STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065052	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Post Acute	2121 Mesa Dr Boulder, CO 80304

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews the facility failed to ensure food was distributed and served under sanitary conditions in the main kitchen. Specifically, the facility to ensure ready-to-eat foods were handled in a sanitary manner to prevent cross-contamination in the main kitchen. Findings include:I. Failed to ensure ready-to-eat foods were handled in a sanitary manner. A. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24) and retrieved on 2/23/26 read in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissues, spatulas, tongs, single-use gloves or dispensing equipment. (2-301.15) Food employees shall clean their hands and exposed portions of their arms as specified under immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and before donning (putting on) gloves to initiate a task that involves working with food. (3-301.11) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (3-304.15)B. Facility policy and procedureThe Dietary Employee Personal Hygiene policy, revised 2025, was provided by the nursing home administrator (NHA) on 2/19/25 at 11:04 a.m. The policy read in pertinent part, It is the policy of this facility to utilize the following as guidelines for employee personal hygiene to prevent contamination of food by foodservice employees. Hands must always be washed after using the restroom, eating or drinking, using tobacco products, coughing, sneezing, blowing nose, before putting on gloves, after removing gloves, and after engaging in other activities that contaminate the hands and gloves are to be worn and changed appropriately to reduce the spread of infection.C. ObservationDuring a continuous observation on 2/17/26, beginning at 11:35 a.m. and ending at 12:45 p.m., the following was observed during the service of the meal:Cook (CK) #2 was plating the food using utensils with bare hands. Without performing hand hygiene, he donned (put on) gloves sliced a hot dog and put it on the plate with the bun. He removed the gloves and went back to using utensils to serve, without washing his hands. He put on another pair of gloves, without washing his hands, to cut another hot dog and removed a bun from the bag the buns came in. He left the gloves on for the remainder of the service. During that time he picked up four grilled cheese sandwiches with the gloved hands, and used the same gloved hands to serve the food using the utensils. CK #2 used the same gloved hands to pull hot dog buns from their bag, open them with his gloved hands and plate the food. D. Staff interviewsThe dietary manager (DM) was interviewed on 2/19/26 at 10:00 a.m. The DM said she expected the dietary staff to put on gloves when touching food and to wash their hands before and after putting on the gloves. She expected that if the dietary staff put on gloves to handle food, the gloves would be removed after the single use and hands would be washed. The DM said she has provided in-services (training) on the topic of single use gloves and hand hygiene since she started three weeks ago.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure that all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards for two of six medication carts. Specifically, the facility failed to ensure inhaler medications and multi-use vials of injectable medications were marked with the date when the medications were opened.Findings include:I. Professional referenceAccording to the haloperidol deconate injection package insert, retrieved on [DATE] from https//fresenius-kabi.com/content/dam/fresenius-kabi/ca/products/product-documents/iv-drugs/haloperidol-inje Multiple-dose vials: Discard unused portion 28 days after initial puncture.According to the Spiriva Respimat (tiotropium bromide) inhaler package insert, retrieved on [DATE] from https://content.boehringer-ingelheim.com/DAM68a8a6b5-4e9a-4508-85d3-af101205009/spiriva%20respimat-u After assembly, the Spiriva Respimat inhaler should be discarded, at the latest, three months after first use or when the locking mechanism is engaged, whichever comes first.According to the Stiolto Respimat (tiotropium bromide and olodaterol inhalationspray) inhaler package insert, retrieved on [DATE] from https://pro.boehringer-ingelheim.com/us/products/respiratory/bipdr/stiolto-respimat-pi#page=18, Three months after insertion of cartridge, throw away the Stiolto Respimat, even if it has not been used, or when the inhaler is locked, or when it expires, whichever comes first.II. Facility policy and procedureThe Storage of Medication policy, revised 2020, was received from the regional clinical resource at 10:44 a.m. on [DATE]. It revealed in pertinent part, Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.III. ObservationsOn [DATE] at 12:15 p.m. the second floor medication cart was observed with licensed practical nurse (LPN) #1. The following observations were made: -Two vials of haloperidol deconate 500 milligrams (mg)/5 ml vial for injection were not marked with the date they were opened; and,-One Spiriva (tiotropium bromide) inhaler was not marked with the date it was opened. On [DATE] at 3:20 p.m. the east third floor medication cart was observed with LPN#2. The following observations were made: -Two vials of haloperidol deconate 500 mg/5 ml vial for injection were not marked with the date they were opened;-One Spiriva Respimat (tiotropium bromide) inhaler was not marked with the date it was opened; and,-One Stiolto Respimat inhaler was not marked with the date it was opened.III. Staff interviewsLPN #1 was interviewed on [DATE] at 12:20 p.m. LPN #1 said the importance of having an open date on medications was to make sure the medication was still effective and not expired.LPN #2 was interviewed on [DATE] at 3:30 p.m. LPN #2 said the importance of writing the open date on the medications was to know when the medication would expire.The director of nursing (DON) was interviewed on [DATE] at 11:00 a.m. The DON said the open dates must be marked on medications to ensure medications were not expired and remained effective.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for two (#1 and #8) of five residents out of 43 sample residents. Specifically, the facility failed to:-Obtain orders for Resident #1's midline catheter (tube inserted into a vein to administer medication) dressing change;-Change Resident #1's midline catheter dressing in a timely manner; and,-Follow physician's orders for Resident #8's sliding scale insulin.Findings include: I. Failed to obtain orders for Resident #1's midline catheter dressing change and change the resident's midline catheter dressing in a timely manner A. Professional reference According to Basic Nursing Thinking, Doing and Caring Treas, L., & [NAME], K., & [NAME] M. (2022) Basic Nursing Thinking, Doing and Caring (3rd ed.), p. 3531, The replacement of transparent dressings should be done at least every five to seven days, or earlier as clinically indicated, for example when the dressing becomes damp, soiled or loose. B. Resident #1 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included gastrostomy (surgical procedure to make an opening for a feeding tube), epilepsy, Alzheimer's disease, dysphagia (difficulty swallowing) and pneumonitis due to inhalation of food and vomit. The 12/31/25 minimum data set (MDS) assessment indicated the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The staff assessment revealed the resident had memory problems with both long and short term memory. The MDS assessment indicated the resident was dependent on staff for all activities of daily living (ADL). 2. Observation On 2/16/26 at 4:45 p.m. licensed practical nurse (LPN) #7 entered Resident #1's room to change her midline catheter transparent dressing. LPN #7 confirmed the date on the dressing was 2/6/26, which was the date the midline catheter was placed, ten days prior. LPN #7 said a midline catheter dressing should be changed every seven to 10 days. 3. Record review The 2/6/26 nurse progress note documented a physician's order was given by Resident #1's physician for the resident to receive intravenous (IV) fluids. The resident's midline catheter was placed on 2/6/26. Review of Resident #1's February 2026 CPO revealed the following physician's orders: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Normal saline flush intravenous solution 0.9 percent (%), use one liter IV one time only for dehydration for one day, ordered 2/6/6. Midline dressing change of the left arm, in the evening, every seven days, ordered 2/17/26. -The February 2026 CPO did not include physician's orders for midline catheter dressing changes for Resident #1 until 2/17/26 (during the survey), 11 days after the resident's midline catheter was placed. C. Staff interviews LPN #7 was interviewed 2/18/26 at 1:16 p.m. LPN #7 said a representative from the pharmacy came to the building to insert Resident #1's midline catheter and said the dressing should be changed every seven to 10 days, but there was no documentation of this in Resident #1's electronic medical record (EMR). LPN #7 said she followed up with the director of nursing (DON) and was told seven days was the standard of practice for the transparent dressing change. She said the physician's order to change the resident's midline catheter dressing was missed. The DON and the regional clinical resource were interviewed together on 2/18/26 at 3:50 p.m. The DON and the regional clinical resource both said the standard of practice for a transparent dressing change was seven days and as needed. The DON said Resident #1's dressing should have been changed seven days after the initial dressing was placed (on 2/6/26), so it should have been changed on 2/13/26. The DON said physician's orders addressing the midline catheter dressing should have been entered into Resident #1's EMR. II. Failed to follow physician's orders for Resident #8's sliding scale insulin A. Resident #8 1. Resident status Resident #8, age less than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia with behavioral disturbance, type 2 diabetes with hyperglycemia and long-term use of insulin. The 12/17/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. The resident was independent for most ADLs. 2. Record review Review of Resident #8's February 2026 CPO revealed the following physician's orders: Lispro insulin injection solution 100 units/milliliter (ml), inject as per sliding scale: if blood sugar is 300 milligrams (mg)/deciliter (dl) to 349 mg/dl inject 6 units; 350 mg/dl to 400 mg/dl inject 8 units; 401 mg/dl to 449 mg/dl inject 10 units. Give injection subcutaneously (under the skin) every 12 hours as needed for hyperglycemia; ordered 3/31/25 and discontinued 2/18/26 (during the survey process). Glargine insulin solution 100 units/ml, inject 26 units subcutaneously in the morning for uncontrolled (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes, hold if blood sugar is below 90 mg/dl; ordered 7/1/25. Check fasting blood sugar twice daily for diabetes; ordered 7/10/24 and discontinued 2/18/26 (during the survey process). If blood glucose is over 400 mg/dl or below 60 mg/dl notify the physician and make a nurse note each shift for glucose monitoring; ordered 7/7/25 and discontinued 2/18/26 (during the survey process). Review of Resident #8's medication administration records (MAR) from 10/1/25 through 2/19/26 did not reveal documentation to indicate the resident had received any administered doses of the sliding scale Lispro insulin solution. A progress note, dated 9/9/25 at 5:13 p.m., revealed Resident #8 was administered 6 units of Lispro insulin. The note documented Resident #8's blood sugar measured 302 mg/dl before his meal. A progress note, dated 12/30/25 at 7:43 p.m., revealed Resident #8's blood sugar was measured and found to be 310 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 12/31/25 at 7:40 p.m., revealed Resident #8's blood sugar was measured and found to be 322 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/1/26 at 7:27 p.m., revealed Resident #8's blood sugar was measured and found to be 336 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/4/26 at 7:24 p.m., revealed Resident #8's blood sugar was measured and found to be 330 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/11/26 at 7:17 p.m., revealed Resident #8's blood sugar was measured and found to be 307 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/13/26 at 7:22 p.m., revealed Resident #8's blood sugar was measured and found to be 330 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/18/26 at 7:20 p.m., revealed Resident #8's blood sugar was measured and found to be 320 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 1/20/26 at 7:23 p.m., revealed Resident #8's blood sugar was measured and found to be 346 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/21/26 at 7:28 p.m., revealed Resident #8's blood sugar was measured and found to be 310 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 1/25/26 at 7:23 p.m., revealed Resident #8's blood sugar was measured and found to be 319 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 2/1/26 at 7:44 p.m., revealed Resident #8's blood sugar was measured and found to be 314 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 2/4/26 at 7:32 p.m., revealed Resident #8's blood sugar was measured and found to be 346 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 2/10/26 at 7:29 p.m., revealed Resident #8's blood sugar was measured and found to be 366 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 8 units was not administered. A progress note, dated 2/11/26 at 8:04 p.m., revealed Resident #8's blood sugar was measured and found to be 328 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 2/17/26 at 7:47 p.m., revealed Resident #8's blood sugar was measured and found to be 304 mg/dl. -However, the sliding scale as-needed Lispro insulin dose of 6 units was not administered. A progress note, dated 2/18/26 at 5:07 p.m. (during the survey process), revealed a nursing staff member reviewed Resident #8's blood sugar history with his physician and received a physician's order to discontinue the resident's sliding scale insulin. B. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 2/18/26 at 1:50 p.m. LPN #4 said for residents with diabetes, the nursing staff would measure their blood glucose levels before meals. LPN #4 said Resident #8's blood sugar was measured twice a day, with both measurements conducted before (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals. LPN #4 said the staff measured Resident #8's blood glucose levels after meals if indicated by any possible signs of hyperglycemia. LPN #4 reviewed Resident #8's physician's orders. LPN #4 said there was a physician's order to notify Resident #8's provider if his blood glucose level measured above 400 mg/dl or below 60 mg/dl. LPN #4 said this order referred to both blood glucose levels measured while the resident was fasting and those measured after meals as needed. LPN #4 said Resident #8 had an order to receive Glargine insulin once a day, and said he did not see any sliding scale insulin orders in the resident's CPO. LPN #4 said Resident #8's blood glucose levels fluctuated because he liked to eat a lot of snacks. LPN #4 said if Resident #8's blood glucose levels were measured and found to be too high or too low, he would notify his physician so they could monitor him more closely or adjust his insulin dosage for better coverage. Resident #8's primary care physician (PCP) was interviewed on 2/18/26 at 2:46 p.m. The PCP said he expected the nursing staff to follow the orders he put in place, or to contact him if they had any concerns or questions. The PCP said for diabetic residents, the nursing staff would ideally check their blood glucose levels after each meal, but said checking the resident's blood sugar twice a day was fine for some residents. The PCP said Resident #8 had refused care at times, so the nursing staff might be assessing his blood glucose level as often as he would allow them to. The PCP said if Resident #8's blood glucose level was measured and found to be over 300 mg/dl and the physician's order for sliding scale insulin was present in the CPO, he would have expected the nursing staff to either administer the insulin as ordered or call him to clarify the order. The PCP said the nursing staff might not have known the sliding scale insulin order was in the CPO. The PCP said he would not have wanted the nursing staff to administer the sliding scale insulin. -However, review of Resident #8's electronic medical record (EMR) did not reveal any communication between the nursing staff and the physician regarding clarification for the sliding scale insulin order. LPN #5 was interviewed on 2/19/26 at 8:58 a.m. LPN #5 said when residents with diabetes received new orders from the physician for insulin, she would look in their CPO to see if there were also orders to check the resident's blood glucose level prior to administering insulin. LPN #5 said the facility did not use sliding scale insulin orders but used long-acting insulin with set schedules. LPN #5 said if she saw a resident had an order for sliding scale insulin dosing, she would clarify the order first with the DON, then with the resident's physician. LPN #5 said the facility used agency staff and that some of the agency staff members were not the best at verifying physician's orders, so she tried to clarify orders whenever possible. The DON and the regional clinical resource were interviewed together on 2/19/26 at 12:46 p.m. The DON said the facility tried to avoid using sliding scale insulin orders, but said the nursing staff should follow the physician's order for sliding scale insulin if one was in place. The regional clinical resource said the expectation of the nursing staff would be to administer the insulin per physician's orders. The DON said she had reviewed Resident #8's EMR and saw there was a scheduled order to notify the physician if his blood glucose measurement exceeded certain parameters. She said she thought that was why Resident #8's blood glucose was being recorded in his progress notes. The DON said she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided the nursing staff with one-on-one education on medication errors on 2/18/26 (during the survey) and had notified Resident #8's physician. The DON said the sliding scale insulin order was supposed to be used based on Resident #8's fasting blood sugar measurements. The DON said she did not think the order specified whether the blood glucose measurement was supposed to be fasted or assessed at any time. The DON said if the nursing staff had noticed the sliding scale insulin order they would have clarified the order. The regional clinical resource said the nursing staff should have asked the physician for clarification regarding the sliding scale insulin order.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure residents with a feeding tube received appropriate treatment and services for one (#1) of one resident reviewed with a feeding tube out of 43 sample residents.Specifically, the facility failed to ensure Resident #1 received her tube feedings per physician's orders. Findings include:I. Facility policy and procedureThe Enteral Tube Feeding via Continuous Pump policy, dated November 2018, was provided by the nursing home administrator (NHA) on 2/18/26 at 11:26 a.m. The policy read in pertinent part, Verify that there is a physician's order for this procedure, review the resident's care plan and provide for any special needs of the resident, ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or this facility.II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician's orders (CPO), diagnoses included gastrostomy (surgical procedure to make an opening for a feeding tube), epilepsy, Alzheimer's disease and dysphagia (difficulty swallowing). The 12/31/25 minimum data set (MDS) assessment revealed the resident had memory problems with both long and short term memory per staff assessment. The MDS assessment documented the resident was dependent on staff for all activities of daily living (ADL). The MDS assessment indicated Resident #1 received 51 percent (%) or more of her total calories through the feeding tube and her daily fluid intake was 501 cubic centimeter (cc) or more.B. Record reviewThe nutrition care plan, dated 10/7/25, documented Resident #1 had the potential for altered nutrition and/or hydration status related to the new gastrostomy tube (G tube), nothing by mouth (NPO) status, malnutrition, dementia and celiac disease. The pertinent interventions included administering nutrition related medications per physician order and monitoring for side effects, provide the enteral nutrition as ordered, monitoring the resident's intake and outtake, monitoring labs when available and reporting significant changes to the physician, observing for signs/symptoms of malnutrition and dehydration and report to physician as needed and the registered dietitian (RD) to reassess as indicated. The enteral nutrition care plan, dated 10/7/25, documented Resident #1 required enteral nutrition related to seizure disorder, malnutrition and NPO status. Pertinent interventions included administering medications through the G tube as ordered, NPO per physician's order, enteral nutrition as ordered, monitoring tolerance to enteral feeding, flush G tube with 30 milliliter (ml) water before and after medication administration and/or as ordered, elevating the head of bed to at least 30 degrees, monitoring for nausea/vomiting, abdominal distension or discomfort with each feeding and as needed, monitor labs when available and report significant changes to the physician, observing for signs/symptoms of malnutrition and dehydration, and referring to RD as indicated.Review of the February 2026 CPO revealed the following physician's orders:Administer Iso-source 1.5 per G tube through the pump. Rate was documented at 60 ml/hour (hr) for 20 hours. Starting at 8:00 a.m. and ending at 4:00 a.m. Administer total volume 1200 ml per 24 hours with free water flushes of 100 ml every six hours, ordered on 1/31/26 and discontinued on 2/5/26. Administer Iso-source 1.5 per G tube through the pump. Rate was documented at 60 ml/hr for 20 hours. Starting at 7:30 a.m. and ending at 3:30 p.m Administer total volume 1200 ml per 24 hrs with free water flushes of 100 ml every six hours, ordered on 2/5/26 and discontinued on 2/7/26.Administer Iso-source 1.5 per G tube through the pump. Rate was documented at 65 ml/hr for 20 hours. Starting at 7:30 a.m. and ending at 3:30 p.m. Administer total volume 1300 ml per 24 hours with free water flushes of 100 ml every six hours ordered on 2/8/26 and discontinued 2/19/26.Administer Iso-Source 1.5 per G tube through the pump. The rate was documented at 70 ml/hr x 20 hrs starting at 7:30 a.m. and ending at 3:30 p.m. Administer total volume 1400 ml per 24 hours with free water flushes of 100 ml every six hours, ordered on 2/19/26. Free water flushes through the feeding tube 100 ml every six hours, at 3:00 a.m., 9:00 a.m., 3:00 p.m. and 9:00 p.m. (continued on next page)

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Boulder Post Acute	2121 Mesa Dr Boulder, CO 80304

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered on 2/5/26. Registered nurse (RN) #1's progress note, dated 2/1/26, documented at 11:33 a.m. revealed the volume from the tube feeding pump read 208 ml. The note documented the nurse administered 32 ml feed bolus (dose given all at one) to equal 240 ml. Resident #1's husband and daughter were in agreement. The note documented At 1:30 p.m. the nurse administered another food bolus of 50 ml and at 6:00 p.m. provided a food bolus of 45 ml per Resident #1's husband's request.-However, there was no physician's order for an as needed (PRN) bolus feeding. The progress note did not indicate the physician had provided an order for the bolus feeding or had been notified of the additional bolus feeding. There was no documentation the RD had been notified or consulted about the bolus feeding. RN #2's progress note, dated 2/2/26, documented Resident #1's tube feeding stopped at 3:30 a.m. and the resident received a total of 1050 ml tube feeding through the tube feeding pump. The nurse provided 150 ml bolus feeding in order to total 1200 ml of the feeding. -However, there was no physician's order for a PRN bolus feeding. The progress note did not indicate the physician provided an order or was notified of the additional bolus feeding. There was no documentation the RD had been notified or consulted about the bolus feeding. A nursing progress note, dated 2/2/26, documented Resident #1's tube feeding was paused during changes and repositioning and the tube feeding gets behind from the daily ordered intake. The nurse provided an additional 60 cc bolus at 4:00 p.m. Resident #1 began coughing and became nauseous. Her family refused anymore bolus feedings at that time.-However, there was no physician's order for a PRN bolus feeding. The progress note did not indicate the physician had provided the order for the bolus feeding or had been notified of the additional bolus feeding. There was no documentation the RD had been notified or consulted about the additional bolus feedings. C. Staff interviewsLicensed practical nurse (LPN) #7 was interviewed on 2/18/26 at 1:16 p.m. LPN #7 said Resident #1 was admitted with the G tube and continuous feeding for 20 hours. LPN #7 said the standard practice was to follow the physician's orders when treating a resident. She said the bolus feeding was decided on how much food was being provided in the 20 hours of continuous feeding compared to the total calculated amount the resident was supposed to receive. She said the feeding was turned off during personal care in order for staff to turn the resident and reposition her and the resident was not receiving the total amount of daily intake. She said the family had brought this to the nursing staff's attention. LPN #1 said there was no physician's order for the bolus feedings that were provided.The primary care physician (PCP) was interviewed on 2/18/26 at 2:30 p.m. The PCP said the RD had been monitoring the fluid and food intake closer than he had. He said he was aware of the bolus feeding after the nurses gave them. He said it would not be his preference to the bolus feeding with the continuous feeding. He said the nurses' should have followed the plan of the continuous feeding. The PCP said he did not think the bolus feedings caused any harm. He said he did not find the resident to be malnourished as evidenced by her lab work and weights. The PCP expected the nurses' to follow Resident #1's orders and was open to the nurses' calling to discuss orders or changes but in the end he expected orders to be followed. RN #1 was interviewed on 2/18/26 at 3:03 p.m. She said Resident #1 was on continuous tube feeding for 20 hours, off for four hours and then it was restarted. RN #1 said she discovered the resident was not meeting her caloric intake needs because of the time the feeding pump was turned off during personal care. RN #1 said she calculated how many mls she was behind and provided bolus feedings during her shift on 2/1/26 to catch up on the feeding intake amount. RN #1 said because Resident #1 had been receiving water boluses, which were scheduled four times a day; she did not feel she needed an order for the feeding boluses as she was not going over the recommended calculated feeding amount. She did not notify the RD or the PCP of the bolus feeding.RN #2 was interviewed on 2/28/26 at 3:19 p.m. RN #2 said she provided Resident #1 with a bolus of 130 ml per the family's request. She said she did call the on-call but did not receive a call back and proceeded with the bolus administration. RN #2 said she would not administer medications without a physician's order even if a family requested it, however she said she gave the bolus this time because Resident #1 did not receive her calculated amount of feeding for the day. She did not (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the RD or the PCP of the bolus feeding. The RD was interviewed on 2/18/26 at 4:38 p.m. The RD said she assessed the caloric needs of residents on feeding tubes based on their weight, nutritional needs and lab results. She said If a resident was showing signs or symptoms of malnutrition (weight loss or negative lab work) she would reassess the residents' needs and recalculate the feedings and increase the milliliter of food intake if needed. She said if a bolus was given she would expect there to be a physician's order for this. The RD said she would have expected to be notified of the bolus feeding or the calculations the nursing staff was using to provide the bolus feeding in order to reassess the resident, however; she was not notified of the bolus feedings until a few days later when she reassessed the resident's intake and changed the tube feeding order. The director of nursing (DON) and the regional clinical resource were interviewed together on 2/18/26 at 3:50 p.m. The DON said she expected the nursing staff to follow the PCP's orders. She said she was aware Resident #1 was on continuous feeding and said bolus feedings could be given to a resident who was on a continuous tube feeding to meet the needs of the resident. She said she would have expected the physician to be called to receive an order for the additional bolus feeding.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure three (#53, #62 and #84) of three residents of 43 sample residents received food prepared in the form designed to meet their individual needs. Specifically, the facility failed to ensure Resident #53, Resident #62 and Resident #84, who were prescribed mechanically altered diets, had food prepared according to their diet orders.Findings include: I. Professional reference The International Dysphagia Diet Standardization Initiative (IDDSI) Patient Handout (January 2019), was retrieved on 2/24/26, from https://iddsi.org/Resources/Patient-Handouts It read in pertinent part, Level two mildly thick drinks may be used if thin drinks such as water, milk, and others flow too quickly for you to swallow them safely. Some milk shakes and thick shakes may be this thickness level already, but other drinks may need thickener added to reach the correct thickness level. Mildly thick drinks flow at a slower rate. Level five minced and moist food may be used if you are not able to bite off pieces of food safely but have some basic chewing ability. Some people may be able to bite off a large piece of food, but are not able to chew it down into little pieces that are safe to swallow. Minced and moist only need a small amount of chewing and for the tongue to collect the food into a ball and bring it to the back of the mouth for swallowing. It is important that minced and moist foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. These foods are eaten using a spoon or fork. Level six soft and bite-sized textures are used if you are not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow. Soft and bite-sized foods need a moderate amount of chewing, for the tongue to collect the food into a ball and bring it to the back of the mouth for swallowing. The pieces are bite-sized to reduce choking risk. Soft and bite-sized foods are eaten using a fork, spoon or chopsticks. An example of level six soft and bite-sized: Meat cooked tender and chopped, so pieces are no bigger than 1.5 centimeter (cm) by 1.5cm lump size. If food cannot serve soft and tender, serve as minced and moist. Level six soft and bite-sized, for safety avoid these food textures that pose a choking risk for adults who need level six soft and bite-sized food: Bread (no regular dry bread, sandwiches or toast of any kind). Use IDDSI level five minced and moist sandwich recipe to prepare bread; use pre-gelled 'soaked' breads that are very moist and gelled through the entire thickness; Hard or dry food include nuts, raw vegetables, dry cakes, bread, dry cereal; (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Crumbly bits include dry cake crumble, dry biscuits (add sauce to make these suitable); Large or hard lumps of food include casserole pieces larger than 1.5 centimeter (cm) x 1.5 cm, fruit, vegetable, meat, pasta or other food pieces larger than 1.5 cm x 1.5 cm. The International Dysphagia Diet Standardization Initiative (IDDSI) Framework: Food and Drink Testing of [NAME] Nutrition Products (January 2023), was retrieved on 2/26/26, from www.abbottnutrition.com/content/dam/an/abbottnutrition/pdf/clinical-resources/nutrition-by-life-stage/adult-nutr The review of the table content revealed that none of the Ensure products meet the criteria for level two, mildly thick liquids. II. Facility policy and procedure The Therapeutic Diet policy, dated October 2017, was provided by the nursing home administrator (NHA) on 2/19/26 at 11:04 a.m. It read in pertinent part, Diet orders should match the terminology used by the food and nutrition services department. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: altered consistency diet. If a mechanically altered diet is ordered, the provider will specify the texture modification. The dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets. Snacks will be compatible with the therapeutic diet. III. Resident #62 A. Resident status Resident #62, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, protein-calorie malnutrition, generalized muscle weakness and palliative care. The 11/26/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident was dependent on staff for most activities of daily living (ADL). The MDS assessment indicated the resident did not have signs and symptoms of a swallowing disorder and required a mechanically altered diet. B. Observations On 2/16/26 at 10:16 a.m. Resident #62 was sitting in a chair at a dining table in the common area with an open packet of saltine crackers in her hands and had crumbled one of the crackers onto the floor and into her shoes. At 1:05 p.m. CNA #3 spoke with Resident #62 to see if she wanted anything else to eat aside from the meal she had been served. CNA #3 offered Resident #62 chips, a granola bar or crackers. Licensed practical nurse (LPN) #6 was standing nearby and asked CNA #3 if Resident #62 had eaten her crackers from earlier, to which CNA #3 replied she had eaten four of her crackers. On 2/17/26 at 12:07 p.m. Resident #62 was served a lunch meal plate. The plate contained four (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meatballs approximately 1.5 inches in diameter, cooked spinach, mashed potatoes and noodles which were approximately 1.5 to 2 inches long. An unidentified staff member spoke with Resident #62 to see if she wanted to be seen by her physician, and when the resident refused, the staff member oriented Resident #62 to her meal tray before leaving. At 12:16 p.m. Resident #62 speared a meatball on her fork and attempted to feed herself. Resident #62 brought the meatball to her mouth and tried to take a bite of it but was unable to do so, and the meatball dropped into her lap and rolled onto the floor. C. Record review The February 2026 CPO revealed the following physician's order: Regular diet, Level 6 soft and bite-sized texture, thin liquids, ordered on 5/22/25. Resident #62's nutrition care plan, revised 11/26/25, revealed Resident #62 was at risk for altered nutritional status due to her cognitive deficits, history of malnutrition and vitamin D deficiency. Pertinent interventions included providing Resident #62 her diet, supplements and vitamins per physician's order and catering to her food preferences and offering alternatives as needed. D. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 2/18/26 at 1:03 p.m. CNA #3 said she had recently started working at the facility and had just finished her orientation. CNA #3 said she had mostly learned the differences between the different diet textures by looking at posters in the common area. CNA #3 said residents who had difficulty swallowing received pureed diet textures, and could not have regular texture food. CNA #3 said Resident #62 was on a soft and bite-sized or minced and moist diet texture. CNA #3 said residents on soft and bite-sized or minced and moist diet textures could have snacks including pudding, applesauce or ice cream. CNA #2 was interviewed on 2/18/26 at 1:31 p.m. CNA #2 said there were a lot of residents on her unit who received altered texture diets. CNA #2 said Resident #62 received an altered texture diet. CNA #2 said she relied on looking at the residents' meal tickets and the poster on the wall to know what diet texture the residents were ordered and what it should look like. CNA #2 said residents who received soft and bite-sized or minced and moist diet textures could have snacks including soft cookies or fig cookie bars. CNA #2 said if those snacks were unavailable, the residents could have ice cream, pudding or applesauce. CNA #2 said the facility provided a lot of education to the nursing staff on diet textures. Licensed practical nurse (LPN) #5 was interviewed on 2/19/26 at 8:58 a.m. LPN #5 said the facility provided in-services on the different diet textures often. LPN #5 said residents who were ordered to have a soft and bite-sized diet texture could have chopped up fruits, oatmeal cookies chopped up and served with milk, or pudding. The registered dietitian (RD) was interviewed on 2/19/26 at 9:35 a.m. The RD said as far as she knew, the staff members serving residents their trays were trained on the different diet textures. The RD said the dietary staff should check the resident's meal ticket while plating, and the dietary aides would check the meal ticket as well. The RD said she did not expect the nursing staff to check residents' plates as they were delivering them, as she thought the two checks in the kitchen should (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but did not get it. He said he would drink his protein drink if he can reach it. An unidentified CNA entered the room, opened a protein drink that was sitting on the table and offered it to the resident. -The unidentified CNA did not thicken the protein drink. D. Record review The February 2026 CPO revealed the following physician's order: Regular diet, soft and bite-sized texture, mildly thick liquids, ordered on 7/28/25. Resident #62's nutrition care plan, revised 7/29/25, revealed Resident #84 had difficulty chewing due to partial upper and lower dentures. Pertinent interventions included providing Resident #84 his diet, supplements and offering the diet as ordered. V. Resident #53 A. Resident status Resident #53, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included weakness on the right dominant side and dysphagia. The 1/1/26MDS assessment revealed the resident was cognitively impaired and a BIMS score was not conducted. The resident was dependent on staff for most activities of daily living (ADL). The MDS assessment indicated the resident did not have signs and symptoms of a swallowing disorder and required a mechanically altered diet. The resident was receiving hospice services. B. Observations On 2/16/26 at 11:23 a.m. resident in bed on his left side, facing the wall, unopened chocolate protein drink observed on the table away from bed. At 1:55 p.m. Resident #53 was served chopped broccoli that did not meet the level five soft and bite sized IDDSI size recommendation of 1.5 cm by 1.5 cm. C. Record review The February 2026 CPO revealed the following physician's order: Regular diet, level five minced and moist texture, mildly thick liquids, ordered on 4/23/25. Resident #53's nutrition care plan, revised 2/17/26, revealed Resident #53 was at risk for malnutrition due to a history of stroke and liver disorder. Pertinent interventions included providing Resident #53 his diet, supplements and offering diet as ordered. D. Staff interviews (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #5 was interviewed on 2/17/26 3:50 p.m. She said Resident #84 was on a soft and bite size diet, and nectar thick liquids. She said all drinks are mixed for him by CNAs. She said she used two packages of thickener per one paper cup of liquid. She said they also had a thickener that was premade. She pointed to the thickened liquid on the hydration cart, the label read honey consistency. CNA #5 said Resident #53 was also on a soft and bite size diet. She said the minced and moist diet was almost the same but meant for residents who did not have teeth. She said the minced and moist was softer and had smaller pieces. She said all protein drinks should be thickened before given to both residents. CNA #3 was interviewed on 2/17/26 at 4:15 p.m. She said Resident #53 was on a moist and minced diet and thickened liquids. She said a protein drink was given to him once, yesterday (2/16/26) in case he wanted anything besides the meal. She said Resident #53 did not eat or drink anything that was offered for lunch on 2/26/26. The RD was interviewed on 2/19/26 at 11:30 p.m She said protein drinks should be served chilled to ensure thickened consistency. - However, the manufacturer's recommendation from the protein company indicated that none of their products meet the criteria for mildly thick liquids. Registered nurse (RN) #3 was interviewed on 2/9/26 at 1:30 p.m. She said Resident #84 was on a soft and bite size diet and thickened liquids. She said protein drink was not thickened, but should be given to the resident chilled as it has thickened consistency when chilled. She said all protein drinks were stored in the refrigerator. VI. Additional observations and interviews During continuous observation on 2/17/26, beginning at 11:35 a.m. and ending at 12:45 p.m., the following was observed during the meal service in the main kitchen: The posted menu indicated residents on a regular diet would receive noodles with meatballs and gravy, cooked spinach which was substituted for cooked broccoli, and a roll. The menu indicated hot dogs were available as an alternative. -At 11:35 a.m. through 12:45 p.m. cook (CK) #2 plated the food, dietary aide (DA) #1 wrapped the plates and DA #2 was placing the plates in the carts. -CK #2 served residents who were prescribed level six soft and bite sized, regular sized noodles. -There were two food bins for the noodles, one bin contained regular noodles and one bin contained noodles for the level five minced and moist diet. There was not a bin for chopped noodles to meet the level five soft and bite sized IDDSI size recommendation of 1.5 cm by 1.5 cm. -There were two bins for the cooked spinach. One bin contained regular cooked spinach and the other bin contained the pureed spinach. There was not a bin for chopped spinach to meet the level five soft and bite sized IDDSI recommended size 1.5 cm by 1.5 cm. (continued on next page)

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	065052	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Post Acute	2121 Mesa Dr Boulder, CO 80304

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CK #2 said there was a substitution for the vegetable and he did not have the extension for the spinach. -CK #2 had cut up a hot dog for a level six soft and bite sized diet, however; after plating there were several pieces that were not the recommended size of 1.5 cm x 1.5 cm on the plate. Upon prompting the plate was removed from service and the hot dog was cut up into smaller pieces. VII. Additional staff interviews DA #2 was interviewed on 2/18/26 at 9:00 a.m. She said she has not had the IDDSI training at this facility but was aware of different diet texture sizes from previous jobs. She said it was her job to double check the meal matched the diet ticket before placing them in the cart. CK #2 and DA #1 were interviewed together on 2/18/26 at approximately 10 a.m. DA #1 said she had not had any formal training on the IDDSI textures. She said her job was to wrap the plates with plastic wrap before they went into the cart and she checked that the meal matched the diet ticket. CK #2 said he had some texture training but mostly was learning from the other cooks on what to serve for the mechanically altered diets. The RD was interviewed on 2/19/26 at 9:33 a.m. She said she and the speech language pathologist (SLP) provided training on the IDDSI diet in the past, but was not sure if everyone had gone through the training. The RD said diet extensions provided the cook a resource to know what foods to plate for the different diets and textures and if there was a change to the menu the dietary manager (DM) was responsible to provide education to the servers on the extensions. The RD said there were checks in place during the meal service to ensure the meal matched the ticket. She said the cook was the first check as they plated the food, then the DA who wrapped the plate in plastic wrap was to ensure the meal matched the meal ticket and there was a third DA who was to check the plates against the meal ticket before placing the meals in the carts for delivery. The RD said all kitchen staff should be trained on diet and mechanically altered textures to avoid wrong diets/textures going to the residents. The RD said for the meal with noodles, meatballs and cooked spinach, she expected the noodles, and spinach to be chopped up. She said the meatballs and hot dogs should have been cut up for the soft and bite-sized diet to the level six soft and bite-sized size. The DM was interviewed on 2/19/26 at 10:00 a.m. The DM said meat, such as the meatballs and the hot dogs, should have been cut up to the correct size for the soft and bite-sized texture. The DM said since she started three weeks ago, she had trained the cooks on the IDDSI diets and planned on the rest of the dietary staff to go through the training. She has three scheduled training opportunities for all staff regarding the IDDSI diets. The DM said to ensure residents receive their correct diet and textures there were three people who check the plates before it goes to the floor, the cook who plated the food, the DA who wrapped the plates and another DA who puts the plate in the cart to be delivered.

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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, record review, and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease.Specifically, the facility failed to:-Ensure staff performed appropriate hand hygiene while assisting residents with eating; and,-Don (put on) appropriate personal protective equipment (PPE) when entering Resident #1's room, who was on transmission-based precautions; and,-Ensure housekeeping staff followed appropriate infection control guidelines when cleaning residents' rooms. Findings include: I. Failed to ensure staff performed appropriate hand hygiene while assisting residents with eating A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 2/23/26 from https://www/cdc.gov/cleanhands/hcp/clinical-safety/index.html, Hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of germs, including those resistant to antibiotics. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings. B. Facility policy and procedure The Hand Hygiene policy and procedure, dated 2025, was provided by the nursing home administrator (NHA) on 2/19/26 at 12:21 p.m. It read in pertinent part, Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hand hygiene will be performed between resident contacts and after assistance with personal body functions. C. Observations On 2/16/26 at 12:16 p.m. certified nurse aide (CNA) #2 was sitting in the dining room at a table assisting two unidentified dependent residents with eating. CNA #2 was alternating offering each resident a bite of food. -CNA #2 did not perform hand hygiene between assisting the two residents. On 2/17/26 at 12:13 p.m. CNA #2 was sitting at a dining table assisting an unidentified dependent resident with eating. CNA #2 stood up to help another unidentified resident unwrap her silverware, then continued assisting the first resident with eating. -CNA #2 did not perform hand hygiene before or after assisting the other resident with her silverware (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or before returning to assist the first resident with eating. At 12:17 p.m. CNA #2 was sitting in the dining room at a table assisting two unidentified dependent residents with eating. CNA #2 was alternating offering each resident a bite of food. -CNA #2 did not perform hand hygiene between assisting the two residents. At 12:25 p.m. CNA #2 wiped one unidentified resident's mouth with a napkin before returning to assist a different resident with eating. -CNA #2 did not perform hand hygiene between assisting the residents. D. Staff interviews The infection preventionist (IP) was interviewed on 2/19/26 at 12:21 p.m. The IP said the nursing staff should perform hand hygiene before entering the dining room, between each resident when passing out meal trays, and after the meal service was finished. The IP said staff members should perform hand hygiene after assisting each resident prior to moving to assisting the next resident. II. Failed to don appropriate PPE when entering Resident #1's the room, who was on transmission-based precautions A. Observations On 2/17/26 at 11:40 p.m. the sign on Resident #1's door read Contact precautions, everyone must wear gloves and gown before entering the room. -At 11:41 a.m. CNA #4 entered the resident's room without putting on a gown or gloves. -At 11:42 a.m. registered nurse (RN) #1 entered Resident #1's room without putting PPE on. RN #1 was holding a large syringe containing a red liquid. At 11:45 a.m. CNA #4 exited Resident #1's room, sanitized her hands, and left the area. -At 11:47 a.m. CNA #4 returned to the resident's room with extra linens and entered the room. CNA #4 again did not put on a gown or gloves before entering the room. B. Staff interviews RN #1 was interviewed on 2/17/26 at 1:05 p.m. RN #1 said Resident #1 was on enhanced barrier precautions (EBP)but she did not know why. She then said the resident was on contact isolation precautions and she did not know why. She said in both cases, whether the resident was on EBP or contact isolation precautions, a gown and gloves should be worn in the resident's room. RN #1 said she had a busy day and she did not read the sign on the resident's door which instructed staff to wear gloves and a gown before entering the room (see above). CNA #4 was interviewed on 2/17/26 at 1:10 p.m. CNA #4 said she put a gown and gloves on in the room, not outside because the resident was on contact precautions. She said the unit manager who was assigned to the resident's room changed the sign several times and it was confusing what (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions the resident was on. Licensed practical nurse (LPN) #7 was interviewed on 2/18/26 at 2:03 p.m. LPN #7 said she was a unit manager assigned to Resident #1's room. She said the resident was on contact precautions for multi-drug resistant organisms (MDROs) in the urine. She said the resident was on enhanced barrier precautions as well because she had indwelling devices such as a midline catheter and a gastrostomy tube. LPN #7 said both precautions required the same PPE of a gown and gloves. The IP was interviewed on 2/19/26 12:43 p.m. The IP said staff should have followed the precautions sign on Resident #1's door. She said the resident was on droplet and contact precautions on Monday (2/16/26), later she was only on the contact precautions and currently was only on enhanced barrier precautions. She said for droplet precautions, a mask must be worn and for contact precautions, a gown and gloves should be put on before entering the room. The IP said she was responsible for placing signs on the residents' doors for precautions and she provided education to staff when isolation precautions were initiated. However, she said at times, the task was delegated to the floor nurse when she was not available in the building. III. Failed to ensure housekeeping staff followed appropriate infection control guidelines when cleaning residents' rooms A. Professional reference According to the Lucasol One Step Hospital Grade Disinfectant manufacturer's guidelines, retrieved on 2/26/26 from https://lucasproducts.com/lucas-products-online-store/lucasol-one-step-hospital-grade-disinfectant-gallon/, Lucasol One Step Hospital Grade Concentrate Disinfectant has a 100% kill rate of bacteria, viruses, and fungus in 10 minutes. B. Observation On 2/18/26 at 10:05 a.m. housekeeper (HK) #1 was observed cleaning resident room [ROOM NUMBER]. She sanitized her hands and donned gloves, then grabbed a clean cleaning rag. She sprayed One Step Hospital Grade Disinfectant on the outer door knob and the entrance door, then immediately dried both areas sprayed with the cleaning rag. -HK #1 did not wait for the dwell time of 10 minutes before wiping off the disinfectant spray (see professional reference above). HK #1 proceeded to spray the sink with the same disinfectant and then immediately wiped the sink with the same cleaning rag. -HK #1 did not wait for the dwell time of 10 minutes before wiping off the disinfectant spray HK #1 retrieved a new cleaning rag, dropped it on the floor, picked it up and proceeded to clean the mirror. -HK #1 failed to obtain a new cleaning rag after dropping the initial cleaning rag on the floor prior to cleaning the mirror. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HK #1 proceeded to spray the toilet bowl with the same disinfectant she had been using. She next used a toilet brush to clean the inside of the toilet bowl, the rim of the toilet, and then the bottom of the toilet seat lid. -HK #1 failed to clean the toilet from the cleanest area to the dirtiest area (the inside of the toilet bowl). HK #1 proceeded to sweep and mop the floor and then exited room [ROOM NUMBER]. C. Staff interviews HK #1 was interviewed on 2/18/26 at 10:20 a.m. HK #1 said she should have gotten a new cleaning rag when she dropped her other cleaning rag on the floor. She said she should have cleaned the outer bowl of the toilet and then the inner bowl of the toilet with the toilet brush. She should have disinfected all the doorknobs and handrails. The IP was interviewed on 2/19/26 at 12:20 p.m. The IP said HK #1 should clean areas from cleaner to dirtier surfaces. She said that there was a risk of greater contamination of surfaces when the process was not followed, which could cause illness. The corporate maintenance director was interviewed on 2/19/26 at 1:15 p.m. The corporate maintenance director said HK #1 should have waited for the appropriate dwell time when using the One Step Hospital Grade Disinfectant. The corporate maintenance director said HK #1 should have cleaned the toilet from the cleaner surface to the dirtier surface. The corporate maintenance director said the housekeeping supervisor would do education with HK #1.