STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065418	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Ridge Health and Rehab LLC	16006 W US Highway 24 Woodland Park, CO 80863

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 - Some	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 three (#1, #2 and #3) of three residents reviewed for abuse out of four sample residents were free from abuse. Specifically, the facility failed to:-Protect Resident #1 and Resident #2 from physical abuse by each other on 8/9/25 and 8/16/25; and,-Protect Resident #3 from physical abuse by Resident #1 on 8/16/25. Findings include:I. Physical abuse between Resident #2 and Resident #1 on 8/9/25 A. Facility investigationThe 8/9/25 facility investigation documented Resident #1 was wandering the halls of the unit. Resident #1 stopped outside of Residents #2`s room. Resident #2 came to the doorway and began to yell at Resident #1 to get out of his room. The investigation documented Resident #2 continued to yell and Resident #1 took a fighting stance with his fists raised. Resident #2 stepped out of his doorway and hit Resident #1 in the chest. Resident #1 then hit Resident #2 in the chest. Resident #1 then grabbed the beard of Resident #2 and pulled him across the hallway. Both residents had a hold of each other. The residents were separated by staff and placed on 15-minutes checks for the next 72 hoursThe investigation documented the incident was witnessed by registered nurse (RN) #1.Both residents were assessed. Resident #2 had a sore chin. No other injuries were noted to either resident. The investigation documented both residents were interviewed and did not recall the incident. Resident #2 reported he became upset when other residents entered his room. The investigation documented the social services director (SSD) conducted interviews with other residents on the unit and no concerns were noted. Staff were interviewed and educated to encourage other residents not to enter Resident #2's room. A stop sign was placed on Resident #2's door. Additionally, Resident #2 was moved off the secured unit as a trial. The investigation concluded abuse occurred. B. Resident #2 (assailant and victim) 1. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included dementia in other diseases classified elsewhere severe with agitation, dementia in other diseases classified elsewhere severe with psychotic disturbance, vascular dementia unspecified severity with other behavioral disturbance and major depressive disorder. The 8/6/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The assessment indicated the resident did not exhibit behavior disturbances during the assessment review look-back period. 3. Record reviewResident #2's behavior care plan, initiated 5/27/25, revealed Resident #2 had a behavior problem of being verbally abusive to staff and becoming agitated and angry. The care plan documented Resident #2`s triggers included he did not tolerate if others wandered into his room and lack of sleep. Pertinent interventions included placing a stop sign across his door and staff was to discourage other residents from wandering into the resident's room.The nursing progress note, dated 8/9/25, revealed a physical altercation occurred between Resident #1 and Resident #2. Resident #1 wandered in front of Resident #2`s room. The note documented the two residents exchanged chest punches then (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	continued into the hallway while grabbing each other without falling. The residents were separated by staff without force. No injuries were noted. C. Resident #1 (assailant and victim) 1. Resident statusResident #1, age [AGE], was admitted on [DATE] and discharged to the hospital on 8/16/25. According to the September 2025 CPO, diagnoses included unspecified dementia, unspecified severity with other behavioral disturbance and dementia in other diseases classified elsewhere severe with anxiety. The 8/16/25 MDS assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The assessment indicated he exhibited physical and verbal behaviors toward others and wandering behavior during the assessment review look-back period. 2. Record reviewResident #1's behavior care plan, initiated 8/14/25, revealed the resident had the potential to be physically aggressive. Pertinent interventions included monitoring and reporting symptoms of danger toward himself or others and to redirect the resident as needed. Review of Resident #1's electronic medical record (EMR) did not reveal documentation regarding the resident-to-resident altercation with Resident #2 on 8/9/25. II. Physical abuse between Resident #2 and Resident #1 on 8/16/25A. Facility investigationThe 8/16/25 facility investigation documented Resident #1 was in Resident #2's room. Resident #2 yelled at Resident #1 to get out of this room. The investigation documented the yelling continued for a couple of minutes. Resident #2 pushed Resident #1 out of his room. Resident #1 then pushed Resident #2 to the ground. Resident #1 then walked away. The investigation documented the incident was not witnessed. The nurse on duty notified the assistant director of nursing (ADON). The ADON reviewed video surveillance. The investigation documented the residents were separated and assessed. Resident #2 sustained an abrasion to his right knee, right elbow and left elbow.The SSD interviewed Resident #2 who said he wanted other residents to stay out of his room and leave him alone. The SSD interviewed other residents on the unit and no concerns were voiced. The investigation documented it was recommended after the last incident between Resident #1 and Resident #2 (on 8/9/25), that Resident #2 was going to be moved off the secured unit. However, a room had not become available yet. The investigation documented a room was opened, but needed to be cleaned prior to the resident moving. It documented the stop sign was in place, but was ineffective as Resident #1 went under the sign.The investigation concluded abuse occurred. B. Resident #2 (assailant and victim) 1. Record reviewThe nursing progress note, dated 8/17/25, revealed Resident #2 was angry about the altercation and that he did not feel safe on the unit. The note documented the facility placed Resident #2`s room under increased hallway checks. Resident #2 was educated to yell for help if another resident entered his room. The note documented the director of nursing (DON) and the ADON were consulted to see if a trial of a do not enter sign on Resident #2's door might be helpful as long as Resident #2 understood that he could enter his room at any time and the sign was meant for other residents.C. Resident #1 (assailant and victim) 1. Record reviewThe 8/17/25 nursing progress note documented Resident #1 had an altercation the day before (8/16/25) at 8:45 p.m. and 8:53 p.m. The altercation between Resident #1 and Resident #2 occurred on 8/16/25 at 8:45 p.m. The altercation between Resident #1 and Resident #3 occurred on 8/16/24 at 8:53 p.m. (see facility investigation below). The note documented that the previous interventions, such as the stop sign banner across the doors and calm redirection had failedIII. Physical abuse by Resident #3 towards Resident #1 on 8/16/25 A. Facility investigationThe facility investigation documented Resident #1 was in common area where could be seen by staff after the previous altercation with Resident #2. The staff took care of Resident #2 while Resident #1 started walking towards his own room. Resident #1 entered his neighbors room (Resident #3) instead of his own and shut the door. Staff heard yelling from the hallway and staff quickly responded. Staff attempted to enter the room but the residents (Resident #1 and Resident #3) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were up against the door inside the room. The nurse told the residents to let each other go and seconds later the staff were able to open the door. Upon entering the room the staff witnessed Resident #1 with his hands on Resident #3's neck and Resident #3 had a hold of Resident #1`s shirt. The certified nurse aide (CNA) was able to separate residents.The investigation documented the incident was witnessed by RN #2 and CNA #3.Resident #1 was placed with a one-to-one caregiver until emergency medical services (EMS) arrived. Resident #3 was assessed and had red marks to his left forearm. The resident was interviewed by the SSD and said he wanted other residents to stay out of his room. Resident #1 was transported to the emergency room for a psychological evaluation and did not return to the facility. The investigation concluded abuse occurred. B. Resident #3 (victim) 1. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included unspecified moderate dementia with agitation, unspecified severity of dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, recurrent depressive disorder and mild neurocognitive disorder due to known physiological condition with behavioral disturbance. The 5/29/25 MDS assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. 2. Record reviewReview of Resident #3's EMR did not reveal documentation regarding the physical abuse incident with Resident #1 on 8/16/25.C. Resident #1 (assailant)1. Record reviewReview of Resident #1's EMR did not reveal documentation regarding the physical abuse incident with Resident #3 on 8/16/25. V. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 9/8/25 at 10:10 a.m. LPN #1 said she saw a positive impact when Resident #2 moved to the second floor. She said the second floor was a more relaxed environment. She said the residents on the second floor were more cognitively intact and understood that they were not to enter other residents' rooms. She said Resident #2 kept his door closed at all times, but he ate his meals in the dining room with other residents. She said Resident #2 started interacting with others and did not exhibit any behavioral problems. She said there were no incidents when other residents attempted to enter Resident #2's room since he had moved to the second floor. She said there were no residents with wandering behaviors on the second floor. She said she had never seen or heard about Resident #2 acting aggressively to staff or other residents. CNA #1 was interviewed on 9/8/25 at 10:30 a.m. CNA #1 said she had been working on the secured unit since June 2025. She said Resident #2 stayed in his room most of the time and kept his door closed. She said it was well known that Resident #2 was protective over his room. She said she did not work on the unit on the day of the incidents between Resident #1 and Resident #2. CNA #1 said she remembered Resident #1 often wandered. She said Resident #2 had a stop sign banner across his door but he kept it above head level. CNA #1 said Resident #1 usually disregarded the stop banners across doors and he ducked under them. She said the staff needed to keep an extra set of eyes on him during their shifts and redirect him often. She said they had two CNAs and one RN on each shift for both hallways. She said the CNAs and the RN would divide the unit up between themselves to monitor residents. She said the nurses' station had cameras and the nurse was able to see all of the residents' doors at the same time. CNA #2 was interviewed on 9/8/25 at 11:00 a.m. CNA #2 said a nurse informed her that Resident #1 often wandered.