STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065420	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Peak Senior Life and Rehabilitation	195 Freestone Rd Eagle, CO 81631

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents was provided the care and services necessary to ensure a safe discharge from the facility to the community out of three sample residents.Specifically, the facility failed to:-Allow Resident #1 to return to the facility after an unplanned discharge to the hospital;-Provide documentation from Resident #1's physician, including the specific resident needs the facility could not meet, the facility's efforts to meet those needs and the specific services the receiving facility would provide to meet the needs of the resident which could not be met at the current facility; and,-Reassess Resident #1 for readmission after he was stabilized at the hospital and ready to return to the facility. Findings include:I. Facility policy and procedureThe Discharge Notice Requirements policy and procedure, revised 4/28/25, was provided by the director of nursing (DON) on 8/20/25 at 1:40 p.m. It read in pertinent part, The facility must document in the resident's record the basis for the discharge. If the basis of the discharge is the facility's inability to meet the resident's needs, the resident's record must show that the facility based this determination on the resident's assessment and status at the time of the proposed return to the facility, not on the resident's needs at the time when he/she was transferred to an acute care facility; and how the resident's needs are distinctly different from other residents' needs. More specifically, the facility can not discharge a resident based on the claim that the facility cannot meet the resident's needs if there are other residents with similar needs whose needs are being met by the facility. If the basis of the discharge is because the facility can not meet the resident's needs, the resident's behavior creates a danger to individuals in the facility, the resident's physician must document the basis for the discharge. The physicians' documentation must show the specific needs the facility can not meet; the facility's efforts to meet the resident's needs; and how and why the discharge location is better equipped to meet the resident's needs. The resident's record should show the receiving location's willingness and capacity to care for the resident.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 7/23/25. According to the July 2025 computerized physician order (CPO), diagnoses included dementia with mood disturbances, Parkinson's disease, Alzheimer's disease and adjustment disorder with anxiety.The 6/30/25 minimum data set (MDS) assessment revealed Resident #1 had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment indicated Resident #1 had behavioral symptoms that were directed toward others. B. Record reviewAn elopement assessment, dated 3/27/25, revealed the resident had an elopement risk of six, which indicated the resident was at risk for elopement.A progress note, dated 7/20/25, revealed that on 7/19/25 at approximately 1:18 p.m. the medical director (MD) declined readmission of Resident #1 from the emergency department. The involuntary discharge was necessary to protect the welfare of other residents. The note documented Resident #1 had displayed increasingly (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unpredictable behaviors over the past few weeks. The behaviors included attempting to have sex with another dementia resident who was unable to consent, eloping from the facility and physically striking a certified nurse aide (CNA). Resident #1 was previously evaluated and interventions such as a one-to-one sitter and starting Depakote (anti-seizure medication used for behaviors) were implemented. The MD documented in her medical opinion, Resident #1 required inpatient geriatric psychiatric treatment until his behaviors stabilized. The MD documented it was unsafe to have Resident #1 in proximity of the other vulnerable residents at the facility and Resident #1 was involuntarily discharged .-There was no documentation to indicate the facility reassessed the resident after he was stabilized at the hospital.-The facility failed to document the needs the receiving facility was going to provide for the resident that the current facility was unable to provide.-Review of Resident #1's electronic medical record (EMR) did not reveal the facility completed a discharge summary for Resident #1.III. Resident #1's representative interviewThe resident's representative was interviewed on 8/20/25 at 2:10 p.m. The representative said the resident was admitted to the hospital because the facility refused to readmit the resident once he was medically cleared. The representative said the facility did not help the resident find an alternate facility. The representative felt the resident was abandoned by the facility. The representative said the resident had no behaviors at the hospital.IV. InterviewsThe case manager from the hospital was interviewed on 8/20/25 at 2:00 p.m. The case manager said the facility left Resident #1 in the hospital's care and did not help the resident find a different facility to be discharged to. She said no one from the facility reassessed Resident #1 when he was medically cleared and there was no reason for the hospital to keep the resident. She said she felt the resident was dumped at the hospital. She said Resident #1 displayed no behaviors of any type while he was in the hospital, so she was confused as to why the facility refused to readmit the resident.The DON was interviewed on 8/20/25 at 2:30 p.m. The DON said when Resident #1 was first admitted to the facility, the family said he was able to go on walks outside the facility by himself. She said during the resident's admission, she found out the resident fell outside by himself a day later when he complained of shoulder pain and explained he fell the day before. The DON said the resident was located a mile away from the facility and was hitchhiking to another state to see his ex-wife. She said there was a second incident where the resident was found a half mile away from the facility and he told the staff he wanted to go to another state. She said the resident was found naked in a female resident's room and she was unable to consent. The DON said the resident also struck a CNA in the face. She said no one from the facility reassessed the resident and she was not aware someone needed to reassess the resident when he was medically cleared prior to discharging him. The DON said the receiving facility for Resident #1 was the hospital. She said she was not aware that the hospital was not an acceptable discharge location.