

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Amberwood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4686 E Asbury Cir Denver, CO 80222	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the resident's representative was informed of changes in condition for one (#1) of three residents out of 17 sample residents. Specifically, the facility failed to: -Inform Resident #1's physician-appointed healthcare proxy when the resident had a change in condition, including when the resident started on an antibiotic medication; and, -Return phone calls to Resident #1's healthcare proxy's voice messages requesting information about the resident's condition in a timely manner. Findings include: I. Facility policy and procedure The Notification of Changes policy, revised 2025, was provided by the nursing home administrator (NHA) on 4/23/26 at 1:21 p.m. It read in pertinent part, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. When residents are incapable of making their own decisions the representative will make any decisions that have to be made. II. Resident #1A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included paralysis and weakness following a stroke, respiratory failure, cognitive communication deficit and encephalopathy. According to the 3/23/26 minimum data set (MDS) assessment, the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. B. Resident #1's representatives interviews Resident #1's designated health care proxy was interviewed on 4/21/26 at 2:55 p.m. The health care proxy said the facility made it very difficult to contact Resident #1. She said facility staff did not return calls for days, making her worry about Resident #1 because she lived so far away and could not just drive over to check on the resident. The health care proxy said the resident was started on antibiotic treatment and she was not informed that Resident #1 had an infection and needed antibiotics until after the resident started on the medication. She said she had several questions about the medication and was not consulted on the medical decision prior to the start of the medication. Another one of Resident #1's representatives was interviewed on 4/21/26 at 2:55 p.m. The representative said she had called the facility several times; however, the facility never answered the phone. She said phone calls went to a general voice mailbox. The representative said her voicemail message requests for a return call were either not answered or took several days for someone from the facility to respond to the messages. C. Record review Grievances filed on behalf of Resident #1 were requested and provided by the NHA on 4/21/26 at 2:17 p.m. The grievances revealed there were several concerns regarding delays in the facility's response to the Resident #1's representatives requests for information about the resident and the delays in reporting changes in the resident's condition. The grievances revealed the following: A grievance, dated 12/30/25, revealed Resident #1's representative had concerns related to the representative's inability to get to speak to Resident #1 over the phone in a timely manner. The resident's representative called the facility to speak to Resident #1 on 12/28/25 but the call was not returned until three days later (on 12/31/25). The documented facility's response to the concerns was that a return call was placed to the resident's representative on 12/31/25 and the call went to the representative's voicemail. -There was no other documentation to indicate that the facility took further actions to resolve the communication (continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 065034	If continuation sheet Page 1 of 7

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>delays. A grievance, dated 1/8/26 and filed by Resident #1's health care proxy revealed the resident's health care proxy wanted weekly calls since she said it was too hard to contact the nurses in the facility. The facility's response to the grievance documented that weekly follow-up calls would be completed in response to the concern, and that the resident's health care proxy was satisfied with the follow-up. A grievance, dated 2/1/26 and filed by Resident #1's health care proxy revealed the resident's health care proxy called to express concern over lack of notification for new medication the resident was started on but she was not informed of. The facility followed up by conducting in-services with their staff on 2/1/26, 2/3/26 and 2/5/26, regarding notifying residents' responsible parties about medication changes, as well as which staff members were responsible for the notifications. Additionally, the facility ensured Resident #1's health care proxy was listed correctly in their resident information. -The grievance failed to reveal information on whether or not the resident's health care proxy was satisfied with the facility's response to the concern. A grievance, dated 3/28/26 and filed by Resident #1's health care proxy revealed the resident's health care proxy expressed concern over a scheduled video call where she was unable to connect with staff. The health care proxy said she was upset about the lack of communication from the facility. The resident's health care proxy was called back on 3/31/26 by the activities director, who apologized for the miscommunication regarding the video call. The activities director said the health care proxy could call her if she needed anything from them. -The grievance failed to reveal information on whether or not the resident's health care proxy was satisfied with the facility's response to the concern. III. Other residents' representatives interviews Resident #10's representative was interviewed on 4/21/26 at 3:19 p.m. Resident 10's representative said Resident 10 was newly admitted to the facility. He said he called to check on the resident's status and the call was sent to the facility's voicemail. Resident #10's representative said it took the facility two days to return his call. Resident #6's representative and a secondary witness were interviewed together on 4/22/26 at 1:27 p.m. They said they attempted to contact the facility to report a suspected instance of verbal abuse that they over heard while on the phone with Resident #6 but the call was sent to the facility's voicemail. They said they tried to call the social services director (SSD) and were again sent to voicemail. They said they never received a return call. IV. Staff interviews The SSD was interviewed on 4/22/26 at 3:15 p.m. The SSD said she was not entirely sure where the concerns about the communication with Resident #1's representatives were coming from. She said all calls to the facility first went to the front desk receptionist and were then transferred to the nurses' stations for direct contact with nursing staff. The SSD said Resident #1's representatives had her cell phone number as well as the cell phone number for the director of nursing (DON), whom they could call if she was unable to get through to the nurses' station. Licensed practical nurse (LPN) #1 was interviewed on 4/23/26 at 11:09 a.m. LPN #1 said one of Resident #1's representatives often called his personal cell phone multiple times a day. The DON, the NHA, and the corporate nurse consultant were interviewed together on 4/28/26 at 12:34 p.m. The NHA said the Resident #1's healthcare proxy wanted a call from the facility staff every single day. The NHA said the facility was aware several of the resident's representatives' phone calls went to voicemail when the nurses were unable to pick up the phone calls. The corporate nurse consultant said that voicemail messages left in the facility's voicemail message system should be returned within 24 hours. The NHA said she did not think it was accurate that Resident #1's healthcare proxy was not getting called back and that the assistant director of nursing (ADON) was texting the health care proxy on a weekly basis to provide information. -However, there was no documentation for the weekly calls provided by the facility. The NHA said Resident #1's representative and health care proxy had her cell phone number as well as the cell phone number for the SSD and the DON. The representatives could have called any of them directly if they were unable to get through to the nurses' station. The NHA said Resident #1's representatives often called during shift change when it was harder to get through to the nurse on duty. The NHA said if the nurse was unable to answer the phone call, the call went directly to voicemail where it was later picked up and returned.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to investigate an allegation of verbal abuse involving one (#6) of seven residents of 17 sample residents. Specifically, the facility failed to investigate an allegation of verbal threats overhead by a family member between Resident #6 and Resident #15. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised April 2021, was provided by the nursing home administrator (NHA) on 4/22/26 at approximately 9:20 a.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: other residents. The facility will identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. The facility will investigate and report any allegations within timeframes required by federal requirements and protect residents from any further harm during investigations. Investigate and report any allegations within timeframes required by federal requirements. The Identifying Types of Abuse policy and procedure, revised September 2022, was provided by the NHA on 4/22/26 at 9:20 a.m. It read in pertinent part: As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents. Examples of mental and verbal abuse include but are not limited to: yelling or hovering over a resident, with the intent to intimidate. II. Resident #6 (alleged victim) A. Resident status Resident #6, aged less than 65, was admitted on [DATE]. According to the April 2026 computerized physician's orders (CPO), diagnoses included dysphagia, hemiplegia of the left side (paralysis of the left due to a stroke), attention and concentration deficit, delusional disorder, and major depressive disorder. According to the 3/20/26 minimum data set (MDS) assessment, Resident #6 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The MDS assessment indicated Resident #6 used a wheelchair for mobility and was dependent on staff for most of his activities of daily living (ADL). B. Resident #6 interview Resident #6 was interviewed on 4/21/26 at 2:23 p.m. Resident #6 said he did not think the arguing back and forth between Resident #15 and himself was a big deal. He said his roommate (Resident #15) said to shut the (explicative), and then they were both yelling back-and-forth at each other. He said he could not remember what they each yelled towards each other. He said there was no pushing, shoving or anything like that. C. Resident #6's representatives interviews Resident #6's guardian was interviewed over the phone on 4/22/26 at 11:55 a.m. She said that Resident #6 called her after the incident and she went to the facility to see what was going on. She said the staff had separated residents because they were yelling at each other. The guardian said apparently threats were made by Resident #15 towards Resident #6. She said Resident #6 told her that he was fearful of Resident #15. Resident #6's representative was interviewed on 4/22/26 at 1:27 p.m. The representative said while she was talking to Resident #6 on the phone on 3/15/26, she heard Resident #15 yelling loudly and making threats towards Resident #6. She then heard the nurse enter the room to calm down the situation. The representative said that she tried to call the facility to report the yelling and threatening behavior, but was sent to voicemail and no one called her back. She said she was worried about the situation, so she called the police and reported the threatening behavior. The representative provided a police report number during the call (see emergency services interview below). III. Resident #15 (alleged assailant) A. Resident status Resident #15, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dementia, cognitive communication deficit, depression, and insomnia. According to the 3/2/26 MDS assessment, Resident #15 had moderate cognitive impairment (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>with a BIMS score of eight out of 15. The MDS assessment revealed Resident #15 used a walker for mobility dependent on staff for most of his ADL. The MDS assessment indicated the resident did not have any behaviors. B. Resident interviewResident #15 was interviewed on 4/21/26 at 2:55 p.m. He said that he did not remember the incident between him and Resident #6.C. Resident #15's representative interviewResident #15's representative was interviewed on 4/23/26 at 10:45 a.m. The representative said Resident #15 did not remember the incident.Resident #15's representative said she was made aware of the incident the day after it happened. She said she was told Resident #6 was talking too loud on the phone and Resident #15 started yelling at Resident #6 to be quiet. She said she was told that because of the yelling the facility initiated a room move that night (3/16/26) to separate the two from being roommates. Resident #15's representative said she agreed to the room change. She said she had asked for the room change prior to 3/15/26 due the behaviors of Resident #6 when she visited Resident #15. She said that Resident #6 would masturbate on the other side of his privacy curtain and would yell racial slurs. She said that she told the director of nursing (DON). IV. Record reviewA request was made for an investigation regarding the allegations of verbal threats by Resident #6 towards Resident #15 (see staff interviews below). Review of both resident's electronic medical record revealed no documentation of the resident to resident verbal altercation or related concerns. A room change form in Resident # dated 3/16/26 revealed the reason for the resident's room change was Resident #15 and his roommate did not get along. Family requested he be moved.IV. Emergency services interviewA non-emergency dispatcher was interviewed on 4/22/26 at 5:26 p.m. The non-emergency dispatcher said there was an incident reported from Resident #6's representative. The non-emergency dispatcher said emergency medical services (EMS) responded to the call and not the police. V. Staff interviewsRegistered nurse (RN) #1 was interviewed on 4/23/26 at 10:00 a.m. RN #1 said she did not remember the verbal altercation between Resident #6 and Resident #15 all that well, since it occurred a while ago. She said that she did remember that there was loud yelling and arguing between Resident #6 and Resident #15. She said she did not hear the exact words exchanged and did not know if any threats were made by either resident.RN #1 said she could not remember exactly, but it was either the police or EMS who responded to the facility related to the resident's yelling. RN #1 said she reported the yelling to the DON that evening, but did not tell the DON about EMS responding to the facility for the residents yelling at each other. RN #1 said she talked to a family member or friend of Resident #6's regarding the verbal altercation. She said she could not remember who she talked to or the relationship to Resident #6.RN #1 said she had helped Resident #15 to change rooms, due to the resident-to-resident incident on 3/15/26.The social service director (SSD) and the corporate nurse consultant were interviewed together on 4/23/26 at 9:40 a.m. The SSD said she did not know much about the incident that took place between Resident #6 and Resident #15 on 3/16/26. The SSD said it was just an argument between two individuals and there were no threats, or anything else that would rise to the occasion of an allegation. She said it was a back and forth between two residents and nothing else.-However the incident was not investigated and the SSD was not present during the incident. Additionally, both residents had cognitive deficits and there was no documented interview with either resident at the time of the incident. The NHA, the DON and the corporate nurse consultant were interviewed on 4/23/26 at 12:30 p.m. The NHA and the DON said RN #1 had called the DON after the incident to initiate a room change for Resident #15 due to worsening dementia. The DON said that Resident #15's representative had asked for a room change prior to the incident that took place due to Resident #6 behaviors. The DON said that she was not made aware that the police or EMS were called about the incident and was not told that EMS had arrived in response to the resident-to-resident verbal altercation. The NHA said she did not report the resident's verbal exchange to the State Agency as abuse of a resident, because there were no threats made by either resident. She said the two residents were just having a disagreement and yelling at each other. The NHA said neither resident called the police or EMS. -However, no facility staff inquired how EMS showed up in response to the resident-to-resident verbal altercation where RN #1 believed it was necessary to (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>initiate an immediate room move to separate the resident permanently. The DON and the NHA said that they followed up to prevent anything from happening in the future, by moving Resident #15 to another room and having compatible roommates.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases in four of four units. Specifically, the facility failed to: -Ensure staff performed hand hygiene before and after providing resident care; and, -Ensure staff followed enhanced barrier precautions (EBP) while providing direct resident care for residents who were identified as being on EBP. Findings include: I. Professional reference According to the Center for Disease Control and Prevention (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers, (2/27/24), retrieved on 5/4/26 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with, handwashing with water and soap, antiseptic hand rub, or surgical hand antisepsis. According to the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO), (4/2/24), retrieved on 5/4/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ gown and glove use during high contact resident activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Examples of high contact resident care activities requiring gown and glove use for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). II. Facility policy and procedure The Enhanced Barrier Precautions policy, revised December 2024, was provided by the nursing home administrator (NHA) on 4/23/26 1:21 p.m. It read in pertinent part, EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. The Hand Hygiene policy, undated, was provided by the NHA on 4/23/26 1:21 p.m. It read in pertinent part, hand hygiene will be done by all employees, volunteers and contract staff to reduce transfer of microbes to patients. Hand hygiene should be done before and after direct patient care, before and after each procedure, after using the bathroom, after blowing or wiping the nose, before and after eating, before and after collecting specimen, when hands are soiled, after any contact with contaminated materials, before re-entering nursing bag or patient's clean supplies. III. Observations On 4/21/26 at 10:48 a.m. an unidentified certified nursing assistant (CNA) was leaving room [ROOM NUMBER], after caring for a resident who was identified as being on EBP, by a sign on the door. The CNA did not wear a gown while providing care. On 4/21/26 at 12:53 a.m. CNA #1 exiting a resident's room not wearing gloves. CNA #1 carried a soiled mechanical lift sling and placed it in the soiled laundry hamper. CNA #1 did not perform hand hygiene. CNA #1 walked down the hall to the nurse's cart. He ran his hands through his hair and over his face. Then CNA #1 used the facility's touch screen to document the care provided. Without performing hand hygiene, CNA #1 entered resident room [ROOM NUMBER] to answer a call light and assist a resident with a request without washing his hands before or after assisting that resident. On 4/22/26 at 9:41 a.m. CNA #2 entered resident room [ROOM NUMBER], who was on EBP per the sign on the door. CNA #2 entered the room and applied gloves, but did not apply a gown. CNA #2 provided the resident with incontinence care. CNA #2 left the resident's room with the soiled linens and trash disposed of in the proper hampers, removed the gloves but did not perform any hand hygiene prior to caring for another resident. On 4/23/26 at 9:59 a.m. licensed practical nurse (LPN) #1 entered room [ROOM NUMBER] to set up the feeding tube. The resident was identified as needing EBP due to the resident having a gastric tube feeding. LPN #1 did (continued on next page)</p>		

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