STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Center	4800 Tabor St Wheat Ridge, CO 80033

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 - Some	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 remove medications and biologicals that were stored and labeled properly according to professional standards in three of five medication carts and two of four medication storage rooms.Specifically, the facility failed to:-Ensure expired medications were discarded; and,-Ensure a drug buster was not stored next to medications. Findings include:I. Professional referencesThe United States Food and Drug Administration (USFDA) Don't Be Tempted to Use Expired Medicines (revised 10/31/24), was retrieved on 5/1/26 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth, and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed, there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.I. Facility policy and procedureThe Storage of Medication policy, undated, was received from the nursing home administrator on 5/1/26 at 3:41 p.m. It revealed in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control and security. All medication rooms are routinely inspected by the consultant pharmacist or discontinued, outdated, defective or deteriorating medications with worn illegible or mislabels.II. ObservationsOn 4/28/26 at 3:45 p.m. the medication cart #2 on the 100 unit was observed with licensed practical nurse (LPN) #1. The drawer on the medication cart for Resident #54 contained the following:-Mirtazapine (medication used to treat depression) oral tablet 7.5 milligram (mg). The order was discontinued on 4/17/26.-Levothyroxine (medication used to treat hypothyroidism) oral tablet 25 micrograms (mcg). The order was discontinued on 1/15/26.The drawer on the medication cart for Resident #24 contained the following:-Xarelto (medication used as a blood thinner) oral tablet 15 mg. The order was discontinued on 2/20/25.The drawer on the medication cart for Resident #64 contained the following:-Albuterol Ipratropium-Albuterol Inhalation solution 0.5-2.5 mg/3 milliliter (ml) (Ipratropium-Albuterol) The medication did not have an expiration date.On 4/28/26 at 4:35 p.m. the medication cart #1 on the 200 unit was observed with LPN #2. The drawer on the medication cart for Resident #2 contained the following:-Benzonatate (medication used as a cough suppressant) oral tablet 100 mg. The order was discontinued on 4/9/26.The drawer on the medication cart for Resident #66 contained the following:-Ondansetron (medication used to prevent nausea and vomiting) oral tablet 4 mg) The medication expired on 3/31/26.On 4/29/26 at 10:12 a.m. the medication storage room for the secured unit was observed with registered nurse (RN) #2. The cabinets in the medication storage room for the secured unit contained the following:-Twenty-two pre-filled normal saline 0.9% flush syringes 10 ml that expired on 5/13/18.-Three pre-filled normal saline 0.9% flush syringes 10 ml that expired on 7/31/21.-Three vials of ceftriaxone (medication used to treat infections) for injection 1 gram (gm) that expired 1/30/23. The emergency medication, non-narcotic, supply box, for the (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	secured unit expired in March 2026. The supply box contained the following medications:-Humulin R (Short acting regular) insulin-Humulin N (intermediate acting) insulin-Humulin 70/30 (premixed) insulin -Humalog (lisprio) insulin-Cathflo Activase (alteplase)-Lantus (glargine) InsulinOn 4/29/26 at 11:00 a.m. the medication storage room on 200 unit was observed with LPN #3. The medication refrigerator for the 200 unit for Resident #11 contained the following:-Two boxes that contained five pens each of Basaglar KwikPen (insulin glargine) 100 units/ml pen that expired on 9/23/25.-One box that contained five pens of Basaglar KwikPen (insulin glargine) 100 units/ml pen that expired on 10/13/25.The medication refrigerator for the 200 unit for Resident #16 contained the following:-Lumigan 0.01 % (eye drop) that expired on 11/30/25. On 4/29/26 at 11:30 a.m. the medication cart #1 on the rehabilitation unit was observed with RN #1. The following items were found.-A 16-ounce bottle of Drug Buster (activated charcoal-based disposal system designed to quickly deactivate and destroy unwanted pills, capsules, liquids, creams) was in the same drawer as liquid medications. III. Staff interviewsLPN #1 was interviewed on 4/28/26 at 3:30 p.m. LPN #1 said all medications should have been discarded immediately upon reaching the medication expiration date. LPN #1 said any nurse who was assigned to this medication card should be checking the expiration dates on the medications. LPN #2 was interviewed on 4/28/26 at 4:40 p.m. LPN #2 said it was the responsibility of all of the nurses to check the expiration dates on medications during their shift and before medication administration. RN #2 was interviewed on 4/29/26 at 10:20 a.m. RN #2 said she did not work on the secured unit very often. RN #2 said she was unsure as to who was responsible for monitoring expired medications in the medication room.LPN #3 was interviewed on 4/29/26 at 11:10 a.m. LPN #3 said it was the nurses responsibility to ensure all expired medications were removed from the medication storage refrigerator. The director of nursing (DON) was interviewed on 4/30/26 at 1:30 p.m. The DON said the nurses were responsible for checking the expiration dates before administering medication to the residents. The DON said medications should be discarded immediately if it was discontinued, or the nurses should verify with the doctor that the medication was no longer needed. The DON said the night supervisor should be checking medication storage rooms once a week. She said she would advised the night supervisors to check the cabinets and drawers in the medication storage rooms for expired medications. The DON said the night supervisors did not understand the explanation of her instructions. The DON said she would initiate education and training with the supervisors today regarding when and how to check the medication rooms The DON said she also started education and training RN's and LPN's to check the medication carts for expired and mislabeled medications. The DON said it was important to keep the medication storage rooms and medications carts free from expired and mislabeled meds to prevent resident harm and to maintain the efficacy of the medication.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, record review and interviews, the facility failed to ensure 16 residents on a mechanical soft diet received food and fluids prepared in a form designed to meet his or her needs per speech therapy recommendation, physician orders and the residents care plan.Specifically, the facility failed to ensure residents who were prescribed a mechanical soft diet had food prepared according to their diet orders of mechanical soft as indicated on their meal tray cards. Findings include:I. Facility policy and procedureThe Mechanical Soft Food Preparation policy, undated, was provided by the registered dietitian (RD) on 4/28/26 at 5:52 p.m. The policy read in pertinent part, The facility will prepare mechanical soft foods in a manner that sustains the nutritional value and taste. The foods will be ground to assure the desired consistency. Mechanical soft foods will be made from regular menu items to assure similar taste and nutritional quality. Recipes for regular menu items will be followed during production. Mechanical soft foods must be ground to the proper consistency per resident's needs/requests.II. Meal service observation and staff interviewsDuring a continuous observation of the dinner meal service on 4/28/26, beginning at 4:11 p.m. and ending at 5:42 p.m., the following was observed:The posted menu documented the dinner meal was a tuna melt grilled sandwich, sweet potato rounds, ambrosia salad (creamy fruit salad) and banana pudding. The mechanically soft altered menu items were a ground grilled tuna melt sandwich and sweet potato rounds.Cook (CK) #1 was interviewed on 4/28/26 at 4:13 p.m. (during meal service). CK #1 said the sweet potatoes in the pan in hot holding were frozen sweet potato rounds and were fried.At 4:26 p.m. CK #1 assembled four meal plates for residents. The plates were placed on a tray for residents whose meal tickets documented they were prescribed mechanical soft diets. The four meal plates included a whole grilled tuna melt sandwich cut in half (triangles) and the fried sweet potato rounds.-The menu extensions provided by the facility documented the mechanical soft modification for the tuna melt sandwich was a ground grilled tuna melt sandwich (see menu extensions below).CK #2 was interviewed on 4/28/26 at 4:28 p.m. (during meal service) CK #2 said he put the raw onions in the food processor before putting them into the tuna salad, but he did not add celery because the facility did not have celery.-The facility was notified the item served was different from the item listed on the extensions. The tuna melt sandwich was served grilled and cut in half instead of ground grilled tuna melt sandwich.CK #2 was interviewed on 4/28/26 at 4:49 p.m. (during meal service). CK #2 said the recipe book for dinner (on 4/28/26) was somewhere, but he made the tuna salad so many times he did not use the recipe.At 4:52 p.m. CK #1 assembled a meal plate of a whole grilled tuna melt sandwich cut in half and sweet potato rounds for a resident whose meal ticket documented a mechanical soft diet order. At 4:53 p.m. CK #1 assembled two meal plates for residents whose meal tickets documented mechanical soft diet orders. The two meal plates included a whole grilled tuna melt sandwich cut in half and fried sweet potato rounds.At 4:54 p.m. the dietary manager (DM) pulled the week five recipe binder. The tuna salad recipe was not present in the binder for the dinner meal on 4/28/26.At 4:55 p.m. CK #1 assembled a meal plate of a whole grilled tuna melt sandwich cut in half and sweet potato rounds for a resident whose meal ticket documented a mechanical soft diet order. At 4:58 p.m. CK #1 assembled a meal plate of a whole grilled tuna melt sandwich cut in half and sweet potato rounds for a resident whose meal ticket documented a mechanical soft diet order. At 5:24 p.m. CK #1 assembled a plate of diced chicken tender, sweet potato rounds and gravy for a resident whose meal ticket documented a mechanical soft diet order. The chicken was diced in one quarter to one half inch pieces.-However, the facility's mechanical soft diet description failed to indicate the appropriate size mechanical soft meat should be cut into (see description below).At 5:33 p.m. CK #1 assembled three meal plates for residents whose meal ticket documented mechanical soft diet orders. The three meal plates included a whole grilled tuna melt sandwich cut in half and mashed sweet potato.CK #1 was interviewed on 4/28/26 at 5:33 p.m. CK #1 said the facility ran out of sweet (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potato rounds during meal service. He said the facility substituted canned sweet potato for a mechanical soft diet as a backup.-The facility failed to serve a ground grilled tuna melt sandwich item as part of the mechanically altered diet. The facility failed to chop foods to the desired consistency (see record review below).On 4/28/26 at 6:04 p.m. a test tray for a mechanical soft diet, which was served at the same time as resident room trays, was evaluated by four surveyors during the dinner meal service. The test tray was assembled in the kitchen at 5:41 p.m., arrived on the unit at 6:04 p.m. and was tested for texture.The test tray meal consisted of a whole grilled tuna melt sandwich cut in half and canned sweet potato. The edges of the tuna melt sandwich were hard and crumbly.III. Record reviewThe mechanical soft diet description from the facility's diet manual was provided by the RD on 4/28/26 at 5:52 p.m. The diet manual documented the following modifications for the mechanically altered food items served during dinner meal service on 4/28/26:Remove desired number of servings to chop for the mechanical soft diets.Use a knife/fork or processor to chop foods to the desired consistency.-The mechanical soft diet description failed to include the residents could have grilled bread or fried items.The mechanical soft menu extensions were provided by the nursing home administrator (NHA) on 4/27/26 at 9:10 a.m. The extensions documented the following modifications for food items served during the dinner meal service on 4/28/26:Three ounces (oz) ground grilled tuna melt sandwich;Four oz sweet potato rounds;Four oz cup of fruit (soft); and,Four oz banana pudding.The recipe for grilled tuna melt was provided on 4/27/28 at approximately 11:00 a.m The grilled tuna melt recipe documented for tuna salad include recipe card #4141. After assembling the sandwiches, heat a large skillet/flat top grill to medium heat, place the sandwich margarine side down, brush the other side with melted margarine. Let bread get crisp and carefully flip the sandwiches. [NAME] to 145 degrees Fahrenheit (F) and serve promptly. Mechanical soft steps: remove the desired number of services to chop for the mechanical soft diets. Use a knife, fork or process to chop foods to the desired consistency.-However, the recipe did not specify what the desired consistency was.IV. Additional staff interviewsThe DM was interviewed on 4/28/26 at 4:43 p.m.(during meal service) The DM said he was trained by the assisted living food service director to make and serve the grilled tuna melt sandwiches and serve the potato rounds (see observations above). The DM said the facility did not use the international dysphagia diet standardisation initiative (IDDSI) diets. The DM pointed to a paper on the table titled IDDSI Menu EC7 (easy to chew level seven) and said that was the facility's mechanical soft diet.The DM and the RD were interviewed on 4/29/26 at 10:45 a.m. The DM said when the facility had mechanical soft sandwiches the staff ground the meat and not the bread. The DM said because the tuna was ground already the staff did not grind the bread. The DM said the staff assembled the tuna melt sandwiches and then toasted the sandwich.-However, the menu extensions documented ground grilled tuna melt sandwiches (see record review above).The RD said some residents had the modified texture diet for dentition (condition of teeth) because they were missing teeth or they had chewing issues. The director of rehabilitation was interviewed on 4/29/26 at 3:45 p.m. The director of rehabilitation said speech pathology staff conducted the resident swallowing assessments and recommended the diet order based on the assessment. She said the speech therapist was notified if a resident refused a modified texture diet and it was the discretion of the speech therapist to do anOTHER evaluation if needed. The director of rehabilitation said they documented all resident refusals of a diet. She said if a resident refused a texture of a food item on their diet the facility could offer a different option of the same texture. The director of rehabilitation said the risk of not following a prescribed diet was aspiration (food, liquid, saliva, or stomach contents enter the airway and lungs instead of the esophagus, causing coughing, wheezing, or silent choking for the resident).CK #2 and the DM were interviewed together on 4/29/26 at 4:30 p.m. CK #2 said he had a full training on food texture when he was hired a year ago. CK #2 said he had some texture coaching with the DM. CK #2 said he referred to the facility's menu program for any mechanical soft modified texture. He said for any alternate menu, he modified the texture based on what the DM taught him.The DM said he taught the cooks how to (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure two (#71 and #86) of four residents out of 51 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to effectively resolve Resident #71 and Resident #86's written grievances (complaints) about call lights previously. Findings include:I. Facility policy and procedureThe Grievances/Complaints Filing policy, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 3:41p.m. The policy read in pertinent part, The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and or representative.The Answering the Call Light policy, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 3:41p.m. The policy read in pertinent part, The facility uses a silent call light system that requires residents to wear a pendant around their neck or on their wrist. The call light system is monitored via electronic devices that alerts staff. General guidelines included: Report all defective call lights to the Nurse Supervisor promptly. Answer the resident's call as soon as possible. Be courteous in answering the resident's call. Steps in the procedure included: Turn off the call light by claiming and clearing on the tablet. Identify yourself and listen to the residents request for assistance. Do what the resident asks of you. If you have promised the resident you will return with an item or information, do so promptly. The following information should be documented through the grievance process or incident report, or medical record as it pertains: If the resident refused the treatment/solution, and the reasons why. If an issue is identified that prevents a resident from using their all light or the system is not able to clear, the nursing supervisor will implement and document 15 minute checks for the resident affected. Documented checks will be turned in to the director of nursing (DON) or designee.II. Resident #71A. Resident statusResident #71, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough causing high blood sugar), necrotizing fasciitis (bacterial infection that destroys tissue under the skin and spreads rapidly), and depression. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 13 out of 15.B. Resident interviewResident #71 was interviewed on [DATE] at 3:11 p.m. Resident #71 said he filed a grievance about long call light wait times on [DATE]. Resident #71 said he continued to have issues with long call light wait times. C. Record reviewA grievance form, dated [DATE], was provided by the DON on [DATE] at 6:05 p.m. Resident #71 wrote that the date of incident/concern was over the past few weeks. The grievance form description of concern revealed call lights had gone unanswered for long periods of time. The grievance description revealed Resident #71 had gone out of his room to get assistance from certified nursing aides (CNA) who were on their phones. The grievance description revealed that the CNAs who were available to assist Resident #71 pushed assisting the resident onto a different CNA, instead of helping Resident #71 themselves. The grievance description revealed that the CNAs who were available to assist Resident #71 did not offer to assist him. The grievance description revealed Resident #71 did not feel his CNAs were being professional and he did not feel that he was being treated with dignity and respect. A follow up section was included in the grievance form documentation. The follow up documentation revealed the following items were reviewed and discussed with staff and Resident #71. The form documented the staff were instructed to answer all call lights timely even if the resident calling for help was not assigned to them. The call light iPads were assessed and it was confirmed that they were working properly. -However, Resident #71 said there continued to be long call light wait times (see resident interview above).On [DATE] at 6:14 p.m. call light logs for Resident #71 were provided by the DON. According to the logs, the call light response times for [DATE] were as follows:Review of Resident #71's call light response log from (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #86 wrote that a CNA finally came into her room and she advised the CNA of the situation, sitting in her soiled brief since before dinner. Resident #86 wrote that the CNA tried to clear the call light alert from the iPad system. Resident #86 wrote that after a while, she told the CNA that the CNA was busy on the iPad, instead of attending to her needs with a burning bottom and a solid brief. Resident #86 wrote that she told the CNA to tend to her soiled brief instead of trying to clear the call light notification on the iPad. Resident #86 wrote that the CNA told her that the CNA needed to clear the iPad. Resident #86 wrote that she raised her voice at the CNA and the CNA told her not to yell at her. Resident #86 wrote that she told the CNA that she would yell because the CNA was playing with her tablet instead of taking care of her. Resident #86 wrote that she finally told the CNA to leave and the CNA did. Resident #86 wrote that she began ringing the bell again and a tall male CNA came in and said someone would be there. Resident #86 wrote that the staff were busy putting people to bed. Resident #86 wrote that apparently that was more important than attending to someone rotting in their brief. Resident #86 wrote that the male CNA left. Resident #86 wrote that it was 7:44 p.m. and still no one had come to assist her. Resident #86 wrote that she was tired of being the last consideration for response. Resident #86 wrote that there was always someone else who would come first. Resident #86 wrote that that was why she was sleeping in her wheelchair the past few weeks. Resident #86 wrote that it had been more than a year since anyone had come to assist her in the morning. Resident #86 wrote that it was 7:49 p.m. and she was still sitting in her soiled brief, burning and getting very sore. Resident #86 wrote, someone please do something about the situation. Resident #86 wrote that she felt like the red-headed stepchild and her butt hurt.The actions taken section of the grievance form revealed the facility pulled call light logs and verified times with the times of the grievance. The grievance form revealed the facility planned to get the resident a new call pendant to ensure call lights would go through to the system.Call light logs for Resident #86 were provided by the DON on [DATE] at 6:14 p.m. The grievance form revealed the resident/complainant was satisfied on [DATE]. -However, the call light log for Resident #86 revealed the following call light wait times after the grievance form had been marked as the resident/complainant being satisfied on [DATE].Call light logs for Resident #86 were provided by the DON on [DATE] at 6:14 p.m. Review of Resident #86's call light response log from [DATE] to [DATE] revealed the following call light response times:The call light was activated and not answered for 20 to 39 minutes, 21 times.The call light was activated and not answered for 40 minutes to one hour, six times.The call light was activated and not answered for one hour and one minute to one hour and 30 minutes, four times.The call light was activated and not answered for over one hour and 30 minutes, 16 times.IV. Staff interviewsCNA #8 was interviewed on [DATE] at 3:50 p.m. CNA #8 said she knew a call light was going off because she looked at her iPad. CNA #8 said the iPad's battery frequently died and it did not jingle or alert her when a call light was going off. CNA #8 said at one point the facility used a television (TV) screen to show when call lights were going off. CNA #8 pointed to the TV screen above her computer which was blank and had no call light information on it. CNA #8 said that in order to turn the call light off, she had to take the iPad into the resident's room and get close to the resident to clear the iPad notification. CNA #8 said that unless you were actively looking at the iPad, you were going to miss a call light going off. CNA #8 said that if the resident pulled the cord, or call light, and no one came to help them, the resident could use the hand bell to get the attention of the staff. CNA #8 said that when residents used the bell, she did not know exactly where the ringing was coming from at first, so she had to go look around to help the resident.CNA #9 was interviewed on [DATE] at approximately 10:35 a.m. CNA #9 said he was an agency nurse and was new to the facility. CNA #9 said when a resident pushed their call light the light above the door went off and you could see their light.CNA #9 was interviewed on [DATE] at 4:08 p.m. CNA #9 said that he had been a CNA for 10 years and that he did not receive any training before starting at the facility because the facility assumed he knew what he was doing. CNA #9 said no one told him how the call light system worked at first and that he did not get a tour of the facility. CNA #9 said previously in the day he thought the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call lights were the lights above the doors of the residents'rooms. CNA #9 said he was mistaken about how the call lights worked and that someone showed him that the iPads actually showed when a resident called for assistance. CNA #9 said that in order to clear the call light, the staff had to bring the call light within close proximity of the resident's call light pendant. CNA #9 said you had to bring the iPad up to the resident wrist band to turn the call light off. The social services director (SSD) was interviewed on [DATE] at 5:17 p.m. The SSD said as soon as she received a grievance she made a copy for herself and gave the person responsible for responding to the grievance a copy as well. The SSD said she also spoke about the grievance in the next morning meeting. The SSD said that she ensured the responsible person received the grievance and followed up with that resident. The SSD said that once the grievance was marked as satisfied by the resident, she gave the grievance to the nursing home administrator (NHA) and also kept a copy for her records. The SSD said she would expect the grievance issue to be solved after the grievance process was completed. The SSD said that sometimes extra things came up and the facility had to do additional follow up later on. The DON was interviewed on [DATE] at 5:30 p.m. The DON said that the call light system worked through the residents pushing a button/pendant on their wrist or necklace or by the residents pulling the call light cord on the wall. The DON said that this would trigger the iPad to bring up the resident's name and room number which told staff the was calling. The DON said that staff had to then take the iPad into the resident's room and clear the call light by placing the iPad close to the pendant, if the resident used the pendant to call staff. The DON said that normal staff members showed the agency staff how the call light system worked. The DON said that the CNAs would tell the agency staff how to clear the iPad alerts and would go into the residents room to clear it for them.The DON said that some residents used hand bells because the facility was having trouble with skynet which was the service that was used to work the tablets. The DON said that sometimes, the call bell service would go down and the call light notifications would not pop up on the iPads, so the facility gave the residents hand bells to alert staff that they needed assistance. The DON said that the facility got a backup battery for their generator so that the system wouldn't go down. The DON said that when the Skynet system went down, call light notifications did not get to the iPads. The DON said that the call light log records only reflected call light wait times from when the iPad system was up and running, not when the system was down.The DON said that she read through the grievance forms and saw what the resident complained about. The DON said that she pulled the call light logs and interviewed staff to find out whether or not a call light was unable to be cleared, which would be documented in the grievance form. The DON said that when residents complained about call lights not being answered timely, the facility did call light audits. The DON said that Resident #86 would not let staff come into her room or would kick them out of her room and would ring her call bell because she was mad. The DON said that she expected call lights to be answered within five to 10 minutes. The DON said that staff could poke their head into the room and say they were tied up if that were the case, and that they would go help the resident when they could. The DON said that she expected the night shift staff to answer call lights within 15 minutes if they were tied up in a room. The DON said that the facility implemented tablets on the medication carts for the nurses so that if a CNA was tied up in a room, the nurses could help the CNAs and assist the resident if they were able to do so. The DON said that the nurses could not clear the call light notification themselves unless they were truly able to take care of what that resident needed. The DON said that it was important to answer call lights timely so that the resident felt safe and so that the residents were comforted knowing they could get someone's help remotely or in a time of distress.The DON said that it sounded like the facility needed to implement better onboarding with agency staff. The DON said that she would tell regular staff that when agency staff first got to the facility that they needed to tell agency staff where things were in the facility and how the call lights work. The DON said that the facility would need to make sure that all staff understood the education. The DON said that the facility would do call light audits and go room to room to ensure proper names and room numbers were coming up for each resident. The DON said that the facility would have to do a daily audit of call lights to assess call light wait times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection for two of four units.Specifically, the facility failed to:-Ensure staff donned (put on) personal protective equipment (PPE) when providing care for a resident who was on enhanced barrier precautions (EBP);-Ensure housekeeping staff followed proper cleaning procedures for disinfecting resident rooms and high frequency touched areas; and,-Ensure staff wore personal protective equipment (PPE) when providing care for Resident #56 who was on transmission based precautions (TBP), which included contact and droplet precautions. Findings include: I. EBP failures A. Facility policy and procedure The Enhanced Barrier Precautions policy was provided by the nursing home administrator (NHA) on 5/1/26 at 3:41 p.m. The policy read in pertinent part, It is the policy of American Baptist Homes of the Midwest to reduce transmission of multidrug-resistant organisms through an infection control intervention designed that employs targeted gown and glove use during high contact resident care activities known as Enhanced Barrier Precautions (EBPs). EBPs are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBPs are indicated for residents with wounds or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Indwelling medical device examples include urinary catheters. For residents whom EBP are indicated, EBPs are employed when performing the following high contact resident care activities: Dressing, bathing or showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, care of a catheter, or wound care. The Infection Prevention and Control Program policy, dated September 2025, was provided by the NHA on 5/1/26 at 3:41 p.m. The policy read in pertinent part, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted by national standards and guidelines. All staff are responsible for following all policies and procedures related to the program. The facility will use standard approaches, as defined by the CDC for transmission based precautions, airborne, contact, and droplet precautions. The category of transmission based precautions will determine the type of personal protective equipment (PPE) to be used. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. High touch objects and environmental surfaces (bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) should be cleaned and disinfected with an EPA-registered disinfectant for healthcare use at least daily and when visibly soiled. B. Observations On 4/28/26 at 10:38 a.m. certified nursing aide (CNA) #4 and CNA #5 went into Resident #52's room. A bin with PPE was present inside the room. There were signs on top of the bin which read Enhanced Barrier Precautions. CNA #5 and CNA #4 provided catheter care to Resident #52. They also cleaned his face and placed his belongings within reach. Then both CNAs left Resident #52's room. -CNA #4 and CNA #5 failed to put on gowns prior to providing care to Resident #52 who was on EBP. C. Staff interviews CNA #5 was interviewed on 4/29/26 at 1:01 p.m. CNA #5 said management placed bins with PPE outside a resident's room when the resident was placed on precautions. CNA #5 said she knew which residents were on precautions because management told them and there were also signs up with bins in front of the resident's door. CNA #5 said if staff were going into a room which required EBPs to change a resident they should wear a gown and gloves. The infection preventionist (IP) was interviewed on 4/30/26 at 2:31 p.m. The IP said isolation precautions were typically set up with new admissions. The IP said the admissions coordinator found out whether or not the resident needed precautions to be in place prior to the resident being admitted and then would inform the IP. The IP said she then would prepare the isolation equipment (bin and signs) for the resident's arrival to the facility. The IP said if the resident arrived over the weekend, the weekend supervisor would arrange for the bin and signs to be set up. The IP said residents could have isolation equipment in their rooms if that was their preference. The IP said staff should still have been donning PPE before performing direct care activities with the resident. The IP said it was important for staff to wear proper PPE for EBPs because it protected both the staff and the resident. The IP said if a resident had an open line into their body such as a catheter, it was possible to transfer organisms from staff to the resident. The IP said it was also possible to transfer organisms from the resident to staff and then be transferred onto other residents. II. Housekeeping failures A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures retrieved on 5/5/26 from from:https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_ Common high touch surfaces include bedrails, sink handles, call bells, bedside tables, doorknobs, and light switches. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Centers for Disease Control and Prevention (CDC) When and How to Clean and Disinfect a Facility on 5/5/26 from https://www.cdc.gov/hygiene/about/when-and-how-to-clean-and-disinfect-a-facility.html#:~:text=During%20use After you apply the disinfectant to the surface, leave the disinfectant on the surface long enough to kill the germs. This is called the contact/wet time. The surface should stay wet during the entire contact time to make sure germs are killed. B. Facility policy and procedure The Routine Cleaning and Disinfection policy was provided by the NHA on 5/1/26 at 3:41 p.m. The policy read in pertinent part, The facility will follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include but not limited to tray tables, bed rails, door knobs and levers and light switches. C. Record review The housekeeping manufacturer guidelines for each chemical spray was received from the maintenance director on 4/30/26 at 10:19 a.m. The manufacturer guidelines revealed the blue rapid multi surface disinfectant cleaner spray used by housekeeping personnel had a kill time of 10 seconds for COVID-19 and a 30 second kill time for the norovirus, influenza A virus, rhinovirus, murine norovirus, and hepatitis B and C. D. Observations On 4/29/26 at 11:26 a.m. housekeeper (HK) #1 was cleaning room [ROOM NUMBER], which was a double occupancy room. HK#1 used a blue rapid multi surface disinfectant solution to spray green rags four times each. HK #1 used the green rags to the door knobs, light switches, and bedside tables. The surfaces were not visibly wet for ten seconds.HK #1 did not clean the call bells present in room [ROOM NUMBER]. On 4/29/26 at 10:48 a.m. HK #2 was observed cleaning room the double occupancy room [ROOM NUMBER]. HK #2 did not clean the call bells present in room [ROOM NUMBER]. E. Staff interviews HK #1 was interviewed on 4/29/26 at 11:46 a.m. HK #1 said if they did not have so many rooms to clean, they would spray the surface and let it sit for longer. Housekeeper #1 said instead, they sprayed cloths and used cloths to wipe surfaces instead, because they had the whole unit to get to. HKr #1 said if all the rooms were filled on the unit, there would be about 70 rooms to clean. HK #1 said there were only four vacant rooms on the unit during the time of survey. HK #1 said call lights were cleaned when performing deep cleans. HK #1 said deep cleans were performed once a week if they had time or when a resident was discharged out of the room. HK #1 was interviewed on 4/30/26 at 12:10 p.m. HK #1 said the dwell time for the blue rapid (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal protective equipment (PPE) appropriately. [NAME] mask upon entry into the patient room or patient space. B. Facility policy and procedure The Transmission-Based (isolation) precautions policy was provided by the nursing home administrator (NHA) on 5/1/26 at 3:41 p.m. The policy read in pertinent part, It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Droplet precautions refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Facility staff will apply transmission based precautions in addition to standard precautions to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. The facility staff will apply Transmission based precautions in addition to standard precautions to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. Signage that includes instructions for use of specific PEE will be placed in a conspicuous location outside the resident's room wing, or facility wide. Additionally, either the CDC category of transmission based precautions (contact droplet or airborne) or instructions to see the nurse before entering will be included in the The facility will have PPE readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission based precautions. Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (respiratory droplets that are generated by a resident who is coughing, sneezing, or talking). A private room is preferential but if not available the resident can be cohorted with a resident with the same infectious agent. Healthcare personnel will wear a facemask for close contact with an infectious resident. Based upon the pathogen or clinical syndrome, if there is risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles or face shield should be worn. C. Observations On 4/28/26 at 9:20 a.m. two signs on Resident #56's door indicated the resident was on TBP for contact and droplet precautions. Resident #56 was on droplet precautions initiated for positive rhinovirus (a highly contagious, common virus and the primary cause of the common cold). The sign of contact precautions read in pertinent part, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also put on gloves and gown before room entry. Discard gloves and gown before room exit. The sign of droplet precautions read in pertinent part, Everyone must clean their hands, including (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. On 4/28/26 at 9:23 a.m. CNA #6 entered Resident #56's room to deliver a breakfast meal. -CNA #6 failed to perform hand hygiene, apply a gown, gloves and face protection when entering Resident #56's room. On 4/28/26 at 12:30 p.m. CNA #6 entered Resident #56's room to deliver a lunch meal. -CNA #6 failed to perform hand hygiene, apply a gown, gloves and face protection when entering Resident #56's room. D. Resident interview Resident #56 was interviewed on 4/29/26 at 2:30 p.m. Resident #56 said staff told her she tested positive for rhinovirus when she came back from the hospital. She said that was the reason she was under isolation precautions. Resident #56 said it was just a cold and she did not understand why people were wearing all that stuff. She said sometimes staff did not put it on. E. Staff interviews CNA #7 was interviewed on 4/30/26 at 11:27 a.m. CNA #7 said if there was a sign on the resident's door that indicated the resident was on droplet precautions, the staff had to wash their hands, put on a gown, gloves, protective glasses, and a face mask prior to entering the resident's room. CNA #7 said staff had to remove PPE prior to exiting the resident's room after completing the tasks and clean their hands once outside the room. CNA #7 said Resident #56 was on droplet precautions for rhinovirus infection. She said staff had to use PPE even when they were delivering meals. CNA #7 said not implementing those precautions staff could catch whatever the resident had and pass it to someone else. LPN #3 was interviewed on 4/30/26 at 1:20 p.m. LPN #3 said the staff should wash their hands and put on a face mask, gloves, and gown before entering a resident's room with a sign that indicated the resident was on TBP. LPN #3 said Resident #56 was on TBP due to rhinovirus infection. She said there was a box of supplies outside of Resident #56's room. LPN #3 said staff should implement all the precautions even though staff were delivering meals. She said not using PPE was wrong. LPN #3 said CNA #6 could get infected with rhinovirus and spread it to the building. The IP and the DON were interviewed together on 4/30/26 at 2:49 p.m. The IP said Resident #56 was on droplet and contact precautions for rhinovirus. The IP said precaution signs were posted outside Resident #56's room door and PPE supplies stored outside the room. She said staff were supposed to put on a gown, gloves, and face mask prior to entering Resident #56's room. The IP said CNA #6 should have used PPE to prevent the spread of the disease in the facility. The DON said CNA #6 should have put on the gown and applied all the precautions in place.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews, the facility failed to ensure certified nurse aides (CNA) received the required 12 hours of annual in-service training for continued competence.Specifically, the facility failed to ensure two CNAs (#2 and #3) of five CNAs received 12 hours of annual training. Findings include:I. Facility policy and procedureThe Required Training, Certification and Continuing Education of Nurse Aides policy and procedure, undated, was received from the nursing home administrator (NHA) on 5/1/26 at 3:41 p.m. It revealed in pertinent part, It is the policy of this facility to comply with state and Federal regulations and requirements as they pertain to the training, certification and continuing education of its nurse aides. The facility will provide at least 12 hours of inservice training annually, based on employment date, not calendar year. Documentation of inservice training will be maintained by the Staff Development Coordinator and retained in an employee personnel or education file in accordance with facility policy. It is the responsibility of the employee to attend required in-service training to maintain employment status with the facility. The required 12 hours of annual in-service training include online education completed through the facility designated learning platform. Employees are assigned online training modules on a quarterly basis and completion of these modules within the designated timeframe is mandatory. II. Training reviewA review of CNA training was reviewed on 4/30/26 at 1:24 p.m. CNA #2 was hired on 3/13/24 and had only completed three hours of the required 12 hours of continuing education units (CEU). CNA #3 who was hired on 5/16/24 and had only completed seven hours of the required 12 hours of CEUs on the platform for education. The facility provided other in-service documentation for CEU however there was no way to determine the contact hours for them as the documentation did not include contact time.III. Staff interviewsThe staff development coordinator was interviewed on 4/30/26 at 3:15 p.m. She said CNAs were required to complete 12 hours minimum of CEU per year. The staff development coordinator said the facility used a platform for education along with inservice training they held. The staff development coordinator said the facility held all staff meetings and had staff signed in to show they were present. The staff development coordinator said she was unable to locate/provide contact hours for the in services provided during all staff meetings.The director of nursing (DON) was interviewed on 4/30/26 at 3:26 p.m. She said it was important for CNAs to complete their 12 hours of CEUs for job safety and residents safety. The DON said starting on May 11th the facility will be having all staff complete 12 hours of CEU prior to their first shift on the floor.