| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065139 | A. Building<br>B. Wing | 01/29/2026 |

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| Good Samaritan Society -- Loveland Village | 2101 S Garfield Ave<br>Loveland, CO 80537 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#108) of eight residents reviewed for accidents out of 35 sample residents remained free from accidents.Specifically, the facility failed to ensure staff consistently implemented fall interventions for Resident #108, which resulted in a fall with major injury.Resident #108 was admitted to the facility on [DATE] with diagnoses of severe obesity, pain in the right knee, muscle weakness, and a right lower extremity hematoma (a solid swelling of clotted blood within the tissue) sustained prior to admission to the facility due to a fall at home from rolling out of bed while asleep. Resident #108 had moderate cognitive impairments, per staff interview, and was at risk for falls related to obesity, right lower extremity hematoma and muscle weakness. Resident #108 required two to three staff members for maximum assistance to roll in bed.Resident #108 experienced an unwitnessed fall on 8/11/25 when staff failed to position a floor mat appropriately in front of the resident's bed, resulting in a traumatic subdural hemorrhage (a condition where blood leaks from damaged veins into the brain) with loss of consciousness.During the facility's investigation of the fall, it was discovered that the floor mat was not positioned in front of the resident's bed, the resident's bed was not in a low position, and the resident was using a standard-size bed despite her body habitus. Staff failed to reposition the resident's fall mat after it had been removed to provide adequate space for the resident's care.Due to the facility's failure to ensure that staff adequately assessed the resident to obtain the proper bed size and to staff placement of a fall mat, Resident #108 sustained a fall on 8/11/25, which resulted in a subdural hemorrhage with loss of consciousness requiring immediate surgery. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 1/26/26 to 1/29/26, resulting in the deficiency being cited as past noncompliance, with a correction date of 8/15/25.I. Incident on 8/11/25On 8/11/25 at 9:30 p.m. staff moved Resident #108's extended sleep surface (floor mat) to provide care for the resident but failed to replace it afterward.At 11:00 p.m. a nurse rounded on Resident #108 and observed her sleeping. However, the nurse failed to notice or correct the missing floor mat.At 11:15 p.m. Resident #108 fell from the bed, hitting her head. The fall was discovered after another resident heard a noise and alerted the nurse.II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #108The corrective action plan implemented by the facility in response to Resident #108's fall on 8/11/25 was provided by the nursing home administrator (NHA) on 1/27/26 at 2:15 p.m.The plan read:On 8/12/25, the facility conducted an investigation of Resident #108's fall. The facility interviewed staff on duty who were involved in care for the resident on the day of the fall (8/11/25) and a few days prior to the fall.Review of Resident #108's admission assessment revealed the resident was provided a standard-size bed, and the fall mat was folded by the window and not in position (on 8/11/25). The staff failed to place the floor mat in front of the resident's bed after removing it to provide care to Resident #108.All interviewed staff on duty providing care for Resident #108 reported that the floor mat was not in place and the resident's bed was not lowered to the floor.The last interaction with the resident was reported around 8:06 p.m., about 3 (three) hours prior to the fall, when a certified nurse<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | aide (CNA) reported that Resident #108 was hallucinating. The CNA reported the resident believed a lady was living in her closet.On 8/12/25, Resident #108's room was set up with additional fall precautions pending the resident's return (from the hospital), which included a bariatric bed, two extended sleep surfaces (floor mat) and an edge-defining mattress pad.On 8/14/25, all direct care staff who were working during the fall and cared for the resident were interviewed.Education was provided to all direct care staff who were involved the night of the resident's fall. (Date not provided).B. Identification of other residentsOn 8/11/25 the facility conducted a root cause analysis to identify other residents who may have been affected by the deficient practice.On 8/14/25 the facility completed four separate audits and identified other residents in the building who were at risk for falls. Ten identified residents were reviewed for appropriate fall interventions, and five of the 10 had the potential to be affected. Two of the five residents had already been discharged from the facility, but their care plans were not updated. The other three residents had their care plans updated on 8/15/25.A fall intervention equipment audit on residents who have had a fall in the last 30 days was completed.On 8/14/25, the initial audit identified 14 residents within the audit criteria who were potentially affected, with no action required.C. Systemic changesOn 8/12/25, education for admissions personnel on Pre-admission Data Collection was completed, and a verbal check was added with the director of nursing (DON) for high-risk admissions to the admission checklist.The interdisciplinary team (IDT) re-educated staff on SAFE: Speaking up for safety, along with examples of how to escalate safety concerns up the chain of command. Training completed on 8/15/25.Nurse management clinical educator re-educated licensed nurses on change of condition policy, SAFE: Speaking up for safety, baseline care plan policy, clinical alerts, and bariatric resource packet. Training completed on 8/15/25.D. MonitoringThe director of nursing (DON) or designee was responsible for completing monthly audits times two, quarterly audits times three, and as needed thereafter.The report summarizing the audit findings was to be completed and forwarded to the Quality Assurance Performance Improvement (QAPI) Committee.The QAPI Report Out was to be reviewed by the QAPI Committee for compliance and trends, and to make additional recommendations as needed to support continued improvement.The facility would be in substantial compliance by 8/15/25.Interviews and record reviews during the investigation revealed corrective actions to identify the resident and other residents who may have been affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place at the time of the survey from 1/26/26 to 1/29/26.III. Facility policy and procedureThe Fall Prevention and Management- Rehab/Skilled, Therapy & Rehab (rehabilitation) policy, revised 10/14/25, was provided by director of nursing (DON) #1 on 1/29/26 at 1:50 p.m. It read in pertinent part, The policy's purpose is to promote resident well-being by developing and implementing a fall prevention and management program, to identify risk factors and implement interventions before a fall occurs, to give prompt treatment after a fall occurs, and to provide guidance for documentation. On admission or readmission, review the applicable documents (discharge summary from transferring agency, transfer record, history and physical, lab values, nursing admit/readmit data collection) and any additional admit information documentation for fall risk factors.IV. Resident #108A. Resident statusResident #108, age greater than 65, was admitted on [DATE] and discharged to the hospital on 8/11/25. According to the August 2025 computerized physician orders (CPO), diagnoses included muscle weakness, pancytopenia (a serious blood disorder defined by a simultaneous, significant reduction in all three major blood cell types), severe obesity and pain in the right knee.The 8/11/25 minimum data sets (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The resident required maximum assistance from staff with mobility, moderate assistance with personal hygiene and setup assistance with eating.B. Record reviewResident #108's fall care plan, initiated 8/9/25 and revised 8/21/25, revealed the resident was at risk for falls. It documented Resident #108 was hospitalized prior to admission for rolling out of bed while asleep with self-reported head injury, weakness, impaired mobility, balance, (continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | endurance and safety awareness. Interventions included reviewing the resident's medical record for medications or a combination of medications that could increase fall risk, reviewing the status of any medical conditions that predisposed the resident to falls or that could increase the risk of injury from falls.According to the facility's fall incident report, dated 8/11/25, Resident #108, who required total assistance for all mobility and had been assessed as a low risk for falls, was found lying face down on the floor next to her bed on 8/11/25 at 11:15 p.m. Earlier that evening, staff provided care at 9:30 p.m. and had moved her extended sleep surface (floor mat), but failed to put it back in place. At 11:00 p.m., the nurse had rounded on the resident and observed her sleeping in bed, but did not notice the missing sleep surface (floor mat).At 11:15 p.m., the resident fell out of bed, hitting her head. She was wearing a CPAP at the time of the fall, which had caused a seven-inch indentation on the right side of her face. She also sustained facial swelling and a right subdural hemorrhage.The fall was discovered when another resident had heard a noise and alerted the nurse.According to the hospital Discharge summary, dated [DATE], Resident #108 was admitted to the hospital on [DATE] after a fall at a long-term care facility. She was diagnosed with traumatic brain injury and soft tissue hematoma. The resident did not return to the facility.V. Staff interviewsLicensed practical nurse (LPN) #4 was interviewed on 1/27/26 at 4:08 p.m. LPN #4 said a resident with a history of falls should be rated as a high fall risk until proven otherwise. She said it was the nursing staff's responsibility to ensure that all safety equipment was in place to prevent accidents. LPN #4 said she was re-educated about fall prevention.Registered nurse (RN) #2 was interviewed on 1/29/26 at 9:20 a.m. RN #2 said it was the responsibility of every admissions nurse to ensure all safety precautions and equipment were available to the resident upon admission. RN #2 said a resident with a history of recent falls would be assessed as high risk for falls for at least the first four weeks after admission to ensure their safety. She said the admission nurse should ensure the resident was assigned the appropriate bed size based on the assessment. RN #2 said she had received education on safe universal reliability skills.The DON #2 was interviewed on 1/28/26 at 5:00 p.m. The DON said Resident #108 had experienced a fall at home and had been hospitalized prior to admission. He said Resident #108 was a high fall risk and was assessed as low risk upon admission to the facility. The DON said his investigation revealed staff on duty the night of the fall (8/11/25) failed to position the floor mat by the resident's bed. DON #2 said the facility staff should have provided a bariatric bed for the resident due to her size. He said he did not know why the staff failed to place the floor mat at the appropriate position. DON #2 said facility staff were all trained on safety measures and facility protocols.The nurse practitioner (NP) was interviewed on 1/28/26 at 4:40 p.m. The NP said Resident #108 was admitted to the facility on [DATE], but he did not meet the resident until 8/11/25, in the morning. The NP said during his assessment of Resident #108 on the morning of 8/11/25, the resident did not exhibit signs of distress or confusion. The NP said he did not recall being notified by staff of the resident's change in condition. He said blood pressure outside the normal parameters was considered a change in condition. The NP said the staff should have notified him earlier in the day of the resident's hallucinations and confusion and ensured the resident's floor mat was in place. The NP said he could not speak to the reason why the resident's floor mat was not in place. He said the floor mat being in place could have prevented or reduced the extent of the resident's injuries.The NHA and DON #1 were interviewed together on 1/29/26 at 5:40 p.m. The NHA said she was involved in the 8/11/25 fall investigation for Resident #108. The NHA said all fall incidents were reviewed by the interdisciplinary team (IDT). The NHA said the rounding nurse on 8/11/25 should have noticed that Resident #108's floor mat was not in place during her rounds, which could have prevented the resident's injury. She said education was provided to all nursing staff on the safety measures to prevent recurrence.DON #1 said the root cause analysis and the fall investigation revealed Resident #108 had her CPAP on, which might have caused the facial injuries. She said wearing a CPAP mask without supplemental oxygen could decrease oxygen saturation but could not say that the resident not having her CPAP on had contributed to the resident's fall. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent abuse for one (#44) of three residents reviewed for abuse out of three sample residents.Specifically, the facility failed to protect Resident #44 from mental abuse involving certified nurse aide (CNA) #4, CNA #5 and CNA #1. Findings include:I. Resident #44A. Resident statusResident #44, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes, obesity and foot drop (the inability to lift the front part of the foot due to weakness).The 12/31/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent upon staff for helping with lower body dressing. The resident used a manual wheelchair and was able to self-propel herself for mobility. B. Resident interviewResident #44 was interviewed on 1/29/26 at 9:54 a.m. Resident #44 said CNA #1 came into her room and asked her if she wanted to help her and CNAs #4 and #5 pull a prank on CNA #3. Resident #44 said she told CNA #1 it was okay. She said CNA #1 hid under Resident #44's bed with a blanket on top of her and waited for CNA #3 to come into the room so she could grab her ankle and scare her. She said CNA #4 was also present in the room, waiting for CNA #3. Resident #44 said CNA #4 put her phone up against the wall and began recording. Resident #44 said none of the CNAs asked her for her permission to set the phone up and record in her room. Resident #44 said the phone was angled toward her bed, while she was sitting in her wheelchair, off to the side of the room. Resident #44 said the phone screen was facing away from her so she could not see herself on the screen and could not tell what was being recorded. Resident #44 said CNA #3 came into her room and CNA #1 attempted to prank her by grabbing her ankle. Resident #44 said after the prank, the CNAs transferred her to her bed and started taking her shorts off when Resident #44 realized the phone was still set up. Resident #44 said she told CNA #4 that her phone was still set up. Resident #44 said CNA #4 apologized and started pushing buttons on her phone and then said Believe me, I don't want that on my phone anyway. Resident #44 said CNA #4 did not show her the phone or what was recorded. Resident #44 said it made her feel very uneasy. She said it bothered her because she did not know what had been filmed. She said she did not know if the video got posted online either.C. Record reviewResident #44's psychosocial care plan, initiated 9/10/25, revealed the resident had a psychosocial well-being deficit related to actual reliving of trauma related to a recent prank as evidenced by heart palpitations, feeling on guard and detached. Interventions included mental health counseling with a psychologist and avoiding discussing the traumatic event with or around the resident.A Trauma Assessment, dated 9/26/25 at 4:00 p.m. identified that in the past month, Resident #44 continued to be affected by her experience with staff members (prank video) earlier in the month. The document further identified that in the past month, Resident #44 was constantly on guard, watchful or was easily startled. It further identified that in the last month, Resident #44 had felt numb or detached from people, activities or her surroundings. The assessment identified that in the past month, Resident #44 had tried hard not to think about the incident and went out of her way to avoid situations that reminded her of the events. The assessment identified that Resident #44's trauma symptoms and triggers included interacting with certain staff members and hearing the event (prank video) discussed. The assessment additionally identified Resident #44's support and coping strategies and indicated Resident #44 began counseling services to help support her psychosocial needs and to help identify helpful coping mechanisms for reliving traumatic experiences. The assessment documented a trauma care plan was added to the resident's medical record.II. Staff interviewsCNA #1 was interviewed on 1/28/26 at 5:30 p.m. CNA #1 said she was part of the prank involving Resident #44 in September 2025. CNA #1 said there was no video taken of the resident, to her knowledge. CNA #1 said she did not discuss the phone with the resident as she was<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on the floor throughout the prank. CNA #1 said she had nothing to do with the phone. CNA #1 said the facility conducted an investigation into the incident and all CNAs were assigned education on patient privacy.CNA #4 was interviewed on 1/29/26 at 3:14 p.m. CNA #4 said she had worked at the facility for eight years and she was familiar with Resident #44. CNA #4 said she was involved in the prank video that occurred in September 2025. CNA #4 said she agreed to play a prank on CNA #3 with CNA #1 and CNA #5. CNA #4 said the goal of the prank was to scare CNA #3 when she came into the room. She said CNA #1 hid under the bed and was going to try to grab CNA #3's ankle. CNA #4 said Resident #44 wanted to be a part of the prank and was okay with the prank taking place in her room. CNA #4 said she set her cell phone up against the wall in Resident #44's room to record the prank on Snapchat, an app which limited recording time to two to three minutes and then stopped recording automatically. CNA #4 said she did not ask Resident #44 if it was okay to prop the phone up and record in the resident's room. CNA #4 said she did not ask Resident #44's permission because Resident #44 seemed happy to be a part of the prank, and the CNAs had a close relationship with the resident.CNA #4 said the phone was positioned up against the wall and was facing Resident #44's curtain and bed. CNA #4 said she recorded the video on Snapchat, which captured two to three minutes of video. CNA #4 said the recording only captured herself, standing by the bed and the curtain, waiting for CNA #3 to come into the room. CNA #4 said Resident #44 was not present in the video at any point in time. CNA #4 said it took about 10 minutes for CNA #3 to come into the room, and by that time the Snapchat video had automatically stopped after a limited two to three minutes. CNA #4 said CNA #3 finally came into Resident #44's room, saw CNA #1 hiding under the bed and the prank did not work. CNA #4 said once the prank was over, she un-propped her phone, deleted the video, and put her phone flat on the sink. CNA #4 said she told Resident #44 that she deleted the video before the CNAs began transferring Resident #44 back to her bed. CNA #4 said she told Resident #44 the video was deleted but did not show Resident #44 her phone.The campus administrator was interviewed on 1/29/26 at 4:45 p.m. The campus administrator said the CNAs should not have created the video in Resident #44's room. The campus administrator said management discussed the incident and reviewed the social media policy with the CNAs. The campus administrator said the CNAs were suspended pending investigation and they were all assigned online education on resident privacy. The campus administrator said all three CNAs had received a written discipline for the incident involving Resident #44.The nursing home administrator (NHA) was interviewed on 1/29/26 at 4:45 p.m. The NHA said CNA #1 was no longer allowed to work with Resident #44. Director of nursing (DON) #1 was interviewed on 1/29/26 at 4:45 p.m. DON #1 said the other CNAs (CNAs #3,#4, and #5) involved in the incident with Resident #44 were kept off of Resident #44's hallway as much as possible and were scheduled to work other hallways as much as possible.III. FACILITY FOLLOW-UPThe facility investigation was provided by the NHA on 1/27/25 at 4:02 p.m. The investigation documented an interview with Resident #44. It read, as follows, The resident indicated on September 5th, 2025 she turned on her call light as she was ready for bed. One of the CNAs came in and stated she wanted to pull a prank on another CNA by getting under the resident's bed and grabbing the ankle of the other CNA. The resident stated she didn't care if they played pranks and agreed to the prank. Another CNA came in while the first CNA got under the bed and was covered with a blanket. The second CNA propped up her phone by the resident's sink while the resident was still in her wheelchair. The resident stated the fourth CNA did not fall for the prank as she saw the blanked under her bed. The third CNA came into the room and the second and third CNAs placed the sling under her and transferred her into bed with the total lift that the fourth CNA subsequently brought in (the CNA who was having the prank played on). The CNAs were assisting with removing her [Resident #44] shorts and brief. The resident then told the second CNA to turn the phone off as she gave permission to the prank, but not permission to be recorded. The resident stated the second CNA told her she wouldn't want that on her phone. After the initial interview and obtaining the residents statement, the next day the resident went to the Director of Social Services office and stated she wanted to make sure none<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of the CNAs were fired. She stated she likes that the girls like to have fun at work,, she just wanted to make sure her butt was not all over social media.Interviews were completed with involved staff as well as other staff who may have had direct knowledge of the allegation. The investigation identified that most CNAs involved in the incident (CNA#1, #4, and #5) were suspended until the facility completed the investigation. The three CNAs involved in the incident received written corrective action for violating the facility's photography and video policy. The facility provided education regarding privacy and confidentiality to the CNAs involved and to all facility staff. The investigation identified that the facility required care in pairs (two people to perform care for the resident together) to ensure Resident #44 felt supported. The facility conducted a trauma assessment for Resident #44 and was offered counseling. The investigation indicated the resident remained at the facility and at her baseline with no lingering signs or symptoms of mental anguish or distress identified. The investigation indicated Resident #44 had been observed participating in her normal daily routine.The investigation conclusion identified the facility did not substantiate neglect of Resident #44's psychosocial wellbeing. The conclusion identified Resident #44 agreed to be part of the prank and laughed during that time. The resident only became concerned when she thought she was being recorded. The facility conclusion identified no recording of the resident occurred. The three CNAs did not intend to record the resident, post it on social media, or hurt the residents feelings in any way. The facility substantiated that the three CNAs violated the facilities' photography and video policy.A Resident Rights Violation documentation was provided by the NHA on 1/20/25 at 4:49 p.m. The document reads in pertinent part, A CNA put her cell phone on the sink facing the resident bed, the curtain between the two residents beds was pulled, the resident was in her wheelchair at the end of the bed. The video started while they waited for the CNA to answer the call light. The CNA they were waiting for did not come for several minutes. The video had stopped recording and the prank did not work, the CNA picked up her phone and x'ed out of the video (which does not save the video) and did not send the video to anyone. The video was not saved or sent from this incident, however the CNAs should never have attempted to video or take photos in a resident room even when the resident was not going to be in the video. It documented this was a violation of the resident's right to privacy as she did not give written consent. It was determined the recording that was deleted did not have the resident on the screen, instead it was of the bed with a CNA hiding under the bed with a blanket over them. This situation does not fall under abuse because there was never intent to demean or humiliate the resident, rather it was the staff playing a prank on the other staff member that the resident had asked to be a part of. The facility concluded the CNAs involved failed to follow the Policy for Resident Dignity under procedure 2 (m): Refraining from taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment, e.g., cameras, smart phones and other electronic devices, and or/keeping or distributing unauthorized photographs or recordings of residents through multi-media messages or on social media. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for three (#1, #4 and #110) of 10 residents out of 35 sample residents. Specifically, the facility failed to: -Ensure an assessment was conducted to determine whether the self-administration of inhaler medications was clinically appropriate for Resident #1 and Resident #110; and, -Ensure an assessment was conducted to determine whether the self-administration of nasal sprays was clinically appropriate for Resident #4.Findings include:I. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included chronic respiratory failure, and chronic obstructive pulmonary disorder (COPD). The 6/13/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required moderate assistance with toileting, bathing, dressing and set up assistance with eating and oral hygiene. B. Resident observation and interviewOn 1/26/26 at 1:00 p.m. Resident #1 was observed in bed in his room. He held an inhaler in his right hand and said he was using it whenever he felt short of breath. He said he had used it for many years but was not sure what kind of inhaler it was. C. Record reviewA review of Resident #1's December 2026 CPO revealed the following physician's order:Albuterol Sulfate (medication used to treat lung diseases) two puffs inhaled orally every four hours as needed for shortness of breath or wheezing, ordered 6/4/25. -A review of Resident #1's electronic medical record (EMR) did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #1 was able to safely administer his own medications.-The EMR did not reveal a physician's order for Resident #1 to self-administer the albuterol inhaler and approval for it to be kept at the resident's bedside.II. Resident #110A. Resident statusResident #110, age greater than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses included chronic respiratory failure and chronic obstructive pulmonary disorder (COPD). The MDS assessment for Resident #110 was not completed at the time of the survey due to the resident's recent admission. B. Resident observation and interviewOn 1/26/26 at 3:00 p.m. Resident #110 was observed in a recliner in her room. Next to her on the table, the resident had an Anora Ellipta (medication used to treat COPD) inhaler. She said she was self-administering the inhaler every morning. C. Record reviewA review of Resident #110's December 2026 CPO revealed the resident did not have a physician's order for the Anoro Ellipta inhaler that she had at her bedside. -A review of Resident #110's EMR did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #110 was able to safely administer her own medications.-The EMR did not reveal a physician's order for Resident #110 to self-administer the Anoro Ellipta inhaler and approval for it to be kept at the resident's bedside. III. Resident #4A. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses included Parkinson's disease and COPD. The 1/7/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required moderate assistance with toileting, bathing, dressing and set up assistance with eating and oral hygiene. B. Resident observation and interviewOn 1/26/26 at 2:00 p.m. Resident #4 was observed sitting in a recliner in his room. Next to him on the table he had a bottle of normal saline nasal spray and fluticasone propionate nasal spray (medication used to treat allergies). He said he self administered both medications independently. C. Record reviewA review of Resident #4's December 2026 CPO revealed the resident did not have a physician's order for the normal saline or fluticasone propionate nasal sprays that he had at the bedside. -A review of Resident #4's EMR did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #4 was able to safely administer his own medications.-The EMR did not reveal a physician's order for Resident #4 to self-administer normal saline or fluticasone propionate nasal sprays and approval for it<br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to be kept at the resident's bedside. IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 1/26/26 at 1:31 p.m. LPN #1 said she did not know that Resident #1 and Resident #110 had inhalers at their bedside or whether or not the residents were able to administer the inhalers themselves. She reviewed the EMRs for both residents and said Resident #1 and Resident #110 did not have an assessment for self- administration of medications. LPN #1 said there should have been an assessment completed to make sure they were capable of administering their own medication. She said if the resident had a self-administration of medications assessment, the assessment would be located in the resident's EMR. -However, there was no self-administration of medications assessment in Resident #1's or Resident #110's EMRs (see record review above). -LPN #1 was not able to locate a physician's order for Resident #110's Anoro Ellipta inhaler. LPN #2 was interviewed on 1/27/26 at 11:10 a.m. LPN #2 said she was unaware Resident #4 had two nasal sprays at his bedside. She said medications should not be left at the resident's bedside without a physician's order. LPN #2 walked to Resident #4's room and observed the normal saline and fluticasone propionate nasal sprays at his bedside. She took the nasal sprays and said she would keep them until the resident was evaluated for self-administration of medications. She said before a resident was able to self-administer their own medications, the nursing staff should determine if the resident knew how to administer their own medications correctly through an assessment. LPN #2 reviewed Resident #4's physician's orders and said the resident did not have a physician order for the nasal sprays that he had at his bedside.Director of nursing (DON) #1 was interviewed on 1/29/26 at 4:50 p.m. DON #1 said if a resident had requested to self-administer medication, the nursing staff would be responsible for completing a self-administration assessment. She said there should be a physician's order in the EMR for the resident to be allowed to self-administer medications. DON #1 said she was not aware that Resident #1, Resident #110 and Resident #4 were self-administering medications without a physician's order and an appropriate assessment. She said she would provide education to the nursing staff to ensure medications were not kept at residents' bedsides without an appropriate self-administration physician's order and a self-administration assessment. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observations and interviews, the facility failed to provide a safe, clean, sanitary and comfortable environment on the 700 unit. Specifically, the facility failed to ensure the common area at the end of the 700 hallway was available to residents for activities.Findings include:I. ObservationsDuring the initial tour of the facility's 700 hallway on 1/26/26 at 9:30 a.m. the following was observed:-Multiple pieces of unused equipment and furniture, such as bed frames, dressers, wheelchairs, and shower chairs were being stored in the common area at the end of the 700 hallway. The area's access was blocked off by yellow tape and two yellow cones. -The area remained a storage area and was unaccessible to residents during the survey on 1/26/26 to 1/29/26. II. Resident group interviewA group of seven alert and oriented residents (#38, #44, #49, #4, #3, #9 and #95), who were deemed interviewable by assessment and the facility, were interviewed on 1/28/26 at approximately 1:00 p.m. The residents said the common area at the end of the 700 hallway had been used as a storage area since summer 2025. The residents said before the area was cluttered with furniture, it used to have tables and chairs where residents could meet with family members and friends. Resident #3 said she used to have a puzzle table in the area at the end of the 700 hallway and now she could not have it because her room was too small for a puzzle table. Resident #44 said she used to meet with her friends and family for a private conversation in the area at the end of the 700 hallway. The residents said they had discussed their concern about not having access to the area at the end of the 700 hallway with management and were told that management was currently working on resolving the matter, however they said it was not resolved. III. Staff interviewsThe maintenance director (MTD) was interviewed on 1/29/26 at 4:30 p.m. The MTD said the common area at the end of the 700 hallway was currently used as a storage area for furniture and equipment. He said when residents moved out and rooms required deep cleaning or renovations, the furniture was moved to the common area on the 700 hallway. He said three sheds (storage areas) that the facility had on the premises were completely full and they had run out of space for storage. The nursing home administrator (NHA) was interviewed on 1/29/26 at 4:50 p.m. The NHA said she was aware of the concerns that residents brought to her regarding the storage area at the end of the 700 hallway. She said residents submitted a petition in early January 2026 asking the facility to clear the area for use and activities. She said the facility was actively searching for other options to store additional equipment. IV. Facility follow upOn 2/1/26 at 3:28 p.m., after the survey exit, the facility submitted electronic pictures of the area. The pictures revealed that the area at the end of the 700 hallway was cleared and supplied with tables and chairs for residents.-However, the concern was not addressed until it was brought to the facility's attention during the survey. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for two of three certified nurse aides (CNA) reviewed. Specifically, the facility did not complete a performance review for CNA #1 and CNA #2.Findings include: I. Record review CNA #1 was hired on 3/12/24. A request for a performance review was made on 1/29/26.-The facility was unable to provide documentation indicating a performance review for CNA #1 was completed in the past 12 months.CNA #2 was hired on 9/19/24. A request for a performance review was made on 1/29/26.-The facility was unable to provide documentation indicating a performance review for CNA #2 was completed in the past 12 months.II. Staff interviews The nursing home administrator (NHA) and director of nursing (DON) #1 were interviewed together on 1/29/26 at 5:40 p.m. DON #1 and the NHA said a skills competency fair was conducted annually and as needed to complete an annual performance review for CNAs. DON #1 said she knew a skills fair took place in summer 2025 but she was unsure of the exact date because it was before she started working at the facility in August 2025. The NHA said the skills fair took place in June 2025. She said the clinical nurse educator was responsible for ensuring an annual performance review was completed for CNAS and she would know when the annual competency skills fair and the annual performance reviews were completed. The clinical nurse educator was interviewed on 1/29/26 at 5:56 p.m. The clinical nurse educator said an annual performance review was not completed for CNA #1 and CNA #2. She said she was not employed when the annual performance reviews were done in summer 2025 and she did not know why CNA #1 and CNA #2 did not have an annual performance review completed. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, record review 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 disease on one of four units.Specifically, the facility failed to ensure enhanced barrier precautions (EBP) were followed during wound care for Resident #10.Findings include:<br><br>I. Professional reference<br><br>According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO), (4/2/24), retrieved on 2/5/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html,<br><br>Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ target gown and glove use during high contact resident activities.<br><br>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.<br><br>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).<br><br>II. Facility policy and procedure<br><br>The Standard, Enhanced Barrier, and Transmission-Based Precautions policy, revised 7/7/25, was provided by director of nursing (DON) #1 on 1/29/26 at 1:50 p.m. It read in pertinent part,<br><br>Enhanced Barrier Precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of a gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi drug-resistant organism (MDRO) to staff hands and clothing.<br><br>EBP are also used for residents with wounds and residents with indwelling medical devices and during high-contact resident care activities, including transfers, dressing, assisting during bathing and providing hygiene.<br><br>III. Observations<br><br>During a continuous observation on 1/27/26, beginning at 4:08 p.m. and ending at 4:20 p.m., a sign was observed posted on Resident #10's doorframe which indicated the resident was on EBP. The sign indicated staff should wear a gown and gloves for high-contact care.<br><br>Licensed practical nurse (LPN) #4 entered Resident #10's room to administer medication to the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident. LPN #4 said Resident #10 had a wound on her right heel and offered to show the wound's location. LPN #4 donned (put on) gloves and obtained the resident's permission to show where the wound was located. She held the resident's feet and removed a heel suspension boot from the resident's foot. LPN #4 removed the dressing on the resident's wound, touched the surface, and gently pressed on it. LPN #4 said the wound was opened, dried, and blanchable. She proceeded to reposition the resident's foot in the heel suspension boot, removed her gloves and returned to her cart. She returned to the room with a new dressing for the resident's wound.<br><br>-LPN #4 failed to don a gown prior to touching Resident #10's wound.<br><br>On 1/28/26 at 1:32 p.m. Resident #10's wound care was observed with the wound care nurse. The wound care nurse entered Resident #10's room and approached the resident who was in bed. She proceeded to remove the dressing from the wound on the resident's heel. The dressing was saturated with yellow drainage. The wound care nurse disposed of the dressing in the trash, removed her gloves and stepped out of the room.<br><br>-The wound care nurse failed to put on a gown prior to removing Resident #10's soiled wound dressing.<br><br>IV. Staff interviews<br><br>LPN #4 was interviewed on 1/27/26 at 4:40 p.m. LPN #4 said Resident #10 was on EBP. She said EBP meant appropriate precautions should be taken when caring for the resident. LPN #4 said there was a sign by the resident's door frame alerting everyone to the precautions required when caring for the resident. LPN #4 said she should have worn a gown before she touched Resident #10's heel wound.<br><br>The wound care nurse was interviewed on 1/28/26 at 3:33 p.m. The wound care nurse said she forgot to put on a gown before she removed Resident #10's dressing, but she was aware that the resident was on EBP.<br><br>Certified nurse aide (CNA) #6 was interviewed on 1/29/26 at 9:20 a.m. CNA #6 said she was familiar with Resident #10. She said the facility's CNAs provided personal care, such as incontinence care and showers. CNA #6 said she did not know what the EBP sign on Resident #10's door frame meant. She said only gloves were required to provide incontinence care and showers for Resident #10.<br><br>The infection preventionist (IP) was interviewed on 1/29/26 at 9:45 a.m. The IP said facility staff had been trained on all precautions. She said a gown and gloves were required for any care that would require staff to come into close contact with a resident on EBP. The IP said LPN #4 should have put on a gown prior to touching the resident's heel wound. She said CNA 6 should have known what the EBP sign meant and the precautions needed to care for Resident #10. She said she did not know why CNA #6 was unable to explain the meaning of the EBP sign. The IP said she would immediately initiate retraining for the staff involved.<br><br>Director of nursing (DON) #1 was interviewed on 1/29/26 at 4:45 p.m. DON #1 said Resident #10 was on EBP due to the wound on the resident's heel. She said nurses should wear gowns when providing wound care to Resident #10.<br><br>DON #1 was interviewed again on 1/29/26 at 5:10 p.m. DON #1 said EBP should be used for residents<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | with wounds and during personal care, such as showers and incontinence care, to prevent the spread of harmful germs and disease. She said staff received training during orientation and as needed. DON #1 said she did not know the reason the staff did not know what the EBP sign on Resident #10's bed frame meant . She said she would ensure staff were retrained on EBP immediately. |