STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065227	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society -- Fort Collins Village	508 W Trilby Rd Fort Collins, CO 80525

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (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

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

Printed: 03/16/2026
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase ROM and/or prevent further decrease in ROM for one (#43) of three residents reviewed for restorative services out of 29 sample residents.Specifically, the facility failed to ensure Resident #43 was provided with a splint or palm guard in her left hand to prevent potential worsening of her hand contracture (a condition of shortening and hardening of muscles, tendons or other tissue, often leading to deformity and rigidity of joints). Findings include:I. Facility policy and procedureThe Range of Motion (ROM) [NAME] policy, revised 8/5/25 was received from the nursing home administrator (NHA) on 9/26/25 at 12:36 p.m. It read in pertinent part, Based on the resident's comprehensive assessment, the location will ensure that a resident entering without a limited range of motion will not experience reduction of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. In addition, the location will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion.II. Resident #43A. Resident statusResident #43, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included type two diabetes, blindness in one eye, fibromyalgia (musculoskeletal pain and fatigue) and chronic congestive heart failure (weakened heart muscle).The 8/6/25 minimum data set (MDS) assessment identified Resident #43 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented Resident #43 was dependent on staff for toileting hygiene, lower body dressing, putting on/taking off footwear, and transferring to/from the bed to chair.B. Resident interview and observationResident #43 was interviewed on 9/25/25 at 9:20 a.m. Resident's left hand was contracted and she was unable to extend all her fingers. The resident said she sometimes had her brace. She said her brace disappeared the other night but therapy was working on finding her a new one. C. Observations On 9/22/25 at 2:30 p.m. Resident #43 was not wearing her palm protector on left hand (a device used to prevent finger contractures).On 9/23/25 at 2:20 p.m. Resident #43 was wearing her palm protector on her left hand.On 9/25/25 at 9:10 a.m. Resident #43 was not wearing her palm protector. It was on her table in her room.D. Record reviewReview of Resident #43's comprehensive care plan did reveal documentation that Resident #43 had a contracture. The care plan did not list any interventions for the management of the contracture. Review of Resident #43's September 2025 CPO did not reveal a physician's order for palm protector to prevent contractures.Review of Resident #43's occupational therapy notes revealed the first palm protector was given to Resident #43 on 7/7/25. Resident #43 complained of left hand pain 8 out of 10 and did not bump it on anything. The nurse compared the right and left hand and the left looked slightly darker than the right. The OT placed a palm guard on Resident #43's left hand to protect it and keep the hand in a better position. The nurse said they would keep an eye on it.-However, her care plan did not indicate how often and for how long the palm protector should be on. Review of Resident #43's Kardex (staff directive tool) did not include information regarding a hand brace or palm protector.D. Staff interviews Registered nurse (RN) #3 was interviewed on 9/25/25 at 9:15 a.m. RN #3 said the RNs or the certified nurse aides (CNA) could put braces or palm protectors on residents. She said information on how and when to apply equipment should be in the treatment administration record (TAR). CNA #1 was interviewed on 9/25/25 at approximately 9:30 a.m. CNA #1 said Resident #43 should have her palm protector put on in the morning and taken off at night when she went to bed. CNA #1 said information on Resident #43's brace and placement could be found on the care plan, physician's orders or the Kardex. CNA #1 said usually there were pop ups (prompts) that the CNAs followed to make sure tasks were completed. CNA #1 said there were currently not pop ups for Resident #43's palm protector.RN #2 was interviewed on 9/25/25 at approximately 9:30 a.m. RN #2 said there was not a physician's order for a brace or palm protector for Resident #43. Occupational Therapist (OT) #1 was interviewed on 9/25/25 at 2:50 p.m. OT #1 said Resident #43 was admitted with a contracted index finger. She said that upon admission, best practice was to take measurements of resident's contractures. She said she was not sure whether or not the therapy department took measurements. OT #1 said when the resident was admitted to the facility, the therapy team offered different things for her to wear to prevent contractures but she did not want them. OT #1 said that should have been documented. The interim director of nursing (DON) was interviewed on 9/25/25 at 4:27 p

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial well-being for two (#70 and #10) of five residents out of 29 sample residents. Specifically, the facility failed to: -Identify Resident #70 had a history of suicidal ideation in order to monitor for worsening signs and symptoms of depression or suicidal ideation; -Identify and implement effective interventions for Resident #10's yelling behavior;-Ensure hours of sleep were monitored for Resident #10 while she was on antidepressant medications known to cause drowsiness; and, -Ensure Resident #70 and Resident #10 were offered mental health services.Findings include: I. Resident #70 A. Resident statusResident #70, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included dementia, chronic myeloid leukemia (cancer of the blood and bone), depression and insomnia. The 9/17/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. He used a wheelchair and had an impairment on both the upper and lower extremities. He required supervision with eating and he required substantial assistance with showering, oral hygiene and personal hygiene. The MDS assessment revealed Resident #70 had little interest or pleasure in doing things, felt down, depressed or hopeless, and felt tired or had little energy on seven to 11 days during the assessment look-back period. The MDS assessment revealed the resident had thoughts he would be better off dead or hurt himself on two to six days during the assessment look-back period. The MDS assessment indicated the resident's patient health questionnaire (PHQ-9 - a multi-purpose tool used for screening, diagnosing, monitoring and measuring the severity of depression) was seven out of 27, which indicated mild depression. B. Resident interview Resident #70 was interviewed on 9/25/25 at 10:28 a.m. Resident #70 said he was not happy at the facility. He said none of his relatives visited him. He said he would talk to a professional about how he felt about living at the new facility if he was given the chance. C. Record review Resident #70's suicide statement care plan, initiated and revised on 9/25/25 (during the survey), revealed the resident made statements he was ready to die and felt he would be better off if he was gone. He denied suicidal ideation, intent and plan. Interventions included giving the resident adequate rest periods per the resident's requests, discussing with the family and resident any concerns, fears and issues, attempting non-pharmacological interventions for depression, enjoying one-on-one conversations, going outside, watching history and nature television programs. -However, despite the resident's expressions of not wanting to be here anymore and feeling bad about himself from the 9/17/25 MDS assessment the facility failed to assess and monitor the resident for signs and symptoms of depression and suicidal ideation. The 9/2/25 physician's progress note revealed Resident #70 was seen for worsening depression. The resident expressed feeling not worthy and wanting to get out of here. He reported feeling sad and stating he was in a nursing home and nobody visited him except for his wife and she could only come so often. He reported difficulty finding enjoyment in activities at the nursing home. He reported he had fleeting suicidal thoughts including thinking about jumping in front of traffic or cutting his artery with a hacksaw. He mentioned sleep saved him and he fell asleep before he was able to act on any of these thoughts. The depression and suicidal ideation plan was discussion of antidepressant medication therapy. The medical power of attorney (MPOA) declined medication initiation at the visit. The physician encouraged frequent mood reassessment once the resident moved to a new facility. The physician recommended implementing increased safety precautions and added orders for more frequent safety checks by staff every two hours and staff removed sharp objects and potential self harm tools from the resident's room and coordinating with facility staff to encourage resident engagement in daily activities. The 9/9/25 referral discharge physician orders revealed Resident #70v may benefit from behavioral health consultation if his mood did not improve following the move. Send last progress notes so the future provider was aware. The 9/13/25 PHQ-9 score revealed a score of nine out of 27 which indicated mild depression. He had little interest or pleasure in doing things on seven to 11 days, felt down, depressed or hopeless on two to six days, felt tired or had little energy on 12 to 14 days, trouble concentrating on things seven to 11 days and moving or speaking so slowly that other people could have noticed occurred on two to six days during the assessment look back period. -Review of Resident #70's electronic medical record (EMR) failed to identify that a suicide lethality assessment was

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for one (#8) of three residents reviewed for hospice services out of 29 sample residents.Specifically, the facility failed to:-Establish an effective communication process, including how the communication would be documented between the facility and the hospice services provider for Resident #8; and,-Ensure the hospice agency's care notes were easily accessible to the facility staff and included consistent documentation of the hospice care visits in Resident #8's electronic medical record (EMR). Findings include:I. Facility policy and procedureThe Hospice Care policy and procedure, revised 11/1/24, was received from the nursing home administrator (NHA) on 9/26/25 at 12:36 p.m. It read in pertinent part, Hospice care addresses symptom management, coordination of care, communication and decision making, clarification of goals of care, and quality of life for the dying resident and their family. Hospice care is provided by an interdisciplinary team (IDT) approach to address the physical, psychosocial, spiritual, and medical care to help someone with a terminal illness live as well as possible for as long as possible, increasing quality of life.II. Facility-Hospice contractReview of Resident #8's EMR revealed a contract between the facility and the hospice services company, which was signed by the resident's representative on 2/21/25. It read in pertinent part, A coordinated comprehensive plan of care shall be jointly developed by the facility and hospice. Hospice participation in the care plan conference and input from the hospice representative are required.III. Resident #8A. Resident statusResident #8, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included dementia, Parkinson's disease, cerebral ischemia (not enough blood flow to the brain leading to brain cell damage), cervical disc degeneration, osteoporosis, anxiety, anemia and hypertension. The 8/13/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident required maximum assistance with activities of daily living (ADL) and had a performance deficit related to incontinence, activity intolerance, aggressive behavior, confusion, dementia, and limited mobility.The assessment documented that the resident was receiving hospice services.B. Record reviewThe September 2025 CPO revealed a physician's order for Resident #8 to be admitted to hospice care services on 2/7/25 due to cerebral ischemia (not enough blood flow to the brain, causing brain cell damage). Review of Resident #8's end-of-life care plan, initiated 9/5/25, revealed the resident was receiving hospice services for end-of-life comfort care. The hospice agency's phone number was included in the care plan.-However, the care plan did not include interventions related to the coordination of the resident's specific needs with hospice staff. -The care plan did not include documentation related to the specific care needs the hospice services company would be providing to the resident.Review of Resident #8's EMR failed to reveal documentation of the hospice service company's visits with the resident and what care was provided to the resident during the visits. IV. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 9/24/25 at 3:45 pm. CNA #3 said the hospice provider would perform some ADL care with Resident #8. CNA #3 said he did not know when hospice would come to the facility and provide care to the resident. CNA #3 said he did not keep track of the hospice care provided to the resident. He said if it was a bath day and the resident had not had a bath, the hospice agency's bath team would give Resident #8 a bath. Licensed practical nurse (LPN) #2 was interviewed on 9/23/24 at 10:20 a.m. LPN #2 said the Resident #8 was receiving hospice services. LPN #2 said Resident #8 would sometimes get music therapy from the hospice provider. LPN #2 said she would need to call the hospice agency's phone number if she had questions or concerns regarding the resident. LPN #2 said she would call the hospice agency for a change in the condition of the resident. LPN #2 said she when she called the hospice agency she could request that the hospice nurse come and see Resident #8 to evaluate the resident due to a change in condition. She said she did not know how often the hospice nurses or hospice CNAs came to see the resident. LPN #2 said she did not have a reference form to refer to for information on who and when hospice provided care for the resident. LPN #2 said she did not have access to the hospice agency's notes in order to see what hospice services were provided during each hospice visit. The hospice registered nurse (RN) was interviewed on 9/24/25 at 3:10 p.m. The hospice RN said she documented her notes in her iPad, and then the notes were sent to the hospice services agency. The hospice RN said the facility would contact the hospice nurse for medication refills. The hospice RN said she did not share her visit

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for two (#16 and #48) of the five residents reviewed for antibiotic use out of 29 sample residents. Specifically, the facility failed to track and monitor the use of long-term antibiotics for Resident #16 and Resident #48. Findings include:I. Professional reference According to The Centers for Disease Control and Prevention (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes (2025), retrieved on 9/29/25 fromhttps://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html?CDC_AAref_Val=https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.htmlTo track how and why antibiotics are prescribed, providers perform reviews on resident medical records for new antibiotics started to determine whether the clinical assessment, prescription documentation, and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians.II. Facility policy and procedureThe Antibiotic Stewardship policy, dated 7/8/25, was received from the nursing home administrator (NHA) on 9/25/25 at 11:04 am. It read in pertinent part, To guide Good Samaritan Society-Fort [NAME] Village locations for antibiotic stewardship plans. To decrease the incidence of multidrug-resistant organisms (MDRO). Promote appropriate use while optimizing the treatment of infections and reducing the possible adverse events associated with antibiotic use. To provide standard definitions to be used as guidelines when initiating antibiotics.III. Resident #16A. Resident status Resident #16, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician order (CPO), diagnoses included congestive heart failure, atrial flutter, long-term anticoagulant use, chronic kidney disease, hyponatremia, urgency of urination and overactive bladder. The 9/3/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of ten out of 15. The assessment revealed the resident was on an antibiotic. B. Resident interview Resident #16 was interviewed on 9/24/25 at 10:03 a.m. She said she did not currently have a urinary tract infection (UTI). The resident said she was not sure the last time she had a UTI. She said when she had a UTI in the past, it made her feel uncomfortable. She said she was not on any antibiotics currently.C. Record review Review of Resident #16's September 2025 CPO revealed the following physician's order:Cephalexin (antibiotic) tablet 250 milligram (mg). Give 1 tablet by mouth one time a day for UTI prophylaxis (to prevent an infection from occuring), ordered 12/9/22.The physician's order for the Cephalexin failed to indicate a stop date for the use of the antibiotic. The antibiotic therapy care plan, revised 12/7/23, revealed the resident was on antibiotic therapy related to UTI prevention. Pertinent interventions included monitoring/documenting signs or symptoms of UTI.Review of Resident's #16 EMR did not reveal documentation regarding the physician's justification for the long-term use of an antibiotic. Review of Resident #16's EMR did not reveal documentation to indicate the facility's infection preventionist (IP) completed an antibiotic use assessment or documented the McGeer's criteria met to justify the physician's order for Cephalexin. Review of the IP infection surveillance documents from 6/25/25 to 8/25/25 revealed that the facility identified residents with active infections. -However, Resident #16 was not included on the infection surveillance documents.The 6/20/25 pharmacist note documented Resident #16 had received an antimicrobial agent, Cephalexin 250 mg once a day, since December 2022 for the prevention of UTI. The note documented prolonged use of antibiotics for infection prophylaxis increased the risk of resistance and the development of C. difficile infection.-However, review of the resident's EMR did not reveal documentation that the facility took action to clarify the antibiotic use for Resident #16. IV. Resident #48A. Resident status Resident #48, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included vascular dementia, atrial fibrillation, prediabetes, muscle weakness and lack of coordination.The 9/10/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of one out of 15. The assessment revealed the resident was on an antibiotic. B. Record reviewReview of Resident #48's September 2025 CPO revealed the following physician's order;Cipro Oral Tablet 250 MG (Ciprofloxacin HCl): Give 250 mg by mouth in the evening for UTI prophylaxis, ordered 2/18/24.-The physician's order for the Cipro failed to indicate the duration for the use of the antibiotic., The antibiotic therapy care plan, revised 8/6/23, revealed the resident was on antibiotic therapy related to UTI