STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Red Rocks	150 Spring St Morrison, CO 80465

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to protect three (#7, #3 and #5) of seven residents reviewed for abuse out of 10 sample residents. Resident #8 was admitted to the facility on [DATE] and was moderately cognitively impaired. He had a history of traumatic brain injury, dementia and diabetes. Resident #7 was admitted to the facility on [DATE] and had a history of dementia, was dependent on staff for all cares and was non-verbal. On 9/29/25 the facility was looking for Resident #8, who was identified as missing. The facility located Resident #8 in Resident #7's room by staff. Resident #8 was found lying on top of Resident #7 with his pants and incontinence brief pulled down below his knees and hips directly over the face of Resident #7.Resident #7 and Resident #8 were separated by staff and police. Resident #7 was sent to the hospital where a sexual assault nurse exam (SANE) was conducted. Hospital records indicated a male (Resident #8) was found with his penis around her mouth and he had stated he attempted vaginal intercourse with Resident #7.Resident #8 was given an immediate discharge notice. Resident #8 was removed from the facility on 9/29/25 by police and was taken to jail.Resident #4 was admitted to the facility on [DATE] and had moderate cognitive impairments. He had a history of dementia, viral hepatitis C and sexually inappropriate behaviors towards female staff. Resident #3 was admitted to the facility on [DATE] and was discharged on 8/29/25. She was cognitively intact and had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (paralysis and weakness). On 8/14/25, Resident #4 requested Resident #3 to have sex with him. Resident #3 informed the facility that Resident #4's actions upset her. The facility implemented 15-minute checks starting on 8/14/25 until 8/16/25. However, the facility did not reassess to ensure if it was appropriate to discontinue the checks. On 8/20/25, Resident #4 again requested Resident #3 to have sex, which Resident #3 declined.The facility failed to implement effective interventions regarding Resident #4's sexual behaviors, which resulted in Resident #4's continued sexual comments on three occasions that were upsetting to the residents. After the incident on 8/20/25, the facility placed both Resident #3 and Resident #4 on 15-minute checks for 72 hours. The facility discontinued the 15-minute checks after 72 hours with no documentation to indicate the residents were reassessed for safety prior to discontinuing the checks. Resident #5, was admitted on [DATE] and had severe cognitive impairments. Resident #5 had diagnoses of unspecified dementia without behavioral disturbance, moderate intellectual disabilities and cognitive communication deficit. On 8/26/25 Resident #5's representative notified the facility that Resident #4 had approached Resident #5 and asked her if she wanted to go to his room to have sex. The facility unsubstantiated the allegations and determined Resident #4 had the right to ask other residents any questions. However, Resident #5's representative said Resident #5 was upset for about a week following the incident.On 8/26/25 the facility implemented a one-to-one caregiver for Resident #4. However, documentation and interviews revealed inconsistencies with a continuous one-to-one caregiver for Resident #4.Specifically, the facility failed to:-Protect Resident #7 from sexual abuse by Resident #8;-Protect Resident #3 from sexual harassment by Resident #4; and, -Protect Resident #5 from sexual harassment by Resident #4.Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Resident #8 was admitted to the facility with diagnoses of dementia and a traumatic brain injury. When Resident #8 was reported missing, the facility staff found Resident #8 in Resident #7's room. Resident #7 had severe cognitive impairments and was non-verbal. Resident #7's pants and brief were pulled down and his hips were above Resident #7's face. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to protect Resident #7 from sexual abuse from Resident #8. Resident #4 who admitted to the facility on [DATE] had a history of being sexually inappropriate with female staff. The facility's failure to implement effective, long term interventions to address Resident #4's sexually inappropriate behaviors, resulted in Resident #4 sexually harassing Resident #3 and Resident #5. The facility's failure to ensure all staff members were aware of Resident #4 behaviors, what to monitor for and how to address the behaviors resulted in further incidents that made Resident #3 and Resident #5 uncomfortable and upset. After Resident #7 was sexually abused, the facility began taking Resident #4's behaviors into consideration and implemented a one-to-one caregiver for Resident #4. B. Facility notification of immediate jeopardy On 10/30/25 at 2:28 p.m., the nursing home administrator (NHA) was notified the facility's failure created an immediate jeopardy situation. C. Facility plan to remove immediate jeopardy On 10/30/25 at 6:33 p.m. the facility submitted a plan to remove immediate jeopardy. The plan read: Identification of residents affected or likely affected: the director of nursing (DON), the social services director (SSD), and designee were to interview/assess residents with brief interview for mental status (BIMS) assessment scores of eight or above for potential abuse, concerns were not identified and completed on 10/30/25. For residents who had a BIMS score below eight, the power of attorney (POA) or residents' representatives would be contacted to identify any concerns regarding abuse, initiated 10/30/25. Resident #8 was issued an immediate discharge notice on 9/29/25 to prevent further abusive behaviors. The following actions were taken to prevent Resident #4 from perpetrating additional abusive behaviors: He was placed on a one-to-one caregiver on 10/1/25 until alternate placement can be found. The one-to-one caregivers were provided resident specific education defining what they were watching for (sexually inappropriate comments, monitoring for any inappropriate responses in sexual nature, with history of sexual assault allegations). The one-to-one caregivers were educated on who to notify if any behaviors were identified/observed. The education would be completed prior to the next scheduled shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The nursing supervisors, the SSD and designee updated Resident #4's behavior monitoring sheets to describe specific behaviors and staff response, completed on 10/30/25. Clinical resource completed a review and updated Resident #4's Kardex (staff directive tool), care plan and physician's orders on 10/30/25. Resident #4 was evaluated by the primary care provider on 10/21/25 and was scheduled to re-visit the resident on 10/31/25. Resident #4 received psychology consultation orders on 10/30/25, a medication adjustment on 8/23/25 to address sexual hyperactivity and a follow-up medication review was scheduled for 10/31/25. Therapy sessions began on 11/3/25 (during the survey) for Resident #4 to begin working with licensed mental health professionals. One-to-one supervision had been in place for Resident #4 since 10/1/25. Updated education was initiated on 10/30/25 with all one-to-one caregivers. Education was also provided to all staff on abuse, abuse prevention, behavior management, how to report new behaviors, how to locate information in the Kardex and care plan, and any one-to-one resident specific education prior to initiation of their next shift. The goal completion date for the education was 11/7/25 for all regularly scheduled employees. All as needed (PRN) employees would receive the education prior to the start of their next shift. Resident #4 could not be seated near female resident(s) at activities or dining when at all possible initiated on 10/30/25. The interdisciplinary team (IDT) reviewed and revised Resident #4's care plan to identify patterns in the resident's behaviors and implemented interventions for Resident #4 on 10/30/25. The care plan revisions and interventions were communicated to front line staff caring for Resident #4 on 10/30/25. Interventions were Resident #4 was not to sit next to a female resident when at all possible. All residents with known behaviors would be reviewed by the IDT team with updates as indicated to their care plans and Kardex. The facility took the following actions to prevent an adverse outcome from reoccurring on 10/30/25: updated the one-to-one education binder to detail residents' behavior pattern/risk; updated Resident #4's care plan; and, updated Resident #4's Kardex. The Abuse policies were reviewed/updated to include all sources of abuse, including resident-to-resident on 10/30/25. The abuse investigation procedure and documentation process were reviewed and revised as needed. The NHA and the DON educated all staff on changes to the policies on 10/30/25. The social SSD, the DON and the NHA re-educated all staff on facility abuse policies during the survey on 10/30/25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The investigation documented the police were on-site at the time of discovery and one officer provided one-to-one care over each resident involved. Resident #7 was transported to the hospital and Resident #8 was taken to jail. The investigation documented the facility issued Resident #8 an immediate discharge notice prior to leaving the facility with the police. Resident #8 refused to sign the discharge paperwork, stating it was consensual. The investigation documented the facility began providing cares in pairs for Resident #7. The staff were instructed to leave the door open to Resident #7's room when care was not being provided. Additionally, Resident #7's bed was moved to be in view from the hallway. The investigation documented the facility attempted to interview Resident #7 on 9/29/25, however Resident #7 was noninterviewable. She did not show an attempt to respond to questions and the resident did not appear to be in pain/discomfort. The resident was lying in bed with her index finger in her mouth. The staff were unable to perform a skin assessment as police instructed the staff should not touch the resident. Resident #8 was interviewed on 9/29/25 at 10:20 p.m. by the interim DON prior to being arrested. Resident #8 said he was in Resident #7's room because she invited him in and they were two consenting adults who had sex. He reported he had sat with the resident in the dining room and she invited him to her room. Resident #8 reported he thought that the resident's name was (provided name that was not consistent with Resident #7 but did match another resident in the facility). The other resident that Resident #8 identified was interviewed by facility staff and she reported she did not know who Resident #8 was and did not have a desire for a sexual partner. The investigation documented the facility substantiated sexual abuse for the incident on 9/29/25 involving Resident #7 and Resident #8. The facility provided education to the staff on 9/29/25 regarding the definition of abuse, how to prevent abuse, how to monitor for changes in behaviors, what consent was and how to identify if a resident was able to consent to sexual activities. The facility also implemented a door tag to identify residents at increased risk due to inability to make their needs known related to cognition, nonverbal or bed bound. The tag was implemented to add a visual reminder that the resident in the room was at increased risk for potential falls and/or abuse. All residents who had the tag were to have increased rounding with visual inspection of the room to ensure resident safety. The staff were also provided education regarding elopement on 9/29/25, as Resident #8 was initially missing when he was found in Resident #7's room. The facility initiated audits to include residents at high risk for abuse to receive increased monitoring starting on 9/29/25 and were ongoing at the time of the survey (10/27/25). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A whole house audit was conducted on 9/29/25 where skin assessments were completed along with asking residents or their POA if they felt safe and assessing for sexual advancements from another resident (due to Resident #4's sexual advances below). -However, during the survey, staff interviews revealed the staff did not know what the door tags were or that there was an education binder available, despite the documentation the facility provided that indicated the staff were educated on the door tags and binder (see interviews below) education was provided to staff. -The facility failed to educate staff on identifying residents who may be seeking a sexual partner within the facility. B. Resident #8 (assailant) 1. Resident status Resident #8, age younger than 65, was admitted on [DATE]. According to the September 2025 computerized physician's orders (CPO), diagnoses included type 1 diabetes (abnormal glucose control), chronic kidney disease stage four (abnormal kidney function), traumatic brain injury and dementia (abnormal memory). The 9/9/25 minimum data set (MDS) assessment indicated the resident had moderate cognitive impairments with a BIMS score of nine out of 15. He needed set-up assistance with eating, dressing and personal hygiene. He was independent with bed mobility, transfers ambulation. 2. Record review Review of Resident #8's comprehensive care plan did not identify that the resident displayed behaviors prior to the altercation. A nurse progress note, documented on 9/29/25 at 12:22 a.m., revealed Resident #8 was found in another resident's (Resident #7) room lying on top of her. The staff immediately separated the two residents and notified the police. One-to-one care was provided to both residents. A nurse progress note, documented on 9/29/25 at 3:37 a.m., revealed Resident #8 was transported to the county jail at 3:30 a.m. An immediate discharge noticed was issued to Resident #8 prior to him being handcuffed. The note documented that he refused to sign the immediate discharge notice. The assistant administrator was present during refusal. Review of Resident #8's electronic medical record (EMR) revealed the facility ran a sexual offender report on Resident #8 after the incident and it was negative. C. Resident #7 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #7, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included fracture of left malleolus of left fibula (broken bone of the lower leg), dementia(abnormal memory), depression, chronic kidney disease and chronic obstructive pulmonary disease (abnormal oxygen exchange). The 8/29/25 MDS assessment revealed the resident had cognitive impairments with short and long term memory issues per staff assessment. She was dependent on staff assistance with eating, toileting, dressing, personal hygiene, bed mobility and transfers. The resident used a manual wheelchair and was dependent on staff for assistance with mobility. 2. Observations On 10/28/25 at 1:12 a.m. Resident #7 was lying in her bed and was seen from the hallway with the door open. 3. Resident #7's representative interview Resident #7's representative was interviewed on 10/28/25 at 12:52 p.m. The representative said Resident #7 had been non-verbal for two years and would not be able to consent to a sexual relationship. The representative said Resident #7 was sent to the hospital and underwent a SANE exam after being found with a male resident in her room. The representative said the assailant was being pursued for criminal charges for assaulting an at-risk adult. 3. Record review Resident #7's September 2025 CPO revealed the following physician's order: Doxycycline hyclate 100 milligram (mg) capsule twice daily for seven days, an antibiotic therapy for possible sexually transmitted disease exposure, ordered on 9/30/25. Review of Resident #7's comprehensive care plan, dated 9/29/25, revealed Resident #7 had potential recent trauma that may impact her psychosocial wellbeing. Pertinent interventions, initiated on 9/30/25, included providing cares in pairs and leaving the resident's bedroom door open when care was not being provided. A nursing progress note, documented on 9/29/25 at 12:31 a.m., revealed that at approximately 10:15 p.m. staff found another resident (Resident #8) lying on top of her. Staff immediately separated the two residents and one-to-one care was provided to each of them. Resident #7's guardian and APS were notified. Resident #7 sustained a skin tear to her right arm. The resident was transferred to hospital for further evaluation. A nursing progress note documented on 9/29/25 at 8:52 a.m. revealed the resident returned to the facility on a new prophylactic antibiotic. The adult protective services (APS) case worker reported that there was no indication for a pelvic exam as it did not appear vaginal sex occurred. It was unclear if oral sex occurred and she was waiting for a call back from the forensic nurse examiner. The resident was stable and appeared to be at baseline (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 8/14//25 facility investigation documented Resident #4 poured coffee on Resident #3 after she denied his advances to go to his room. The investigation revealed Resident #4 did pour coffee on Resident #3 after she declined his offer to join him in his room. Resident #3 was visibly upset by Resident #4's requests. The investigation documented the facility determined there was no intention of harm from Resident #4. -However, Resident #3 was observed to be upset and crying after the incident. The investigation documented the facility placed Resident #4 on 15-minute checks from 8/14/25 to 8/16/25. The 15-minute checks were discontinued after an IDT team discussion. -However, there was no documentation to indicate why 15-minute checks were discontinued. -Review of Resident #4's care plan on 10/30/25 revealed the facility did not update Resident #4's with any interventions to prevent further sexual abuse or for sexually inappropriate advances towards female residents. The investigation documented the facility substantiated the abuse towards Resident #3 by Resident #4 on 8/14/25. B. Facility investigation on 8/20/25 The 8/20/25 facility abuse investigation, documented at 4:28 p.m., revealed Resident #3 reported that Resident #4 asked to engage in sexual behavior with her. Immediate safety measures included temporarily moving Resident #3's room and placing both residents on 15-minute checks. The police were notified on 8/20/25 at 3:47 p.m. The investigation documented Resident #3 was assessed by the assistant director of nursing (ADON) on 8/20/25 with no new concerns. Resident #3 was interviewed and said she had previously consented with Resident #4 but did not want to at the time. Resident #4 was interviewed and denied the allegation. He said he did not remember this happening. Interviews with staff and other residents revealed Resident #3 and Resident #4 were often together in the smoking area communicating with each other. The investigation documented that Resident #3's care plan was updated to reflect her behavior and wishes and Resident #4 remained on 15-minute checks. -However, review of Resident 3's care plan on 10/30/25 did not reveal updates to the care plan following the 8/20/25 incident. The investigation concluded the occurrence was unsubstantiated. -However, abuse occurred due to Resident #4's continued sexual harassment towards Resident #3, despite Resident #3 not wanting to engage in sexual activity with Resident #4. B. Resident #4 (assailant) 1. Resident status (continued on next page)

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	065188	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Red Rocks	150 Spring St Morrison, CO 80465

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #4, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia with behavioral disturbance and viral hepatitis C without hepatic coma (blood borne disease). The 10/7/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of nine out of 15. He required partial assistance with bathing. He was independent with other activities of daily living (ADL). The MDS assessment documented no behavioral symptoms toward others. 2. Observations On 10/28/25 at 10:45 a.m. Resident #4 was in his room while staff was seated outside the room and provided continuous one-on-one supervision. On 10/28/25 at 4:17 p.m. Resident #4 stepped out of his room and asked CNA #5, who was providing one-on-one supervision, if he could go to the smoking area. He received a cigarette from the nurse and he was escorted outside to the designated smoking area. A 4:22 p.m. Resident #4 was escorted back inside the building and he sat in the lobby area while CNA #5 continued to provide one-on-one supervision. At 4:30 p.m. CNA #5 escorted the resident back to his room. On 10/29/25 at 9:40 a.m. an unidentified staff member was seated outside Resident #4's door while he was in his room. On 11/3/25 at 11:30 a.m. Resident #4 was walking back from the smoking area with a one-on-one caregiver next to him. 3. Record review The behavioral care plan, initiated 8/5/24 and revised 11/15/24, documented Resident #4 had dementia and at times displayed inappropriate behaviors related to his diagnosis. The care plan indicated the resident occasionally made unwelcome and inappropriate, sometimes sexual, comments directed toward female staff. Pertinent interventions, initiated on 11/4/24, included documenting each instance of inappropriate comments, noting any potential triggers, time of day, location, and response strategies that were effective, responding to inappropriate comments with a calm, neutral tone, monitoring behavior episodes to determine underlying causes and intervening as necessary to protect the rights and safety of others. The care plan included interventions, initiated on 11/4/24, for staff to monitor Resident #4 closely when in common areas, especially around female staff or residents, and to provide frequent redirection. The care plan documented additional interventions, initiated on 10/10/25, which included that Resident #4 was to receive one-to-one care from staff and was to be closely monitored at all times with readiness to de-escalate any behaviors. The 7/14/25 IDT note revealed Resident #4 was able to make his needs known verbally and effectively. The note revealed Resident #4 had demonstrated inappropriate behavior toward female residents and continued to ha

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents had adequate supervision to prevent accidents for one (#2) of three residents reviewed for accident hazards out of 10 sample residents. Specifically the facility failed to provide adequate supervision to prevent an elopement for Resident #2 after he informed staff he was not staying at the facility on the day he was admitted to the facility. Resident #2, who had diagnoses of dementia, Alzheimer's disease and history of a traumatic brain injury, was admitted to the facility on [DATE]. Upon the resident's admission, during initial completion of admission paperwork with the resident and his family, Resident #2 stated to licensed practical nurse (LPN) #5 that he was not staying at the facility.-However, LPN #5 failed to notify the appropriate staff regarding the resident's comment or put immediate interventions in place to prevent the resident's elopement.Upon completion of the admission paperwork, Resident #2's family left the facility. The resident followed his family outside when they left and was redirected back into the facility by the admissions coordinator. The admissions coordinator sat with the resident briefly in the lobby and then left. When she returned to the lobby, Resident #2 was gone. -The admissions coordinator failed to notify staff that Resident #2 followed his family outside and failed to ensure he was further supervised.Resident #2 was found by bystanders at a gas station near the facility where he had fallen. The resident was transported by emergency medical services (EMS) to the hospital where it was discovered he had a fracture of his right hand. The resident did not return to the facility. Findings include:I. Facility policy and procedureThe Elopements and Wandering Residents policy, dated June 2025, was received on 10/30/25 from the director of nursing (DON). It read in pertinent part, The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Adequate supervision will be provided to help prevent accidents or elopements.The New admission Dementia Protocol, undated, was received on 11/3/25 at approximately 4:40 p.m. from the regional clinical resource. It read in pertinent part, Review with resident and family dementia protocol prior to admission. Request wander guard (a device which tracks the location of the resident and alarms at exit points) placement for the first seven days for any mobile resident with or without an assistive device. Review the increased risk for elopement. Explain that the skilled admit unit has easy access to the outside and that to increase safety and security while we get to know their loved ones this is our protocol. Ensure wander guard consent is signed. admission assessment to be completed by floor nurse that includes the elopement assessment. Order placed for wander guard including location and to check placement and functioning every shift. Order to be placed for review of ongoing need for a wander guard after seven days of behavior tracking. On day seven, the interdisciplinary team (IDT) will review all documentation, update elopement evaluations and evaluate the ongoing need for wander guard.II. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia, Alzheimer's disease (a brain disorder that causes memory loss and confusion), history of traumatic brain injury (damage to the brain caused by a sudden external force) and conversion disorder with seizures or convulsions (a mental health condition where a person experiences physical symptoms such as seizures or convulsions).The minimum data set (MDS) assessment was not completed. Progress notes revealed Resident #2 was alert and was walking and talking upon his arrival to the facility.B. Facility investigation of Resident #2's elopement incident on 8/12/25 Review of the facility's investigation of Resident #2's elopement incident, dated 8/12/25, revealed the resident was admitted to the facility on [DATE] and was ambulatory without an assistive device. The investigation revealed Resident #2 was admitted to an unsecured unit. He was in his room with family and a nurse while the admission paperwork was completed. He then went to the lobby to say goodbye to his family and followed them outside the facility. Resident #2 was redirected to come back inside the facility by the admissions coordinator who then sat with Resident #2 in the lobby briefly. The admissions coordinator left and upon her return to the lobby, she noticed the resident was gone. The resident was reported missing and an immediate search was initiated at 3:45 p.m. Resident #2 was found at a gas station in town at 3:55 p.m. The investigation indicated staff conducted an assessment on the resident and he was observed to have minor abrasions (superficial wearing off of skin) to bilateral (both) knees and a laceration (cut) to the forehead The

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for staff based on the facility assessment and resident population for four of five certified nurse aides (CNA) reviewed. Specifically the facility failed to:-Ensure CNA #6 and CNA #7 had dementia training;-Ensure CNA #6, CNA #7 and CNA #8 had behavioral health management training;-Ensure CNA #5 and CNA #7 had resident rights training;-Ensure CNA #5 and CNA #7 had infection control training;-Ensure CNA #5, CNA #6 and CNA #7 had quality assurance performance improvement (QAPI) training; and,-Ensure CNA #7 had effective communication. Findings include:I. Record reviewA request for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics, and resident rights training was made on 11/3/25 at 10:30 a.m. for CNA #5, CNA #6, CNA #7 and CNA #8.The facility was unable to provide documentation that CNA #5 (hired on 6/1/25) had received QAPI training upon hire.The facility was unable to provide documentation that CNA #6 (hired 6/1/25) had received dementia, behavioral health, QAPI training upon hire. The facility was unable to provide documentation for CNA #7(hired on 8/15/25) had received effective communication, resident rights, dementia, QAPI, Infection control and behavioral health management training upon hire.The facility was unable to provide documentation for CNA #8 (hired 6/1/25) had behavioral health training upon hire. II. Staff interviewsThe staff development coordinator (SDC) was interviewed on 11/4/25 at 9:20 a.m. The SDC said she had only worked at the facility since late June 2025. The SDC said she provided education and in services to staff as education opportunities arose. She said she provided education during monthly staff meetings, and by placing an education binder at the nurses' station and providing tests to ensure the staff knew the information. The SDC said staff education was important to ensure staff were aware of what they were required to do and how to complete their job duties.The SDC said the facility held a skills fair at the end of June 2025 where different departments educated the staff on different topics.The nursing home administrator (NHA) was interviewed on 11/4/25 at 10:04 a.m. He said he had only worked at the facility a month. The NHA said he was informed there were gaps in staff education requirements and would be working with human resources to ensure staff files were up to date, which would include mandatory education. The NHA said they had recently set up an online training platform to help improve tracking of education. He said currently education was provided at staff meetings and at time of hire.