STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065341	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casey's Pond Senior Living	2855 Owl Hoot Trl Steamboat Springs, CO 80487

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from abuse for one (#26) of two residents reviewed for abuse out of 25 sample residents. Specifically, the facility failed to protect Resident #22 from sexual abuse by Resident #26. Findings include: I. Facility policy and procedure The Abuse Non-Tolerance policy, dated October 2022, was provided by the nursing home administrator (NHA) on 3/18/24. It read in pertinent part, Residents and clients must be free from abuse by anyone, including associates, other residents or clients, consultants or volunteers, family members or legal guardians, friends or other individuals. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. Capacity and consent: Residents and clients have the right to engage in consensual sexual activity. However, if the community has reason to suspect that a resident may not have the capacity to consent to sexual activity, the community must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity. Protection of the person who may have been a victim of abuse: -Changing caregiver assignments; -Restricting visitors; -Frequent monitoring of the resident; -Relocating the resident to a more visible area; -Utilizing a companion or sitter to stay with the resident; and, -Have the resident leave the community as appropriate and if desired with friends or family. (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: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Facility investigation The facility investigation, dated 2/5/24, documented the following information in pertinent part, (Resident #22) and (Resident #26) were sharing transportation to church. (Resident #22) reports that they were holding hands in church and it was consensual. On the bus ride back to the community, they were also holding hands. (Resident #22) reports that she let go and when she did (Resident #26) did not remove his hand from her person and that his hand lingered on her clothing over her breast. She did not say anything and he removed his hand. (Resident #22) reported the incident to a nurse after returning to the community. Nurse provided information to DON (director of nursing) and Social Worker via email, which was read the following day just prior to submission of report. (Resident #22) denies feeling unsafe with (Resident #26), and states 'we are friends, he is a boob man, he's not aggressive.' (Resident #22) would like to continue to share the bus to church on Sundays. No physical redness, bruising. Resident is relaxed in body language and denies feeling unsafe. No physical harm, (Resident #22) did not provide consent, also wishes to continue to have interactions with alleged assailant (Resident #26). Every 30 minute observations of alleged assailant (Resident #26). Behavior monitoring updated in treatment administration record (TAR) to be more individualized to (Resident #26) specific behaviors of concern. Continue observation monitoring when resident is out of room. Additional education provided to nursing staff regarding behaviors, interventions and documentation. Place next to male or out of reach of females when possible during activities and transportation. Consider alternative living arrangement. Resident and POA (power of attorney), notified of concern regarding pattern of behavior and inability to retain education or control impulses secondary to TBI (traumatic brain injury). Social services will assist family in looking for alternate living options. If the behaviors continue (Resident #26) may be facing involuntary discharge. Review of the State Agency portal revealed the facility reported the incident on 2/5/24. III. Resident #26 (assailant) A. Resident status Resident #26, age younger than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included personal history of traumatic brain injury, hemiplegia (paralysis), unspecified, affecting left non-dominant side, mild cognitive impairment, psychophysiologic insomnia, personality change due to known physiological condition and other sexual dysfunction not due to a substance or known physiological condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The 1/29/24 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score 14 out of 15. No behaviors were documented. He required set-up assistance with toileting, moderate assistance with bathing and maximal assistance with lower body dressing. He was independent with transfers.

B. Resident interview

Resident #26 was interviewed on 3/17/24 at 4:42 p.m. Resident #26 said he had lived at the facility for four years. He said he stayed in his room most of the time and kept himself busy watching movies on his television (TV) and computer, reading and writing emails and people could visit with him if they wanted. He said he did not want to leave his room because he was accused of touching a female resident. He said when he was in his twenties, he spent many years living and working in Brazil as a model. He said he wrote a book about that time but it was not published yet.

C. Record review

A review of Resident #26's comprehensive care plan, initiated 1/30/2020, revealed the resident had a diagnosis of a traumatic brain injury (TBI) and had impulse control issues. The resident had hypersexuality and watched pornography at times. Interventions included: Be aware of any behaviors that put the resident or others at risk and report this to the DON , nurse manager or social service director (SSD), initiated 5/4/2020; If the resident was inappropriate in anyway staff was to directly tell him in the moment that what he was doing was not alright; If the resident was confused, staff was to tell him what behaviors were appropriate, if the resident was masturbating in front of others, staff was to tell him it was not an appropriate time to do that, and allow him to have some privacy in his room, initiated 1/30/2020; If the resident was out of his room, staff was to supervise him so he did not put himself and others at risk, if the resident's zipper was down and he was exposing himself, staff were to let him know and either take him back to his room or ask him to return to his room, initiated 11/16/2020; the resident required two certified nurse aides (CNAs) to provide personal care and bathing at all times; If the resident made inappropriate sexual comments or began to masturbate while being showered, staff was to tell him to stop and tell him it was inappropriate, initiated 6/12/23; The resident was to be placed/encouraged to sit next to males or out of reach of females during events or during transportation, initiated 2/9/24.

-The care plan did not address the need for the resident to have close staff supervision when Resident #26 was outside of his room.

The life enrichment (activities) care plan, initiated 2/4/2020, revealed Resident #26 shared interest in going out to church services on Sundays. All arrangements were made to help with transportation, initiated: 9/13/21.

\

-The care plan failed to address appropriate supervision when Resident #26 was outside of the facility.

Review of Resident #26's electronic medical record (EMR) revealed the following progress notes:

On 9/13/23, a nurse documented in pertinent part, Resident was seen touching another resident in an inappropriate manner. Resident was made aware that his behavior was inappropriate and separated

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from other resident. Physician assistant and DON informed. Orders received to increase resident's Sertraline (antidepressant) in order to control his behaviors. On 9/13/23, a physician documented in pertinent part, Hemiparesis, left. Due to TBI. Wheelchair dependent. Cognitive and neurobehavioral dysfunction following brain injury. Cognitive and behavioral problems with executive dysfunction, impaired decision-making, disinhibition, lack of safety awareness, impulsivity, irritability, and inappropriate sexual behaviors. He tends to have unrealistic expectations, and poor insight into the limitations of his impairments. Inappropriate behaviors involving female residents, risk of harm, will increase Zoloft (antidepressant) to 75 mg (milligrams) qd (daily). On 9/20/23, a nurse documented in pertinent part, CNA reported that resident was behaving in a way that was sexually inappropriate. She stated that he was in his doorway with his penis in his hands while the housekeepers were mopping. Resident was told to go into his room and not to expose himself in the hallway. On 10/24/23, a social worker documented in pertinent part, Resident #26 is a long term care resident who resides in a private room in the (name) neighborhood at the (facility). Resident #26 experienced a TBI as a young adult. His only daughter, (name), lives in (town). Resident #26 does not engage in many activities or socialization, preferring to stay in his room and watch TV. His room is covered in pictures of himself pre-TBI and family members. Occasionally he will attend an activity, especially if it involves food. Resident #26 has also attended a photography activity before, which he enjoyed. Even if he does not want to attend many group activities, Resident #26 enjoys it if you stop by him and engage in conversation 1:1 (one-on-one). He enjoys listening to stories about others' lives, and telling you about his life. He has written a book about his life, and sometimes asks for help in getting it published. [NAME] can sometimes make inappropriate sexual comments, if this happens it is important to tell him that it was inappropriate. Resident #26 enjoys attending church services at the Christian church on Sundays when there is a driver available. On 2/5/24, the DON documented in pertinent part, Interview with Resident #26 regarding allegation of sexual misconduct by another resident. (Name of social worker), LSW (licensed social worker) present. Resident #26 acknowledges that he was holding hands with another resident, denies touching breast or lingering hand states 'I didn't do that .she's old .On the bus? I was here and she was over there. We were closer at church.' On 2/9/24, the DON documented in pertinent part, Spoke with resident regarding the investigation of sexual misconduct. (Name of social worker), LSW present. Resident #26 reports that as he has considered our previous conversation. He recalls when Resident #22 removed her hand and his remained on her body and said 'but her (breasts) are huge, they're down to here, so what am I supposed to do, plus she never said anything, she could've moved my hand.' The vulnerability of the surrounding population, likelihood of cognitive impairment and inability to know other individuals medical history was reviewed. Resident informed of requirement and importance of not touching other residents. Discussed an established pattern of behavior and need to seek alternate living arrangement if the behaviors persist. Resident said 'I won't, these people are all old around here, I don't get off touching old ladies.' Resident acknowledges his understanding. Resident is aware of notification to POA (power of attorney). -Despite the facility's awareness of Resident #26's hypersexual behaviors and history of inappropriately touching a female resident, the facility allowed the resident to travel next to a female (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casey's Pond Senior Living	2855 Owl Hoot Trl Steamboat Springs, CO 80487

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

resident in a van (see facility investigation above).

-The facility failed to protect Resident #22 from being inappropriately touched by Resident #26.

IV. Resident #22 (victim)

A. Resident status

Resident #22, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 CPO, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, post-traumatic stress disorder, alcohol dependence with alcohol-induced persisting dementia and major depressive disorder.

The 1/21/24 MDS assessment revealed the resident had intact cognition with a BIMS score of 13 out of 15. The resident had no hallucinations, delusions or behaviors. She had a range of motion impairment on one side of both the upper and lower extremity. She required substantial/maximal assistance with toileting, bathing and dressing and partial/moderate assistance with transfers.

B. Resident interview

Resident #22 was interviewed on 3/20/24 at 12:42 p.m. Resident #22 said she had experienced inappropriate touching in the past. She said one evening Resident #26 was sitting at the computer desk on her unit when she went down to use the computer. She said he moved over and let her use the computer and started telling her about his time in Brazil and how he loved the women there because they did not wear shirts and the men could touch and kiss the women's breasts. She said when she was finished on the computer she bent over causing her breast to fall with gravity and Resident #26 touched her right breast. She said she told him this isn't Brazil and we aren't going to be doing that. She said she did not wear a bra. She said she was not afraid of Resident #26 and did not feel uncomfortable around him because she knew how to take care of herself. She said after the computer incident, Resident #26 was banned from going down to her unit and was even banned from being around her for a while.

C. Record review

A review of Resident #22's comprehensive care plan, initiated 6/20/19, revealed the resident had impaired cognitive function/dementia or impaired thought processes. She did not have safety awareness and was often impulsive. Interventions included: Reminding the resident of goals she had set such as not over eating and focusing on keeping her weight low, providing gentle reminders if staff saw her doing anything unsafe or making poor decisions, providing the resident with simple instructions and reminders when needed and staff was to remember, due to the resident's cognitive impairments, she would I often have the same conversation over again.

The mood care plan, initiated on 6/20/19, revealed the resident struggled with alcohol addiction in the past and used alcohol to treat her depression and get to sleep. The resident would overeat because she thought it would make her feel better and she was often down which would present as irregular sleep patterns, irritability and overeating. The resident saw a therapist but due to her dementia, insight work was sometimes difficult. Interventions included: Arranging for psychological consultation and follow up as indicated, assisting the resident with developing/providing her with a program of activities that was meaningful and of interest, Encouraging and providing opportunities for

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exercise and physical activity, discussing with the resident, her family and caregivers any concerns, fears or issues regarding health or other subjects as they occur, encouraging the resident to express her feelings and giving her time to talk., avoiding challenging her behavior as she did not respond well and showing the resident care and gentleness. -The care plan failed to address Resident #22's vulnerability and risks for being a victim of sexual abuse. -Review of Resident #22's EMR did not reveal documentation that she was inappropriately touched by Resident #26. V. Staff interviews The SSD was interviewed on 3/18/24 at 11:25 a.m. The SSD said Resident #26 was sexually and verbally inappropriate towards staff and would ask for sexual favors. She said the resident was observed by staff placing his hand on a female resident's leg while she was playing piano. The residents were immediately separated. She said the facility investigated an incident when a female resident reported that Resident #26 touched her breast while on a bus trip to church on 2/4/24. She said the female resident was not upset or afraid of Resident #26, she said the residents were still friends. She said Resident #26 was always accompanied/supervised by staff when he wished to leave his room and join any group activities. Certified nurse aide (CNA) #5 was interviewed on 3/19/24 at 9:30 a.m. CNA #5 said she was aware of Resident #26 being sexually inappropriate towards staff. She said the resident's behaviors were documented in the care plan. She said she had not experienced any inappropriate situations with Resident #26. She said she worked mostly night shifts and the resident was always respectful when she was assisting him with activities of daily living (ADL). Licensed practical nurse (LPN) #2 was interviewed on 3/19/24 at 9:36 a.m. LPN #2 said she was aware of Resident #26's inappropriate sexual behaviors towards staff and female residents. She said she witnessed the incident when Resident #26 placed his hand on a female resident's leg. She said staff immediately separated both residents. She said she was aware of Resident #26 exposing his lower body parts to some staff, mostly housekeepers as the housekeeping closet was across the hall from the resident's room. She said Resident #26 was easy to redirect. She said once a staff member observed his inappropriate behavior, the resident would apologize. VI. Facility follow-up Resident #26's care plan was updated on 3/20/24 (during the survey) to include the following intervention: I enjoy attending church on Sundays. Please place me in my w/c (wheelchair) out of reach of any other residents when riding the bus.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations and interviews, the facility failed to provide services in accordance with currently accepted professional principles. Specifically, the facility failed to follow accepted standards of practice for medication administration by pre-pouring medications prior to confirming the resident was ready and available for medication administration. Findings include: I. Professional references Nursing rights of medication administration, updated on 9/5/22, was retrieved from https://www.ncbi.nlm.nih.gov/books/NBK560654/ on 3/22/24 at 9:00 a.m. It read in pertinent part: 'Right time'-administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms. Long Term Care Nursing: Medication Pass, updated on 1/24/24, was retrieved from https://ceufast.com/course/long-term-care-nursing-medication-pass on 3/22/24. It read in pertinent part: Medication errors are serious and can cause resident harm or even death. It is human nature to want to simplify things when there is much to be done. In an attempt to do this, sometimes shortcuts are made. However, this is not good practice. Especially when it comes to medications. Do not take shortcuts. More specifically, do not, under any circumstances, try to pre-pour medications to save time. Pre-pouring medications are against regulations. In addition, it increases the risk of making mistakes. II. Facility policy and procedure The Medication Storage policy, version one 2024, was provided by the director of nursing (DON) on 3/21/24 at 8:49 a.m. It read in the pertinent part, Medications are administered at the time they are prepared. Medications are not pre-poured. III. Observations On 3/19/24 at 8:36 a.m., the medication pass on the Mountainside unit was observed with the registered nurse (RN) #1. At 9:06 a.m., RN #1 prepared medications for Resident #44. RN #1 walked to the resident's room and found the resident was not in her room. RN #1 returned to the medication cart, wrote the resident's name on the medication cup and put it in the top drawer. RN #1 began preparing medications for the next resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN #1 did not destroy the dispensed medications. -The dispensed medications were not administered to the resident until 10:14 a.m., over an hour after RN #1 prepared them. At 9:11 a.m., RN #1 prepared medications for Resident #50. She dispensed four of the ordered medications into a medication cup for the resident and then stopped. She put the medication cup in the top drawer of the medication cart and locked the cart. RN #1 did not label the medication cup with the resident' sname. She left the medication cart and went to another resident's room to finish flushing a foley catheter. -RN #1 did not destroy the dispensed medications. At 9:27 a.m., RN #1 returned to the medication cart, removed the medication cup for Resident #50 and continued to dispense the remaining medications. At 9:30 a.m. RN #1 took the medication cup to the resident's room and the resident was asleep. She returned to the medication cart, placed the medication cup back in the top drawer and began preparing medications for the next resident. -RN #1 did not destroy the dispensed medications. -The dispensed medications were not administered to the resident until 10:26 a.m., almost an hour after RN #1 prepared them. IV. Staff interviews RN #1 was interviewed on 3/19/24 at 9:11 a.m. RN #1 said she realized she was not supposed to put dispensed medications in the top drawer of the medication cart but she did not know what she should have done because she needed to flush a foley catheter. The DON was interviewed on 3/20/24 at 1:05 p.m. The DON said storing dispensed medications in a medication cup in the top drawer of the medication cart was not safe practice and was not permitted in the facility. The DON said the nurse should have destroyed the medications and dispensed them again when the resident was ready for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 2855 Owl Hoot Trl, Steamboat Springs, CO 80487	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#7 and #49) of four residents out of 25 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, the facility failed to: -Ensure Resident #7's portable oxygen concentrator was turned on while she was out of the building at an appointment; and, -Ensure Resident #49 was assisted with removing her cervical collar (c-collar) during meal times. Findings include: I. Resident #7 A. Resident status Resident #7, age [AGE], was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included chronic respiratory failure (shortness of breath) and chronic obstructive pulmonary disease (COPD) (airflow blockage and breathing related problems). The 2/1/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance with transferring, dressing and personal hygiene. B. Resident observation and interviews On 3/19/24 at 9:21 a.m., Resident #7 returned to the facility from an outside appointment. She said she left the building at 8:15 a.m. via facility transportation for the appointment but when she arrived at the appointment was told she did not have an appointment scheduled. The dial of Resident #7's portable oxygen tank was positioned on zero. Resident #7 said she received 2 liters per minute (LPM) of oxygen. She said she was unable to tell if oxygen was flowing through the nasal cannula. At 9:25 a.m. licensed practical nurse (LPN) #1 approached Resident #7 and asked about the appointment. LPN #1 said Resident #7 required 2 LPM of oxygen. LPN #1 turned the dial on the portable oxygen tank to 2 LPM. LPN #1 said Resident #7 had cold hands and proceeded to warm Resident #7's hands up using friction from her own hands prior to placing a pulse oximeter (a non-invasive device which measures the level of oxygen in the blood) on Resident #7's finger. The pulse oximeter indicated Resident #7 had an oxygen saturation level (SpO2) of 87 percent (%). After being on 2 LPM of oxygen for just under two minutes, Resident #7's SpO2 increased to 92%. LPN#1 said the certified nurse aides (CNA) were supposed to ensure the resident's portable oxygen tank was turned on once she was positioned in her wheelchair. She said the CNAs must have forgotten to turn the oxygen tank on before Resident #7 left for her appointment. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2024 CPO revealed the following physician's order: -Oxygen 2 LPM via nasal cannula (NC) every day and 3 LPM via NC every night. Check pulse oximeter on day and evening shift, ordered 9/11/23. The oxygen therapy care plan,initiated on 6/20/19, revealed Resident #7 utilized oxygen. Pertinent interventions included monitoring for signs and symptoms of respiratory distress and the oxygen flow rate was 2 LPM at night. -The care plan failed to include an oxygen flow rate for day time use. -The care plan failed to reflect the correct oxygen flow rate of 3 LPM at night. The 3/19/24 progress note (during the survey) revealed nursing staff had spoken to the CNA who had assisted Resident #7 out of bed. The CNA told the nursing staff she turned the portable oxygen tank off to fill it and must have forgotten to turn it back on. D. Facility follow up On 3/19/24 at 10:30 a.m. (during the survey), the director of nursing (DON) began providing facility staff education on portable oxygen tank expectations. The education revealed in pertinent parts: When a resident requires supplemental oxygen, please ensure the following: nasal cannula is in their nose, portable oxygen is set to their ordered amount, tank has enough oxygen in it to provide resident with their needed amount for the needed time before a refill is needed. When transferring residents between surfaces please ensure oxygen tubing is hooked up to the appropriate source and the source is turned on to ordered flow rate. The DON also provided written follow up revealing in pertinent: An audit was conducted of all residents with portable tanks on their wheelchairs to ensure that portable oxygen tanks were turned on to the appropriate amount. No additional issues were noted. an education was provided to nursing team members working on 3/19/24, including team members who were working with the above noted resident. Nursing team members not working on 3/19/24 will also be educated. An audit was created for the nursing leadership team (or designees) to monitor random residents from each neighborhood two times per week. This audit will be brought to the community's GO (QAPI) meeting and reported to ensure substantial compliance. -However, the facility's corrective actions began after the concern with the portable oxygen tank was brought to the facility's attention. II. Resident #49 A. Resident status Resident #49, age [AGE], was admitted on [DATE]. According to the March 2024 CPO, diagnoses included fracture of the neck and muscle weakness. The 2/20/24 minimum data set MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance with bathing, dressing, toileting, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 Owl Hoot Trl Steamboat Springs, CO 80487	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited assistance with personal hygiene and set up / clean up for eating. B. Resident observation and interview On 3/17/24 at 5:00 p.m., Resident #49 was sitting in the main dining room at a table eating soup. The resident was wearing a cervical collar (c-collar) (a collar used to support and limit movement of neck and head). Resident #49 had awkward movements while eating as she had to bring the eating utensil to eye level and then to her mouth while eating. Resident #49 was interviewed on 3/18/24 at 9:00 a.m. Resident #49 was sitting in her wheelchair in her room eating breakfast with the c-collar on. The resident said she was at the facility receiving therapy after she fell at home in January 2024. She said she fractured her right hip and her neck. Resident #49 said she was doing better than when she first admitted to the facility and was told the c-collar could be removed during meals. Resident #49 said she was unsure who was allowed to remove the c-collar and thought only certain staff were trained on this because only some of the staff would offer to remove the c-collar during meals. Resident #49 said the c-collar was uncomfortable and made eating difficult. She said eating foods containing a lot of liquid, such as yogurt, soup or hot and cold cereals, presented the most difficulty with spilling. Resident #49 said if she could not stab food with her fork or the food did not stick to her spoon she usually spilled food on herself Resident #49's c-collar had multiple small dark circular stains on the padding where her chin was resting. On 3/18/24 a 12:09 p.m., Resident #49 was sitting in her room eating lunch wearing the c-collar. Resident #49 was interviewed again on 3/19/24 at 9:20 a.m. Resident #49 was sitting in her wheelchair in her room eating breakfast wearing the c-collar. She said staff had not offered to remove the c-collar while she was eating. On 3/19/24 at 1:00 p.m., LPN #1 was assisting Resident #49 in her room with a scheduled treatment. LPN #1 said the c-collar could be removed by any nurse or CNA and should be removed at meals. She said the c-collar was removed and reapplied by two velcro straps. LPN #1 said Resident #49 could adjust the velcro on her own if she wanted to. Resident #49 said she was unaware she could do this and did not think she had enough strength in her arms after therapy to adjust the c-collar on her own. On 3/20/24 at 12:15 p.m., Resident #49 was sitting up in her wheelchair in her room eating lunch without her c-collar on. She said someone offered to remove the c-collar while she was eating. On 3/21/24 at 9:30 a.m. Resident #49 was sitting in her wheelchair in her room eating breakfast wearing the c-collar again. The breakfast consisted of fruit mixed with yogurt. She said staff had not offered to remove the c-collar while she was eating. C. Record review -Review of Resident #49's comprehensive care plan, initiated 2/12/24, did not reveal a care plan focus for the resident's c-collar. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Casey's Pond Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 2855 Owl Hoot Trl, Steamboat Springs, CO 80487	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2024 CPO revealed the following physician's order: -Every day and night shift keep the c-collar in place at all times except when eating, ordered 2/26/24. C. Additional interviews CNA #3 was interviewed on 3/20/24 at 10:00 a.m. CNA #3 said Resident #49's c-collar could be removed when she was eating. She said CNAs could assist the resident with removing the c-collar. CNA #3 said she assisted Resident #49 if she asked for help and offered to help the resident remove the collar sometimes. CNA #4 was interviewed on 3/20/24 at 10:00 a.m. CNA #4 said Resident #49's c-collar could be removed while she was eating. She said CNAs and nurses could assist the resident with removing the c-collar. She said she offered to assist the resident remove the c-collar when she worked with her. The DON and LPN #1 were interviewed on 3/20/24 at 10:20 a.m. LPN #1 said she observed Resident #49 eating that morning (3/20/24) without her c-collar. LPN #1 said she was unsure if the resident had her c-collar removed for all meals. The DON said the physician's order would be clarified to instruct staff to assist Resident #49 with removing the collar at all meals. D. Facility follow up On 3/20/24, the DON began providing staff education it read in pertinent: Please assist Resident #49 to remove her neck brace at meals. It is difficult for her to feed herself with it on and she may not remember every time to ask. On 3/20/24, the March 2024 CPO revealed the revised order: Please encourage and assist me to wear my c-collar when I am not eating and assist me to remove at meals, if I decline please educate me on reasons and benefits. -However, the facility's corrective actions began after the concern with Resident #49's c-collar was brought to the facility's attention. -The facility failed to include updating the care plan to include the c-collar as part of facility follow up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casey's Pond Senior Living	2855 Owl Hoot Trl Steamboat Springs, CO 80487

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications and biologicals were stored in accordance with accepted professional standards for one of one medication refrigerators. Specifically, the facility failed to ensure controlled medications were in a locked storage container that was permanently affixed to the refrigerator. Findings include: I. Observations On 3/18/24 at 11:09 a.m., the medication refrigerator was observed with the registered nurse liaison (RNL). A vial of liquid Ativan (a benzodiazepine and a schedule IV controlled substance used to treat anxiety) was in a storage box. -The storage box was not permanently affixed to the inside of the refrigerator. II. Staff interviews The RNL was interviewed on 3/18/24 at 11:11 a.m. The RNL said she was new to the facility and still in training. She said she was not aware that controlled medications were required to be in a permanently affixed locked compartment in the refrigerator. She said she understood anyone with access to the refrigerator could just take the controlled medication boxes out of the refrigerator. The director of nursing (DON) was interviewed on 3/20/24 at 1:10 p.m. The DON said she was not aware that refrigerated controlled medications were required to be in a permanently affixed locked compartment, however, the maintenance department had attached the storage box to the inside of the refrigerator (during the survey).