #16 already took the medication she was allegedly given by Resident #11. The operations manager said he had a conversation with Resident #11 and said the facility either had to have the police come to the facility and investigate Resident #16's allegation or issue Resident #11 an immediate discharge notice. The DON and the NHA both said Resident #11 refused to submit to a police investigation. The DON said the facility had not initiated any behavior contracts with Resident #11. Regional nurse consultant #1 said she saw a progress note in Resident #11's EMR which revealed a behavioral health services provider was scheduled to come to the facility to evaluate Resident #11. Regional nurse consultant #1 said she could not see any documentation in Resident #11's EMR which revealed the resident had actually been seen by the behavioral health services physician or any follow-up notes after 3/17/26. The operations manager said Resident #11's son came to pick her up and said the resident would be staying with him. The operations manager said Resident #11's son said his house would be safe for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident. The operations manager said Resident #11's son told the facility he did not want the resident to live in his house long-term but said it was safe for her in the meantime. -However, the operations manager said in an earlier interview that the facility staff had suspected Resident #11's son was supplying her with illicit substances (see interview above). The operations manager said Resident #11's immediate discharge was dependent on Resident #16's claim that Resident #11 gave her oxycodone. The DON said the instance with Resident #16 was the first instance Resident #11 had been accused of giving another resident medications. The DON said when the police came to the facility in February 2026 to investigate Resident #11's bag of illicit substances, the police officer told the DON that having illicit substances in the facility could get the facility shut down. The DON said Resident #11 did not have any history of any other behaviors. The DON said Resident #11 sometimes had people coming in and staying the night in her room, or she would go out of the facility and come back late at night. The DON said the facility was not aware the resident was homeless. The operations manager said Resident #11 had appealed her discharge with the facility on 4/21/26 and was denied. The operations manager said he received notification on 5/6/26 that Resident #11 was appealing her discharge with the facility's grievance committee. He said the grievance committee had also denied her appeal. The medical director was interviewed on 7/27/26 at 12:42 p.m. The medical director said Resident #11 was dealing drugs to other residents. He said he had a discussion with the IDT about a behavior contract for the resident. He said if a concern caused issues with other residents or involved other residents, he thought it was standard to discharge a resident if other residents were at risk. He said he was not aware that Resident #16's allegation was not substantiated against Resident #11. He said he was not aware Resident #11's 2/8/26 toxicology screen was negative. He said he thought it was substantiated and agreed with the discharge. He said he would discuss immediate discharges with the IDT.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were provided prompt efforts by the facility to resolve grievances for five (#10, #13, #14, #24 and #8) of six residents reviewed for grievances out of 22 sample residents. Specifically, the facility failed to provide timely follow-up on grievances reported by Resident #10, Resident #13, Resident #14, Resident #24 and Resident #8 or their representatives. Findings include: I. Facility policy and procedure The Resident and Family Grievances policy and procedure, implemented 4/11/25, was received from regional nurse consultant #2 on 7/9/26 at 3:57 p.m. It read in pertinent part, The grievance officer is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, and issuing written grievance decisions to the resident. The facility will make prompt efforts to resolve grievances. II. Resident #10A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, type 2 diabetes, chronic respiratory failure and vascular dementia. The 4/1/26 minimum data set (MDS) assessment revealed the resident had significant cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. The resident required partial to moderate assistance from staff for most activities of daily living (ADL). B. Resident representative interview Resident #10's representative was interviewed on 7/9/26 at 9:51 a.m. The resident's representative said she had filed a lot of grievances with the facility regarding Resident #10's incontinence care, not following care conference agreements, medication errors, diet textures and lack of assistance. The resident's representative said the facility's response to her grievances had not been good. The resident's representative said the week prior she had attended a care conference during which she had highlighted several ongoing problems with Resident #10's care. The resident's representative said the director of nursing (DON) said she would address her concerns that Monday (7/6/26) but the resident's representative still had not heard from her. The resident's representative said when the facility finally got around to answering her grievances they called her to tell her their action plan, had her come in to the facility and sign the grievance to say the issue was resolved. The resident's representative said she was not going to sign any more grievances unless she actually felt the grievance was resolved. The resident's representative said the facility's grievance process was frustrating to say the least. The resident's representative said she had filed approximately 20 grievances in the span of a year, but said she stopped submitting them for a while because she felt the facility was not doing anything with them. The resident's representative said she felt like the facility was not listening to her concerns and not changing anything. C. Record review A grievance form, dated 6/6/26, revealed Resident #10's representative submitted a grievance regarding Resident #10's diet texture. The grievance findings summary documented the facility had contacted Resident #10's physician to repeat a swallow study in order to see if her diet could be liberalized. A written decision was issued on 6/16/26 and the grievance was signed on 6/16/26 by Resident #10's representative, the social services director (SSD) and the nursing home administrator (NHA). -However, the written decision was not issued until 10 days after Resident #10's representative filed the grievance. III. Resident #13A. Resident status Resident #13, age [AGE], was admitted on [DATE]. According to the July 2026 CPO, diagnoses included chronic congestive heart failure, acute respiratory failure, and chronic obstructive pulmonary disease. The 6/1/26 MDS assessment revealed the resident was cognitively intact with a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIMS score of 15 out of 15. The resident required partial to maximal assistance from staff for most ADLs.B. Resident representative interviewResident #13's representative was interviewed on 7/9/26 at 12:43 p.m. The resident's representative said it seemed like it took the facility a while to get back to her about any grievances she submitted on behalf of Resident #13. The resident's representative said she submitted one grievance where it took the facility nearly five months for the facility to respond. The resident's representative said there was an instance a few months ago in which Resident #13 was improperly transferred and nearly had a fall as a result. The resident's representative said she submitted a grievance regarding the situation and it took a long time for the facility to get in touch with her. The resident's representative said the facility usually took so long to get back to her about the grievances she submitted that she would forget what the issue was that she initially had concerns about.C. Record reviewA grievance form, dated 5/4/26, revealed Resident #13's representative had submitted a grievance. The concern listed was that a new certified nurse aide (CNA) was working with Resident #13 and attempted to assist the resident into the bathroom. The CNA did not engage the brakes on the mechanical lift and Resident #13 began to fall. Resident #13 was supposed to be transferred with two people.The grievance summary of findings revealed the administration confirmed the CNA did not properly engage the brakes on the mechanical lift and that Resident #13 did require two people to assist her during transfers. The nursing staff were reeducated on Resident #13's transfer status and proper transfers.A one-to-one inservice on transfers for the CNA involved in the transfer was attached to the grievance and dated 5/22/26.Resident #13's representative documented she was not satisfied with the resolution of the grievance on 5/28/26 as she noted the CNA performing the transfer was repeatedly told by Resident #13 that she needed two people to assist her during transfers. Resident #13's representative noted no amount of extra training would benefit the situation as it was a matter of integrity.The form documented the SSD had discussed the grievance in detail during Resident #13's care conference on 6/8/26 and noted Resident #13's representative still refused to sign the grievance. A written decision was issued on 6/8/26 and was signed by the grievance official (the SSD) and the nursing home administrator (NHA) on 6/8/26. -However, the decision was issued 35 days after Resident #13's representative had submitted it, and did not include any information regarding follow-up of the concerns Resident #13's representative documented on 5/28/26.IV. Resident #14A. Resident statusResident #14, age [AGE], was admitted on [DATE]. According to the July 2026 CPO, diagnoses included coronary artery disease, generalized muscle weakness and cognitive communication deficits.The 2/7/26 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of nine out of 15. The resident required partial to substantial from staff for most ADLs.B. Resident representative interviewResident #14's representative was interviewed on 7/9/26 at 11:13 a.m. The resident's representative said it took the facility a long time to get back to her about any grievances she submitted on behalf of Resident #14. The resident's representative said it took the facility five weeks to get back to her about her most recent grievance and said the concern still had not been fixed. The resident's representative said the SSD told her she was overwhelmed with grievances. The resident's representative said when she tried to address her concerns with the staff in person they did not want to hear about the issue then, so they told her to write a grievance. The resident's representative said it felt like the facility was tired of hearing from her. The resident's representative said if she felt like an issue from a grievance was not resolved, the SSD would tell the resident's representative she would talk with the staff and get back with her. The resident's representative said she felt like she was at a dead end.C. Record reviewA grievance form, dated 5/10/26, revealed Resident #14's representative filed a grievance regarding floors in the dining room being sticky and the dining room (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not having paper towels or coffee available. The grievance findings summary revealed staff were provided education on maintaining the dining room atmosphere. Supplies, including coffee and paper towels, were in place. Regular cleaning of the dining room was in place, and the director of maintenance was to monitor the dining room atmosphere. A written decision was issued on 5/12/26. Resident #14's representative documented she was satisfied with the resolution of the grievance and signed the grievance on 5/25/26, and the SSD and NHA signed the grievance on 5/20/26. -However, the grievance was not signed by Resident #14's representative until 15 days after the grievance was filed. A grievance form, dated 6/23/26, revealed Resident #14's representative filed a grievance regarding delays in Resident #14's ADL care and the floors of the facility being sticky. The grievance findings summary revealed Resident #14's call light was not consistently in reach and the floors were confirmed to be sticky. ADL timing concerns were partially validated based on staffing workflow. The issues identified required follow-up to support safety and timeliness of care. The grievance was signed on 6/29/26 by the SSD and the NHA. -However, no written decision was issued, and Resident #14's representative did not sign the grievance or document whether or not she was satisfied with the resolution. Additionally, the grievance was not signed by the SSD or NHA until six days after it was initially filed. V. Resident #24A. Resident statusResident #24, age [AGE], was admitted on [DATE]. According to the July 2026 CPO, diagnoses included osteoarthritis, congestive heart failure and atrial fibrillation. The 4/8/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required setup or cleanup assistance from staff for most ADLs. B. Record reviewA grievance form, dated 5/22/26, revealed Resident #24 submitted a grievance related to breakfast meal service. Resident #24 documented his breakfast was served late every day which was causing him to miss his transportation each morning. The grievance findings summary revealed Resident #24's meal ticket would be served first during meal service. A written decision was issued 6/16/26. Resident #24 documented he was satisfied with the results of the grievance and signed the grievance on 6/16/26 along with the SSD and NHA. -However, a written decision was not issued until 25 days after Resident #24 initially filed the grievance. VI. Resident #8A. Resident statusResident #8, age less than 65, was admitted on [DATE] and discharged to another facility on 6/11/26. According to the June 2026 CPO, diagnoses included type 1 diabetes with diabetic neuropathy. According to the 6/11/26 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent for most ADLs. B. Record reviewA grievance form, dated 5/21/26, revealed Resident #8 submitted a grievance which documented he had not gotten his breakfast or lunch trays on multiple occasions. The grievance findings summary revealed there had been a few instances in which the kitchen did not have the ingredients to make what Resident #8 had requested or did not have his meal ticket. The dietary staff were educated on how to handle issues with missing ingredients. A written decision was issued on 5/30/26 and the form documented Resident #8 was satisfied with the resolution. A note on the grievance form revealed Resident #8 was not available to sign the grievance form and did not answer his phone when the facility attempted to call him. -However, the written decision was issued nine days after the resident filed the grievance, and marked as resolved despite the facility not being able to make contact with the resident. VII. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 7/9/26 at 9:09 a.m. CNA #4 said if a resident had a concern she would fill out and turn in a grievance form. CNA #5 was interviewed on 7/9/26 at 9:19 a.m. CNA #5 said if a resident or their family voiced a concern she would tell the nurse about it, and the nurse would handle it. CNA #5 said she never had to fill out a grievance form because if a resident was missing an item she was usually able to find it fairly quickly. CNA #6 was interviewed on 7/9/26 at 9:35 a.m. CNA #6 said if a resident or their family voiced a concern she (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would let the nurse know. CNA #6 said she had never filled out a grievance form and said she did not know when she would need to fill out a grievance form. Licensed practical nurse (LPN) #3 was interviewed on 7/9/26 at 12:58 p.m. LPN #3 said if a resident or their family expressed a concern or said they were missing an item, she would fill out a grievance form and let the DON know. The SSD was interviewed on 7/9/26 at 1:26 p.m. The SSD said the facility had a grievance binder and grievance tracking log. The SSD said whenever someone submitted a grievance it was supposed to be turned in to her first. The SSD said grievances were discussed each morning during the staff's morning meeting, and she would pass out the grievances to their respective departments. The SSD said the facility's individual departments were supposed to work to resolve the issue and said she was supposed to follow up and ensure it was complete. The SSD said ideally the issue would be resolved sometime between 72 hours and seven days after the grievance was submitted. The SSD said she had taken over as the grievance official at the beginning of March 2026. The SSD said she had found some old grievances that had not been followed up on because they had not been documented in the grievance tracker. The SSD said she had dropped the ball on some of the grievances that were submitted over the weekend, as the grievances were sometimes then distributed to their respective department before she could review them. The SSD said she tried to go through her grievance tracker if grievances came up during the facility's angel rounds or if a number of grievances are received about the same issue, and look to make sure all of the grievances in the tracker were completed and see if she had missed any. The SSD said the facility's grievance process is supposed to be set up in a way that she (the SSD) received the grievances first before they get distributed. The SSD said if the family member or resident still was not satisfied she would follow up with them and tried to have them document why they were dissatisfied. The SSD said she tried to follow up with family members in that case whenever they visited next. The SSD said she verbally brought up when people were dissatisfied with the grievance resolution during interdisciplinary team (IDT) meetings so the team could brainstorm solutions. The SSD said once the grievance has a record conclusion or finding, she would present the resident or their family member with the grievance and have them sign and date it. The DON, the NHA and regional nurse consultant #1 were interviewed together on 7/9/26 at 1:56 p.m. The DON said any staff member could help a resident fill out a grievance form if the resident has a concern, and the grievance form would then be turned in to the SSD. The DON said the SSD reviewed grievances during the facility's morning meetings before distributing the grievance to the proper department. The DON said the facility's goal was to follow-up on the grievance within 72 hours as often as possible. The DON said sometimes the resident or their family member were still not satisfied with the conclusion of the grievance. The DON said if the resident or their family member were not satisfied with a specific staff member she would remove the staff member from that resident's service. The NHA said the facility also reviewed grievances during their daily afternoon meetings. The NHA said when a resident or their representative were still dissatisfied, they would meet with the SSD to determine a root cause of the issue or set up a care conference with the resident and their representative to talk about and continue to address their issues. The DON said the facility had experienced some turnover in staffing and had started providing the staff with education on grievances and returning grievances to the SSD in a timely manner. Regional nurse consultant #1 said the facility had started a performance improvement plan on grievance processes that day and had also started their staff education on grievances that day (7/9/26).-However the facility did not identify or begin to address the issues in the facility grievance process until 7/9/26 (during the survey process).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to provide written notification of room changes and roommate changes for one (#15) of three residents reviewed for notifications out of 22 sample residents. Specifically, the facility failed to provide timely written notification of room changes to Resident #15 and/or the resident's representative in a language the resident could understand. Findings include: I. Facility policy and procedure The Change of Room or Roommate policy, undated, was provided by the regional clinical resource #2 on 7/9/26 at 3:57 p.m.. The policy read in pertinent part, It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary and/or when requested by the resident or resident representative. Before making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands, and will include the reason(s) why the move or change is required. II. Resident #15A. Resident status Resident #15, age [AGE], was admitted to the facility on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included anxiety disorder, depressive episodes, muscle weakness, history of falling, and transient ischemic attack (stroke). The 4/22/26 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. The MDS assessment indicated that the staff should not conduct an assessment for mental status. She was independent with eating. She required substantial to maximal assistance with oral hygiene, showers and bathing, and upper- and lower-body dressing and chair-to-bed transfers. She was dependent on staff for toileting hygiene. The MDS assessment indicated her preferred language was Korean. B. Record review The communication care plan, initiated 7/26/25, revealed the resident was at risk for impaired cognitive function/dementia. The notice of room change notification form, dated 5/20/26, revealed a verbal okay via phone call was obtained from the guardian of Resident #15 to change rooms for census needs. The form documented consent was given verbally and was signed by the social services director (SSD).-However, there was no documentation in Resident #15's electronic medical record (EMR) to indicate the facility provided the resident with written notification of the room change in her preferred language. The notice of room change notification form, dated 5/29/26, revealed a verbal okay via phone call was obtained from the guardian of Resident #15 to change rooms for census needs. The form documented consent was given verbally and was signed by the SSD.-However, there was no documentation in Resident #15's EMR to indicate the facility provided the resident with written notification of the room change in her preferred language. The notice of room change notification form, dated 6/3/26, revealed a verbal okay via phone call was obtained from the guardian of Resident #15 to change rooms for census needs. The form documented consent was given verbally and was signed by the SSD.-However, there was no documentation in Resident #15's EMR to indicate the facility provided the resident with written notification of the room change in her preferred language. C. Staff interviews Registered nurse (RN) #1 was interviewed on 7/7/26 at 1:10 p.m. RN #1 said Resident #15 did not speak English very well. She said the resident could answer simple yes or no questions in English. She said the resident's primary and preferred language was Korean. She said if there were room changes that need to be communicated to the resident, the facility staff would use Google translate. She said the SSD was responsible for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informing the resident about the room change and documenting it in the resident's EMR. The SSD was interviewed on 7/7/26 at 1:18 pm. The SSD said Resident #15 changed rooms because of facility census needs. She said she notified the resident's guardian every time there was a facility-initiated room change. She said the resident did not speak English. She said she would use Google translate to communicate with the resident if needed. She said she always used Google Translate because she was unsure if the facility had a translation service. She said she did not inform the resident of the room changes, because the guardian said she would inform the resident of the room change. She said she should have made an attempt to inform the resident of the room change via Google translate. The director of nursing (DON) and regional clinical resource #2 were interviewed together on 7/7/7 at 2:15 p.m. The DON said if the resident was agreeable to a room change, the SSD would provide written notification to the resident with a five-day notice of appeal. She said the room change notification documentation would be completed by the SSD. She said documentation would be available in the resident's EMR either in the progress notes or on an uploaded room change notification form. Regional clinical resource #2 said a performance improvement plan was initiated recently because the facility identified that the lack of documentation was not being uploaded in the residents' charts regarding room changes. She said she would reeducate the SSD immediately regarding the importance of informing the resident directly and documenting it in the resident's EMR.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident's next of kin when there was a significant change in the resident's condition for one (#12) of three reviewed out of 22 sample residents. Specifically, the facility failed to notify the resident's next of kin in a timely manner when Resident #12 passed away. Findings include: I. Facility policy and procedure The Change of Condition policy and procedure, dated 3/3/26, was provided by the regional clinical resource #2 on 7/9/26 at 3:57 p.m. It read in pertinent part, A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting), impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source, there is a significant change in the resident's physical, mental, or psychosocial status; to include active substance use/abuse, there is a need to change the resident's room assignment, a decision has been made to discharge the resident from the facility, and/or it is necessary to transfer the resident to a hospital/treatment center. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. II. Resident #12A. Resident status Resident #12, age less than 65, was admitted on [DATE] and passed away on 4/19/26 at the facility. According to the April 2026 computerized physician orders (CPO), diagnoses included polyneuropathy, type two diabetes without complications, and unspecified protein-calorie malnutrition. The 2/16/26 minimum data set (MDS) assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. B. Next of kin interview Resident #12's next of kin was interviewed on 7/8/26 at 11:50 a.m. She said that the conversations between her and the facility social worker were very few and far between. She said when the resident admitted to hospice, he did not contact his family, because he did not want to be a burden on his family members. She said she thought it was because he did not want to be a burden and that he understood that he was going to die. She said one time, the facility social worker had called her to give her the facility phone number. Resident #12's next of kin said she gave the phone number to multiple friends and family members and none of them (including herself) were able to get through. She said the phone would just ring and ring and no one would pick up. She said she was contacted by the facility two days after Resident #12 passed away. She said she was surprised and disappointed the facility had not contacted her sooner. She was told that Resident #12's body had been taken to the county coroner's office. She said because she lived out of state, she did not realize that there were three different county coroner's offices. She said she called all three of them and none of them had Resident #12's body. She said during the time that she was trying to locate Resident #12's body, she continued to try and contact the facility. She said when she called the facility the phone would just ring and ring. She said she eventually called the local police to go to the facility to find out what was going on. She said she got a phone call after the police went to the facility. She said when the social worker called her she was told that hospice had been called in when Resident #12 passed away and that Resident #12 was taken to a funeral home. She said the social worker gave her the phone number to the hospice provider. She said she tried calling the hospice provider, but they never picked up or called her back. She said she then began calling (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each funeral home and mortuary to locate Resident #12's body. She said she eventually got a call back from one stating that they had Resident #12's body. She was told by the mortuary that she was listed as his next of kin. She said it was heartbreaking not knowing where Resident #12's body was. She said Resident #12 had his wife's ashes in his belongings at the facility when he passed away. She said the mortuary helped her coordinate with getting his ashes and her ashes shipped out to her. She said the facility did not help with that at all. She said she had to call the police to go out to the facility two more times to get any kind of call back from the facility. She said she was told by the facility that they had tried calling Resident #12's son. She said that Resident #12 and his son had not been in contact with each other for a while. III. Record reviewResident #12's care plan was initiated on 5/19/26 (31 days after he passed) documented Resident #12 needed to identify a medical power of attorney. The care plan documented the resident had the cognitive ability to appoint an agent. The care plan further documented the resident was on hospice care. A social services note, dated 10/29/25, documented that Resident #12's son wanted to be removed from the resident's contact list and to be removed as the financially responsible party. -Review of Resident #12's EMR revealed the facility failed to remove the son as the resident's emergency contact #2.A weight change note, dated 2/13/26, documented that staff stated Resident #12 had worsening mood/motivation following recent family issues. -However, there was no documentation of the family issues. A social services note, dated 2/16/26, documented that verbal consent was obtained to contact Resident #12's sister (next of kin), who lived out of state, for support. -However, there was no documentation on what was discussed with his sister. A social services note, dated 2/27/26, documented that palliative care and hospice services were discussed with Resident #12 as well as having a medical power of attorney. The note documented that a good candidate would be his sister. The note documented that Resident #12 was agreeable. -However, the EMR did not have any further documentation of his sister agreeing or disagreeing to be his medical power of attorney or any documentation of Resident #12 disagreeing to have her as his medical power of attorney. A social services note, dated 3/4/26, documented that a referral for hospice care was being prepared.A physician's order documented that Resident #12 was admitted to hospice on 3/4/36. A nurse's note, dated 4/19/26 at 6:09 p.m., documented that Resident #12 was found by a certified nurse aide (CNA) unresponsive. The note documented that Resident #12 was a do-not-resuscitate (DNR). The note documented Resident #12 did not have a heartbeat, was not breathing and did not have a pulse. The note documented that hospice was notified and arrived about 30 minutes later and finalized all the paperwork needed for the mortuary to come and pick up the body of Resident #12. A nurse's note, dated 4/20/26 at 8:42 a.m., documented Resident #12 was found in bed unresponsive on 4/19/26 at 6:20 p.m. Resident #12 was assessed by two nurses and then hospice was notified. The hospice nurse arrived to the facility at 7:44 p.m. and the county coroner was notified by the hospice nurse. The county coroner pronounced Resident #12's death at 7:55 p.m. The note documented that, per hospice, Resident #12 did not authorize family contact. A social services note, dated 4/20/26, documented that social services called the resident's son who was listed as the emergency contact #2 and left a voice message. A social services note, dated 4/21/26, documented that social services called the resident's son and left a voice message. -However, the 10/29/25 progress note documented the son did not want to be the resident's emergency contact (see above).IV. Staff interviewsThe director of nursing (DON) was interviewed on 7/7/26 at 3:43 p.m. The DON said the hospice staff communicated with the facility through email, verbally, and communication binders. She said depending on what hospice company the resident was with, either the hospice company or the facility notified the family of the death. She said that Resident #12 was alert and oriented and did not want his family notified. She said that Resident #12's son was very (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	angry at the resident. The social services director (SSD) was interviewed on 7/7/26 at 4:28 p.m. The SSD said that she currently had Resident #12's belongings. She said that Resident #12's son wanted them to throw them out. She said the facility did not have any documentation that Resident #12 did not want his family to be notified of his death. She said she had gotten verbal permission from Resident #12 to call his sister (his next of kin) on 2/16/26. She said when she spoke to his sister it sounded like she was ready to be his medical power of attorney. She said she did not document the conversation that she had with his sister. She said she said Resident #12's son was never taken off as emergency contact #2. She said she would contact the hospice care company and get their documentation on Resident #12 not wanting to notify his family. -The hospice documentation was uploaded to Resident #12's EMR on 7/8/26 during the survey process (see record review above).V. Facility follow-up On 7/13/26 at 1:31 p.m., an attestation was sent by the regional clinical resource #1. The attestation documented that the SSD recalled Resident #12 expressing that he did not want his family notified upon his passing. The attestation documented that the conversation happened in the presence of a hospice care consultant. It further documented that the SSD did not document Resident #12's statement. The attestation documented that upon review of the hospice documentation, the resident was consistently referred to as being estranged from his family.-However, the SSD said during the survey that she did not document the conversation (see interviews above).On 7/13/26 at 6:26 p.m., a hospice coordination note was sent by the regional clinical resource #1. The note dated 4/1/26, documented that Resident #12's son had been visiting him but Resident #12 did not want to add him as his power of attorney or on the contact list. The note documented that Resident #12 did not want his family to be updated. -However, hospice documentation was not received until 7/8/26 (during the survey).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#4 and #16) of six residents reviewed for abuse out of 22 sample residents were kept free from abuse. Specifically, the facility failed to:-Protect Resident #4 from verbal abuse by Resident #5; and,-Protect Resident #16 from sexual abuse by Resident #4. Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy and procedure, revised 5/6/26, was received from regional nurse consultant #2 on 7/9/26 at 3:57 p.m. It read in pertinent part, The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. Identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect.II. Incident of verbal abuse between Resident #4 and Resident #5A. Facility investigation The facility investigation, dated 5/8/26, was provided by regional nursing consultant #2 on 7/7/26 at 9:03 a.m. The investigation revealed the following:On 5/8/26, Resident #4 reported to facility staff that Resident #5 had verbally threatened him. Resident #4 said Resident #5 had called him a pervert and said he (Resident #5) would dismember his penis and crush his skull. Resident #4 expressed fear for his safety as a result of those statements.The residents were separated. Resident #5 was put on 15-minute checks for closer monitoring and was referred to a mental health services provider. Monitoring was additionally initiated for Resident #4 and measures were taken to support Resident #4 and address his concerns. An interview with Resident #4, dated 5/8/26, revealed Resident #4 said Resident #5 threatened him, called him a pervert, and said he was going to dismember Resident #4's penis and crush his skull in five days.An interview with Resident #5, dated 5/8/26, revealed Resident #5 did not deny Resident #4's allegations and said he did call Resident #4 a pervert. Resident #5 said if Resident #4 did not leave him alone in five days he would crush his skull.The facility substantiated the abuse allegation based on staff documentation and the residents' interview statements. The investigation documented though there was no evidence of physical injury, Resident #5's behavior resulted in emotional distress for Resident #4 and required immediate intervention by the facility staff.The investigation documented a statement from the operations manager, undated, which revealed prior to 5/8/26, Resident #4 and Resident #5 were observed interacting regularly and appeared friendly. On 5/8/26 Resident #4 approached the operations manager and told him he felt nervous after Resident #5 told him he would have a biker gang put his head on the flagpole. The operations manager spoke with Resident #5 who was surprised Resident #4 had taken his comment as a threat, as he did not intend to threaten the resident. The operations manager documented he saw Resident #4 and Resident #5 speaking together on 5/9/26 and Resident #5 apologized and said he did not mean for his comments to be interpreted as threatening. The operations manager spoke with Resident #4 who said he felt better after talking with Resident #5. -However, the facility substantiated the allegation of verbal abuse, and verbal abuse did occur between Resident #5 and Resident #4 after Resident #5 made specific threats of bodily harm toward Resident #4.B. Resident #5 (assailant)1. Resident statusResident #5, age less than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included major depressive disorder, generalized anxiety disorder and attention-deficit hyperactivity disorder.The 6/8/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required setup or cleanup assistance from staff for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most activities of daily living (ADL).The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.2. Record reviewThe psychotropic medication care plan, revised 5/22/26, revealed Resident #5 used psychotropic medications. Pertinent interventions included administering the medications as ordered and reporting lack of effectiveness or breakthrough behaviors.A behavior care plan, initiated 5/20/26, revealed Resident #5 demonstrated difficulty maintaining appropriate interpersonal boundaries and engaged in negative verbalizations or discussions about other residents, contributing to potential psychosocial distress and risk for resident-to-resident conflict. Resident #5 had a history of interpersonal concerns noted in communal living environments. Pertinent interventions included providing Resident #5 education on appropriate boundaries and respectful communication with peers, monitoring for signs of interpersonal conflict, and providing interventions as needed to address social skills and coping strategies.A progress note, dated 4/23/26 at 6:57 p.m., revealed Resident #5 was yelling at a nurse because a behavioral health provider had not seen him yet that day. Resident #5 appeared increasingly anxious and was going in and out of the facility repeatedly. A progress note, dated 5/3/26 at 11:20 p.m., revealed Resident #5 was observed by nursing staff with a strong odor consistent with marijuana use and demonstrated restless, intermittent agitation and repeated pacing in and out of the facility.A behavior note, dated 5/4/26 at 5:33 p.m., revealed Resident #5 had an appointment with an outside dental services provider. While there, Resident #5 admitted to their staff he was drinking alcohol and smoking marijuana each day. The dentist called the facility and Resident #5 became belligerent with the dental staff and cursed at the dentist. The dental services provider communicated to the facility Resident #5 was no longer welcome at their clinic due to his behaviors. Resident #5 was picked up by facility transportation at a liquor store. A change in condition note, dated 5/8/26 at 12:56 p.m., revealed Resident #5 was evaluated by the nursing staff for a change in condition. Resident #5 was documented as having physical aggression, verbal aggression, personality changes and was a danger to himself or others. Resident #5 was disruptive upon his return to the facility and stated to a staff member that he was very drunk and went down the street to drink. Resident #5 then yelled nonsensical ramblings at a staff member. Resident #5 then said he wanted to know why another resident (Resident #4) was still in the building and said he would cut his penis off. Resident #5 additionally told the nursing home administrator (NHA) that he was going to bash (Resident #4)'s skull in five days.A progress note, dated 5/8/26 at 6:54 p.m., revealed Resident #5 was noted to be intoxicated with alcohol as evidenced by his slurred speech, smell of alcohol and verbal aggression. The NHA and the director of nursing (DON) were aware. Resident #5's physician was notified and his medications were held.A progress note, dated 6/23/26 at 11:05 p.m., revealed Resident #5 returned to the facility from the emergency room that evening. The emergency medical technicians transporting Resident #5 relayed to facility staff that the resident had tested positive for alcohol over the legal limit and possible methamphetamines. The emergency medical technicians found a pocket knife on Resident #5's person which was placed in the facility nurse's medication cart for safe keeping.A psychiatric evaluation note, dated 6/25/26 at 8:00 a.m., revealed Resident #5 was seen by his psychiatrist. Resident #5 had a history of major depressive disorder, anxiety disorder, post traumatic stress syndrome (PTSD) and history of stimulant misuse. Facility staff reported Resident #5 had an increase of aggression and had been identified drinking alcohol. C. Resident #4 (victim)1. Resident statusResident #4, age less than 65, was admitted on [DATE] and discharged to another facility on 6/27/26. According to the June 2026 CPO, diagnoses included bipolar disorder, cognitive communication deficits, traumatic brain injury, depression and paraphilia (intense, persistent sexual interest or urges involving atypical objects, situations, activities, or non-consenting (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individuals).The 6/15/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The resident required setup or cleanup assistance from staff for all ADLs.The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.2. Record review-Review of Resident #4's electronic medical record (EMR) revealed no documentation related to the verbal abuse incident with Resident #5 on 5/8/26 (see investigation above).D. Staff interviewsRegistered nurse (RN) #1 was interviewed on 7/9/26 at 1:04 p.m. RN #1 said Resident #5's behaviors depended on the day and he was unpredictable. RN #1 said Resident #5 used to yell at staff and other residents, but said his behavior had gotten better over time. RN #1 said Resident #5 could generally be redirected when having behaviors by having a conversation with him, but said the resident was manipulative and would push the limits on any facility rules.The DON and the NHA were interviewed together on 7/9/26 at 1:56 p.m. The DON said Resident #5 was generally a nice guy, but became belligerent when he was under the influence. The DON said Resident #5 became verbally abusive toward staff when he was under the influence and was not redirectable. The DON said the facility staff had found paraphernalia in Resident #5's room, including alcohol bottles, and had offered the resident sobriety resources. The DON said Resident #5 was very coercive and had broken a lot of the facility's rules. The DON said the facility had recently had to call for police assistance with Resident #5 and the police had found drug paraphernalia and pills on the resident's person. The DON and the NHA said Resident #5 and Resident #4 were roommates but had started to not get along, so Resident #4 was moved to a different room. The DON said the facility had initiated a behavior contract with Resident #5 as his behavior could affect other residents and the facility staff.III. Incident of sexual abuse by Resident #4 toward Resident #16A. Facility investigationThe facility investigation, dated 6/13/26, was provided by regional nurse consultant #2 on 7/7/26 at 9:03 a.m. The investigation revealed the following:On 6/13/26 at 10:00 a.m. Resident #16 reported via grievance form that Resident #4 had touched her inappropriately during breakfast the day prior (6/12/26). The residents were separated and assessed, and Resident #4 was placed on one-to-one supervision by staff.An interview with Resident #16, dated 6/13/26, revealed Resident #4 touched inside Resident #16's shirt and made contact with her breast. Resident #16 described the touch as unwanted and not consensual. An interview with Resident #4, dated 6/13/26, revealed Resident #4 acknowledged he had touched Resident #16 and said he thought she was comfortable with the interaction because they were friends. The facility substantiated the abuse allegation based on the interviews from both residents.B. Resident #4 (assailant)1. Record reviewA behavior care plan, dated 3/5/26, revealed Resident #4 had a history of inappropriate sexual behaviors. Pertinent interventions included monitoring Resident #4 for impulsive or sexualized behaviors, using redirection to maintain boundaries, and providing one-to-one supervision while awake with staff remaining within line of sight at all times.The safety awareness care plan, initiated 5/25/26, revealed Resident #4 had impaired judgement and decreased safety awareness related to his history of traumatic brain injury. Pertinent interventions included providing supervision, cueing and redirection as needed for safety and appropriate decision making, reinforcing safe behaviors, and monitoring for changes in mood, behaviors of function.A nursing summary evaluation, dated 4/20/26, revealed Resident #4 had experienced multiple behavioral episodes at the time. Resident #4 had to be redirected by nursing staff about exhibiting sexual behaviors, attempting to kiss staff members and speaking inappropriately.A progress note, dated 4/28/26 at 3:23 p.m., revealed nursing staff had to redirect Resident #4 for being in other people's personal space and attempting to kiss another resident.A progress note, dated 6/16/26 at 7:11 a.m., revealed Resident #4 was being monitored each shift for behaviors after he touched a female resident's breasts. Review of Resident #4's June 2026 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CPO revealed the following order:Monitor episodes of verbal outbursts, hypersexual behaviors, extreme mood swings, manic episodes and difficulty concentrating and record non-pharmacologic interventions each shift for anti-psychotic medication monitoring, ordered 2/18/26.Review of Resident #4's May 2026 treatment administration record (TAR), from 5/1/26 to 5/31/26, revealed the following:-Resident #4's behavior monitoring was not recorded for 13 out of 62 total opportunities; and,-Resident #4 had 14 documented behavioral episodes during the period.Review of Resident #4's June 2026 treatment administration record (TAR), from 6/1/26 to 6/27/26, revealed Resident #4's behavior monitoring was not recorded for seven out of 54 total opportunities.C. Resident #16 (victim)1. Resident statusResident #16, age less than 65, was admitted on [DATE]. According to the July 2026 CPO, diagnoses hemiplegia and hemiparesis (weakness and paralysis on one side of the body), major depressive disorder, cognitive communication deficits, panic disorder, generalized anxiety disorder and adjustment disorder.A 3/26/26 BIMS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15.The 4/16/26 MDS assessment revealed the resident required substantial to maximal assistance from staff for most ADLs. The MDS assessment documented the resident did not have physical behaviors directed at others. The assessment documented the resident had verbal behaviors directed at others and other behavioral symptoms not directed toward others on one to three days of the seven day assessment period.2. Resident interviewResident #16 was interviewed on 7/9/26 at 10:37 a.m. Resident #16 said there was another resident at the facility a while ago who touched her, but he had since left the facility. Resident #16 said the other resident (Resident #4) had touched her breasts and tried to go into her shirt to grab her breast. Resident #16 said Resident #4 did this because he thought they were friends, but Resident #16 said they were not that close, so she reported him to the facility. Resident #16 said the incident made her feel violated and said she was glad Resident #4 was no longer in the facility. Resident #16 said she thought Resident #4 felt they were close because his girlfriend was her roommate, and Resident #4 touched her roommate like that too.3. Record reviewThe psychosocial care plan, revised 6/16/26, revealed Resident #4 had a psychosocial wellbeing problem due to being inappropriately touched. Pertinent interventions included allowing the resident time to answer questions and verbalize her feelings, consulting with pastoral care, social services and psychiatric services, and assessing and monitoring her psychosocial wellbeing.A progress note, dated 6/13/26 at 1:45 p.m., revealed Resident #16 reported being touched inappropriately by another resident during breakfast the day prior (6/12/26). Resident #16 verbalized concerns regarding the incident. Resident #16 was assessed and provided with emotional support and reassurance. The incident was then reported to the DON and abuse coordinator. Resident #16 said another resident was sitting next to her at a table in the dining room when he suddenly intentionally reached for her breasts. Resident #16 said she told him to stop, and when she looked away he tried to touch her underneath her shirt and put his hand under her shirt. Resident #16 told him to stop again and left the dining room.A progress note, dated 6/25/26 at 1:15 p.m., revealed Resident #16 was seen by her psychiatrist. Resident #16 had a depressed mood and said she had not been feeling well since she had an altercation with another resident. Resident #16 had anxiety.A progress note, dated 6/29/26 at 8:33 a.m., revealed Resident #16 was seen on 6/25/26 by her psychiatrist due to her incident with another resident (Resident #4). Resident #16 reported an increase in anxiety. The psychiatry team recommended starting sertraline (an antidepressant) for anxiety and depression.D. Staff interviewsLicensed practical nurse (LPN) #3 was interviewed on 7/9/26 at 12:58 p.m. LPN #3 said for residents who exhibited behaviors, she would monitor the resident for behaviors each shift, document any behaviors they had in the TAR, and let the DON know if the resident had any behavioral episodes. RN #1 was interviewed on 7/9/26 at 1:04 p.m. RN #1 said (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 had a traumatic brain injury, was very friendly and liked to help people. RN #1 said Resident #4 tried to kiss her hand at one point but she established a boundary with him and that never happened again. RN #1 said Resident #4 had a girlfriend at the facility but said she only ever saw them holding hands. The DON, the NHA and the operations manager were interviewed together on 7/9/26 at 1:56 p.m. The DON said Resident #4 had hypersexuality due to his traumatic brain injury. The DON said Resident #4 had a tendency to reach out at people, which other people interpreted as groping. The DON said she had worked with Resident #4 to try to practice doing high-[NAME] and fist-bumps instead of reaching out, and she had provided education to the resident related to appropriate interactions multiple times. The DON said Resident #4 did make contact with Resident #16's breast. The DON said Resident #4 was subsequently put on one-to-one supervision by staff until he was discharged to another facility. The DON said Resident #4 had a history of being sexually inappropriate but could be redirected. The DON said Resident #4 thought he and Resident #16 were okay because he thought they were friends. The DON said Resident #16 initially reported feeling distressed because of the situation, so the facility had a psychiatrist evaluate her, but she said the resident did not have any long-term impacts or psychological distress. The operations manager said he had spoken with Resident #4 several times after the incident and Resident #4 denied having any malicious intent in the situation. The operations manager said Resident #16 initially yelled and pulled away when Resident #4 touched her and she reported the situation to the facility the following day (6/13/26).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide the necessary services to maintain personal hygiene to two (#10 and #22) of four residents reviewed for services to maintain the highest practicable quality of life out of 22 sample residents. Specifically, the facility failed to ensure:-Resident #10 received timely incontinence care; and,-Resident #22 received his scheduled bed baths.Findings include:I. Facility policy and procedureThe Activities of Daily Living policy and procedure, dated 4/11/25, was provided by regional clinical resource #2 on 7/9/26 at 3:57 p.m. It read in pertinent part: Care and services will be provided for the following activities of daily living: bathing, dressing, grooming and oral care, transfer and ambulation, toileting, eating to include meals and snacks, and using speech, language or other functional communication systems. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.II. Resident #10A. Resident statusResident #10, age greater than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), type two diabetes without complications, and vascular dementia. The 4/1/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. The resident needed partial to moderate assistance with toilet transfers and toilet hygiene. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. B. Resident representative interviewResident #10's representative was interviewed on 7/6/26 at 12:46 p.m. She said Resident #10 has had five urinary tract infections (UTIs) since she was admitted to the facility in December 2025. She said Resident #10 was often left in her bed and recliner wet in urine. She said Resident #10 could walk with a walker and to the bathroom with the standby assistance of staff. She said Resident #10 was on a toileting program and should be taken to the toilet every two hours. She said staff were not doing that as evidenced by the toileting log. She said the toileting log was hanging in the bathroom behind the door. C. ObservationsDuring a continuous observation on 7/7/26, beginning at 9:18 a.m. and ending at 2:44 p.m., the following was observed: At 9:18 a.m. certified nurse aide (CNA) #2 assisted Resident #10 out of the common area to her room. At 9:26 a.m. CNA #2 came out of Resident #10's room and removed her gloves at the nurse's cart, after providing incontinence care. At 10:16 a.m. Resident #10 was asleep in her recliner and staff had not checked on her since being taken to the bathroom at 9:26 a.m. At 10:41 a.m. Resident #10's toileting log was observed hanging in her bathroom. There was a sign next to the log stating that Resident #10 needed to be toileted every two hours due to enlarged ventricles and because she was unable to tell when her bladder was full. The toileting log starting on 7/2/26, documented she had been toileted on:7/2/26 at 1:00 p.m. and 2:14 p.m.7/3/26 at 7:20 a.m., 10:30 a.m., 1:30 p.m., 4:20 p.m., and 7:45 p.m.7/4/26 at 6:37 a.m., 10:30 a.m., 1:15 p.m., and 4:00 p.m.7/5/26 at 6:55 a.m., 10:00 a.m., and 3:00 p.m.7/6/26 at 7:20 a.m., 9:20 a.m., and 1:00 p.m.7/7/26 at 7:25 a.m.At 11:23 a.m. staff had not checked on Resident #10. Resident #10 was sleeping in her recliner. At 12:11 p.m. staff had not checked on Resident #10. Resident #10 was sleeping in her recliner. At 12:36 p.m. an unidentified nurse and an unknown visitor went into her room, the door was left open and they did not offer to take her to the restroom. At 12:53 p.m. an unidentified laundry staff member delivered Resident #10's laundry and closed the door as she left Resident #10's room. At 1:03 p.m. an unidentified staff member entered Resident #10's room to deliver her lunch. The unidentified staff member assisted Resident #10 with her lunch tray by making sure it was in front of her and all the items were uncovered. The staff member then exited the room and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed the door. The staff member did not offer to take Resident #10 to the bathroom. At 1:40 p.m. an unidentified housekeeper went into her room and began to clean, Resident #10 was sleeping in her recliner and not eating her lunch. At 1:45 p.m. the unidentified housekeeper exited the room and closed the door behind her. At 2:14 p.m. Resident #10 remained in her room and the staff had not checked on her or offered toileting At 2:39 p.m. CNA #1 opened Resident #10's door and closed it behind her. At 2:44 p.m. Resident #10 was sitting on the toilet. -The facility failed to offer the resident toileting for five hours and 18 minutes hours from 9:26 a.m. to 2:44 p.m.D. Record reviewThe bowel and bladder care plan initiated on 8/6/25 revealed Resident #10 had actual or potential for incontinence related to diuretic use, dementia, diverticulosis, diabetes, decreased mobility, and dysphagia. Pertinent interventions included notifying the nursing staff if Resident #10 was incontinent during activities, monitoring fluid intake to determine if natural diuretics such as coffee, tea, or cola were contributing to increased urination and incontinence, monitoring for signs and symptoms of UTIs, monitoring/documenting/reporting any possible causes of incontinence, and offering to toilet every two hours utilize yellow toileting log placed in resident's bathroom hanging inside the door. Review of the July 2026 CPO revealed the following physician's order:Providing frequent and toileting throughout the shift, ordered on 1/15/26. -However, observations and review of the toileting log in the resident's bathroom revealed the resident was not toileted every two hours (see observations above).E. Staff interviewsCNA #2 was interviewed on 7/7/26 at 3:05 p.m. CNA #2 said she toileted residents every two to four hours. She said that the nurses would let the CNAs know when a resident was on a toileting schedule. She said that Resident #12 was on a toileting schedule and she was to be toileted every two hours. -During the interview, the toileting log in the resident's room was observed with CNA #2. The log indicated the resident was toileted at 10:30 a.m. However, the resident was toileted at 9:26 a.m. (see observations above). CNA #1 was interviewed on 7/7/26 at 3:12 p.m. CNA #1 said Resident #10 was supposed to be toileted every two hours. She said that night shift did not fill out the toileting log. Licensed practical nurse (LPN) #2 was interviewed on 7/7/26 at 3:26 p.m. LPN #2 said residents should be checked, changed, and toileted every two hours. She said she knew when a resident was on a toileting program because there was an order for it in their chart. She said that Resident #10 was on a toileting program and should be toileted every two hours. She said there was a toileting log in her bathroom. She said she did not check the log to see if it was being filled out. The director of nursing (DON) was interviewed on 7/7/26 at 3:43 p.m. The DON said residents should be toileted every two hours. She said there were two different toileting programs. She said there was one where the log was hung up in the bathroom, which was the preference of the family and then the other one was where the CNAs entered the information into the computer. She said she needed to educate her staff on filling out the sheets in the bathrooms. She said Resident #10 should have been taken to the bathroom every two hours. III. Resident #22A. Resident statusResident #22, age [AGE], was admitted on [DATE]. According to the July 2026 CPO diagnoses included acute and chronic respiratory failure with hypoxia (inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood), chronic diastolic (congestive) heart failure, and morbid (severe) obesity due to excess calories. A 6/30/26 BIMS assessment revealed the resident was cognitively intact with a score of 15 out of 15. B. Resident interviewResident #22 was interviewed on 7/8/26 at 10:34 a.m. He said he had not had a bed bath since he was admitted on [DATE]. He said he was unable to get out of bed, which was why he preferred bed baths. He said the facility had not told him why he had not had a bath yet. During the interview, the resident's hair was unbrushed and greasy.C. Record reviewReview of Resident #22's electronic medical record (EMR) (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed his showers were to be on Monday, Wednesday, and Saturday.-However, review of the EMR did not reveal any documentation indicating the resident had been showered since we was admitted on [DATE].D. Staff interviewsCNA #1 was interviewed on 7/8/26 at 10:48 a.m. CNA #1 said that Resident #22 should have been getting his bed baths on Monday, Wednesday, and Saturday during the evening shift. She said after reviewing the electronic medical record (EMR) he had received a bed bath on 6/30/26, which was the day that he was admitted . She said she did not see any other documentation regarding his baths. CNA #2 was interviewed on 7/8/26 at 11:05 a.m. CNA #2 said that she could not find any records of Resident #22 refusing his baths or any records of him receiving his baths since he was admitted to the facility. The DON and regional clinical resource #1 were interviewed together on 7/8/26 at 12:20 p.m. She said that CNAs documented showers in the EMR. She said the assistant director of nursing (ADON) looked at the shower refusal sheets and cross-referenced the refusals in the computer system. She said that showers also included bed baths. She said that upon admission, the residents were asked their preferences on days and times of their showers. She said the resident's shower days and times were based on the resident's preferences. She said she was unsure of when Resident #22's shower days were. Regional clinical resource #1 said she reviewed Resident #22's EMR and his documented shower days were Monday, Wednesday, and Saturday on the evening shift. The DON said it looked like his showers were uploaded incorrectly into the computer system so, his shower was not coming up under the CNA's task. She said that CNAs should be documenting residents' shower refusals and when the showers were given. She said that showers should never be skipped.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents were free from significant medication errors for two (#13 and #8) of four residents reviewed for medication errors out of 22 sample residents. Specifically, the facility failed to ensure physician orders were transcribed correctly for Resident #13 and Resident #8. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G et.al, Fundamentals of Nursing, 10th ed., (2023). Elsevier, St. Louis, Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Facility policy and procedure The Medication Reconciliation policy and procedure, implemented 4/11/26, was provided by regional Clinical Resource #2 on 7/9/26 at 3:57 p.m. It read in pertinent part, This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors, and that the facility's medication error rate is less than five percent. Medication reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. Medication reconciliation involves collaboration with the resident/representative and multiple (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff. Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed. New orders require a second nurse to cosign the orders, indicating review of the orders for accuracy. Perform 24-hour chart checks to verify all new orders have been addressed. III. Resident #13 A. Resident status Resident #13, age [AGE], was admitted on [DATE] and was readmitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included acute on chronic congestive heart failure (CHF), morbid obesity, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and hypertension (high blood pressure). The 6/1/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial/maximal assistance with toileting hygiene, personal hygiene, toilet transfers, and bed-to-chair transfers. She required partial/moderate assistance with showering/bathing, rolling left and right, lying to sitting on the bed side, and sitting to standing. She required setup or clean-up assistance with oral hygiene and was independent with eating. The assessment revealed the resident was taking a diuretic medication, a high-risk drug class, per pharmacological classification. B. Resident and resident representative interviews Resident #13's representative was interviewed on 7/6/26 at 2:30 pm. She said the director of rehabilitation stopped her session today because she was wheezing. She said she requested that Resident #13 be seen by the nurse practitioner (NP). She said the NP came to assess Resident #13 and said she had wheezing in her lungs. She said the NP said the resident was not taking any of her Lasix (diuretic) medication, because it was not a current order in her CPO. The resident's representative said the NP conveyed to her that Resident #13 was never supposed to stop taking her Lasix medication. The resident's representative said Resident #13 had been taking Lasix medication on a long-term basis continuously for multiple years for CHF. The resident's representative said she did not know why Resident #13 was not taking her daily dose of Lasix. She said Resident #13 had a recent doctor's appointment with her pulmonologist and received a three day order to increase her Lasix, and then resume her previous daily dose. The resident's representative said she was not sure if resident #13's Lasix dose was transcribed correctly after she visited with the pulmonologist. Resident #13 was interviewed on 7/6/26 at 2:53 p.m. Resident #13 said she noticed she felt short of breath for the past week. She said she would tell the nurses about her symptoms and was given a breathing treatment. She said the breathing treatment would help her breathing for a short time. She said she had also been feeling more tired than normal the past week or so and had some swelling in her abdominal area. She said she did not tell the nurses about her swelling, because she thought it (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would just go away. Resident #13 said she had been taking the Lasix medication for a very long time and was unsure of the exact number of years. She said she was not aware she was not taking her daily Lasix dose. C. Record review Resident #9's care plan, revised 7/2/25, revealed she was on diuretic therapy related to CHF. Pertinent interventions, initiated 6/19/25, included administering diuretic medications as ordered by physician, monitoring for side effects and effectiveness, monitoring for other medications that may interact, monitoring/documenting/reporting adverse reactions to diuretic therapy such as dizziness, postural hypotension, fatigue, and an increased risk for falls, reporting pertinent lab results to physician especially hematocrit, sodium, and potassium. Review of Resident #13's June 2026 CPO revealed the following physician's orders: Furosemide oral tablet 40 mg (Lasix), give two tablets by mouth in the morning for CHF for three days. Ordered on 6/23/26. Furosemide oral tablet 40 milligrams (mg) (Lasix), give one tablet by mouth in the evening for CHF for three days. Ordered on 6/23/26. Furosemide oral tablet 40 mg (Lasix), give one tablet by mouth, two times a day for CHF. Ordered on 5/22/26. Discontinued on 6/23/26. The 6/23/26 pulmonologist paperwork documented the following physician's order: Increase furosemide 40 mg for three days, to two tablets in the morning and one tablet in the evening for three days. After three days, go back to one tablet in the morning and one tablet in the evening. -However, the Lasix order that was entered on 6/23/26 did not match the physician's orders to continue the Lasix after the temporary three-day dose increase. IV. Staff interviews The NP was interviewed on 7/6/26 at 3:05 p.m. The NP said she had been the provider for Resident #13 for one year. She said the resident had a history of chronic pulmonary edema and CHF. She said the resident's representative approached her because the resident was having difficulty breathing during her physical therapy session. She said when she assessed the resident, she noticed the resident was having difficulty breathing. She said she listened to the resident's lungs and heard wheezing and crackles at the bases bilaterally. She said those lung sounds indicate the resident was having some fluid buildup in her lungs. She said she checked the resident's medication and discovered the resident lasix ordered had been discontinued. She said the medication order should have never been stopped because she had chronic pulmonary edema. She said if the resident did not take her Lasix, fluid could build up in her lungs and could result in the resident having increased fluid around her lungs that could cause difficulty with her breathing. She said the resident should have had weekly (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight monitoring. She said the medication Lasix could have a significant impact on weight, because not taking the medication could result in increased fluid accumulation in the body. She said monitoring the resident's weight could indicate if the medication was effective. The director of rehabilitation was interviewed on 7/6/26 at 3:05 pm. The director of rehabilitation said he worked with Resident #13 today. He said he had to stop the therapy session today (7/6/26) because the resident was having difficulty breathing. He said he reported the breathing difficulty to the nursing staff and requested a breathing treatment for the resident. He said he tested the resident's oxygen level to be 93% while she was on one liter per minute of oxygen via nasal cannula. He said he would document the resident's breathing problems in the resident's electronic medical record (EMR). Licensed practical nurse (LPN) #1 was interviewed on 7/7/26 at 10:00 a.m. LPN #1 said when a resident returns to the facility from an outside appointment, she would give the paperwork to the assistant director of nursing (ADON) and the DON for them to do a second review. She said the second order review was to ensure the orders were transcribed into the resident's EMR correctly. She said she had worked with Resident #13 twice, but was not very familiar with her medication history. She said Resident #13 had breathing difficulty yesterday and was given a breathing treatment. She said she did not ask the resident how often she had breathing difficulty or the onset of her breathing difficulty. The director of nursing (DON) and regional clinical resource #1 were interviewed together on 7/7/26 at 12:40 p.m. The DON said if a resident had a new physician's order when returning from an outside provider, the nursing staff would transcribe the new orders into the EMR. She said a second nurse would review and verify that the new orders were transcribed correctly before it was placed on the resident's medication administration record (MAR). She said the second verification review was an important step to ensure the medication orders were transcribed accurately to prevent medication errors. The DON said the interdisciplinary team would run a new order audit every day to review any new medication orders for facility residents. The DON said the medication error for Resident #13 was discovered on 7/6/26. She said the resident's representative reported to the nurse that Resident #13 was not feeling well and having some breathing difficulty. She said this information was reported to the NP in-house. The DON said the NP assessed Resident #13, reviewed her medication records, and discovered that the resident was not taking her Lasix medication. She said the resident was taking Lasix for over a year to treat her CHF. The DON said Lasix was used as a diuretic to prevent fluid accumulation in the lungs and the rest of the body. The DON said Resident #13 had a pulmonary apt on 6/22/26 and received new orders to increase Lasix for three days, and then resume her previous dose afterwards. She said the resident had not received her Lasix for nine days. She said the resident's last dose of Lasix was on 6/26/25. She said the resident did not receive her Lasix dose due to an error in the medication being transcribed. The DON said there were several missed steps that contributed to the medication error. She said the medication was not transcribed correctly, no nurse completed a second check of the new medication order, and there were no new order audit reports run for the resident. The DON said she was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for running the new order report audits. She said she did not remember why she missed this very important step in the order transcription process. The DON said as a result of the resident not taking her Lasix medication, the resident could have had fluid buildup in her lungs and the rest of Resident #13's body. She said this could have resulted in labored breathing, lowered oxygen levels, and irregular electrolyte levels. The DON said the NP placed a new order to restart the resident on her previous dose of Lasix, daily weights, lab work, and vital signs every shift. She said after the medication error was discovered, the nursing staff notified the resident's primary care provider. Regional clinical resource #1 said the new order audit was done to ensure the order was accurate, the duration of the medication was accurate, appropriate monitoring was in place, and the resident care plan was updated as needed. She said a risk assessment document was completed, and education was started on 7/6/26 for the nursing staff about the process of transcribing new orders when the resident returns from the outpatient doctor's appointments. The pharmacist consultant was interviewed on 7/7/26 at 3:21 pm. She said she had worked at the facility for two months. She said she conducted medication reviews for current facility residents monthly and upon admission. She said if Resident #13 was not given her Lasix medication, she could have elevated edema (increased fluid buildup in the body's tissues), weight gain, and increased blood pressure. She said Lasix was a diuretic and prevents fluid accumulation around the heart and lungs. IV. Resident #8 A. Resident status Resident #8, age less than 65, was admitted on [DATE], discharged to the hospital on 4/28/26, readmitted on [DATE] and discharged to another facility on 6/11/26. According to the June 2026 CPO, diagnoses included type 1 diabetes with diabetic neuropathy. According to the 6/11/26 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent for most ADLs. The assessment indicated the resident received hypoglycemic medications including insulin. B. Record review The diabetes care plan, initiated 5/1/26, revealed Resident #8 had diabetes. Pertinent interventions included notifying Resident #8's physician with any concerns and providing medications as ordered. Review of the April 2026 CPO revealed the following orders: Insulin glargine (an extended-release insulin) 100 units per milliliter (ml), inject 15 units subcutaneously two times a day for diabetes, hold for blood sugar readings under 100 micrograms (mcg) per ml, ordered 4/22/26 and discontinued 4/27/26. Insulin glargine 100 units per ml, inject 16 units subcutaneously two times a day for diabetes, ordered (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/26 and discontinued 4/29/26. A progress note, dated 5/12/26 at 3:20 p.m., revealed Resident #8 readmitted to the facility at 10:55 a.m. that day (5/12/26) from the hospital. Resident #8's medications were reconciled with the provider and entered into his electronic medical record (EMR). A hospital Discharge summary, dated [DATE], revealed several of Resident #8's medications had not changed during his hospitalization and he was to continue them as ordered. The discharge summary listed the following orders: -Insulin glargine 100 units per milliliter (ml), inject 16 units into the skin two times a day; and, -Insulin lispro 100 units per ml, inject sliding scale into the skin three times daily before meals. A physician's note, dated 5/13/26, revealed Resident #8 was seen by his physician following his readmission to the facility. Resident #8 was concerned he was not getting a proper insulin dose. Resident #8 returned from the hospital on only a sliding-scale insulin dose with no extended release insulin. Resident #8 was an insulin-dependent diabetic and was previously receiving 15 units of glargine twice a day. The physician noted Resident #8 was worried about his insulin as he understood his disease, and the physician promised the resident he would review his chart and start him on extended release insulin. Resident #8 was upset about not being on an extended-release insulin. Review of the May 2026 CPO revealed the following orders: Insulin glargine 100 units per ml, inject 10 units subcutaneously two times a day for diabetes, hold for blood sugar readings under 100 micrograms (mcg) per ml, ordered 5/13/26 and discontinued 5/14/26. Insulin glargine 100 units per ml, inject 16 units subcutaneously two times a day for diabetes, ordered 5/13/26. Review of Resident #8's May 2026 medication administration record (MAR), from 5/1/26 through 5/31/26, revealed Resident #8 did not receive any doses of long acting insulin on 5/12/26 or during the day shift on 5/13/26. C. Staff interviews The DON was interviewed on 7/8/26 at 12:37 p.m. The DON said when a resident readmitted to the facility from the hospital, they follow the physician's orders from the hospital, verify the medications with the facility's physician and assess the resident. The DON said one nurse would enter the resident's orders from the hospital admission packet and a second nurse would confirm the orders. The DON said Glargine was a long-acting insulin. The DON said Resident #8 had physician's orders for both long-acting and short-acting insulin, but it was not transcribed correctly when he returned from the hospital. The DON said the long-acting insulin had a scheduled administration. The DON said since Resident #8's readmission she had begun educating the nursing staff on inputting orders. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed on 7/9/26 at 12:58 p.m. LPN #3 said she was not sure who put in physician's orders when a resident returned from the hospital. LPN #3 said short-acting insulin worked to lower blood glucose levels within thirty minutes while long-acting insulin took a few hours to begin working. LPN #3 said long-acting insulin was crucial and said a resident could not miss a dose as it could affect their blood glucose levels.		