STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinidad Rehabilitation and Healthcare Center	409 Benedicta Ave Trinidad, CO 81082

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 residents received treatment and care in accordance with professional standards for one (#1) of five residents reviewed for failure to transcribe and initiate the physician's orders out of nine sample residents.Specifically, the facility failed to ensure Resident #'1 post hospitalization orders for hematoma care were entered into the electronic medical record (EMR) and followed. Findings include:I. Facility policy and procedureThe Hematoma Aftercare procedure, undated, was received from the nursing home administrator (NHA) on [DATE] at 2:36 p.m. It read in pertinent part, Aftercare for a hematoma involves monitoring vital signs and neurological status, applying cold compresses, and promoting elevation of the affected area. Nurses should also assess for signs of complications like worsening pain or infection, carefully manage any anticoagulant medications as ordered by the physician. and educate the patient and family when to seek further medical attention. Monitoring and assessing:-Vital signs;-Neurological status;-Signs of deterioration ; and,-Skin integrity. Treatment and care:-Rest;-Elevation;-Cold compresses; and,-Medication management. Patient and family education-Activity restrictions;-Signs of complications; and,-Wound care. Work closely with the physician to manage the hematoma and any complications; and consult with a certified wound nurse if the hematoma is complex or failing to heal properly.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and expired in the facility on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included stage four kidney disease, diabetes mellitus, unsteadiness of feet, difficulty walking, abnormal gait, depression, atrial fibrillation, dementia, macular degeneration and a history of falling.The [DATE] 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. Resident #1 required substantial to maximum assistance from staff for sitting to lying in bed and partial to moderate assistance from staff for bed mobility, for sitting to standing, and transfers. Resident #1 was non-ambulatory and used a manual wheelchair for mobility. The MDS assessment documented that Resident #1 was prescribed anticoagulant, Eliquis 2.5 milligrams (mg) twice daily.B. Record review-Review of Resident #1's comprehensive plan of care did not reveal documentation regarding the resident's abrasion and hematoma treatments or monitoring.The [DATE] fall occurrence progress note revealed Resident #1 fell from his wheelchair during a transfer. The progress note read that Resident #1 fell onto his left knee and then fell and hit his head. The nurse completed an assessment and documented vital signs: blood pressure 94/52 millimeters of mercury (mmHg), temperature 97.4 degrees Fahrenheit, heart rate 49 beats per minute, and respirations 16 per minute. The progress note revealed Resident #1 had a large knot on his left forehead with a small open area oozing blood. Resident #1 was transferred to the emergency department for evaluation. The [DATE] nurse progress note revealed the facility nurse spoke with the hospital nurse, who reported Resident #1 had a head computerized topography (CT) scan and determined the findings were (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	negative (no active bleeding in or around the brain) and Resident #10 was doing well and would return to the facility.The [DATE] hospital discharge instructions revealed Resident #1 was evaluated for a same-level fall and had an abrasion and hematoma on his head. Resident #1 was diagnosed with an abrasion and a hematoma. The special notes of the discharge instructions read in pertinent part, the CT scan did not show any sign of internal bleeding or fracture. Please follow up with your primary care provider in two to three days. Return to the emergency department with symptoms worsening. Occasionally, hematomas can calcify. Recommend placing ice on the immediate face to help with inflammation. In two to three days, switch over to heat to help the body reabsorb the blood. The [DATE] hospital discharge instructions included wound care instructions and read in pertinent part: Abrasion care:-Your abrasion will be cleaned with water and mild soap;-An antibiotic ointment may be applied to your abrasion to prevent infection; and,-A bandage may be placed on your abrasion to keep it clean;-Clean your wound one to two times a day with soap and water;-Keep your dressing clean and dry;-Check your wound every day for signs of infection;-If directed, put ice on the injured area; and-If possible, raise the injured area above the level of your heart while you are sitting or lying down. Hematoma care:-If directed, to put ice on the injured area and leave the ice on for 20 minutes, two to three times a day for the first couple of days;-If directed, apply heat to the affected area as often as told by your provider with a heat source recommended. Leave the heat on for 20 to 30 minutes; and-Raise the injured area above the level of your heart while you are sitting or lying down.-However, Record review revealed the facility failed to review and reconcile medications when Resident #1 returned to the facility. The medication reconciliation form, dated [DATE], was blank and unsigned.-Further review of Resident #1's EMR revealed the facility nursing staff did not transcribe or enter the new treatment orders into Resident #1's EMR. As a result, nursing care was not provided for the abrasion and hematoma. III. Staff interviewsThe DON was interviewed on [DATE] at 2:00 p.m. The DON said when residents returned to the facility from the emergency department, the admitting or charge nurse was responsible for reviewing the documents for new physician's orders or changes to existing orders. The DON said the [DATE] emergency department discharge instructions were not reviewed, noted, or entered into Resident #1's EMR. The DON said when physician's orders were not entered into the EMR, nursing staff would be unaware of specific resident needs because nurses refer to physician orders for required medications and treatments. The DON said staff monitored Resident #10 after he returned from the hospital on [DATE] and said she was unable to find documentation that nursing care was provided for the abrasion and hematoma. The DON said on [DATE], Resident #1 had a change in condition and was transferred to the emergency department. The DON said while Resident #1 was at the hospital, his family, friends, and power of attorney opted to place Resident #1 on hospice care, and Resident #10 expired on [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards for one (#1) of five residents reviewed for maintaining resident health records out of nine sample residents.Specifically, the facility failed to ensure physicians' progress notes for Resident #1 were available in the electronic medical record (EMR). Findings include:I. Resident #3A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included history of stroke, left-sided paralysis, atrial fibrillation, epilepsy, diabetes mellitus, high blood pressure, depression, chronic pain and mild intellectual disabilities.The 8/28/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. Resident #1 was dependent on staff for her activities of daily living. B. Record reviewThe record review revealed there were no physicians' progress notes in Resident #3's EMR for the period of 1/1/25 to 10/7/25. II. Staff interviewsThe director of nursing (DON) was interviewed on 10/7/25 at 2:00 p.m. The DON said the Resident #3's physician documented the physician evaluations and progress notes in a health record system that the facility did not maintain. The DON said if physician records were required by nursing or other health care providers, the physician records were not immediately available. The DON said the current process to obtain physician progress notes was that she contacted the physicians' office staff with the records request, and the records were forwarded the same day or the next day by secure email messaging. The DON said the facility would review the health record requirements with the physician and develop a process to ensure physicians' evaluations and progress notes were available in the facility's EMR system.