| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure five (#40, #28, #45, #5 and #43) of seven residents reviewed for abuse out of 27 sample residents were kept free from abuse. Specially, the facility failed to:-Protect Resident #40 from physical abuse by Resident #45;-Protect Resident #28 from physical abuse by Resident #45; -Protect Resident #28 and Resident #45 from physical abuse by each other;-Protect Resident #5 from physical abuse by Resident #28; and, -Protect Resident #43 from physical abuse by Resident #32.Findings include: I. Incident of physical abuse of Resident #40 by Resident #45 on 6/3/25A. Facility investigation The 6/3/25 facility investigation documented a nurse witnessed Resident #40 back his motorized wheelchair into the hallway. Resident #45 was ambulating down the hallway and came upon Resident #40 and hit him on the back of the head (near the base of the skull/top of neck) with the back of her open hand. The staff redirected Resident #45 away from the Resident #40. Resident #40 continued moving his wheelchair and did not acknowledge that anything had occurred.The two residents were separated by staff and assessed for injuries and no injuries were noted. When interviewed by staff, neither resident could recall the events due to their cognitive impairments. The residents resided on the same secured unit of the facility. Resident #45 was assigned one-on-one observation by staff and new interventions were added to offer a milkshake for distraction, redirect others from Resident #45 or step between her and other residents at times of increased agitation. The physician was notified and an increase of Resident #45's antipsychotic medication was requested. The facility substantiated the incident, but did not substantiate abuse as there was no injury and no fear.-However, abuse occurred due to Resident #45 being observed slapping Resident #40 in the head. B. Resident #45 (assailant)1. Resident statusResident #45, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included unspecified dementia and a traumatic brain injury (TBI). The 7/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to participate in the brief interview for mental status (BIMS) assessment. A staff assessment for mental status revealed the resident had short and long term memory impairments and had severe impairments to her daily decision-making skills. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), physical and verbal aggression, rejecting care, and wandering. The resident experienced delusions. 2. Record reviewResident #45's behavior care plan, revised 6/13/25, revealed the resident had behaviors of verbal aggression with other residents related to dementia and a history of TBI. The resident would pace and wander to the point of exhaustion and did not have awareness of others' space and would enter others' rooms. The resident could be paranoid and did not not get along with another female resident on the unit and would have altercations with her if in close proximity. The resident would strike others unprovoked and could become<br><br>(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 |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | verbally aggressive if feeling threatened. Interventions, initiated 4/14/25, included redirecting the resident from others' space and to her room or common areas, allowing the resident to sit in chairs in the hallway, engaging with the resident when passing her in the hallway with smiles and greetings, if the resident felt she was being followed, offering reminders of where the other resident's rooms were and offering to walk away from them with her, offering sweet treats, assisting with turning on the resident's television in her room during times of frustration, allowing the resident independent visits with her male friend in the unit, offering the resident compliments on her appearance, and offering to paint her nails. Interventions, initiated 6/4/25, included offering the resident a milkshake when agitated, and staff were to create a space between her and others or stand between them if unable to redirect the resident away from others. Interventions, initiated 6/7/25, included providing one-on-one staff at times of increased agitation and with busy waking hours.Interventions, initiated 6/9/25, included encouraging a calm bedtime environment and relaxation to promote sleep, offering the resident a back rub, smoothing of the resident's hair, providing soft or calming music and encouraging the resident to take walks outside with staff daily to reduce [NAME] up energy and reduce the risk of agitation .Interventions, initiated 6/13/25, included for the facility to purchase an identical pillow for the resident as another resident had as Resident #45 frequently took the other resident's pillow, which caused conflict, redirecting the resident away from the female resident she did not get along with and redirecting her from going into others' rooms or taking their belongings. Interventions, initiated 6/30/25, included reducing one-on-one observation to afternoon hours or with times of agitation. A nursing progress note, dated 6/3/25, revealed that Resident #45 had been upset, anxious, and agitated while pacing and cursing throughout the unit. As Resident #45 was pacing the hallway, Resident #40 was wheeling backwards down the unit and Resident #45 used her flat hand and smacked Resident #40 in the back of the head. Staff separated the residents. Further review of Resident #45's electronic medical record (EMR), from 2/24/25 to 8/5/25, revealed the resident had a history of wandering into other residents' rooms, and verbally antagonizing other residents, resulting in altercations with other residents.-The facility failed to address Resident #45's behaviors of wandering into other residents' rooms in the care plan until 4/14/25 and failed to address the resident's behaviors of verbally antagonizing other residents.C. Resident #40 (victim)1. Resident statusResident #40, age less than 75, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included anxiety and intracranial injury (TBI). The 5/22/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of seven out of 15. The MDS assessment indicated the resident experienced delusions. 2. Record reviewResident #40's behavior care plan, revised 6/3/25, revealed the resident took an antipsychotic medication related to an anxiety disorder with target behaviors of verbal outbursts/aggression. Interventions, revised 6/14/24, included offering one-on-one, redirection, offering food/fluids, toileting, removing from the situation, offering an activity, assessing for pain or offering massage/back rub. -Resident #40's care plan failed to address the incident with Resident #45 on 6/3/25.II. Incident of physical abuse of Resident #28 by Resident #45 on 6/4/25 A. Facility investigationThe 6/4/25 incident investigation documented a dietary aide witnessed an altercation between Resident #45 and Resident #28 in the dining area of the secured unit that both of the residents resided on. Resident #45 had been assigned one-on-one observation by staff after the incident between Resident #45 and Resident #40 on 6/3/25 (see 6/3/25 incident above). However the dietary staff member who reported the incident between Resident #45 and Resident #28 to the nursing staff was the only staff member present at the time of the incident. Nursing staff were not present or observing Resident #45 at the time of the incident. Resident #28 had been sitting at the<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | dining room table for lunch. Resident #45 entered the dining room to take her seat for lunch, but approached Resident #28 unprovoked and hit her in the head with a pillow four to five times and then walked away. Resident #28 yelled out and said no to Resident #45. The two residents were separated by staff and assessed for injuries and no injuries were noted. Resident #45 had been assigned one-on-one observation by staff and was assisted with an activity off the unit with staff.When interviewed by staff, neither resident could recall the events due to cognitive impairments. The residents resided on the same secured unit of the facility. Resident #45 was assigned one-on-one observation by staff and a medication review was requested. The facility substantiated the incident, but did not substantiate abuse due to no injury. -However, abuse occurred due to Resident #45 being observed hitting Resident #28 with a pillow. B. Resident #45 (assailant)1. Record reviewA nursing progress note, dated 6/4/25, revealed that a dietary staff member informed the nurse that Resident #45 hit Resident #28 in the face in the dining room. The nurse separated the residents and assessed for injury and there were no injuries. The NHA and the director of nursing (DON) were contacted. C. Resident #28 (victim)1. Resident statusResident #28, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included Alzheimer's disease, dementia with mood disturbance and major depressive disorder.The 6/18/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of two out of 15. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), wandering, delusions and physical aggression. B. Record reviewResident #28's behavior care plan, revised 6/13/25, revealed the resident would strike out at other residents if she felt threatened or if they were in her personal space. The resident did not get along with another female resident on the unit and was at high risk for having altercations with that other resident.Interventions, initiated 6/13/25, included redirecting all residents from Resident #28's space/room and her personal belongings, redirecting Resident #28 away from the female resident on the unit that she did not get along with, providing space between the two residents when passing in common areas and creating a barrier if possible by standing between them or ambulating on the passing side of the resident.Interventions, initiated 7/23/25, included providing as needed one-on-one observation related to periods of agitation/frustration that was not easily redirectable with person-centered interventions.-Resident #28's care plan did not reveal that the resident's care plan was reviewed to determine if the current interventions were effective or if new interventions were needed to prevent further abuse incidents. -Additionally, Resident #28's care plan did not reveal that the resident's care plan was reviewed to determine if the current interventions were effective or if new interventions were needed to prevent further abuse incidents following the incidents with Resident #45 on 6/8/25 and 6/12/25 or following the incident with Resident #5 on 7/5/25 (see 6/8/25, 6/12/25 and 7/5/25 incidents below).A nursing progress note, dated 6/4/25, revealed that a dietary staff member informed the nurse that Resident #45 hit Resident #28 in the face in the dining room. The nurse separated the residents and assessed for injury, no injuries. The NHA and the DON were contacted.III. Incident of physical abuse of Resident #45 and Resident #28 by each other on 6/8/25A. Facility investigationThe 6/8/25 incident investigation documented a nurse witnessed an altercation between Resident #45 and Resident #28 in the hallway of the secure unit that both residents resided on. Resident #45 was pacing down the hallway and teasing and laughing at Resident #28. Resident #45 than passed Resident #28 on the opposite side of the hallway. Resident #45 raised her fist and made punching motions in the air. When Resident #28 walked down the hallway on the side of the hallway were Resident #45 was, Resident #45 then tapped Resident #28's arm with a closed fist and Resident<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | #28 tapped Resident #45 in the upper arm with a closed fist in return. The two residents were separated by staff and assessed for injuries, no injuries noted. Resident #45 was assigned one-on-one observation by staff and assisted with an activity off the unit with staff.When interviewed by staff, neither resident could recall the events due to cognitive impairments. The residents resided on the same secured unit of the facility. Resident #45 was assigned one-on-one observation by staff and a medication review was requested. -However, Resident #45 had been assigned one-on-one observation by staff after the incident with Resident #28 on 6/4/25 and that intervention failed to mitigate the altercation on 6/8/25. The facility unsubstantiated the incident due to cognitive impairments. -However, abuse occurred due to Resident #45 being observed hitting Resident #28 with a closed fist.B. Resident #45 (assailant and victim)1. Record reviewA nursing note, dated 6/8/25, revealed that Resident #45 was witnessed walking up and down the hallway laughing and teasing Resident #28. Resident #45 continued pacing despite being redirected many times, and got closer to Resident #28. As Resident #45 got closer, Resident #45 raised her fist and punched the air while looking at Resident #28. Resident #28 walked down the hallway but came too close to Resident #45, resulting in Resident #45 using her fist to tap Resident #28 in the left arm. Resident #28 responded by using her fist to tap Resident #45 in the right arm. Resident #45 was redirected to go outside for a walk and Resident #28's arm was assessed with no injury. C. Resident #28 (victim and assailant) 1. Record reviewA nursing note, dated 6/8/25, revealed that Resident #45 was witnessed walking up and down the hallway laughing and teasing Resident #28. Resident #45 continued pacing despite being redirected many times, and got closer to Resident #28. As Resident #45 got closer, Resident #45 raised her fist and punched the air while looking at Resident #28. Resident #28 walked down the hallway but came too close to Resident #45, resulting in Resident #45 using her fist to tap Resident #28 in the left arm. Resident #28 responded by using her fist to tap Resident #45 in the right arm. Resident #45 was redirected to go outside for a walk and Resident #28's arm was assessed with no injury. IV. Incident of physical abuse of Resident #45 and Resident #28 by each other on 6/12/25A. Facility investigationThe 6/12/25 incident investigation documented a nurse observed Resident #45 go into Resident #28's room and took her pillow from the room. Resident #28 had been in the hallway and became upset when Resident #45 walked past her with Resident #28's pillow. Resident #28 then hit Resident #45 in the head with an open hand and Resident #45 hit Resident #28 in the shoulder with an open hand in return. Resident #28 hit Resident #45 again in the head twice with an open hand before staff intervened. The two residents were separated by staff and assessed for injuries and no injuries noted. Resident #45 was assigned one-on-one observation by staff and assisted with an activity off the unit with staff.When interviewed by staff, neither resident could recall the events due to cognitive impairments. The residents resided on the same secured unit of the facility. Resident #45 and Resident #28's care plans were updated to instruct staff to keep the two residents away from each other and staff received training to keep the residents away from each other. Resident #45 was assigned one-on-one observation by staff. -However, Resident #45 had been assigned one-on-one observation by staff after the incidents on 6/4/25 and 6/8/25 and that intervention had failed to mitigate the altercation on 6/12/25.The facility unsubstantiated the incident due to no injury.-However, abuse occurred due to Resident #45 and Resident #28 were observed hitting each other. B. Resident #28 (assailant and victim) 1. Record reviewA nursing note, dated 6/12/25, revealed Resident #45 took Resident #28's pillow from her bedroom, which made Resident #28 upset, resulting in Resident #28 hitting (open handed) Resident #45 on the head. Resident #45 then hit Resident #28 back in the left shoulder, causing Resident #28 to hit Resident #45 in the head two times open handed. Both residents were separated, redirected and assessed. Both residents<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | did not recall the situation and denied pain. C. Resident #45 (victim and assailant) 1. Record reviewA nursing note, dated 6/12/25, revealed Resident #45 took Resident #28's pillow from her bedroom, which made Resident #28 upset, resulting in Resident #28 hitting (open handed) Resident #45 on the head. Resident #45 then hit Resident #28 back in the left shoulder, causing Resident #28 to hit Resident #45 in the head two times open handed. Both residents were separated, redirected and assessed. Both residents did not recall the situation and denied pain. V. Incident of physical abuse of Resident #5 by Resident #28 on 7/5/25A. Facility investigation The 7/5/25 incident investigation documented activities assistant (AA) #1 witnessed an altercation between Resident #28 and Resident #5 in the outside secure unit courtyard during an activity. Resident #28 walked up to Resident #5 and pushed Resident #5 in the arm and was redirected by staff. However, Resident #28 returned to Resident #5 and pushed her in the arm a second time. The two residents were separated by staff and offered snacks, both residents were taken inside and assessed for injuries. No injuries were noted. Resident #28 was assigned one-on-one observation by staff on 7/8/25, three days after the incident. -Review of Resident #28's EMR and care plan revealed one-on-one observations were not initiated until 7/8/25 (three days after the incident), despite Resident #28 being involved in other incidents of physical abuse towards other residents on 6/8/25 and 6/12/25 (see 6/8/25 and 6/12/25 incidents above).When interviewed by staff, neither resident could recall the events due to cognitive impairments. The residents resided on the same secured unit of the facility. Resident #28 was assigned one-on-one observation by staff on 7/8/25 (three days after the incident) and the physician was notified.The facility unsubstantiated the incident due to no injury. -However, abuse occurred due to Resident #28 being observed pushing Resident #5 twice, despite being redirected. B. Resident #28 (assailant) 1. Record reviewReview of Resident #28's progress notes revealed there was no progress note related to the incident.C. Resident #5 (victim)1. Resident statusResident #5, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included vascular dementia, anxiety and insomnia. The 6/19/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of six of 15. The MDS assessment indicated the resident had behaviors of wandering and experienced delusions. 2. Record reviewResident #5's behavior care plan, revised 6/9/25, revealed the resident was an elopement risk related to disorientation to place, impaired safety awareness, and wandering aimlessly which significantly intruded on the privacy of activities. The resident wandered daily and had a lack of awareness of other's personal space/boundaries and would benefit from a smaller, more structured environment of the secure unit. Interventions, initiated 6/9/25, included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book, and providing structured activities such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Interventions, initiated 7/7/25, included redirecting the resident away from others' personal space as needed.-Resident #5's care plan failed to address the incident with Resident #28 on 7/5/25.Review of Resident #5's progress notes revealed there was no progress note related to the incident. VI. Incident of physical abuse of Residents #43 by Resident #32 on 8/4/25A. ObservationOn 8/4/25 at 1:11 p.m. Resident #32 was observed in the doorway of the room he shared with Resident #43. During the observation, Resident #32 had his right arm around Resident #43's neck with his left hand positioned to lock the hold by grabbing his right hand. Resident #43 was standing with his hands down to his sides and was not engaging physically with Resident #32. Certified nurse aide (CNA) #5 ran over to the two residents to intervene. B. Facility investigation The 8/4/25 incident investigation documented the CNA #5 witnessed an altercation between Resident #32 and Resident #43 as they exited their room together. Resident #32 had his hand on the<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | neck of Resident #43 and Resident #43 was pushing Resident #32 in the neck with his open hands. The two residents were separated by staff and assessed for injuries, no injuries noted. Resident #32 and Resident #43 were assigned one-on-one observation by staff. When interviewed by staff, Resident #32 said he was cleaning his side of the room and looked over at his roommate's side of the room and told his roommate, Resident #43, to clean his side of the room. Resident #43 responded by telling Resident #32 to get out of his room and an argument started. When interviewed by staff, Resident #43 could not describe the events but said he wanted Resident #32 out of his room. The residents resided on the same secured unit of the facility and shared a room. Resident #43 and Resident #32 were both assigned one-on-one observation by staff on 8/4/25 and the physician was notified.The facility unsubstantiated the incident due to no injury. -However, abuse occurred due to Resident #32 being observed with his hand around Resident #43's neck (see observation above). -Additionally, the facility's description of the incident did not match the observation of the incident (see incident above).C. Resident #32 (assailant)1. Resident statusResident #32, age under 70, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included anxiety and Wernicke's encephalopathy (alcohol-induced encephalopathy). The 6/25/25 MDS assessment revealed the resident had severe cognitive impairments and was unable to participate in the BIMS assessment. A staff interview for mental status revealed the resident had short and long term memory impairments and had severe impairments related to his daily decision making skills. The MDS assessment indicated the resident had behaviors of hallucinations, delusions, rejecting care, and wandering. 2. Record reviewResident #32's mood care plan, revised 8/4/25, revealed the resident could become verbally aggressive when frustrated or throw items. The resident had an episode of physical aggression toward his roommate. The resident could become frustrated if his roommate's side of the room was dirty/cluttered. Interventions, initiated 8/4/25, included reminding others to respect the resident's personal space and offering to assist with tidying of his room as the resident allowed.Resident #32's behavior sheet, undated, was kept at the nurses station and was reviewed on 8/5/25. The behavior sheet revealed that Resident #32 had behaviors of becoming aggressive, throwing things, and could become triggered if his roommate's side of the room was cluttered. Resident #32 had an aversion to being around other men and could become fearful and aggressive. Interventions included assisting him to a quiet area, redirecting him from other residents, offering chocolate ice cream or chocolate milk, allowing him to read a book of choice, assisting him in calling his sister, encouraging the resident to stay in his room and reorganizing if desired, encouraging the resident to keep a distance from other men, allowing him to sit alone in the dining room or encouraging female peers to sit with him, allowing him to watch the television in the dayroom and offering to assist the resident in tidying his personal space. -However, Resident #32's care plan and behavior monitoring orders failed to identify potential challenges with Resident #32 being around other males (see care plan above). A psychoactive medication evaluation meeting minute note, dated 6/20/25, revealed a physician note written during the meeting indicated Resident #32 had recently moved to the secure unit and he would be getting a roommate, which had historically increased Resident #32's behaviors, anxiety, and distress. The facility was to monitor and assess Resident #32's adjustment. A room change form revealed Resident #32 moved to his room in the secure unit on 5/21/25. -Resident #32's EMR failed to reveal staff provided psychosocial checks on Resident #32 once Resident #43 moved into his room on 6/30/25. -Resident #32's care plan, behavior monitoring orders, and behavior sheet failed to identify potential challenges with Resident #32 once he received a roommate. A nursing note, dated 8/4/25, revealed Resident #32 had an altercation with his roommate. Both residents came out of their room holding each other's necks. No injuries were noted. D. Resident #43 (victim)<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Resident statusResident #43, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included unspecified dementia with behavioral disturbances, post traumatic stress disorder (PTSD), major depressive disorder and anxiety. The 6/30/25 MDS assessment documented Resident #43 had severe cognitive impairments with a BIMS score of three out of 15. The MDS assessment indicated Resident #43 had behaviors of being verbally abusive, experiencing delusions and wandering.2. Resident interviewResident #43 was interviewed on 8/4/25 at approximately 3:30 p.m. However, he became agitated when his roommate was mentioned, although he was unable to say why.3. Record review Resident #43's behavior care plan, initiated 6/30/25, revealed the resident had a history of aggressive behaviors at his previous facility towards female caregivers and other residents. The resident would become frustrated when he felt that others were in his personal space andcould become physical to show where his boundaries were. He had exhibited physical aggression toward others with times of frustration (pushing and hitting), revised 8/4/25, during the survey. Interventions, initiated 6/30/25, included approaching the resident from the side when attempting to engage in conversation with a slow and calm demeanor while using open body language andspeaking in a low, soft tone. Avoiding making prolonged eye contact with the resident as this frustrated him and made him feel uneasy and if the resident became physically aggressive, ensure he was in a safe space and give him a few minutes alone to calm down. If possible, staff were to sit next to the resident and face forward rather than turning towards the resident during conversation. Interventions, initiated 8/4/25, during the survey, included engaging the resident in talking about the town where he was from and farming, assisting the resident with praying, offering snacks (sweets and hot chocolate) and offering time outside. -Resident #43's care plan failed to address the incident on 8/4/25. A nursing note, dated 8/4/25, revealed Resident #43 had an altercation with his roommate. Both residents came out of their room holding each other's necks. No injuries were noted. Resident #43 was yelling He needs to get out of my room.Resident #43's behavior sheet, undated, was kept at the nurses station and was reviewed on 8/5/25. The behavior sheet revealed that Resident #43 had behaviors of becoming verbally aggressive or physically aggressive (hitting and pushing). Interventions included engaging the resident in talking about where he was from or farming, approaching the resident from the side when attempting to engage in conversation with a slow and calm demeanor while using open body language and speaking in a low, soft tone, avoiding making prolonged eye contact with the resident as this frustrated him and made him feel uneasy and if the resident became physically aggressive, ensure he was in a safe space and give him a few minutes alone to calm down. If possible, staff were to sit next to the resident and face forward rather than turning towards the resident during conversation -A review of Resident #43's care plan and behavior monitoring orders failed to identify Resident #43's specific triggers (body language, body positioning and eye contact) that were identified on his behavior sheet. Review of Resident #43's EMR, from 6/30/25 to 8/5/25, revealed the resident had behaviors of believing he was being held against his will/in prison twice, refusing care due to agitation five times, exit seeking three times, demanding to go home twice, paranoid of others twice and attempting to hit staff three times. -Review of Resident #43's EMR failed to reveal resident specific behavior monitoring for the behaviors displayed since admission, nor did it reveal staff had assisted Resident #43 to unpack or organize his room, despite his roommate having identified triggers related to clutter (see Resident #32's behavior sheet above) and Resident #43 having triggers of others being in his personal space (see care plan above). -Review of Resident #43's EMR failed to reveal staff provided psychosocial checks on Resident #43 and his roommate, Resident #32, during the period Resident #43 was having disruptive behaviors (see above). VII. Staff interviewsCNA #5 was interviewed on 8/5/25 at 1:27 p.m. She said she<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | came around the hall when she heard a commotion and found Resident #32's hand on Resident #43's neck. CNA #5 said she had not witnessed the two residents initially leaving their room and was not certain exactly where everyone's hands were with all the commotion. She said Resident #43 had been struggling to adjust to placement and she was unaware that Resident #32 had issues with males. She said the staff were currently providing both residents with one-on-one observation and this consisted of staff ensuring the residents were never in the room together. She said management was working on a room move for Resident #32. -During the interview, Resident #43 sat at the table with CNA #5 and became increasingly agitated and paranoid there was a plan to harm him.CNA #5 said Resident #45 would instigate altercations with Resident #28, but she was unclear on why Resident #28 triggered Resident #45. She said management had staff keep the two residents separated as much as possible as a new intervention after the altercations. The dietary aide (DA), who witnessed the incident on 6/4/25, was interviewed on 8/6/25 at 12:52 p.m. The DA said she saw Resident #45 walking past Resident #28 in the dining room as Resident #28 was sitting in her seat waiting for lunch. The DA said she did not see anything happen between the two residents leading up to the incident. She said Resident #45 approached Resident #28 and hit her in the head with a pillow four to five times and she said she physically got in between the two residents until a CNA arrived shortly after. The memory care director was interviewed on 8/6/25 at 11:53 a.m. The memory care director said physical aggression was a new behavior for Resident #28 and Resident #45 had been the original aggressor. She said that Resident #45 had a history of being kicked out of her previous facilities due to behaviors, but once Resident #28 admitted to the facility, Resident #45 started going after her. The memory care director said she believed that it was due to Resident #28 having a flat affect and sometimes making sounds that were not directed at Resident #45, however, seemed to trigger Resident #45. She said her root cause analysis of the repeated incidents between the two residents, was that Resident #45 was getting one-on-one staff supervision and Resident #28 perceived she was getting less attention, and began acting out as well. The memory care director said that both women had strong personalities and the staff tried to redirect them away from each other. She said that Resident #45 would have increased pacing, made negative statements towards others, and become more fidgety when she was beginning to ramp up her aggression. The memory care director said that Resident #28 would also have increased pacing and make more nonverbal noises with a more negative tone of voice. She said that Resident #28 would keep her mouth closed and not smile, while holding he |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that one (#42) of 10 residents reviewed for freedom from involuntary seclusion out of 27 sample residents was provided the least restrictive environment and was not placed on a secured locked unit without an evaluation, assessment, justification, or documentation.Resident #42 was cognitively intact and had no history of wandering. On 7/13/25, following an incident in which she attempted to leave the facility to walk to a nearby store, staff redirected Resident #42 to a room on the secured locked memory care unit. Facility documentation revealed no physician's order, no completed assessment justifying locked secured unit placement, no evidence the secured placement was the least restrictive alternative and no interdisciplinary team (IDT) review before or immediately after the move.Although initial notes reflected Resident #42's temporary agreement to remain on the secured unit for the night, progress notes and interviews revealed that the secured unit placement continued beyond that evening, with the resident not knowing the door code and requiring staff assistance to exit. The resident reported feeling awful about being in a place where the door would not open, said she could not communicate with peers on the secured unit and expressed fear of certain male residents who knocked on her door at night.Resident #42's representative said there was no written consent, no assessment and no evaluation of the resident's emotional reaction to secured unit placement. The representative reported the resident was more agitated since the move and was struggling mentally.Specifically, the facility failed to ensure Resident #42 was removed from the secured unit after she agreed to stay overnight on the unit, which led to fear for the resident.Findings include:I. Facility policy and procedureThe Restraint Management policy, dated March 2023, was provided by the nursing home administrator (NHA) on 8/6/25 at 1:49 p.m. It revealed in pertinent part, Restraints are implemented in accordance with State and Federal regulations. If indicated, the least restrictive restraint is used for the least amount of time. Restraints are not used as a disciplinary action or for the convenience of the facility to control behavior. In cases where restraints are implemented based on the resident's assessment, the facility will make reasonable efforts to systematically and gradually reduce their use.II. Resident #42A. Resident statusResident #42, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and delusional disorder (false beliefs).The 6/5/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She had behaviors of verbal aggression towards others. She did not have behaviors of physical aggression towards others. She did not have behaviors of wandering. She required setup and cleanup assistance with bathing. B. Resident representative interviewResident #42's representative was interviewed on 8/7/25 at 10:25 a.m. The representative said Resident #42 was doing well from a health perspective but she had been frustrated and struggling from a mental perspective at being in the facility. The representative said the resident had told her there was a situation where she left the facility and an employee led her back inside. She said Resident #42 was upset when redirected by the certified nurse aide (CNA) and she was frustrated because she could not go to the grocery store. The representative said the resident had told her that staff had been overly aggressive and she did not want to return to her normal room because the CNA was in that section of the facility. She said that ever since then, the resident did not want to leave the secured unit. The representative said staff had been trying to get her back to her room in the non-secured section of the building, but she refused. The representative said it was supposed to be a temporary placement in the memory care unit due to a transition to another state.The<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | representative said no assessment or evaluation had been completed for the memory care unit placement and there was no written consent, only verbal. The representative said that since the secured unit placement, the resident had been fussier and more agitated. The representative said Resident #42 continued calling her to pick her up and get her out of the facility. C. Resident interview Resident #42 was interviewed on 8/5/25 at 11:47 a.m. Resident #42 said her daughter had brought her to the facility three years earlier and had told her to take a look inside and see if she liked it, but then had left her there and dumped her. She said she did not come to the facility out of her own free will and had felt people in the facility had hurt her emotionally. She said she had come to the secured unit after an incident when she wanted to be taken to the store before it closed at 7:00 p.m. to get hairspray. She said staff at the front desk had said someone would take her, but as it was getting closer to 7:00 p.m., she had become worried. She said she realized the staff had no intention of taking her to the store and perceived they were laughing at her. She said she decided to walk to the store herself. She said she was not sure how it happened, but then several staff members tried to stop her and she became fearful. She said she had been told she was free to leave the facility whenever she wanted and then they would not let her. She said as a result of being fearful of staff, she asked to stay the night in an empty room and had been brought to the locked unit. Resident #42 said she felt awful about being in a place where the door would not open and she had been very unhappy in the unit. She said she had also been fearful of moving back to the other side of the building because she believed she had been physically attacked by staff when trying to go to the store. She said she was scared of some of the men on the secured unit and that they would knock on her door at night. She said there was a man who pushed on the exit door and set the alarm off all of the time. She said she could not talk to the other residents in the secured unit because they did not understand what she was saying. She said she had asked for the code to the door and had reiterated she was supposed to be able to leave whenever she wanted, but she did not know the code to the locked door.D. Record reviewThe behavioral care plan, initiated 12/20/22 and revised 3/28/24, documented Resident #42 had delirium related to unspecified dementia with behavioral disturbances and delusional disorders. Pertinent interventions included monitoring signs of delirium, providing gentle reorientation, maintaining consistent routines and caregivers, monitoring cognitive changes, providing activities suited to abilities, administering medications with monitoring and communicating with the resident and family.The elopement care plan, initiated 2/13/25 and revised 5/20/25, documented Resident #42 was alert and oriented and not at risk for elopement but had a history of leaving the facility without alerting staff. It documented the resident declined a wanderguard. It indicated due to barricading behavior and refusal of the wanderguard, the facility provided a lock on the room door for safety with nursing retaining emergency access. Pertinent interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, educating the staff to alert them before the resident would leave the building and ask for a ride when needed, identifying the pattern of wandering to determine if it was purposeful, aimless, or escapist, assessing whether the resident was looking for something and evaluating if wandering indicated a need for more exercise.The social services care plan, revised 7/14/25, revealed Resident #42 chose to admit to the memory care unit with guardian consent. Pertinent interventions included completing daily wellness checks and allowing the resident to leave the unit as requested, educating staff to allow the resident to leave the secured when she requested and allowing the resident to return to her room on the 200 hall as requested.Review of Resident #42's August 2025 CPO did not reveal a physician's order for the resident's placement on the secured unit.An elopement evaluation, dated 6/3/25,<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | revealed Resident #42 ambulated independently. It indicated the resident had no history of elopement at home or the facility, had not expressed a desire to leave or pack belongings, was not recently admitted and did not wander.An elopement evaluation dated 6/21/25 revealed Resident #42 ambulated independently and had a history of elopement at home and the facility. It documented the resident did not express a desire to leave, pack belongings, or stay near exits. It indicated the resident was not recently admitted and did not wander.The facility's census of admissions and room moves was reviewed. It documented Resident #42 was admitted to the secured memory care unit on 12/7/22. It indicated the resident was moved to another room within the secured memory care unit on 12/12/22 where she remained until 8/6/23. It revealed on 8/7/23 the resident was moved to a non-secured unit. It identified the resident was then moved back to the secured memory care unit on 7/14/25.Resident #42's progress notes were reviewed from 6/21/25 to 8/5/25 and revealed the following:A nursing progress note, dated 6/21/25, revealed Resident #42 wanted to go to the store to get food. The note documented the staff had told her that they would get her something she liked from the kitchen and that someone might take her to the store on Monday. When the staff returned from the kitchen, the resident was no longer there. The therapy manager had taken her to the store and brought the resident from the store and returned her safely to the facility. Resident #42 was agitated upon returning from the store and a CNA was assigned to provide one-on-one supervision with 15-minute checks due to safety concerns. Resident #42 declined a skin assessment.A nursing progress note, dated 7/13/25, documented that around 5:45 p.m., Resident #42 escalated after staff informed her no one was available to immediately take her to the local grocery store (less than 0.5 miles away). Staff told her the delay was due to unsafe environmental conditions from the high heat index and poor air quality. Staff redirected Resident #42 to an area near her preferred nurse and provided education about the dangers of walking to the store, which she refused to accept. It revealed that the resident called emergency services and the police responded. The note documented the officer told the resident it was not safe to walk to the store and suggested she wait for a safer time. The staff attempted to redirect the resident to her assigned room, which she refused, stating she would not sleep there because she did not know who had been in there. The director of nursing (DON) offered to inspect her assigned room and offered to go to the store or accompany her, which she refused. The resident demanded to see another room and the DON showed her an available room on the secured unit, which had been prepared for admission. The resident agreed to use the secured unit room for the night if staff moved some of her comfort items. The staff told the resident the move was for the evening only and that she could access her original room at any time. It revealed the resident responded with verbal aggression and the DON left the interaction. A message was left for the representative after the move occurred.A social services progress note, dated 7/14/25, documented that the memory care coordinator met with Resident #42 and reminded her she could leave the secured and access the rest of the facility with staff assistance. It revealed the resident understood this information. The NHA and the social services director (SSD) met with her to review the weekend events and room options. Resident #42 said she preferred to remain in the secured unit. Resident #42 was educated she could not have a lock on her personal door on the secured unit and she would need staff assistance to exit the secured unit. It revealed that both the resident and her representative later consented to her staying in the secured unit.An administration progress note, dated 7/16/25, revealed Resident #42 reported an allegation of rough treatment by staff during the move to the secured unit but she had no injuries. It documented she was initially fearful of the staff member, but after reassurance, elected to remain in the secured unit. The resident and her representative consented to the permanent move. The staff documented increased resident<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | engagement with peers and activities and the resident's acknowledgment that she may leave the secured unit at any time upon request.An administration progress note, dated 7/23/25, revealed Resident #42 appeared to be adjusting well to the secured unit and the staff observed increased door-blocking behavior but noted the resident allowed staff access to her room. The resident had been approved for flight to another state with discharge anticipated.An activities progress note, dated 7/30/25, documented staff observed Resident #42 standing at the front door attempting to leave the facility. Staff engaged the resident, who said she wanted to leave the facility and go to a different city. Staff assisted the resident in calling the police and the police officers reassured the resident and she was returned to her room and became calm. The DON, the SSD and the NHA were notified.III. Staff interviews The NHA was interviewed on 8/5/25 at 12:03 p.m. The NHA said Resident #42 suffered a lot of trauma from World War 2 where her family had to flee and hide. She said she had behaviors related to that trauma (barricading herself in her room, paranoia) and her representative had told the facility the resident had always been this way.CNA #5 was interviewed on 8/5/25 at 1:27 p.m. CNA #5 said Resident #42 previously lived in the 200 hall and would not allow staff into her room in the morning, displayed paranoia and barricaded her door. CNA #5 said she did not know of any interventions that worked with the resident. CNA #5 said she was unsure of the exact reason Resident #42 was currently on the secured unit.CNA #6 was interviewed on 8/6/25 at 11:44 a.m. CNA #6 said Resident #42 preferred to be alone in her room and became triggered when staff repeatedly asked her questions or knocked on her door. He said the staff attempted interventions for the resident that included allowing her to lock her room, providing choices, not touching her personal items without permission and knocking before entering. He said when the resident was on the unsecured unit, she interacted with other residents and had favorite residents and staff she would speak with regularly. He said that since being on the secured unit, he had not seen the resident talking with other residents, though she did have favorite staff she talked to, especially female staff. He said Resident #42 expressed a neutral view about being on the secured unit and did not describe it as better or worse.The memory care director and the SSD were interviewed on 8/6/25 at 2:03 p.m. The memory care director said that secured unit placement depended on the resident's individual situation. The memory care director said if the resident came from an external source, the interdisciplinary team (IDT) reviewed the case, considered recommendations from a third-party reviewer, then obtained approval before discussing placement with the family. She said the review included wandering risk, elopement risk, communication ability, decision-making capacity and the BIMS assessment. The memory care director said the facility conducted a secured unit evaluation prior to admission, with follow-up evaluations at 30 days, quarterly, with any changes and annually. She said if a resident already lived at the facility, the memory care director requested documentation and recommendations from a third-party reviewer to determine if the resident was a good fit for the secured unit. The memory care director said the difference between the secured and the unsecured units was that residents in the unsecured units generally had higher cognition, made better decisions and often participated in activities without staff assistance. She said the secured unit had controlled access with doors that locked to prevent wandering outside. The memory care director said evaluations occurred before admission to the secured unit. She said when residents came from the community, it was implied they would be placed on the secured unit, with conversations held with their representatives and documentation completed in care conferences and social services progress notes after admission. The memory care director said Resident #42 had been living in the secured unit due to exit seeking behaviors and by personal choice due to being scared of staff on the unsecured unit. The memory care director said there had been no evaluation or assessment for<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | appropriateness of secured unit placement, and according to the assessment, Resident #42 would not qualify because her placement was voluntary. The memory care director said she had offered to move Resident #42 back to the other side of the building, but the resident appeared to feel more supported on the secured unit and had not expressed fear since. The memory care director said she had not offered to give Resident #42 the exit code for the secured door because she did not know which residents on the unit were allowed to come and go freely.The SSD said the residents in the secured unit often could not sit still and required one-to-one assistance with activities and more supervision to stay focused, while residents in the unsecured unit engaged more independently. The SSD said Resident #42 was social for the first two weeks after moving to the secured unit but was now hyper-focused on discharging to another state. The SSD said that about three weeks ago, Resident #42 had an incident with a staff member after expressing she wanted to leave the facility to walk to the store. The SSD said a staff member guided her back into the building, but two or three additional staff members were also present, and being around a crowd was triggering for her.The social services consultant was interviewed on 8/6/25 at 4:09 p.m. The social services consultant said that all staff working with a resident needed to be aware of their trauma triggers to prevent retraumatizing the resident. She said if staff were not aware of triggers, it would put the resident at higher risk of being traumatized repeatedly. The social services consultant said if a resident was living on the secured memory care unit in a voluntary capacity, there should be a plan on how the facility was working to reintegrate the resident to the unsecured side of the facility. She said part of this process would be to trial the resident with the door code so they could come and go off the unit independently. She said if this was not feasible, the staff on the secured unit would need to drop everything they were doing every time the resident wanted to leave the secured unit in order to prevent the resident from being restricted to the secured unit. The NHA and the DON were interviewed together on 8/7/25 at 12:49 p.m. The NHA said the difference between the secured and unsecured units was that residents on the unsecured unit were more autonomous and engaged in activities more independently, while the secured unit was more structured with additional staff trained for dementia and behavior management. The NHA said residents who could not verbalize their needs were better supported on the secured unit to prevent escalation and allow for redirection and calming. The NHA said staff education was important to maintain safety, both emotionally and physically, and improve quality of life. The NHA said for new admissions, the IDT reviewed information, discussed needs and goals with the resident's representative and collaboratively determined placement. The NHA said factors considered included elopement risk and exit-seeking behavior. The NHA said the primary care provider (PCP) was contacted for orders and input on placement appropriateness. The NHA said for current residents, placement decisions involved reviewing documentation and observations, IDT collaboration, input from a third party reviewer and conversations with family. The NHA said the facility informed families if they recommended a move to enhance quality of life. The NHA said least restrictive measures were used first, such as wanderguards and redirection, and if these were unsuccessful then placement on the secured unit was considered and documented in the care plan. The NHA said they tried offering Resident #42 the option to move back to the unsecured unit, but she continued to decline the move. The NHA said Resident #42's discharge to another state was pending, with a recent court order and physician clearance and travel arrangements were up to the daughter. The NHA said conversations continued about the resident's wishes to leave the secured unit, and staff were educated that she was free to leave. The NHA said behavior monitoring included regular check-ins but no specific monitoring was documented on the medication administration record (MAR). The NHA said that Resident #42's stay on the secured unit was<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0603<br>Level of Harm - Actual harm<br>Residents Affected - Few | completely voluntary. The NHA said their consultant recommended documenting the voluntary nature of the placement.The DON said staff were assigned to the secured unit who better understood and could manage residents' specific needs. The DON said the IDT considered whether the resident was at risk of danger to self. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that one (#28) of ten residents out of 27 sample residents were free from chemical restraint and were receiving the least restrictive approach for their needs. Specifically, for Resident #28, the facility failed to provide adequate documentation to justify the addition of new psychotropic medications, the increase in dosage of psychotropic medications and/or the continued use of psychotropic medications. Findings include:I. Facility policy and procedureThe Behavior Assessment, Intervention, and Monitoring policy, undated, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:01 p.m. It read in pertinent part,Interventions are individualized and part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent or relieve the residents distress or loss of abilities.Non pharmacologic approaches are used to the extent possible to avoid or reduce the use of psychotropic medications to manage behavioral symptoms. Psychotropic medications are prescribed for behavioral symptoms and documentation includes rationale for use, potential underlying causes of the behavior, non-pharmacological approaches and interventions tried prior to the use of the psychotropic medication, specific target behaviors and expected outcomes, monitoring for efficacy and adverse consequences, and plans (if applicable) for gradual dose reductions. II. Resident #28A. Resident statusResident #28, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with mood disturbance and major depressive disorder.The 6/18/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), wandering, delusions and physical aggression. B. Record reviewResident #28's depression care plan, revised 7/10/25, revealed the resident took Sertraline (an antidepressant) related to depression with target behaviors of isolation and loss of interest in things she enjoyed. She additionally took Trazodone (an antidepressant) for insomnia. Interventions, revised 7/10/25, included to redirect, provide a quiet environment, take on a walk, reposition, offer music, offer activity of interest or provide snacks or beverages.Review of Resident #28's August 2025 CPO revealed the following physician's orders:Trazodone 50 milligrams (mg) tablet. Give one tablet in the evening for insomnia, ordered 4/15/25. Sertraline 50 mg tablet. Give one tablet a day for depression, ordered 6/16/25.Monitor for behaviors related to antidepressant medication Sertraline. 1-Isolation 2-Loss of interest in activities the resident is known to enjoy. Use non-pharmological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/10/25.Review of Resident #28's electronic medical record (EMR), from 5/1/25 to 8/4/25, revealed the following progress notes:Between 5/1/25 to 5/30/25, there was no documentation to indicate Resident #28 exhibited any episodes of isolating or decreased interest in activities she was known to enjoy.Between 6/1/25 to 6/31/25, there was no documentation to indicate Resident #28 exhibited any episodes of isolating or decreased interest in activities she was known to enjoy. A system order note, dated 6/8/25, revealed Resident #28 was standing in her doorway when another resident walked past her and teased and laughed at her. The other resident then raised her fist at Resident #28, walked away, and then returned. At that time, the other resident hit Resident #28 in the arm and Resident #28 hit her back in the arm. Both residents were separated and redirected.Cross reference F600 for failure to<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | protect residents from physical abuse. A depression screen evaluation note, dated 6/10/25, revealed Resident #28 participated in a depression screen and did not show any signs or symptoms of depression, with a score of zero out of nine.A system order note, dated 6/12/25, revealed another resident (same resident from 6/8/25) took a pillow out of Resident #28's room, upsetting Resident #28. Resident #28 then hit the other resident in the head and the other resident hit Resident #28 in the arm. Both residents were separated and redirected. A system order note, dated 6/16/25, revealed Resident #28 had been started on Sertraline for depression.-However, review of Resident #28's EMR failed to reveal documentation to justify the addition of the antidepressant medication or a physician's rationale for the medication.An at-risk review note, dated 6/18/25, revealed after the initiation of Sertraline, there were no noted change in behaviors. The staff were to continue to offer person-centered interventions and redirect Resident #28 from the resident she frequently had altercations with. An at-risk review note, dated 6/25/25, revealed Resident #28 had been without behaviors toward others and no aggression was reported or observed.Between 7/1/25 to 7/31/25, there was no documentation to indicate Resident #28 exhibited any episodes of isolating or decreased interest in activities she was known to enjoy. A nursing note, dated 7/5/25, revealed Resident #28 went outside with supervision and pushed another resident in the arm and was easily redirected. -Between 5/1/25 to 8/5/25, there was no documentation to indicate Resident #28 exhibited any episodes of isolating or decreased interest in activities she was known to enjoy with a zero depression score on 6/10/25. However, Sertraline was ordered on 6/16/25 for depression (see physician's orders above). A review of Resident #28's behavior monitoring documented on the May 2025 through August 2025 medication administration records (MAR), from 5/1/25 to 8/4/25, revealed Resident #28 had one behavior on 7/2/25 of a loss of interest in activities she was known to enjoy. A review of progress notes failed to indicate the specific behavior on 7/2/25.-A psychoactive medication evaluation meeting minute note, dated 6/20/25, failed to reveal the rationale for the addition of Sertraline on 6/16/25. A pharmacist consultant report, dated 5/6/25, revealed the pharmacist documented a request for review of Resident #28's Trazodone due to the hours of sleep not being charted for all shifts (only morning charting was completed).A pharmacist consultant report, dated 6/9/25, revealed the pharmacist documented this was the second request for review of Resident #28's Trazodone due to the hours of sleep not being charted for all shifts (only morning charting was completed).A pharmacist report to the physician, dated 7/8/25, revealed the pharmacist recommended a dose reduction of Resident #28's Trazodone from 50 mg to 25 mg due to Resident #28 sleeping eight to 12 hours a day and the use of a hypnotic at that dose could not be supported. -Review of Resident #28's August 2025 CPO failed to reveal a dose reduction had occurred (see physician's order above).-Review of Resident #28's EMR failed to reveal documentation to justify the rationale for not decreasing the resident's Trazodone.Review of Resident #28's behavior sheet, undated, which was kept at the nurses' station, was reviewed on 8/5/25and revealed that Resident #28 had behaviors of becoming physically aggressive with staff and other residents and would have altercations with Resident #45. Interventions focused on ways to redirect the resident related to physically aggressive behaviors. -There was no behavior sheet located which indicated Resident #28 had behaviors related to depression or insomnia.III. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 8/5/25 at 1:27 p.m. CNA #5 said Resident #28 had behaviors of refusing care in the afternoons and becoming agitated if overstimulated. She said when Resident #28 first came to the facility in March 2025, she used to communicate more but in the last two months, CNA #5 said she had noticed Resident #28 makes more noises instead of talking. She said non-pharmacological interventions that worked for Resident #28 were to sing to her and show her family pictures. CNA #5 said the staff found<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident behaviors and interventions in the behavior book at the nurses station, however CNA #5 said she doesn't use the behavior book because she knows the residents. CNA #5 said the CNAs documented behaviors on the CNA behavior monitoring task but the behaviors and interventions indicated on the task were generic and the same for all the residents. CNA #2 was interviewed on 8/5/25 at 3:05 p.m. CNA #2 said that Resident #28 had behaviors of becoming agitated and she liked to color when upset. She said the CNA's found the behaviors and interventions in the CNA behavior monitoring task but the behaviors and interventions indicated on the task were generic and the same for all the residents. Registered nurse (RN) #3 was interviewed on 8/5/25 at 3:15 p.m. RN #3 said Resident #28 did not really have behaviors. She said the nurses documented the residents' behaviors and interventions on the MARs and made progress notes. CNA #6 was interviewed on 8/6/25 at 11:44 a.m. CNA #6 said he had been at the facility for six months. CNA #6 said he had to retrieve the behavior binder because he could not recall the person-centered interventions or resident specific behaviors for Resident #28. He read the behaviors and interventions from the binder. CNA #6 said the CNAs did not document behaviors but told the nurse who then would document any behaviors in the progress notes. The NHA and the director of nursing (DON) were interviewed together on 8/7/25 at 12:50 p.m. The DON said that the facility determined the efficacy of psychoactive medications being administered by using behavior monitoring physician's orders within the MAR, with resident specific behaviors listed. She said her expectation was that the nurses documented behaviors on the MAR and also put in a behavior progress note to include the non-pharmological interventions attempted. The DON said that there should be non-pharmacological interventions on the behavior monitoring order for the nurses. She said that non-pharmacological interventions were important because the facility did not want to use psychotropic medications as a first resort and instead wanted to use non-pharmacological interventions first because it was more humane and ethical for the care of the resident. The DON said that the behavior monitoring physician's orders provided data that was used during the psychotropic drug meeting to decide on increasing medications or considering gradual dose reductions. She said that she continuously trained her staff on where to find the non-pharmacological interventions and what they were, as well as providing education on triggers. The DON was unaware that the CNAs and nursing staff on the secure unit were not consistent in knowing where to find behaviors and interventions for residents.The NHA said that if the staff were not consistently or accurately documenting resident behaviors, it would be difficult to determine the effectiveness of the medications and this prevented the monitoring from demonstrating a clear picture of behaviors. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide residents who were unable to carry out activities of daily living (ADLs) the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (#1) of three residents reviewed out of 27 sample residents. Specifically the facility failed to -Offer repositioning to Resident #1, and;-Provide assistance with toileting for Resident #1. Findings include: I. Resident #1A. Resident status Resident #1, age [AGE], was admitted on [DATE] and readmitted [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included acute respiratory failure, irritable bowel syndrome, osteoarthritis and history of pneumonia. The 5/19/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 14 out of 15. She required substantial/maximal staff assistance with chair/bed to chair transfer with and substantial/maximal staff assistance with toileting transfers. B. Resident interview.Resident #1 was interviewed on 8/4/25 at 3:32 p.m. The resident said she was supposed to be checked every two hours because she needed help going to the bathroom. She said the nursing staff did not check on her. Resident #1 said she had to make sure she did not drink too much water so she did not go to the bathroom. C. Observations During a continuous observation on 8/5/25, beginning at 12:30 p.m. and ending at 4:12 p.m., the following was observed: At 12:33 p.m. Resident #1 was in bed eating her lunch and watching television. At 12:45 p.m. an unidentified staff member went into Resident #1's room. The staff member asked the resident if she was done with her meal and removed her lunch tray.At 12:55 p.m. Resident #1 was in bed lying on her back watching television.At 1:30 p.m. Resident #1 remained in bed lying on her back looking at a book with her television on.At 1:50 p.m. Resident #1 was in bed lying on her back watching televisionAt 2:15 p.m. the nursing home administrator (NHA) brought a vase of flowers into the resident's room. -However, the NHA did not ask the resident if she needed to be repositioned or use the restroom.At 3:30 p.m. Resident #1 was in her bed watching television.At 4:06 p.m. Resident #1 initiated her call light for assistance.At 4:12 p.m. certified nurse's aide (CNA) #1 and registered nurse (RN) #2 went into Resident #1's room to answer her call light. CNA #1 and RN #2 changed the resident's brief. The resident's brief was saturated with urine. There was a blue line on the outside of the brief that indicated the brief was wet.-The resident was not provided incontinence care from 12:30 p.m to 4:12 p.m. D. Record review The ADL care plan, initiated on 3/27/24 and revised on 5/28/25, revealed Resident #1 had a self-care performance deficit. Pertinent interventions included the resident required staff assistance for repositioning-However, observations revealed staff failed to offer or provide Resident #1 with repositioning for four hours (see observations above).E. Staff interviewsCNA #1 was interviewed on 8/5/25 at 4:21 p.m. CNA #1 said the staff needed to check on Resident #1 every two hours. CNA #1 said he was busy and was unable to check on the resident. CNA #1 said it was important to check the residents every two hours because they may need assistance changing out of the wet brief. He said if a resident stayed in a wet brief for more than two hours, it can lead to urinary infections or skin breakdown. RN #2 was interviewed on 8/6/25 at 10:18 a.m. RN #2 said Resident #1 required staff assistance for toileting. RN #2 said it was the responsibility of the nursing staff to check on the resident every two hours to make sure she was not sitting for prolonged periods in a wet brief. The director of nursing (DON) and the NHA were interviewed together on 8/7/25 at 2:35 p.m. The DON said the nursing staff should be checking on residents who were dependent on staff for toiling assistance at a minimum of every two hours. The DON said if the staff did not stick with the two hour time frame for providing incontinence care, it could expose the resident to developing<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | skin breakdown or urinary infections. The NHA said she would provide education to the nursing staff regarding providing the residents with according to their care plan. The NHA said adhering to the resident's care plan in regards to incontinent care to maintain skin integrity was important. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#8) of two residents reviewed for respiratory care out of 27 sample residents were provided respiratory care consistent with professional standards of practice.Specifically, the facility failed to ensure cleaning and proper care of Resident #8's CPAP (continuous positive airway pressure) machine according to manufacturer's instructions and per physician's orders.Findings include:I. Facility policy and procedureThe CPAP/BiPAP (bilevel positive airway pressure) Support and Cleaning, Respiratory and Pulmonary Conditions policy and procedure, revised March 2015, was provided by the nursing home administrator (NHA) on 8/7/25 at 4:37 p.m. It read in pertinent part, Purpose: To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen; To improve arterial oxygenation (Pa02) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease; To promote resident comfort and safety. General Guidelines for Cleaning: These are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier of the PAP device. These guidelines are for single-resident use cleaning. Machines must be preprocessed for use between residents by the supplier of the device. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. Humidifier (if used): Use clean, distilled water only in the humidifier chamber. Clean humidifier weekly and air dry. To disinfect, place vinegar-water solution (one to three ratio) in a clean humidifier. Soak for 30 minutes and rinse thoroughly. Filter cleaning: Rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. Replace disposable filters monthly. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for five minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. Document the following in the resident's medical record: general assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure; time CPAP was started and duration of the therapy; mode and settings for the CPAP; oxygen concentration and flow, if used; how the resident tolerated the procedure; and oxygen saturation during therapy.II. Manufacturer's instructionsThe [NAME] Respironics CPAP Machine cleaning instructions were provided by the NHA on 8/6/25 at 5:35 p.m. It read in pertinent part, - Daily Cleaning: Items to clean: Mask cushion, tubing (optional), and humidifier chamber (if used); Unplug the CPAP machine; Disassemble the mask - separate the cushion from the frame and headgear; Wash the mask cushion in warm water with mild, non-antibacterial soap. Rinse thoroughly. If desired, rinse the tubing with warm water (not necessary daily unless visibly soiled). Empty the humidifier chamber (if applicable), rinse with warm water, and let air dry. Air dry all parts on a clean towel - do not expose to direct sunlight. Wipe the CPAP unit exterior with a dry cloth - do not submerge or spray with water. Weekly Cleaning: Items to clean: Tubing, mask frame, headgear, humidifier chamber. Soak the tubing, mask frame, headgear, and humidifier chamber in warm, soapy water for 15-30 minutes. Rinse all items thoroughly to remove all soap residue. Hang tubing to air dry - make sure it dries completely before reconnecting. Wipe the outside of the CPAP device with a soft, damp cloth. Monthly Cleaning: Items to check/replace/clean: Air filter. Inspect the reusable pollen filter (gray foam) for dust or discoloration.Wash gently with water if reusable. Let dry completely before reinserting. If using a disposable fine filter (white), replace it monthly or as needed (do not wash). Check for signs of wear and tear on the mask, tubing, and chamber. Do Not Use: Bleach, alcohol, antibacterial soap, or harsh cleaners. Dishwasher (unless your model specifically states parts<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | are dishwasher-safe). Direct sunlight to dry. Machine parts while wet. Replacement Schedule (General Guidelines): Mask cushion/pillows are replaced every two to four weeks; Tubing replaced every three months; Humidifier chamber replaced every six months; Filter (disposable) replace monthly; Filter (reusable foam) replace after six months (wash monthly). Full mask/headgear replaced every six months.III. Resident #8A. Resident statusResident #8, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on the right side), traumatic brain injury, cognitive communication deficit, status post fracture of right pubis (pelvis) and sleep apnea. The 5/29/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She was dependent with bed to chair transfers, toilet transfers and shower transfers. She required substantial/maximal assistance with bed mobility, showering, and lower body dressing. She required partial/moderate assistance for personal hygiene and was independent with eating.The assessment indicated the resident had functional limitation in range of motion with impairment on one side in the upper and lower extremities. B. Resident interview and observationResident #8 was interviewed on 8/4/25 at 2:42 p.m. Resident #8 said she used a CPAP machine but it did not have distilled water in it because the facility ran out of water last week. The CPAP machine sat on a small shelf next to the bed, the large tubing was touching the floor. The CPAP mask was sitting on top of the machine under the shelf. Resident #8 said she cleaned the CPAP mask herself by giving the mask a quick rinse with water in the sink in the morning. Resident #8 mimicked with her left arm running the mask under the facet. Resident #8 said she never used soap to clean the CPAP mask or machine, only water. Resident #8 said the staff never cleaned her machine so she just did it.C. Record reviewReview of Resident #8's CPAP care plan, initiated 11/11/18 and revised 12/11/22, revealed the resident was at risk for altered breathing patterns/altered gas exchange/ineffective air exchange related to asthma as evidenced by wheezing, need for aerosol/inhaler medications and CPAP at resting hours. Pertinent interventions included monitoring the use of the CPAP machine every night shift, initiated 11/16/23. -The care plan failed to include cleaning frequency for the CPAP or cleaning instructions.Review of Resident #8's August 2025 CPO revealed the following physician's orders related to the resident's CPAP machine: CPAP at night time only. Every night shift clean equipment per manufacturer recommendations daily. Resident to perform daily cleaning, ordered 11/28/18.-However there was no documentation on the medication administration record/treatment administration record (MAR/TAR) that this was being completed.Monitor proper use of CPAP every night shift, ordered 10/24/23.Resident requires the use of CPAP supplies related to sleep apnea, ordered 2/21/24.IV. Staff interviewsThe NHA and the director of nursing (DON) were interviewed together on 8/7/25 at 12:49 p.m. The NHA said she had no documentation that Resident #8 was instructed how to clean her CPAP machine and that the facility should be doing that. The DON said she added a new physician's order (during the survey) for the nurses to be cleaning Resident #8's CPAP machine. She said Resident #8 should not be cleaning her own equipment, especially since she had a disabled arm. The NHA and the DON said Resident #8's CPAP machine was not being cleaned per the manufacturer's recommendations but it should be for best practice and hygiene. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one (#42) of five residents with a documented history of trauma out of 27 sample residents.Specifically, the facility failed to identify and create a person-centered individualized care plan that addressed Resident #42's past history of trauma, and/or triggers which may cause re-traumatization and train staff on the residents trauma and triggers.Findings include:I. Resident #42A. Resident statusResident #42, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and delusional disorder (false beliefs).The 6/5/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident's health questionnaire (PHQ-9) assessment for depression scored zero out of 27 which indicated no depression. B. Resident representative interviewResident #42's representative was interviewed on 8/7/25 at 10:25 a.m. The representative said that Resident #42 became increasingly agitated and distressed due to staff interventions and the lack of trauma-informed care. The representative said that no assessment, evaluation or written consent had been completed to guide staff in supporting the resident's trauma history. She said that the resident refused to return to her previous room in the unsecured unit and was frustrated and upset with staff interactions. C. Resident interviewResident #42 was interviewed on 8/5/25 at 11:47 a.m. Resident #42 said her daughter had brought her to the facility three years earlier and had told her to take a look inside and see if she liked it, but then had left her there and dumped her. She said she did not come to the facility out of her own free will and had felt people in the facility had hurt her emotionally. She said she had come to the secured unit after an incident when she wanted to be taken to the store before it closed at 7:00 p.m. to get hairspray. She said staff at the front desk had said someone would take her, but as it was getting closer to 7:00 p.m., she had become worried. She said she realized the staff had no intention of taking her to the store and perceived they were laughing at her. She said she decided to walk to the store herself. She said she was not sure how it happened, but then several staff members tried to stop her and she became fearful. She said she had been told she was free to leave the facility whenever she wanted and then they would not let her. She said as a result of being fearful of staff, she asked to stay the night in an empty room and had been brought to the locked unit. Resident #42 said she felt awful about being in a place where the door would not open and she had been very unhappy in the unit. She said she had also been fearful of moving back to the other side of the building because she believed she had been physically attacked by staff when trying to go to the store. She said she was scared of some of the men on the secured unit and that they would knock on her door at night. She said there was a man who pushed on the exit door and set the alarm off all of the time. She said she could not talk to the other residents in the secured unit because they did not understand what she was saying. She said she had asked for the code to the door and had reiterated she was supposed to be able to leave whenever she wanted, but she did not know the code to the locked door.Cross reference F603 for failure to keep residents free from involuntary seclusion. D. Record reviewThe Colorado preadmission screening and resident review (PASRR) Level II notice of determination for mental illness, dated 2/1/23, documented that Resident #42 had a PASRR condition of delusional disorder. The PASRR Level II evaluation indicated the resident had a known or suspected diagnosis of a major mental illness. The<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASRR Level II identified that the resident had a history of trauma and recommended individual therapy as a specialized service. -However, Resident #42 did not have a care plan that addressed the trauma identified in the PASRR Level II, the triggers or person-centered individualized interventions to prevent re-traumatization.The social services director (SSD) updated Resident #42's care plan, during the survey on 8/5/25, and addressed the resident's preferences, triggers, and need for individualized trauma-informed approaches. New interventions included avoiding speaking with Resident #42 about her daughter unless Resident #42 brought her up, monitoring and reviewing with the resident regularly and obtaining the resident's and her representative's consent for the resident to remain in the secured memory unit as it made Resident #42 feel safe. -However, the care plan was not updated to include person-centered individualized interventions, personalized triggers or personalized signs and symptoms to prevent re-traumatization of Resident #42. The behavioral care plan, initiated 12/20/22 and revised 3/28/24, documented that Resident #42 had delirium related to unspecified dementia with behavioral disturbances and delusional disorder. Pertinent interventions included monitoring intake and output, observing environmental factors and signs of delirium, providing gentle reorientation, maintaining consistent routines and caregivers, monitoring cognitive changes, providing activities suited to abilities, administering medications with monitoring and communicating with the resident and family.-However, the care plan did not address the trauma identified in the PASRR Level II (see above) and it did not include person-centered individualized interventions, specific triggers or personalized signs and symptoms to prevent re-traumatization of Resident #42.The trauma life event screening questionnaire, dated 7/31/25, revealed that Resident #42 had experienced significant and repeated traumatic events throughout her life. The screening documented the following traumatic events:-Physical assault, such as being attacked, hit, slapped, kicked, or beaten up;-Assault with a weapon, such as being shot, stabbed, or threatened with a knife, gun or bomb;-Combat or exposure to a war zone, either in the military or as a civilian;-Captivity, such as being kidnapped, abducted, held hostage, or being a prisoner of war;-Severe human suffering;-Loss of home or property, such as through homelessness or divorce;-Witness to a sudden violent death;-Upsetting thoughts or memories about the above-mentioned events that came into her mind against her will;-Feeling as though the above-mentioned events were happening again;-Feeling upset by reminders of the above-mentioned events;-Talking about the above-mentioned events induced bodily reactions, such as a fast heartbeat or stomach churning;-Experiencing irritability or outbursts of anger;-Feeling jumpy or startled by something unexpected; and,-Heightened awareness of potential dangers to herself and others.II. Staff interviewsThe nursing home administrator (NHA) was interviewed on 8/5/25 at 12:03 p.m. The NHA said Resident #42 suffered a lot of trauma from World War 2 where her family had to flee and hide. She said she had behaviors related to that trauma (barricading herself in her room, paranoia) and her daughter had told the facility the resident had always been this way.Certified nurse aide (CNA) #5 was interviewed on 8/5/25 at 1:27 p.m. CNA #5 said Resident #42 previously lived in the 200 hall and would not allow staff into her room in the morning, displayed paranoia and barricaded her door. CNA #5 said she did not know of any interventions that worked with the resident.CNA #6 was interviewed on 8/6/25 at 11:44 a.m. CNA #6 said Resident #42 preferred to be alone in her room and became triggered when staff repeatedly asked her questions or knocked on her door. He said the staff attempted interventions for the resident that included allowing her to lock her room, providing choices, not touching her personal items without permission and knocking before entering.The social services director (SSD) and the memory care director were interviewed together on 8/6/25 at 2:03 p.m. The SSD said that when a new resident was admitted , if staff discovered any signs of trauma, the facility added it to the care plan<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and offered the resident a visit to the facility's clinic. The SSD said that after trauma was identified, a trauma evaluation was completed to identify triggers, such as past caregiver incidents. The SSD said psychological services were offered, and the facility was working with a company to provide that service consistently. The SSD said interventions listed in the care plan would trigger updates to the Kardex (a tool utilized by staff to provide consistent resident care) and staff were educated on how to approach residents with trauma. The SSD said Resident #42's triggers were documented in her care plan. The SSD said the behavior binder the facility kept at the nurses' station for staff reference could be a little more specific for a better trauma-informed approach. The SSD said moving forward, resident's trauma-related triggers would be taken to the interdisciplinary team (IDT) and Resident #42 would be offered the option to return to the unsecured unit while maintaining the same interventions. The SSD said the resident had refused occupational therapy (OT) and physical therapy (PT) had been offered multiple times, but the resident had refused every attempt.The memory care director said that when a resident had identified trauma, she considered potential triggers, spoke with the resident and the resident's family about the trauma and triggers, and created a plan of care. The memory care director said a trauma assessment was completed with Resident #42 two to three weeks ago. The memory care director said the resident was open about her past life and reported being held captive in Russia for 10 years, that her family could not survive and that her family was shot in front of her. The memory care director said the resident's triggers included family-related triggers. The memory care director said the resident had thought people were coming from the television and believed it was her daughter, which had been a recurring issue. The memory care director said she had not provided staff with any information regarding Resident #42's trauma history because she was concerned the resident might overhear staff discussing it or that staff would be unable to act surprised if they already knew. The memory care director said the facility did not list specific triggers in the behavior binder because talking about them could have created more anxiety for the resident. The memory care director said she was concerned that staff knowing specific details of the resident's trauma history could worsen the issue. The memory care director said she understood that providing staff with Resident #42's triggers and interventions related to her trauma would help prevent incidents of re-traumatization. The social services consultant was interviewed on 8/6/25 at 4:09 p.m. The social services consultant said that all staff working with a resident needed to be aware of their trauma triggers to prevent re-traumatizing the resident. She said if staff were not aware of triggers, it would put the resident at higher risk of being traumatized repeatedly. The NHA and the director of nursing (DON) were interviewed together on 8/7/25 at 12:49 p.m. The NHA said it was important for staff to know a resident's trauma history in order to prevent future behaviors, to maintain emotional and physical safety and to improve quality of life. She said the facility did a lot of education with the staff prior to taking care of a new resident with trauma; however, this education was not documented and was primarily verbal. She said Resident #42 went to the secure unit as a trauma response after she was triggered by a CNA trying to redirect her back into the building when she wanted to leave. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to identify and address the behavioral health care needs of two (#45 and #32) of 10 residents out of 27 sample residents. Specifically, the facility failed to:-Develop individualized interventions related to psychotropic medications for Resident #45 and Resident #32; and,-Consistently document the non-pharmacological interventions that were attempted and/or effective for Resident #45 and Resident #32's behaviors.Findings include:I. Facility policy and procedureThe Behavior Assessment, Intervention, and Monitoring policy, undated, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:01 p.m. It read in pertinent part,Interventions are individualized and part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent or relieve the residents distress or loss of abilities.Non-pharmacological approaches are used to the extent possible to avoid or reduce the use of psychotropic medications to manage behavioral symptoms. Psychotropic medications are prescribed for behavioral symptoms and documentation includes; rationale for use, potential underlying causes of the behavior, non- pharmacological approaches and interventions tried prior to the use of the psychotropic medication, specific target behaviors and expected outcomes, monitoring for efficacy and adverse consequences, and plans (if applicable) for gradual dose reductions.II. Resident #45A. Resident statusResident #45, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included unspecified dementia and a traumatic brain injury (TBI). The 7/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to participate in the brief interview for mental status (BIMS) assessment. A staff interview for mental status revealed the resident had short and long term memory impairments and had severe impairments to her daily decision-making skills. The MDS assessment indicated the resident had behaviors not directed at others (physical symptoms such as scratching self, pacing, smearing bodily fluids or food, disrobing, public sexual acts, screaming or disruptive sounds), physical and verbal aggression, rejecting care and wandering. The resident additionally experienced delusions. B. Resident observationDuring a continuous observation of Resident #45 on 8/5/25, beginning at 11:04 a.m. and ending at 1:24 p.m., the resident was observed pacing back and forth across the secure unit. No staff members attempted to offer any interventions to the resident to redirect her from her continuous pacing or engage with her while she paced. C. Record reviewResident #45's behavior care plan, revised 6/13/25, revealed the resident had behaviors of verbal aggression with other residents related to dementia and a history of TBI. The resident paced and wandered to the point of exhaustion, lacked awareness of others' space and would enter others' rooms, experienced paranoia, struck out at others unprovoked due to agitation, and did not get along with another female resident on the unit and would altercate with her if in close proximity. Interventions included redirecting the resident from others' space, allowing the resident to sit in chairs in the hallway, offering finger foods while pacing, engaging with the resident when passing her in the hallway, offering her sweet treats, offering the resident compliments on her appearance and offering to paint the resident's nails. Resident #45's mood care plan, revised 7/9/25, revealed the resident had a mood problem related to the disease process of dementia with behavioral disturbances. Interventions included observing for signs and symptoms of mania or hypomania, racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep and agitation or hyperactivity. Resident #45's psychosocial care plan, revised 7/22/25, revealed the resident took antipsychotic medications for agitation related to dementia with a target behavior of striking out at<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | others. Interventions included consulting with the pharmacist and the physician to consider dosage reductions when clinically appropriate at least quarterly (initiated 1/16/25), monitoring and documenting occurrence of target behaviors symptoms and updating target behavior documentation as needed (initiated 1/16/25) and trying non-pharmacological interventions, such as one-on-one, redirect, offer food/fluids, toilet, remove from situation, activity, assess for pain, or massage/back rub (initiated 5/27/25). Review of Resident #45's August 2025 CPO revealed the following physician's orders:Rexulti (an antipsychotic medication) 1 milligram (mg) tablet. Give one 1 mg tablet one time a day for dementia with agitation, ordered 1/2/25 and increased 6/7/25.Rexulti 3 mg tablet. Give 0.5 tablet (1.5 mg) by mouth twice a day for Alzheimer's disease, ordered 6/7/25. Trazodone (antidepressant medication) 50 mg tablet. Give 75 mg at bedtime for insomnia, ordered 3/21/25. Monitor for behaviors of agitation due to dementia for Rexulti. Use non-pharmacological interventions 1. Refused. 2. One-on-one. 3. Redirect. 4. Offer snacks/fluids. 5. Toilet. 6. Remove from the situation. 7. Offer activity. 8. Assess for pain. 9. Massage/back rub. 9. See nurses note for additional information, ordered 5/1/25 and discontinued 7/14/25. Lamotrigine (mood stabilizer) 100 mg. Give one tablet twice a day for hypomania, ordered 5/12/25.Monitor for behaviors of 1. Restlessness. 2. Pacing to the point of exhaustion. 3. Irritability associated with Lamotrigine. Use non-pharmacological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/14/25.Monitor for behaviors of inability to sleep associated with Trazodone. Use non-pharmacological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/14/25.Trazodone 50 mg tablet. Give one tablet in the morning for insomnia and depression, ordered 7/22/25.Monitor for behaviors of striking others unprovoked associated with Rexulit. Use non-pharmacological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/22/25.Hydroxyzine (antihistamine used for anxiety) 25 mg. Give one tablet every six hours as needed for anxiety/agitation related to unspecified dementia, ordered 6/7/25 and discontinued 6/20/25.-The non-pharmacological interventions documented for all three of Resident #45's active behavior monitoring physician's orders indicated the same identical, non person-centered non-pharmacological interventions were to be used for every behavior, regardless of the behavior. Review of Resident #45's progress notes, from 6/4/25 to 8/4/25, revealed the following:Resident #45 had 13 episodes of verbal and physical aggression towards others (on 6/4/25, 6/8/25, 6/16/25, 6/17/25, twice on 6/18/25, twice on 6/19/25, twice on 6/20/25, 6/23/25, 6/24/25, and 6/25/25) without identified non-pharmacological interventions attempted. -Of the 13 episodes of verbal and physical aggression towards others, eight times an as needed (PRN) medication was given to the resident for anxiety and agitation. However, there was no documentation to indicate what non-pharmacological interventions were attempted prior to the administration of the medication.-Review of Resident #45's behavior monitoring for June 2025 failed to reveal monitoring had been ordered for the PRN Hydroxyzine. -The electronic medical record (EMR) failed to reveal which identified non-pharmacological interventions had been attempted and if the interventions were effective or not prior to increases in Resident #45's Rexulti or Trazodone. A psychoactive medication evaluation meeting minute note, dated 6/20/25, revealed Resident #45 had an addition of Hydroxyzine for aggressive behaviors, an increase in Rexulti with continued behaviors. Hydroxyzine was discontinued and Trazodone 50 mg was added. A pharmacist consultant report, dated 7/8/25, revealed the pharmacist documented the diagnosis of hypomania for the Lamotrigine needed to be changed to dementia with behaviors with<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | specific behaviors indicated to the Lamotrigine use. -A review of Resident #45's EMR failed to reveal the diagnosis for the Lamotrigine had been corrected or the behaviors of hypomania clarified and monitored. The resident's behavior sheet, undated, which was kept at the nurses' station, was reviewed on 8/5/25. The behavior sheet revealed that Resident #45 had behaviors of being verbally aggressive with others, paranoid about others following her causing verbal aggression, pacing to the point of exhaustion, physical aggression, especially towards Resident #28, and striking out at others unprovoked. Interventions included allowing the resident to rest in chairs placed in the hallway, offering finger foods while walking, smiling and greeting the resident, offering to walk with her if she became paranoid someone was following her, offering her chocolate, allowing her independent visits with her male friend, complimenting her on her appearance, offering to paint her nails when she was pacing or frustrated, offering a milkshake, offering to take her outside for a walk, offering her simple tasks (watering plants, folding napkins, wiping tables), creating space between the resident and others, promoting relaxation (offer back rub, smoothing hair, or soft music), providing one-one-one when agitated, redirecting the resident from taking items from others' rooms and redirecting her when within arm's reach of Resident #28. -Resident #45's behavior monitoring in the August 2025CPO and the behaviors in the care plan failed to include the resident specific and person-centered interventions included on her behavior sheet (see physician's orders and care plan above).III. Resident #32A. Resident statusResident #32, age less than 70, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included anxiety and Wernicke's encephalopathy (alcohol induced encephalopathy). The 6/25/25 MDS assessment revealed the resident had severe cognitive impairments and was unable to participate in the BIMS assessment. A staff interview for mental status revealed the resident had short and long term memory impairments and severe impairments to his daily decision-making making skills. The MDS assessment indicated the resident had behaviors of hallucinations, delusions, rejecting care and wandering. B. Record reviewResident #32's mood care plan, revised 1/1/24, revealed the resident took antianxiety medication related to anxiety with target behaviors of increased pacing, finger wringing, and clenching fists. Interventions, initiated 8/27/23, included redirecting, offering food or fluid, toileting, removing from the situation, offering activities, assessing for pain and offering massage/back rub. Resident #32's depression care plan, revised 10/7/24, revealed the resident took antidepressant medication related to Wernicke's anxiety disorder with target behaviors of negative statements. Interventions, initiated 2/26/24, included monitoring/documenting for side effects of anti-depressant therapy, change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts or withdrawal. Resident #32's psychosocial care plan, revised 3/24/25, revealed the resident took an antipsychotic medication related to Wernicke's encephalopathy with target behaviors of verbal outbursts/threats. Interventions, initiated 8/27/23, included redirecting, offering food or fluid, toileting, removing from the situation, offering activities, assessing for pain and offering massage/back rub.Review of Resident #32's August 2025 CPO revealed the following physician's orders:Lorazepam (an antianxiety medication) 0.5 mg. Give two times a day for anxiety, ordered 2/28/24. Seroquel (an antipsychotic medication) 300 mg. Give one tablet two times a day for Wernicke's encephalopathy, ordered 5/17/24. Sertraline (antidepressant medication) 100 mg tablet. Give one tablet a day for anxiety, ordered 5/17/24.Monitor for behaviors related to antianxiety medication Lorazepam. 1-increased pacing; 2-finger wringing; 3-clenched fists. Use non-pharmological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/11/25.Monitor for behaviors related to antidepressant medication Sertraline. 1-negative statements. Use<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | non-pharmacological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/11/25.Monitor for behaviors related to antipsychotic medication Seroquel. 1-verbal outbursts. 2. Threats. Use non-pharmacological interventions 1. Redirect. 2. Reposition. 3. Offer snacks. 4. Offer fluids. 5. Adjust room temperature. 6. Distraction/offer activity. 7. See nurses note for additional information, ordered 7/11/25.-The non-pharmacological interventions documented for all three of Resident #32's behavior monitoring physician's orders indicated the same identical, non person-centered non-pharmacological interventions were to be used for every behavior, regardless of the behavior. -Review of Resident #32's EMR from 6/1/25 to 8/4/25, revealed no documentation to indicate Resident #32 had displayed any behaviors related to the usage of Lorazepam, Sertraline or Seroquel. A psychoactive medication evaluation meeting minute note, dated 6/20/25, revealed there had been no dose reductions of Resident #32's Seroquel, Sertraline or Lorazepam. The physician note during the meeting indicated Resident #32 was recently moved to the secure unit and he would be getting a roommate, which had historically increased Resident #32's behaviors, anxiety, and distress. The facility was to monitor and assess Resident #32's adjustment. The resident's behavior sheet, undated, which was kept at the nurses' station, was reviewed on 8/5/25. The behavior sheet revealed that Resident #32 had behaviors of becoming aggressive, throwing things, and could become triggered if his roommate's side of the room were cluttered. Resident #32 had an aversion to being around other men and could become fearful and aggressive. Interventions included assisting him to a quiet area, redirecting him from other residents, offering chocolate ice cream or chocolate milk, allowing him to read a book of choice, assisting him in calling his sister, encouraging the resident to stay in his room and reorganize if desired, encouraging the resident to keep a distance from other men, allowing him to sit alone in the dining room or encouraging female peers to sit with him, allowing him to watch the television in the dayroom and offering to assist the resident in tidying his personal space. -Resident #32's behavior monitoring from the August 2025 CPO and the behaviors in the care plan failed to include the resident specific and person-centered interventions included on his behavior sheet (see physician's orders and care plan above).IV. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 8/5/25 at 1:27 p.m. She said Resident #45 had behaviors of walking continuously throughout the day and becoming agitated around too many residents and overstimulated. CNA #5 was unaware of non-pharmacological interventions that helped for Resident #45. CNA #5 said Resident #32 had behaviors of becoming agitated and throwing things. CNA #5 said Resident #32 could become depressed, tearful and focused on going home. CNA #5 said interventions that worked for Resident #32 were to offer him a less stimulating environment, offer to take him outside for a walk or talk to him about the Bible. CNA #5 was unaware Resident #32 had behavioral triggers related to being around other males. CNA #5 said the staff found resident behaviors and interventions in the behavior book at the nurses' station, however CNA #5 said she did not use the behavior book because she knew the residents. CNA #5 said the CNAs documented behaviors on the CNA behavior monitoring task but the behaviors and interventions indicated on the task were generic and the same for all the residents. CNA #2 was interviewed on 8/5/25 at 3:05 p.m. CNA #2 said Resident #45 had behaviors of pacing and an intervention that worked for her was to take her outside for a walk. CNA #2 said Resident #32 had behaviors of becoming agitated and staff had to redirect him to his room.Registered nurse (RN) #3 was interviewed on 8/5/25 at 3:15 p.m. RN #3 said Resident #45 had behaviors of pacing and the interventions that worked for her were to offer her chocolate milk and space. RN #3 said Resident #32 did not really have behaviors and he liked to read, have soda and sit alone in the dining room.CNA #6 was interviewed on 8/6/25 at<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11:44 a.m. CNA #6 said he had been at the facility for six months. CNA #6 needed to retrieve the behavior binder because he could not recall the person-centered interventions or resident specific behaviors for Resident #45 and Resident #32. He read the behaviors and interventions from the binder. CNA #6 said the CNAs did not document behaviors but told the nurse, who then would document it in the progress notes.The memory care director and the social services director (SSD) were interviewed together on 8/6/25 at 2:00 p.m. The SSD said that he was fairly involved with the psychoactive medication reviews and that he reviewed the activity assessments and social service assessments when preparing for the psychotropic medication meeting. The SSD said the behavior monitoring orders on the list in the physician's orders documented specific behaviors for the resident's psychoactive medications along with specific non-pharmacological interventions that should also match the interventions in the resident's care plan.-However, the non-pharmacological interventions listed for each of Resident #45 and Resident #32's psychotropic medications were identical for each medication, despite what behavior might be exhibited (see record review above).The NHA and the director of nursing (DON) were interviewed together on 8/7/25 at 12:50 p.m. The DON said that the facility determined the efficacy of psychoactive medications being administered by using behavior monitoring physician's orders within the MAR with resident specific behaviors listed. She said her expectation was that the nurses documented behaviors on the MAR and also put in a behavior progress note to include the non-pharmological interventions attempted. The DON said that there should be non-pharmacological interventions on the behavior monitoring order for the nurses. She said that non-pharmacological interventions were important because the facility did not want to use psychotropic medications as a first resort and instead wanted to use non-pharmacological interventions first because it was more humane and ethical for the care of the resident. The DON said that the behavior monitoring physician's orders provided data that was used during the psychotropic drug meeting to decide on increasing medications or considering gradual dose reductions. She said that she continuously trained her staff on where to find the non-pharmacological interventions and what they were, as well as providing education on triggers. The DON was unaware that the CNAs and nursing staff on the secure unit were not consistent in knowing where to find behaviors and interventions for residents.The NHA said that if the staff were not consistently or accurately documenting resident behaviors, it would be difficult to determine the effectiveness of the medications and this prevented the monitoring from demonstrating a clear picture of behaviors. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of three units. Specifically, the facility failed to: -Ensure staff performed hand hygiene prior to providing wound care for Resident #19;-Ensure staff followed appropriate infection control guidelines for handling of wound care supplies for Resident #19; and,-Ensure staff wore the appropriate personal protective equipment (PPE) when providing incontinence care for Resident #6, who was on enhanced barrier precautions (EBP) for having an indwelling urinary catheter.Findings include:I. Failed to ensure staff performed hand hygiene prior to providing wound care and handled wound care supplies appropriately for Resident #19 A. Observations On 8/4/25 at 2:39 p.m. Resident #19's right foot was observed to be wrapped with wound dressings.On 8/6/25 at 10:26 a.m. registered nurse (RN) #4 entered Resident #19's room to complete wound care for the resident. RN #4 donned gloves and a gown prior to entering the room. -However, RN #4 failed to complete hand hygiene prior to donning the gown and gloves and before proceeding to perform the resident's wound care.On 8/6/25 at 10:27 a.m., after completing wound care for Resident #19, RN #4 dropped a partially opened package of medical gauze that was used for the resident's wound care bandages on the floor. The opened package of gauze landed upside down on the floor, with the exposed gauze touching the floor. RN #4 picked up the package of gauze and proceeded to place the package of gauze into a clean medical supply basket designated for Resident #19. -RN #4 placed contaminated medical wound dressing supplies into a clean basket of medical supplies.II. Failed to ensure staff wore the appropriate PPE when providing incontinence care for Resident #6, who was on EBP for having an indwelling urinary catheterA. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 8/10/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts,Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing.B. Facility policy and procedureThe Enhanced Barrier Precautions policy, undated, was received from the nursing home administrator (NHA) on 8/6/25 at 1:49 p.m. The policy read in pertinent part, Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDRO) to residents. Enhanced barrier precautions refer to infection prevention and control interventions designed to reduce the transmission of multi drug resistant organisms during high contact resident care activities. EBP apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical device, and does not have secretions or excretions that are unable to be covered or contained. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include dressing, bathing or<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, prolonged, high contact with items in the residence room, with residents equipment, or with residents clothing or skin, device care or use including central lines urinary catheters feeding tubes tracheostomies or ventilators, and wound care. C. Observations On 8/4/25 at 2:25 p.m. there was a sign on Resident #6's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 8/4/25 at 2:39 p.m. Resident #6 was sitting on his bed. He had an indwelling urinary catheter draining yellow urine attached to his bed. On 8/7/25 at 11:12 a.m. certified nurse aid (CNA) #3 was providing incontinence care to Resident #6. -However, CNA #3 failed to put on a protective gown prior to providing incontinence care to Resident #6, who was on EBP.D. Resident interviewOn 8/4/25 at 3:50 p.m. Resident #6 said he only needed help with using the bathroom and staff would assist him with that task. He said the staff did not wear a gown when they were assisting him with toileting.III. Staff interviewsRN #1 was interviewed on 8/5/25 at 12:05 p.m. RN #1 said Resident #6 was on enhanced barrier precautions because he had a Foley catheter. She said staff were supposed to wear a gown and gloves when emptying his Foley catheter and assisting him to the bathroom. She said nursing staff were supposed to wash or sanitize their hands before entering and exiting the room when providing direct care to residents on EBP.RN #4 was interviewed on 8/6/25 at 10:30 a.m. RN #4 said staff were supposed to wash their hands before entering a resident's room to provide wound care in order to prevent the spread of germs and potential infections. RN #4 said if medical supplies were dropped on the floor, they should be discarded because they were considered contaminated. RN #4 said she was moving too quickly after providing wound care for Resident #19 and did not realize she dropped the clean bandages on the floor before placing them back into the clean supply bin. CNA #3 was interviewed on 8/7/25 at 11:30 a.m. CNA #3 said she thought she only needed to wear a gown for Resident #6 if she emptied his indwelling Foley catheter. CNA #3 said she was agency staff and was not provided with any education on enhanced barrier precautions before working in the facility. CNA #4 was interviewed on 8/7/25 at 11:59 a.m. CNA #4 said she did not receive any specific education from the facility regarding EBP. However, she said she knew to wear a gown and gloves whenever she came in close contact with any resident that had a wound or a Foley catheter. CNA #4 said she understood the importance of the need to maintain EBP to prevent the spread of infections. The infection preventionist (IP) and the director of nursing (DON) were interviewed together on 8/6/25 2:00 p.m. The IP said she conducted audits for hand washing in addition to educating staff on infection protocol and policy. The IP said the staff should wash or disinfect their hands before entering a resident's room and after the staff exited the room. She said it was important to maintain EBP precautions to prevent the spread of infectious organisms throughout the facility. The IP said Resident #6 was currently being treated for a urinary tract infection and Resident #19 had wounds on his foot. The IP said both of these residents had portals of entry for infections which lead them to be highly susceptible to acquiring an infection.The DON said all nursing staff were provided education regarding EBP and she said staff would be re-educated accordingly. She said it was important that the staff understood the proper policies and procedures to protect the health of the facility's residents. The DON and the NHA were interviewed together on 8/7/25 at 2:35 p.m. DON said if medical supplies were dropped on the floor, they needed to be thrown into the trash and not placed back into an area designated for clean, uncontaminated items because they were considered dirty at that<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | time. The NHA said nursing staff were to follow the policies and procedures in place for enhanced barrier precautions. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance for one (#6) of two residents out of 27 sample residents. Specifically, the facility failed to ensure clinical signs and symptoms of an infection were identified and/or culture results were obtained prior to the administration of antibiotics for Resident #6.Findings include:I. Professional referenceThe Centers for Disease Control and Prevention's (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, dated 2019, was retrieved on 8/10/25 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html. It read in pertinent part,Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections.II. Resident #6 A. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included congestive heart failure, anemia, hypertension (high blood pressure), benign prostate hyperplasia (BPH - an enlargement of the prostate), obstructive uropathy (a condition where urine flow is blocked, causing a backup of urine into the kidneys) and asthma. According to the 6/9/25 minimum data set (MDS) assessment, Resident #6 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required minimal assistance for showering/bathing, dressing and transferring. The MDS assessment revealed the resident was receiving an antibiotic medication.B. Resident interview Resident #6 was interviewed on 8/4/25 at 2:55 p.m. Resident #6 said he had a catheter because he retained urine. Resident#6 did not think he had any infections.C. Record review Review of Resident #6's August 2025 CPO revealed the following physician's order:Cefdinir (antibiotic) oral tablet 300 milligrams (mg). Give one tablet by mouth two times a day for urinary tract infection (UTI) for five days, ordered 8/1/25.The 7/30/25 nursing progress notes documented Resident #6 was admitted to the hospital for a urinary tract infection and discharged back to the facility the same day. Review of Resident #6's electronic medical record (EMR) revealed a urinalysis was completed during his hospital stay on 7/30/25 with results positive for a UTI and an indication for a culture and sensitivity (a two-part diagnostic procedure used to identify the cause of an infection and determine the most effective treatment). -There was no documentation in the resident's EMR to indicate the culture and sensitivity was completed, prior to the start of the resident's antibiotics.III. Staff interviews Registered nurse (RN) #1 was interviewed on 8/5/25 12:05 p.m. RN #1 said there was no specific monitoring or documentation that needed to be done for residents on antibiotics. RN #1 said the physician would order the antibiotic for a resident if the resident had an infection. RN #1 said the facility would send out a urine test to confirm the presence of a UTI in a resident.The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 8/6/25 at 2:00 p.m. The IP said she started in her role at the facility on 7/14/25. She said her role as IP involved monitoring infections and antibiotic use with mapping and monitoring trends. The IP said she used the McGreer's criteria when assessing a resident who may need an antibiotic. She said the McGreers's Criteria consisted of symptoms, such as burning with urination and cloudy urine, which would require a urinalysis and a culture and sensitivity to be completed before initiating antibiotic treatment.The IP said Resident #6 was the only resident who was being treated for a<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | UTI. She said the resident was sent to the hospital and diagnosed with a UTI and started on antibiotics. The IP said the UTI was confirmed via urinalysis with a culture and sensitivity pending. The IP said she never followed up with the hospital for the culture results. The IP said because the facility did not have the culture results for Resident #6, it was possible the facility did not treat his UTI effectively.The DON said Resident #6 was started on an antibiotic in the hospital after the hospital conducted a urinalysis on the resident. The DON said the facility did not receive any documentation from the hospital regarding the results of a culture and sensitivity that was indicated. The DON said the facility should have followed up on the culture and sensitivity because the culture and sensitivity results would identify what antibiotic would most effectively treat the UTI. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for two (#19 and #7) of five residents reviewed for immunizations out of 27 sample residents.Specifically, the facility failed to offer the pneumonia vaccine to Resident #19 and Resident #7.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC), updated 2025, Recommended Immunization Schedule for Adults Aged 19 years or Older, retrieved on 8/11/25 from https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/adult/adult-combined-schedule.pdf,Pneumococca vaccination-Routine vaccination-Age 50 years or older who have not previously received a dose of PCV13 (pneumococcal conjugate vaccine), PCV15, PC20, OR PCV21 or whose previous vaccination history is unknown: one dose PCV15 or PCV20 or one dose PCV21. If PCV15 is used, administer one dose PPSV23 at least one year after the PCV15 dose (may use a minimum interval of eight weeks for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak). Previously received only PCV7: follow the recommendation above.Previously received only PCV13: one dose PCV20 or one dose PCV21 at least one year after the last PCV13 dose.Previously received only PPSV23: one dose PCV15 or one dose PCV20 or one dose PCV21, at least one year after the last PPSV23 dose. If PCV15 is used, no additional PPSV23 doses are recommended.Previously received both PCV13 and PPSV23 but no PPSV23 was received at age [AGE] years or older; one dose PCV20 or one dose PCV21 at least five years after the last pneumococcal vaccine dose.Previously received both PCV13 and PPSV23, and PPSV23 was received at age [AGE] years or older: Based on shared clinical decision making, one dose of PCV20 or one dose of PCV21 at least five years after the last pneumococcal vaccine dose.II. Facility policy and procedureThe Pneumococcal Vaccine policy, revised March 2022, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:48 p.m. It read in pertinent part,All residents will be offered pneumococcal vaccines to aid in preventing pneumonia or pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series unless medically contraindicated or the resident has completed the current recommended vaccine series. Before receiving a pneumococcal vaccine the resident or legal Representatives receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Residents have the right to refuse vaccination. If refused, appropriate information is documented in the residence medical record indicating the date of the refusal of the pneumococcal vaccination. For each resident who receives a vaccine, the date of the vaccination, Lot number, expiration date, person administering and site of the vaccinations are documented in the resident's medical record.III. Resident #19 A. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included atrial fibrillation (irregular heartbeat), lymphedema (swelling), hypertension (high blood pressure), dermatitis and open wound of the left lower leg. The 2/27/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required substantial/maximal assistance with toileting, personal hygiene. He required partial/moderate assistance with bed mobility and was independent with eating.The assessment did not indicate the resident was offered the pneumonia vaccine. B. Resident interviewResident #19 was interviewed on 8/4/25 at 4:07 p.m. Resident #19 said he received some vaccines years ago while living at home, but was not offered any vaccinations while living at the facility.C. Record reviewReview of Resident #19's electronic medical record (EMR) on 8/6/25 did not reveal documentation that the pneumonia vaccine was offered to the resident. The August 2025 CPO revealed a physician's<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | orders for the pneumonia vaccine, ordered on 2/20/25. -However, review of the EMR failed to reveal documentation in the resident's EMR that the pneumonia vaccine was administered.IV. Resident #7A. Resident statusResident #7, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic osteomyelitis (infection) in the right ankle, diabetes type 2, cirrhosis of the liver, anxiety and depression. The 7/17/25 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 10 out of 15. He was independent with toileting or personal hygiene. He required partial/moderate assistance with wound care and was independent with eating.The assessment did not indicate the resident had not been offered the pneumonia vaccine. B. Resident interviewResident #7 was interviewed on 8/4/25 at 4:18p.m. Resident #7 said he had not received, nor was he offered any vaccines while living at the facility. C. Record reviewA review of the EMR on 8/6/25 did not reveal documentation that the pneumonia vaccine was offered to the resident. The August 2025 CPO revealed a physician's order for the pneumonia vaccine, ordered on 7/11/25. -However, a review of the EMR on 8/6/25 failed to reveal documentation in the resident's EMR that the pneumonia vaccine was administered.D. Staff interviewsThe director of nursing (DON) and the NHA were interviewed together on 8/7/25 at 2:35 p.m. The DON said it was the responsibility of the admitting nurse to offer, obtain consents and administer vaccinations to newly admitted residents to the facility. The DON said the facility utilized the immunization tab in the resident's EMR to documented relevant historic vaccination information, such as refusals or administration of vaccinations. The DON said she remembered Resident #19 declined to receive any vaccine after it was offered to him from the facility. The DON said she would look for additional information regarding Resident #7 vaccination status. -However, the facility did not provide any additional information regarding Resident #7's vaccination status.D. Facility follow-up-The facility provided vaccine declination (influenza, pneumonia and COVID-19) documentation for Resident #19 with a signature date of 8/7/25 at 6:25 p.m. (after the survey exit). |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement policies and procedures related to COVID-19 immunizations for two (#19 and #7) of five residents reviewed for immunizations out of 27 sample residents.Specifically, the facility failed to offer the COVID-19 vaccine was offered to Resident #19 and Resident #7. Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC), COVID-19 guidelines (revised 1/7/25), retrieved on 8/10/25 from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html. Everyone ages six months and older should get a 2024-2025 COVID-19 vaccine. The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death. It is especially important to get your 2024-2025 COVID-19 vaccine if you are age [AGE] and older, are at risk for severe COVID-19, or have never received a COVID-19 vaccine. Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine.II. Facility policy and procedureThe COVID vaccine policy, revised March 2022, was provided by the nursing home administrator (NHA) on 8/6/25 at 2:48 p.m. It read in pertinent part,All residents will be offered COVID vaccines to aid in preventing COVID infections. Prior to or upon admission, residents are assessed for eligibility to receive the COVID vaccine series, and when indicated, are offered the vaccine series unless medically contraindicated or the resident has completed the current recommended vaccine series. Before receiving a COVID vaccine the resident or legal Representatives receive information and education regarding the benefits and potential side effects of the COVID vaccine. Residents have the right to refuse vaccination. If refused, appropriate information is documented in the residence medical record indicating the date of the refusal of the COVID vaccination. For each resident who receives a vaccine, the date of the vaccination, Lot number, expiration date, person administering and site of the vaccinations are documented in the resident's medical record.III. Resident #19 A. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included atrial fibrillation (irregular heartbeat), lymphedema (swelling), hypertension (high blood pressure), dermatitis and open wound of the left lower leg. The 2/27/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required substantial/maximal assistance with toileting, personal hygiene. He required partial/moderate assistance with bed mobility and was independent with eating.The assessment did not indicate that the resident was ever offered the covid vaccine. B. Resident interviewResident #19 was interviewed on 8/4/25 at 4:07 p.m. Resident #19 said he received some vaccines years ago while living at home, but was not offered any vaccinations while living at the facility.C. Record reviewReview of Resident #19's electronic medical record (EMR) on 8/6/25 did not reveal documentation that the COVID-19 vaccine was offered or administered to the resident. IV. Resident #7A. Resident statusResident #7, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic osteomyelitis (infection) in the right ankle, diabetes type 2, cirrhosis of the liver, anxiety and depression. The 7/17/25 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 10 out of 15. He was independent for toileting or personal hygiene. He required partial/moderate assistance with wound care and was independent with eating.The assessment did not indicate that the resident was offered the COVID-19 vaccine. B. Resident interviewResident #7 was interviewed on 8/4/25 at 4:18 p.m. Resident #7 said he did not receive, nor was he offered any vaccines while living at the facility. C. Record reviewReview of Resident #7's EMR on 8/6/25 did not reveal documentation that the COVID-19 vaccine was<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065251 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Paonia Care and Rehabilitation Center | 1625 Meadowbrook Blvd<br>Paonia, CO 81428 |

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 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | offered or administered to the resident. D. Staff interviewsThe director of nursing (DON) and the NHA were interviewed together on 8/7/25 at 2:35 p.m. The DON said it was the responsibility of the admitting nurse to offer, obtain consents and administer vaccinations to newly admitted residents to the facility. The DON said the facility utilized the immunization tab in the resident's EMR to document relevant historic vaccination information, such as refusals or administration of vaccinations. The DON said she remembered Resident #19 declined to receive any vaccine after it was offered to him from the facility.-However, documentation indicating Resident #19 declined the COVID-19 vaccination was not provided. The DON said she would look for additional information regarding Resident #7 vaccination status. -However, the facility did not provide additional information regarding Resident 37's vaccination status. |