STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbine West Health and Rehab LLC	940 Worthington Cir Fort Collins, CO 80526

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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 - 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 interviews and record review, the facility failed to protect and promote an environment free from resident-to-resident sexual abuse. The facility failure affected four of four residents (#1, #2, #3, and #4) out of seven sample residents and contributed to incidents of abuse by Resident #2 and #4. Residents #1 and #2 resided in the facility's secured unit. Fourteen residents resided in the secured unit: four male (including Resident #2) and 10 female (including Resident #1). Residents #3 and #4 resided in the non-secured unit. Resident #2 had a history of being verbally sexually inappropriate toward female residents and staff. On 2/5/25, staff observed Resident #2 grabbing the breast of female Resident #1 and lifting her shirt. When told to stop, Resident #2 stated, She likes it. Although Resident #2 was placed on one-to-one supervision from 2/5/25 until 2/7/25 at 9:30 a.m. when his medication was changed, interviews with staff revealed that not all staff were aware of Resident #2's inappropriate behavior toward Resident #1, were not educated on how to respond to his behavior toward female residents, and were not monitoring his behavior. Resident #4 had a history of being sexually inappropriate with female residents and staff. On 8/8/24, staff observed Resident #4 rubbing Resident #3's left breast. Although the facility updated Resident #4's care plan to read Resident #4 was to be seated next to male residents in group settings, interviews with staff on 2/25/25 revealed they had not been informed of the resident's inappropriate behavior toward female residents and on 2/26/25, Resident #4 was observed sitting at the nurses' station within arm's reach of a female resident. The facility's failure to inform and educate staff on Resident #2 and Resident #4's sexually inappropriate behaviors, monitor the residents' behaviors, and implement planned interventions created a reasonable expectation, absent immediate correction, that an adverse outcome resulting in serious harm could occur. Cross-reference F744 - failure to ensure a resident diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Cross-reference F867- failure to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented. (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: 065245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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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 - Few	Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Resident #2, who was admitted to the facility in November 2022, had a history of being verbally sexually inappropriate to staff and female residents. The facility failed to prevent Resident #2 from grabbing Resident #1's breast on 2/5/25. The facility's response to the incident on 2/5/25 was one-to-one supervision of Resident #2 until Resident #2's medical provider could see him. Once the provider saw him and ordered a medication change, one-to-one supervision was lifted on 2/7/25 at 9:30 a.m. However, based on interviews and observations, staff were not aware of Resident #2's sexually inappropriate behavior and left Resident #2 alone with female residents. Resident #4, who was admitted to the facility on [DATE], had a history of sexual behavior toward female staff. On 8/8/24, Resident #4 was observed by a staff member rubbing Resident #3's left breast. The resident's care plan, initiated on 8/8/24, revealed the resident was to sit next to other male residents in group settings to mitigate risk of inappropriate expressions towards other residents. However, on 2/26/25, Resident #4 was observed sitting at the nurses' station within arm's reach of a female resident. Staff interviews on 2/25/25 revealed that staff were unaware of the resident's inappropriate behavior and the intervention not to place him next to female residents. The facility's failure to inform and educate staff on Resident #2 and Resident #4's sexually inappropriate behaviors, monitor the residents' behaviors, and implement planned interventions created a reasonable expectation, absent immediate correction, that an adverse outcome resulting in serious harm could occur. On 2/26/25 at 2:45 p.m., the nursing home administrator (NHA) was notified that the facility's failure to protect and promote an environment free from resident-to-resident sexual abuse created an immediate jeopardy situation. B. Facility plan to remove immediate jeopardy On 2/27/25 at 10:18 a.m., the facility submitted a plan to remove the immediate jeopardy. The plan read: Immediate actions: Nursing home administrator (NHA) assigned a one-to-one staff member to ensure that Resident #1 and other residents were protected from Resident #2. The one-to-one supervision will continue until 2/27/25 then additional staff will be added to the schedule on all shifts indefinitely for the secured unit. This will help ensure that all residents on the secured unit will be safe. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 2/26/25 all staff that were currently working and all staff prior to the upcoming shift will be educated regarding the sexualized behaviors of Residents #2 and #4 and identified interventions as listed on the care plan. Education will be provided by written, verbal, and or digital means (Workday) for all resident's sexual expressions of need. All working staff were to have completed this as of 2/27/25. Starting on 2/26/25, identify other residents residing in the facility that have demonstrated sexual expressions of need (behaviors) in the past 6 (six) months and ensure that appropriate care plan interventions were in place. Starting on 2/26/25, immediate review of resident information sheets to ensure that interventions were in place for residents with inappropriate behavior. Education to be provided to clinical staff (nurses and certified nurse aides) regarding newly added expressions of need and interventions. Identification of other residents at risk: Residents at risk identified include all female residents residing in the facility. Sustainable fix: Implement a shift-to-shift report book with an emphasis on communicating expressions of need (behaviors) exhibited by residents on all units of the facility. Residents with active expressions of need will be identified in the shift-to-shift book. The oncoming shifts, both eight-hour and 12-hour shifts, will review and sign prior to the start of shift, this includes both nurses and CNAs (certified nurse aides). Events will be opened when new or changed expressions of need were noted. Events were to stay open until reviewed by the behavioral management team (BMT) and closed upon no expressions identified for 48 hours or stable with current interventions. Social services and/or nurse managers or their designee to ensure all residents demonstrating sexual expressions of need have a care plan and interventions in place. Any change in interventions or plan of care will result in an update to the resident information sheet (RIS). Monitoring: Shift-to-shift report book for all units will be monitored/reviewed by a secure unit manager, nurse manager or designee daily for one week, weekly for two weeks, monthly for two months All expressions of need events will be reviewed by the interdisciplinary team (IDT) or off-business hours designee daily for one week, then weekly per IDT BMT meeting. The event will be closed with demonstration of successful intervention and resolution of expressions of need. During the IDT BMT meeting, care plans will be audited based on the previous week events to ensure appropriate interventions were in place. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review and update the RIS will be a part of the IDT BMT review process documentation. C. Removal of immediate jeopardy On 2/27/25 at 3:20 p.m., the NHA was notified that the facility's plan to remove the immediate jeopardy was accepted based on the facility's plan and evidence of implementation of the measures outlined in the plan. However, deficient practice remained at an E level, a pattern with the potential for more than minimal harm. Interviews conducted on 2/27/25 verified that staff had been educated on sexual abuse and resident behaviors per the facility plan to remove the immediate jeopardy. -CNA #7 was interviewed on 2/27/25 at 10:55 a.m. He said he was assigned to provide Resident #2 with one-to-one supervision. He said that he was monitoring for any sexually inappropriate behaviors. He said that interventions were listed on the RIS. He said the RIS also gave tips on how to redirect. He also stated that there was a communication book that CNAs and nurses were supposed to use to write or check if there were any changes in resident behavior. -Licensed practical nurse (LPN) #3 was interviewed on 2/27/25 at 11:05 a.m. He said that he was updated on monitoring for any sexual behaviors for Residents #2 and #4. He said that they were supposed to keep them away from females. He also said that there was a new binder for communication for updating the next shift on any new behaviors. -CNA #5 was interviewed on 2/27/25 at 11:10 a.m. She said Resident #4 was known to be sexually inappropriate with female residents and female care providers. CNA #5 said Resident #4 should only be cared for by a male CNA or two female CNAs. CNA #5 said she had worked the hall four days ago and noticed the RIS had been updated for Resident #4's behaviors toward females. -CNA #4 was interviewed on 2/27/25 at 11:12 a.m. She said that she was educated on Resident #2 and how to monitor for his sexually inappropriate behaviors, who to report them to, new interventions on the RIS, and about the new communication binder for nurses and CNAs. She said that she worked only on the secured unit. -RN #1 was interviewed on 2/27/25 at 11:15 a.m. She said she had been educated on Resident #4's behaviors and that he should not be seated next to female residents due to inappropriate behaviors towards them. RN #1 said a new communication book was implemented for any staff member to document behaviors, and as the assigned floor nurse, she was required to review them. -CNA #2 was interviewed on 2/27/25 at 11:15 a.m. She said that she was educated on both Resident #2 and Resident #4, about their sexually inappropriate behaviors, who to report to, and to use the communication book to update the next shift. She said that they were also to refer to the residents' RIS for any updates. -Dietary aide (DA) #1 was interviewed on 2/27/25 at 2:11 p.m. She said that she was educated on both Resident #2 and Resident #4. She said that she was taught how to redirect them when they were sexually inappropriate and, if that behavior did happen, to report it to the charge nurse or the director of nursing (DON). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Director of therapy (DOT) was interviewed on 2/27/25 at 2:34 p.m. The DOT said that her entire department was educated together on both Resident #2 and Resident #4. She said they were educated on their sexually inappropriate behaviors. She said that if either of the residents had any of those behaviors, they would let the charge nurse know. II. Facility abuse policy The Abuse Prevention policy, revised on 1/18/24, was received from the NHA on 2/25/25 at 2:02 p.m. It read in pertinent part: The facility does not condone resident abuse. Residents must not be subjected to by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, friends or other individuals. The facility has developed a staff screening, orientation, education and policy and procedure to prevent physical, mental, verbal abuse, or misappropriation of resident funds and possessions. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. All employees must immediately report to the administrator or their supervisor any suspected, observed or reported incident of a crime, whether by staff members, family members, or any other persons. The facility will conduct an internal investigation. That investigation includes interviewing any staff members, residents or family members/responsible party who might have knowledge of the crime. In each case of suspected or alleged abuse, the resident will be protected from any further abuse. Actions, as deemed necessary by the administrator or designee, will be implemented immediately. Upon completion of the investigation, the administrator or designee will prepare a written summary. The facility assesses each potential resident prior to admission. This assessment includes behavioral history. Persons with significant history or high risk of violent behavior were not knowingly admitted to the facility. If a resident experiences a behavior change resulting in aggression toward other residents the facility arranges for a psychiatric evaluation of the resident. The resident's care plan was revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization, can then be implemented. Incidents were considered for the QAPI (quality assurance and performance improvement) program and investigations were monitored quarterly by the quality improvement committee. III. Incident on 2/5/25- Sexual abuse of Resident #1 by Resident #2. A. Resident #2 - assailant (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), the resident's diagnoses included unspecified dementia severe, cognitive communication deficit, and depression. The 1/7/25 minimum data set (MDS) assessment revealed that Resident #2 was severely cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. The assessment revealed that he needed partial to moderate assistance with most of his activities of daily living (ADL). The MDS assessment further revealed that Resident #2 did not have any verbal behaviors directed towards others. However, interviews with staff and record review indicated otherwise (see below). 2. Record review Record review revealed documentation of Resident #2's sexually inappropriate comments. The expressions of need (behavior) care plan, last reviewed on 1/22/25, documented that Resident #2 had inappropriate comments evidenced by making sexual or rude comments about people's physical appearance. Interventions listed were: redirect Resident #2's attention following adverse interaction, ensure Resident #2 was part of group conversation and one-to-one conversation when his interactions were appropriate, assess whether the aggression endangered Resident #2 or other residents, intervene if necessary, seat Resident #2 where constant or near constant observation if possible, and maintain a calm environment. The record revealed a nursing note dated 2/5/25 at 2:36 p.m. that documented a staff member reported Resident #2 inappropriately touched a female resident. It documented that an event was opened and that the family and provider were notified. The record revealed a nursing note dated 2/5/25 at 10:13 p.m. that documented a staff member reported Resident #2 had made sexually inappropriate comments toward staff while assisting the resident with his shower. The resident was noted to have attempted to kiss the staff member when the staff member was assisting the resident with shaving. No further sexual comments or behaviors were noted during the shift. Expressions of need charting (behavior monitoring and charting) was initiated by the facility on 2/5/25 after the incident with a female resident and discontinued on 2/19/25. However, there was no documentation showing what discussions were held and what factors were considered for discontinuing behavior monitoring and charting on 2/19/25. The record further revealed that Resident #2's care plan, which read the resident made inappropriate sexual or rude comments (see above), was not updated to include Resident #2's behavior of touching female residents. B. Resident #1 -victim of sexual abuse 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 - Few	Resident #1, age [AGE], was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Alzheimer's disease, stage two kidney disease, depression, and anxiety disorder. The 11/28/24 MDS assessment revealed that Resident #1 was unable to complete the brief interview for mental status assessment. The staff assessment revealed that she had short-term and long-term memory deficits. The staff assessment further revealed that she was moderately impaired in her daily decision-making. The MDS assessment revealed that Resident #1 wandered and ambulated without assistance and needed moderate to partial assistance with most of her ADLs. 2. Record review There were no progress notes in the electronic medical record (EMR) for Resident #1 concerning the incident on 2/5/25. Expression of needs progress notes (behavior monitoring and charting) were initiated on 2/5/25 and were discontinued on 2/19/25. However, there was no documentation showing what discussions were held and what factors were considered for discontinuing behavior monitoring and charting on 2/19/25. The comprehensive care plan documented Resident #1 had physical aggression, such as hitting and swearing at others. She also had a history of verbal aggression toward staff and other residents (initiated on 11/27/24). There was no reference to the incident with Resident #2 on her care plan. 3. Resident representative interview Resident #1's responsible party was interviewed on 2/27/25 at 9:30 a.m. She said her mother had dementia, but if she was in her right mind, she would have been enraged by being touched by someone inappropriately. C. Facility response to the incident on 2/5/25 involving Resident #1 and Resident #2 1. Facility incident report The 2/5/25 facility incident report revealed that a staff member working on the secured unit witnessed Resident #2 grabbing Resident #1's breast and, when told to stop, the resident said, She likes it. The report further read: - The facility staff separated the residents and notified social services, APS (adult protective services), the police, the ombudsman, and Resident #2's provider. - Immediate interventions included one-to-one supervision of Resident #2 until he was seen by his provider and monitoring for any sexual behaviors toward female residents. 2. Facility investigation The facility investigation on 2/5/25 of the incident involving Resident #2 and Resident #1 revealed that Resident #1 and #2 resided in the secured unit, and both residents were interviewed. Resident #1 was interviewed on 2/5/25 but had no verbal response to the incident. Resident #2 was not interviewed until 2/7/25 (two days later) and did not recall the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The investigation further revealed that Resident #2 was seen by the nurse practitioner (NP) on 2/7/25, and a medication change occurred. The NP put the resident on 5 mg (milligrams) of methimazole, an antithyroid medication, for agitation and hypersexual behaviors. D. Failures in facility response 1. See above; Expressions of need charting (behavior monitoring and charting) for Resident #2 and #1 was initiated by the facility on 2/5/25 after the incident with a female resident and discontinued on 2/19/25. There was no documentation showing what discussions were held and what factors were considered for discontinuing behavior monitoring on 2/19/25. 2. See above; Resident #2 started a new medication on 2/7/25 to address agitation and hypersexual behaviors. There was no documentation that staff was monitoring the medication for effectiveness. Further, as of 2/25/25 (during the survey), the provider had not seen the resident to assess the resident's behavior and the effectiveness of the medication. 3. See above; neither Resident #2 nor Resident #1's care plan was updated to reference and address the incident on 2/5/25 to prevent a recurrence. A review of the record revealed that Resident #2's care plan had not been updated with his inappropriate touching of female residents, and no new interventions were put in place. A review of the record revealed that Resident #1's care plan had not been updated to document the 2/5/25 incident and to monitor her for a potential psychosocial response. 3. See below; staff interviews revealed not all staff were aware of Resident #2's sexually inappropriate behavior. E. Observations On 2/25/25 at approximately 10:20 a.m., it was observed that the secured unit was separated from the rest of the facility by doors that were locked. A code was needed to enter and leave the unit. It was noted that the nurse who cared for the secured unit was assigned part of the non-secured hallway, too, and was not constantly on the secured unit. On 2/25/25 at 10:32 a.m., Resident #1 was observed in the common area, bent over, wiping furniture, doors, and windows with a yellow grippy sock. Resident #2 was observed in his room in his bed. On 2/25/25 at 10:39 a.m., the activities staff was seen entering the common area and inviting residents to listen to him read the Daily Chronicle. Resident #1 was still in the common area bending over and touching chairs and pulling open drawers and wandering around in the common area. Resident #2 was present in the common area for the activity. On 2/25/25 at 11:15 a.m., the activities staff was reading the Daily Chronicle in the common area. Both CNAs were in different rooms, providing care with the doors closed. The nurse was not on the unit. Resident #1 was still in the common area bending over and touching objects in close vicinity of Resident #2. Residents #1 and #2 were not in constant or near-constant observation by staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/25/25 at 11:28 a.m., the registered nurse (RN) entered the unit to pass medications to other residents. On 2/25/25 at 11:40 a.m., both Resident #1 and Resident #2 were in the common area, sitting at different tables but still very close to each other. One CNA, often with her back to Residents #1 and #2, was passing drinks. The other CNA was gathering residents to come to the common area in preparation for lunch. On 2/25/25 at 1:22 p.m., Resident #1 was observed sleeping in a double occupancy male room on the bed that was currently open. CNAs were observed walking past the room and not waking her to move to her own bed. On 2/25/25 at 1:36 p.m., both CNAs were in different rooms providing care with the doors closed. There were seven residents in the common area, and the RN was not on the unit. Resident #2 was in his room with the door open, and Resident #1 was wandering the common area and hallways. On 2/25/25 at 4:03 p.m., Resident #2 was in the common area eating a snack. Resident #1 was wandering around the common area. The CNAs were not consistently in the area, entering and leaving frequently to assist other residents. The nurse was not on the unit. On 2/25/25 at 4:04 p.m., Resident #1 was walking around the common area, bent over touching different items in close proximity to Resident #2. The CNAs were not consistently in the area, entering and leaving frequently to assist other residents. The nurse was not on the unit. On 2/25/25 at approximately 6:00 p.m., Resident #2 was put on a one-to-one supervision. F. Staff interviews Staff interviews revealed that not all staff were aware of Resident #2's inappropriate sexual behavior toward female residents. 1. CNA #4, who worked on the secured unit, was interviewed on 2/25/25 at 1:41 p.m. CNA #4 said that if there was a situation between residents, she would try to de-escalate the residents and then go and tell the nurse. If the residents were on any kind of behavior precautions, she said she would get that information from the nurse and through report. CNA #4 said she would also look for any open events in the electronic medical record (EMR). She said the charge nurse usually did rounds on the secured unit about every two hours if they were not too busy. CNA #4 said that she was unaware of any sexual situation that had happened between Resident #1 and #2 and was unaware of any behavior monitoring for Resident #2. 2. RN #2, who worked as a floor nurse and was assigned to the secured unit and a non-secured hallway, was interviewed on 2/25/25 at 1:45 p.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	He said that the CNAs working the secured unit let him know if any behaviors had happened. He said he did medication pass around 7:00 a.m. or 8:00 a.m. on the secured unit, and it took him about two hours to complete the medication pass. He said that if the CNAs needed anything on the secured unit, they had a walkie-talkie that they could use to call the charge nurse over. He said they really relied on the CNAs to communicate anything concerning that they saw or heard. He said that he had heard about the incident between Residents #1 and #2 and that they were charting on both residents' expressions of need while the event was open. He said he had observed Resident #2 reaching for Resident #1's breast on a different day, but he had not made physical contact. He said that if the resident had made contact, he would have reported it to social services (SS) or the director of nursing (DON) and then filled out a report. 3. CNA #3, who worked on the secured unit, was interviewed on 2/25/25 at 4:04 p.m. She said she learned of any behaviors through report. She said there was normally a clipboard on the podium (located just outside the common area in the secured unit) that would give them information. She said that if there was a change in a resident's care plan, there was a piece of paper that staff had to sign to show they had read the updated care plan in the report room. She said she did not think that staff was monitoring Resident #2 for anything except for self-transferring. She said that she was unaware of any sexually inappropriate incident between Residents #1 and #2. 4. LPN #1, who worked on the secured unit, was interviewed on 2/25/25 at 4:19 p.m. She was working the floor as a CNA. She said she got new information from the verbal shift report. She said she also looked at open events. She said they monitored residents for behaviors every day by keeping eyes on all the residents. She said that she had heard about the incident between Residents #1 and #2 and said she had asked the CNAs if there were any behaviors exhibited by either of the residents when the event was open. 5. LPN #2, who worked on the secured unit, was interviewed on 2/25/25 at 4:26 p.m. She said that they really relied on the CNAs to communicate with the nurses. She said she had heard about the incident between Residents #1 and #2. She said that they were monitoring Resident #2's expressions of needs when the event was open. However, progress notes for Resident #2 revealed the interdisciplinary team (IDT) closed the 2/5/25 event on 2/19/25, and sexually inappropriate behavior monitoring stopped, except for one submission on 2/20/25 from the night shift nurse who charted at 6:30 a.m. at the end of her shift. 6. The DON was interviewed on 2/25/25 at 4:54 p.m. She said that if an event was being opened for a resident, nursing staff documented on the event. She said there was a chart that the nurses followed that determined how often they had to chart on that particular event. She said that behaviors should be charted on every shift and the nurse was to chart in the EMR under event charting. She said that if the event was a new type of event for the resident, there should be a prepopulated template for the care plan. If there was not a template, then the MDS coordinator would review the event the next business day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Columbine West Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Worthington Cir Fort Collins, CO 80526	

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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 - Few	She said care plans were reviewed on admission and then quarterly, and anyone who had access to the EMR had access to the care plans. CNAs did not have access to the care plan; they got their information from the Resident Information Sheet (RIS) and from the preference binders that were found in each report room. She said staff were notified of new interventions and what to monitor for on education sheets that were placed in report rooms, and the staff development coordinator (SDC) monitored to ensure staff had read the education sheet. She said that there were 14 residents in the secured unit; four residents were male, and 10 residents were female. She said that she did not have any staffing concerns for the secured unit. She said agency staff was trained by going through orientation if they had never worked in one of their facilities before. Behavior and care concerns were reported to agency staff through verbal reports and by what was on the RIS. She said that her expectations for the nurse assigned to the secured unit to monitor both the secured and non-secured unit was to use the secured unit as their home base. The nurse should be doing their charting on the secured unit. The only time they should be off the secured unit was when they were providing care to the residents on the non-secured unit. She said that they were in the process of implementing a walkie-talkie system. She said that at night, the CNA should have the walkie-talkie on them at all times, but the day shift could use it as well. She said that CNAs charted in a separate system, but she was not as familiar with what or where the CNAs charted. She said that the incident report for the 2/5/25 event was filled out by the social services director (SSD). She said that the interventions were to keep Resident #2 separate from Resident #1, and staff were to monitor Resident #2. She said that there were no audits done on the monitoring of Resident #2. She said that the event was closed based on the IDT notes. However, see above; IDT notes about the closing of the event were not found in the EMR. 7. The NHA was interviewed on 2/25/25 at 5:32 p.m. She said new behaviors caused an event to be opened, and they had an IDT meeting where they discussed behavior monitoring and if interventions were meeting the resident's needs. The NHA said that floor staff did a small huddle where they met and discussed interventions put in place for a resident. 8. The SSD was interviewed on 2/26/25 at 9:24 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SSD said the nurse notified her on 2/5/25 about the incident involving Residents #1 and #2. The SSD said that nursing provided the assessment for Resident #1. The SSD said that she then interviewed three other residents who resided in the secured unit on the day of the incident. The SSD said she also interviewed the staff members who witnessed the incident. She said she did not interview Resident #2 the same day as the incident because she was more concerned about Resident #1. She said that since Resident #2 was on one-to-one supervision, he did not have access to Resident #1. However, see above; Resident #2's one-to-one supervision was removed on 2/7/25. 9. The NHA was interviewed again on 2/26/25 at 9:43 a.m. She said that there was not any formal education provided to the staff regarding the 2/5/25 incident. She said that education was completed verbally. The NHA said that CNAs did not document resident behaviors but were to verbalize the behaviors to the nurse, who in turn was to document the behaviors in the EMR. The NHA said they would now be initiating a communication binder for CNAs, starting 2/26/25. The NHA said the facility closed the event for Resident #2 because he had not shown any behaviors, and it seemed that the medication regime had returned him to his baseline. However, see above; Resident #2 had not been seen by the provider for an effective response to the new medication started on 2/7/25 (see below). 10. The nurse practitioner (NP) was interviewed on 2/26/25 at 10:54 a.m. She said Resident #2 was prescribed Methimazole due[TRUNCATED]

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F 0744 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 dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#1) of one resident who were diagnosed with dementia, received the appropriate treatment and services to attain or maintain the highest practicable physical, mental and psychosocial well-being out of seven sample residents. Specifically, the facility failed to effectively identify person-centered approaches for dementia care for Resident #1. Cross reference F600: failure to protect Resident #1 from abuse. Findings include: I. Facility policy and procedure The Dementia Care policy, dated 7/1/24, was provided by the nursing home administrator (NHA) on 2/27/25 at 4:20 p.m. it read in pertinent part, Each resident who displays or is diagnosed with dementia will receive the appropriate treatment and services to attain or maintain his or her hightest practicable physical, mental and psychosocial well-being. An individualized, person-centered care plan will be developed for each resident through an interdisciplinary team (IDT) approach, which includes input from the resident and/or their representative. All approaches to care are monitored for efficacy, risks, benefits, harm and revised as necessary. Specialized support and services will be provided as necessary. Expressions of need may represent a resident's attempt to communicate. Use of the Dementia Tool is encouraged, which includes communication techniques. The Expression of Need Management policy, revised 3/7/24, was proved by the NHA on 2/27/25 at 4:20 p.m. It read in pertinent part, Expression(s) of need (previously known as behaviors) will be handled in a professional and caring manner in order to not endanger either the resident or others. Necessary care and services will be provided with a person-centered approach that reflect the resident's goals, while maximizing the resident's quality of life. The IDT team shall monitor residents on-going for expression(s) of need. If a resident has a history of expressions of need that have been care planned, the plan of care will be followed to reduce, eliminate, or manage the expressions. Upon identification of a new or worsening expression of need, interventions will be implemented immediately and an event (incident) will be opened. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Expressions of need will be reviewed by the IDT team. The care plan will be reviewed and revised or implement individualized approaches, including involvement in meaningful activities. The Dementia Tool, undated, was provided by the NHA on 2/27/25 at 4:20 p.m. It read in pertinent part: -Things that work in every situation, slow down (move slowly, talk slowly); -Approach from the front so the resident can see you; -Reduce stimulation; -Approach again later; -Do not scold, confront or become angry with the resident; -Use written reminders; and, -Use non-threatening approach II. Resident #1 A. Resident status Resident #1, age [AGE] was admitted on [DATE]. According to the February 2025 computerized physician's orders (CPO), diagnosis included Alzheimer's disease, stage two kidney disease, depression, and anxiety disorder. The 11/28/24 minimum data set (MDS) assessment revealed Resident #1 was unable to complete the brief interview for mental status. The staff assessment revealed she had short-term and long-term memory deficits. The staff assessment further revealed she was moderately impaired in her daily decision-making. The MDS assessment revealed Resident #1 wandered and ambulated without assistance. She needed moderate to partial assistance with most of her activities of daily living (ADL). B. Observations On 2/25/25 at 10:32 a.m. Resident #1 was in the common area bent over wiping furniture, doors and windows with a yellow sock. On 2/25/25 at 10:39 a.m. the assistant activities director (AAD) entered the common area and began inviting residents to listen to him read the daily chronicle. Resident #1 was still in the common area bending over and touching chairs and pulling open drawers and wandering around in the common area. Resident #1 was not invited to the activity. On 2/25/25 at 11:15 a.m. The AAD was reading the daily chronicle in the common area. Both certified nurse aides (CNA) were providing care to residents in their rooms with the doors closed. The nurse was not on the unit. Resident #1 was still in the common area bending over and touching objects. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #1 was not in the direct line of sight of a staff member as directed on the resident's plan of care (see record review below). On 2/25/25 at 1:22 p.m. Resident #1 was sleeping on a bed in a double occupancy male room. CNA #2 and CNA #4 walked past the room and did not encourage Resident #1 to return to her bed. On 2/26/25 at 12:17 p.m. Resident #1 was walking up and down the secured unit hallway. She was pushing another resident's wheelchair trying to get them to move faster. The staff did not redirect her. On 2/27/25 at 2:16 p.m. Resident #1 was sitting on a love seat at the end of the hallway, alone. Staff was at the front of the unit conversing with each other while an activity was being run in the common area. -Resident #1 was not in the staff's near-constant observation, per the resident's plan of care (see record review below). C. Record review The activities care plan, revised on 12/5/24, revealed the resident was very pleasant and at times spoke in nonsensical sentences. The care plan documented that Resident #1 was interested in holding and caring for a baby doll, spending time outdoors, listening to music and her religion. Interventions included offering one-to-one visits for social interactions, offering walks and going outdoors, encouraging Resident #1 to join group activities of possible interest and offering material needed for activities of interest such as a baby doll. The expressions of need care plan, revised on 2/19/25, revealed Resident #1 experienced physical aggression such as hitting or swearing at others. Interventions included giving her a baby doll or other items of comfort, separating her from the other residents, assisting Resident #1 to sit where constant or near-constant observation was possible. -However, observations revealed the resident was not always in near-constant supervision of sight of staff and was not offered her baby doll (see observations above). The 11/25/24 nursing progress note documented Resident #1 was wandering and going from room to room. The note revealed this was not a new behavior. The 11/26/24 nursing progress note documented Resident #1 remained restless and ambulated around the secured unit touching other residents. -Review of the resident's electronic medical record (EMR) did not reveal the staff tried any interventions to prevent Resident #1 from touching other residents. The 11/28/24 nursing progress note documented Resident #1 had agitation and aggression. She was attempting to pull food away from other residents. She was also entering other resident's bedrooms and trying to pull their blankets away from them. She was attempting to hit and pinch staff. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of the EMR revealed that the staff administered Ativan (antianxiety medication), but it was not always effective and the floor staff tried to provide supervision and redirection but, it was not always effective. The 12/1/24 nursing progress note documented Resident #1 was wandering and touching other residents. The 12/3/24 nursing progress note documented Resident #1 was showing signs of aggression towards a male resident. The 12/4/24 nursing progress note documented Resident #1 was wandering, going from room to room and was touching other residents. The note documented this was not a new behavior. The 2/12/25 nursing progress note documented Resident #1 continued to wander the secured unit and she was not always careful or aware of her surroundings. The 2/13/25 nursing progress note documented Resident #1 wandered from room to room on the secured unit. The 2/14/25 nursing progress note documented Resident #1 was wandering from room to room with her head down. The 2/17/25 nursing progress note documented Resident #1 was wandering from room to room. The 2/19/25 nursing progress note documented Resident #1 was up and wandering the secured unit. She was in and out of other rooms and beds. Review of the January 2025 and February 2025 activity participation sheets revealed Resident #1 had two social visits (one-on-one) with activities during the month of January 2025. According to the participation sheet for February 2025 (2/1/25 to 2/26/25), Resident #1 had not had any social visits. The participation sheet documented during most of the activities during the months of January 2025 and February 2025 Resident #1 was walking or was given water by a staff member. The resident information sheet (staff directive tool) for Resident #1 documented that the resident need to be in line of sight due to being a high fall risk. III. Staff interviews The NHA was interviewed on 2/25/25 at 5:32 p.m. The NHA said that all staff members received dementia training upon hire. CNA #5 was interviewed on 2/26/25 at 12:09 p.m. CNA #5 said Resident #1 wandered all day and would go in other resident's rooms and get into other resident's space. She said Resident #1 annoyed some of the other residents by wandering into their rooms or by getting into their personal space. She said the staff would intervene before the situations got physical. She said Resident #1 did not attend activities because she wandered too much and would not stay still. She said Resident #1 was not able to engage in the activities. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #6 was interviewed on 2/26/25 at 12:17 p.m. CNA #6 said Resident #1 wandered most of the time. CNA #1 said Resident #1 liked to touch and feel everything. He said she went into other residents'rooms and that annoyed the other residents. He said she did not do things to purposefully harm or annoy the other residents. He said Resident #1 had not been in any recent altercations with any of the residents. He said she was mostly the victim in the altercations with the other residents. He said it was hard to engage Resident #1 in activities because she will not sit in one place for very long. He said giving her a baby doll would sometimes help with her wandering. He said Resident #1 enjoyed warm baths to calm her down Registered nurse (RN) #2 was interviewed on 2/26/25 at 12:22 p.m. RN #2 said Resident #1 was alert and oriented to herself. He said she self-ambulateed and grabbed objects and other residents. He said she was easily redirectable. He said he did not know if there was anything that would keep her from entering into other resident's rooms. The assistant activities director (AAD) was interviewed on 2/26/25 at 12:26 p.m. The AAD said the activities staff tried to do one-on-one visits with Resident #1. He said if they happened to see her enter the room while they were doing an activity they would invite her over to join. CNA #8 was interviewed on 2/27/25 at 10:55 a.m. CNA #8 said that the activities department were going to try to add additional activities on the secured unit. He said they currently only had two activities that happen on the unit. He said it might help keep the behaviors down on the secured unit. The AAD was interviewed again on 2/27/25 at 3:25 p.m. The AAD said there was a binder in the activities office where they would track to see if a resident came to the activity. He said that there was also a special care book that was resident-specific. He said that they tried to do one-on-one visits with Resident #1. He said she would join current events or reminisce groups. He said that one-on-one visits happened one to two times a week. -However, the activity participation log revealed Resident #1 had two one-on-one visits in January 2025 and did not have any in the month of February 2025. The director of nursing (DON) was interviewed on 2/27/25 at 5:15 p.m. The DON said the staff on the secured unit should utilize the dementia tool (see facility policy and procedures above). She said Resident #1 typically wandered and the staff should redirect her. She said that Resident #1 wandered into other resident's rooms and laid in open beds. She said Resident #1 did not understand that the bed or the room was not hers She said the staff needed to redirect Resident #1 by offering her comfort items such as a baby doll to hold while walking. She said if Resident #1 was sleeping in a bed that was not hers, the staff should let her be if she was not affecting other residents. She said that there was a potential for another resident not liking that Resident #1 was sleeping in their bed. She said Resident #1 had been involved in several resident to resident altercations recently. She said Resident #1 was primarily the victim. She said a resident that wandered was at increased risk of altercations with other residents. The NHA was interviewed again on 2/27/25 at 5:30 p.m. The [NAME] said the staff were aware of which residents wandered. She said the staff should redirect residents who do not understand personal space, especially if they were in a dangerous situation. She said a resident laying in another resident's bed could be a dangerous situation.

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F 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life and resident safety.

Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to freedom from abuse, reporting and investigating that rose to the level of immediate jeopardy and created a situation where a serious adverse outcome occurred and caused harm.

Findings include:

I. Facility policy and procedure

The Quality Assurance and Performance Improvement Plan (QAPI) policy and procedure, reviewed April 2022, was received from the nursing home administrator (NHA) on 2/27/25 at 6:39 p.m. It revealed in pertinent part, The purpose of QAPI is to take a proactive approach to continuously improving the way we care for and interact with our residents, caregivers, and family members/responsible parties so we are able to realize our vision to provide quality health care services to our residents while promoting individual choice, resident satisfaction and employee retention. To do this, all employees will participate in ongoing QAPI efforts which support our mission and vision.

QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.

The facility makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.

The QAPI Steering Committee and facility QAPI teams will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in the daily life of our residents. This will be achieved by utilizing the current evidence (data, national benchmarks, published best practices, clinical guidelines) and benchmarks.

Clinical Care:

Levels of care: post-acute care/rehabilitation, chronic care management, dementia care and services, end of life/hospice care, social services, dietary, nursing services, MDS (minimum data set assessments), medication management, infection prevention, wound care, assistance with activities of daily living and restorative care.

Data shall be collected from multiple sources to monitor the care and service areas defined above, including the following: input from caregivers, residents, families, and others, adverse events, performance indicators, survey findings and complaints.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Data is collected and analyzed at both the facility and corporate level. The facility QAPI team reviews the data and compares against available benchmarks and/or established targets, then uses the information to charter facility level Performance Improvement Projects (PIPs). II. Review of the facility's regulatory record revealed it failed to operate a QA (quality assurance) program in a manner to prevent repeat deficiencies and initiate a plan to correct F600 Free from abuse and neglect During the recertification survey on 4/11/24, F600 was cited at a D scope and severity, a potential for more than minimal harm, isolated. During the abbreviated survey on 2/27/25, F600 was cited at a J scope and severity, immediate jeopardy to resident health or safety, isolated. III. Cross-reference citations Cross-reference F600: The facility failed to ensure residents were protected from resident-to-resident sexual abuse. The facility's failure to protect residents from resident-to-resident sexual abuse put residents in a situation where a serious outcome occurred and created an immediate jeopardy situation. IV. Staff interviews The NHA was interviewed on 2/27/25 at 6:05 p.m. The NHA said the QAPI committee consisted of the medical director, the director of nursing (DON), the staffing coordinator, the medical records director, the infection preventionist, the wound care/restorative nurse, the dietician, the pharmacist and the NHA. The NHA said the QAPI committee met monthly and would discuss any concerns that had been identified from current issues in the facility, such as events/occurrences and infections. The NHA said the facility did not have a PIP for abuse in place since they were put back into compliance from the last recertification survey (April 2024). -The facility had not previously identified any concerns related to abuse, despite the facility being cited for abuse on their last recertification in April 2024.