STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065142	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemay Avenue Health and Rehab LLC	4824 S Lemay Ave Fort Collins, CO 80525

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#5 and #15) of four residents reviewed for accidents hazards received adequate supervision out of 16 sample residents. Resident #5 was admitted on [DATE]. Resident #5 required partial assistance from staff to transfer from surface to surface. In December 2025 Resident #5 was presenting with increased anxiety; yelling out; requests to use the bathroom and attempting to self transfer herself to get to the bathroom without staff assistance. Resident #5 fell on 2/4/26 while attempting to self transfer to use the bathroom. The facility failed to address the resident's impulsiveness to attempt to self transfer to use the bathroom. On 2/16/26, Resident #5 fell again and hit her head during an attempt to self transfer to use the bathroom. During this fall, the resident sustained a laceration above her left eye and a brain injury. The resident had a significant change in cognitive status following the fall. Resident #15 was admitted on [DATE] with diagnoses of dementia and severe cognitive impairment. On 4/9/26 and 5/20/26 Resident #15 sustained unwitnessed falls. The facility did not review or update the resident's care plan with new person-centered interventions. On 5/26/26, six days after her last fall, Resident #15 had another unwitnessed fall, resulting in a fracture to her right elbow. Specifically the facility failed to:-Prevent repeated falls resulting in significant injuries for Resident #5 and Resident #15; -Develop and implement person-centered fall care plans to prevent falls for Resident #5 and Resident #15; and,-Ensure all nursing staff were fully trained, understood and were following the facility's fall protocols, including following the purposeful rounding program and the resident person-centered fall prevention care plans for Resident #5 and Resident #15.Findings include:I. Facility policy and procedure The Fall Prevention policy, implemented 4/11/25, was provided by the nursing home administrator (NHA) 6/1/26 at 5:27 p.m. It read in pertinent part, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The facility utilizes a standardized risk assessment for determining a residents fall risk. A fall risk assessment is completed every 90 days and as indicated when the resident's condition changes. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed.The Purposeful Rounding Program document was provided by the NHA on 5/27/26 at 3:55 p.m. It read in pertinent part, Residents placed on the purposeful rounding program may be at higher fall risk, a new admission, have difficulty communicating needs, experiencing a decline, or attempting to anticipate needs. The four P's of the purposeful rounding program include possessions, positioning, personal needs and pain. Staff are to round routinely to meet the resident needs to prevent falls and other injuries by anticipating their needs. II. Resident #5A. Resident statusResident #5 age greater than 85, was admitted on [DATE]. According to the June 2026 computerized physicians orders (CPO), diagnoses included hemiplegia (paralysis) and hemiparesis (partial weakness) following cerebrovascular (stroke) disease affecting the left side, anxiety, overactive bladder, and cognitive communication deficit. According to the 1/28/26 minimum data set (MDS) assessment, the resident was cognitively intact with a brief (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interview for mental status (BIMS) score of 15 out of 15. The resident needed partial to moderate assistance to perform toileting tasks where the staff lifted, held and supported the resident's trunk or limbs. The assessment documented the resident had a history of one fall with injury while residing in the facility.According to the 2/19/26 MDS assessment, the resident had severe cognitive impairments with a BIMS of three out of 15 with disorganized thinking (unclear or illogical flow of ideas). The resident was dependent on staff to perform transfer and toileting tasks. The assessment documented the resident had not sustained any falls while residing in the facility. -However, Resident #5 sustained a fall with major injury on 2/16/26. According to the 5/13/26 MDS assessment, the resident had severe cognitive impairments with a BIMS of two out of 15 with fluctuating disorganized thinking, incoherent rambling or irrelevant conversation, unclear or illogical flow of ideas or unpredictable switching from subject to subject. The resident was dependent on staff to perform transfer and toileting tasks. The assessment documented the resident had not sustained any falls while residing in the facility. -However, Resident #5 sustained a fall with major injury on 2/16/26.B. Record review The fall prevention care plan, initiated 11/18/25 and revised 2/3/26, revealed Resident #5 had the potential for falls related to advanced age, disease process, history of a stroke and a history of falls with the goal of minimizing falls through interventions. The care plan documented the resident refused to wear grippy socks. Pertinent interventions included providing a one-to-one sitter provided by family as much as possible (initiated 2/24/26); anticipating and meeting the resident's needs; keeping frequently used items within reach; placing the resident's bed against the wall; placing the resident's bed in low position; placing a bolster sheet to bed; educating, encouraging and assisting the resident to wear appropriate footwear such as non-skid socks or shoes when ambulating and mobilizing; encouraging the resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility; encouraging utilization of common areas for supervision; placing a fall mat at bedside when resident was in bed; orienting the resident to call light and keeping the resident's call light within reach and encouraging the resident to use it for assistance as needed. -Review of the resident's fall care plan did not reveal the facility reviewed the resident's care plan after she fell on 2/4/26 to ensure the fall interventions remained appropriate. The nursing note, dated 12/26/25, documented Resident #5 had been calling out more at night for assistance rather than using her call light. The note documented the call light was clipped to the blanket and was within the resident's reach.The nursing note, dated 12/29/25, documented the resident was added to the purposeful rounding protocol related to increased anxiety, calling out and falling out of bed. -However, review of the resident's fall care plan did not include purposeful rounding as an intervention. The nursing note, dated 12/30/25, documented Resident #5 was on follow-up monitoring post-fall. The interdisciplinary team (IDT) note, dated 1/30/26, documented the staff were to monitor the resident for signs and symptoms, such as loud crying and calling out in the hall along with impatience, perseverance and attention seeking behaviors because the resident had continued calling out and tearfulness. The nursing note, dated 2/4/26, documented Resident #5 fell and hit her head on the bedside table. The resident told staff she was trying to get to the bathroom. The IDT note, dated 2/9/26, documented the staff were monitoring the resident for increased anxiety with symptoms, such as loudly crying and calling out in the hall along with impatience, preservation, and attention seeking behaviors. The IDT discussed asking the physician to assess the resident and her medications. The resident also had an increase in urge to use the bathroom this past weekend. The note documented the IDT would continue to monitor for behaviors. The IDT weekly fall note, dated 2/11/26, documented Resident #5 had an unwitnessed fall on 2/4/26 at 5:00 p.m. The resident was observed on the floor under her bedside table. The resident said she was trying to go to the bathroom and said she hit her head during the fall. No injury was noted to her head or body. The resident did not use the call light prior to self transfering to use the bathroom. The IDT weekly fall note documented the interventions included placing the bed against wall to decrease obstacles without limiting mobility and in low locked position; items of frequent use including call light kept within reach; proper (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	footwear encouraged; implementation of the purposeful rounding program; a personalized toileting program, and use of a personal care provider arranged by the family. The resident was not compliant with the latest new interventions, including using the call light for assistance with transfer. The fall note, dated 2/16/26, documented the resident fell due to a self transfer attempt to use the bathroom. The resident sustained a laceration above her left eye. The resident's physician was in the facility and requested the resident be transferred to the hospital emergency room for evaluation. The post-fall investigation, dated 2/16/26, revealed certified nurse aide (CNA) #3 entered Resident #5's room to assist her to get up out of bed so she could eat her breakfast. The resident was not assisted or offered toileting assistance. After assisting the resident into her wheelchair and setting up the meal for the resident, CNA #3 left to assist another resident next door at 8:35 a.m. CNA #3 said she noticed Resident #5's call light on and returned to Resident #5's room approximately 15 minutes after leaving her to eat breakfast. CNA #3 entered the room and observed Resident #5 lying on her left side on the bathroom floor. The resident's head was in the shower area and her feet were next to the toilet. The investigation documented that the nurse assessed the resident and notified the resident's physician of the fall and the assessed injuries. The investigation documented that the resident had a laceration that needed sutures. The resident was sent to the emergency room for evaluation and treatment. The investigation documented that Resident #5 had used her call light to call for staff assistance, but attempted a self transfer to get to the bathroom before staff arrived to assist her with using the bathroom. -CNA #3 failed to assist Resident #5 to the bathroom upon getting her up that morning before transferring the resident into her wheelchair to eat breakfast (see CNA #3's interview below).The hospital documentation included computed tomography (CT - imaging scan) results, dated 2/16/26, which revealed that Resident #5 sustained a new multicompartment intracranial hemorrhage, including subarachnoid (bleeding in multiple spaces within the skull); with hemorrhaging (bleeding) along the bilateral frontal lobes and left frontal lobe of the brain. Additional findings included a hemorrhagic contusion, and intraventricular hemorrhage in the lateral and third ventricles. A right temporal convexity subdural hemorrhage (localized bleeding), measuring up to nine milliliters (mm) in thickness. There was no evidence of acute vascular injury (a tear in the veins of the brain).The fall risk evaluation note, dated 2/18/26, revealed Resident #5 had three or more falls in the past three months while residing in the facility, had intermittent confusion, was chair bound and incontinent. The psychiatric follow up note, dated 4/7/26, documented the resident was alert in bed being cared for by a hospice aide. Staff reported that the resident continued to yell out throughout the day except when receiving Ativan (anti-anxiety medication).C. Staff interviewsCNA #3 was interviewed on 5/28/26 at 2:20 p.m. CNA #3 said she was assigned to care for Resident #5 on 2/16/26, the day she sustained a fall. CNA #3 said on 2/16/26, shortly after 8:00 a.m. she assisted Resident #5 to put on her socks and shoes and transfer from her bed to a chair for breakfast. CNA #3 said Resident #5 was completely alert and oriented at the time and was able to make needs known, so CNA #3 did not offer to assist the resident to the restroom or suggest that she go prior to breakfast. -However, the 2/11/26 IDT progress note documented the resident was on a personalized toileting schedule.CNA #3 said after setting the resident up for the meal, she left the room to assist other residents. She said within 10 minutes of leaving Resident #5's room, CNA #3 noticed Resident #5's call light on and heard Resident #5 yelling for help. CNA #3 responded to the resident's call and found the resident on the floor in the bathroom with her head on the shower floor with visible blood observed. CNA #3 said Resident #5 was known to call a lot to use the bathroom.CNA #3 said she did not know Resident #5 was on a personalized toileting schedule the day that she fell (2/16/26). CNA #3 said she was not familiar with how the purposeful rounding program worked, but defined the program as requiring staff to perform rounds every two hours to check on the residents for unmet needs. CNA #3 said that was the standard level of care for all residents. CNA #3 did not know of any other rounding expectations for Resident #5. CNA #3 said she was provided a resident information sheet at the beginning of each shift that documented the care needs of each resident she was assigned to care for. She said the sheet (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was not always updated timely when a resident had a change in condition. CNA #3 said she did not know who was responsible for updating the assignment sheetRegistered nurse (RN) #3 was interviewed on 5/28/26 at 9:45a.m. RN #3 said she had never heard of the purposeful rounding program. CNA #4 was interviewed on 6/1/26 at 1:33 p.m. CNA #4 said he had never heard of the purposeful rounding program or a personalized toileting program but the CNAs were expected to conduct rounds checking on residents every two hours. CNA #4 said each resident should be offered toileting assistance when getting them up in the morning and before and after meals and every two hours.Licensed practical nurse (LPN) #2 was interviewed on 6/1/26 at 3:00 p.m. LPN #2 said the purposeful rounding program was an hourly rounding for those residents who were identified as being on the program. She said there was no standard rounding protocol for those who were not on the program. The director of nursing (DON) and the corporate nurse consultant were interviewed together on 6/1/26 at 6:00 p.m. The DON and the corporate nurse consultant said they were unable to describe the personalized toileting program that was initiated for Resident #5 by the IDT. -However, implementation of a personalized toileting program was listed as an intervention in an IDT note dated 2/11/26. III. Resident #15A. Resident statusResident #15 age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included Alzheimer's disease, contracture to her right hand and fingers, history of falls and weakness.According to the 3/30/26 MDS assessment, the resident had poor short and long term memory recall, poor decision making skills and disorganized thinking with incoherent rambling, irrelevant conversation, unclear or illogical flow of ideas per staff assessment. The assessment documented the resident had difficulty focusing attention and was easily distractible. The assessment documented the resident was able to walk at least 150 feet in a corridor with staff supervision and occasional touching assistance and/or verbal cues in order to stabilize herself. The assessment documented the resident did not have any falls in the facility.B. Record reviewThe fall prevention care plan, initiated and revised 11/25/25, revealed Resident #15 had a history of falls. Pertinent interventions included ensuring lighting was adequate; maintaining a clutter free environment; ensuring the call light was within reach and encouraging use; ensuring items were within reach;providing assistive devices as needed; and, reviewing information on past falls and attempting to determine the cause of falls as indicated.A post-fall investigation, dated 4/9/26, documented Resident #15 had an unwitnessed fall in another resident's room. The resident was lying on her back in between the recliner and sink. The note documented the resident said she did not hit her head. The resident was assessed and then lifted into a recliner with the mechanical lift. The note documented that range of motion in both the resident's upper and lower extremities were within normal limits. The resident complained of some tenderness to the right ribs. A post-fall report, dated 5/20/26 at 3:15 p.m., documented Resident #15 was found by a CNA, sitting on the floor next to her bed. The staff asked the resident if she was trying to sit on the edge of the bed and missed and the resident said yes. The note documented vital signs and neurological checks were taken and within normal limits. The report revealed poor lighting, confusion and walking without assistance were determined to be factors of the fall.A post-fall report, dated 5/26/26 at 11:30 a.m., documented a CNA on duty found Resident #15 lying face down on the floor in her room. The resident was last seen walking around her room without an assistive device before falling. After the fall, the resident was observed with one shoe on and the other foot had three socks on. The resident was known to put on and take off multiple clothing items throughout the day. The resident was assessed for injury. The assessment revealed swelling to the right elbow. The resident was experiencing pain and was unable to fully extend the right elbow. The investigation revealed that confusion, wandering, poor safety awareness and improper footwear were determined to be factors of the fall. The resident was sent to the hospital for evaluation and treatment.The nursing note, dated 5/26/26, documented Resident #15 returned to the facility from the emergency room with discharge paperwork that revealed Resident #15 had a closed displaced elbow fracture. The note documented a sling was in place.The IDT note, dated 5/27/26, documented Resident #15 was sent to the emergency department on 5/26/26 for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	imaging and workup. Resident #15 returned with a diagnosis of a right elbow fracture. The IDT note documented Resident #15 was impulsive and required stand-by assist when not using an assistive device. Resident #15 ambulated frequently and was on the purposeful rounding program since she did not call or use her call light to use the bathroom very often. C. Observations During a continuous observation on 5/27/26, beginning at 11:22 a.m. and ending at approximately 11:40 a.m., the following was observed:Resident #15 was sitting in a chair in the dining room while a volunteer was reading to her. The resident's right arm was splinted and immobilized in a sling. Once that activity was over, Resident #15 stood up from her chair unaccompanied, took a few steps and stopped. She began to slowly bend over at the waist and attempted to pick something up off the floor that was not there. She remained in that position for a few seconds and then slowly straightened back up and began walking herself to her room with a slow shuffling gait. There were staff members present in the dining room.-However, the staff members did not provide touch or verbal cuing assistance for safety as the resident bent over to the floor as was care planned (see care plan above). D. Resident's representative interviewResident #15's representative was interviewed on 5/28/26 at 12:08 p.m. The representative said to her knowledge, there were no changes in care or modifications made to Resident #15's care plan to prevent future falls.E. Staff interviewsRN #5 and RN #4 were interviewed together on 5/27/26 at 2:00 p.m. RN #5 and RN #4 said they were familiar with the purposeful rounding program. RN #5 said Resident #15 fell on 5/26/26 and broke her elbow, but she was not aware that the resident had a fall on 5/20/26. RN #5 said Resident #15 was very mobile and confused, so a fall mat was contraindicated as it would pose a tripping hazard. RN #5 said she was not aware of other interventions other than implementation of the purposeful rounding program for fall prevention for Resident #15. The assistant director of nursing (ADON) was interviewed on 6/1/26 at 6:00 p.m. The ADON said when in place, the purposeful rounding program directed the CNAs to monitor residents on the program every hour. The ADON said the residents who were placed on the purposeful rounding program were highlighted on the resident information sheet.The ADON said Resident #15 was placed on the purposeful rounding program, but even if staff checked on her more frequently, she could still fall in between checks. The ADON said staff checked on Resident #15 more often than every hour and for the most part, staff knew where the resident was throughout the day.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide appropriate treatment and services to prevent urinary tract infections (UTI) for one (#16) of four residents out of 16 sample residents.Specifically, the facility failed to prevent recurring UTIs for Resident #16.Findings include:I. Facility policy and procedureThe Incontinence policy, revised 12/1/25, was provided by the regional vice president of operations on 6/1/26 at 6:00 p.m. It read in pertinent part, Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.The Infection Prevention and Control Program policy, revised 12/1/25, was provided by the regional vice president of operations on 6/1/26 at 6:00 p.m. It read in pertinent part, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.II. Resident #16A. Resident statusResident #16, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), the diagnoses included urinary tract infection (UTI), sepsis due to Escherichia coli (E. coli), hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left non-dominant side and type 2 diabetes mellitus.The 3/11/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. The 4/4/26 MDS assessment revealed the resident required substantial/maximal assistance with showering and dressing, and required partial/moderate assistance with toileting, personal hygiene and ambulating. The assessment documented the resident had an active diagnosis of a UTI in the seven day assessment period and in the past 30 days. The resident was taking antibiotics with indication (diagnosis of an infection).B. Resident interviewResident #16 was interviewed on 5/27/26 at 10:30 a.m. Resident #16 said she had been having frequent UTIs, but she did not know why. She said there had been times when she was incontinent and had to wait for nursing staff to change her, and she said it made her feel bad to sit in wet clothes.C. Resident #16's representative interviewResident #16's representative was interviewed on 5/26/26 at 12:30 p.m. The representative said the resident complained of UTI symptoms for two weeks without receiving treatment before it turned into sepsis. He said he told nursing staff about her complaints, but all they did was encourage the resident to drink extra fluids. The representative said the staff were not regularly checking the resident for incontinent care needs, and there was a time the staff pushed his mother in her wheelchair to him with feces running up her back. He said he could smell the feces as soon as the resident got close and he had to tell the staff that she needed to be cleaned up and changed. Resident #16's representative was interviewed again on 5/28/26 at 10:30 a.m. The representative said the resident has had recurring UTIs since October 2025 while residing in the facility, but she had not had recurring UTIs previous to that time.D. Record reviewReview of Resident #16's May 2026 CPO revealed the following physician's orders:Macrodantin (nitrofurantoin macrocrystal) oral capsule 50 milligram (mg). Give 50 milligram (mg) by mouth four times a day for UTI for three days, ordered 4/3/26 and discontinued 4/6/26.Sepsis screening every shift. If two or more of the following are true, notify the provider: 1) Temperature greater than 100 degrees fahrenheit (F); 2) Pulse greater than 100 beats per minute (bpm); 3) Systolic blood pressure less than 100 millimeters of mercury (mmHg) or greater than 40 mmHg from baseline; 4) Respiration rate greater than 20 or oxygen saturation (SpO2) greater than 90 percent (%); or, 5) Altered Mental Status. Every shift encourage fluids and monitor for nausea and vomiting, ordered 4/4/26.May obtain urinalysis (UA) (and culture if indicated) as needed for dysuria (painful urination) and/or fever, ordered (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/10/26.Review of Resident #16's progress notes revealed the following documentation:On 4/1/26 at 12:48 p.m. a nurse's note documented the resident's representative visited that morning. The representative voiced concerns of Resident #16 complaining of abdominal discomfort and requesting for a UA. Alert charting was opened to monitor for signs/symptoms of UTI, the physician was notified and the physician planned to see the resident on this date.On 4/2/26 at 6:50 a.m. a nurse's note documented the resident's representative visited on 4/1/26 in the morning with an additional follow-up phone call in the afternoon. The family representative had concerns related to a possible UTI and the resident's toileting schedule. All concerns were addressed, the physician was notified and orders were in place to obtain a UA.On 4/4/26 at 6:53 p.m. a nurse's note documented an UA was obtained via clean catch on 4/2/26. The urine culture revealed 80,000 E. Coli and 80,000 Aerococcus urinae (A. urinae). The resident was currently on Macrobid 50 mg four times a day for three days for UTI. The resident was currently on contact isolation related to vomiting. The resident was started on the sepsis protocol on this date. The note documented the resident's vital signs were stable. The resident continued to report dysuria (pain when urinating).On 4/4/26 at 6:50 p.m. a nurse's note documented the resident's representative was at the nursing desk voicing concern of the resident having a UTI and vomiting. The representative requested the resident be sent to the hospital for further evaluation and treatment.Resident #16's 4/7/26 urine culture result revealed 10,000 to 50,000 colonies/milliliter (ml) of E. coli and greater 100,000 colony-forming units per milliliter (cfu/ml) of A. urinae.Resident #16's 4/10/26 hospital discharge summary said the resident was treated for severe sepsis due to a UTI with extended-spectrum beta-lactamases (ESBL - a strain of bacteria resistant to most common antibiotics) and E. coli.Review of Resident #16's bowel and bladder care plan, initiated 3/16/26, revealed the resident was at risk for complications related to bowel and bladder incontinence. Pertinent interventions, initiated 3/16/26, included to clean the perineal (groin) area with each incontinence episode; encourage fluids during the day to promote prompted voiding responses; ensure the resident had an unobstructed path to the bathroom; incontinence products per resident information sheet (RIS); limit fluids two to three hours prior to bedtime; monitor and document intake and output as per facility policy; monitor fluid intake to determine if natural diuretics such as coffee, tea, or cola were contributing to increased urination and incontinence; monitor/document for signs/symptoms of UTI such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating pattern; and, monitor/document/report as needed any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke and/or medication side effects.-However, the facility failed to identify person-centered interventions to prevent recurring UTIs.Review of Resident #16's grievances, provided by the regional vice president of operations on 5/28/26 at 8:30 a.m., revealed that on 3/25/26 the resident's family representative filed a grievance which stated he had concerns that Resident #16's every two hour checking and changing toileting program was not being followed. On 4/3/26 the resident's family representative filed a grievance, which stated Resident #16 had been in the activity room before she was assisted in her wheelchair to the dining room sitting in urine and fecal matter. The grievance form indicated the family representative was concerned that nursing staff were unaware of the two hour checks, and he wanted the two hour checks in place due to the resident's history of frequent UTIs. The grievance form documented the following resolution: Two hour checks/purposeful rounding program was on Resident #16's resident information sheet at the time of the concern.-However, the facility failed to make sure that all nursing staff were all aware of the purposeful rounding program protocol (see interviews below).Review of 4/8/26 care conference meeting notes revealed the resident had a history of UTIs and the family was concerned regarding the two hour checks. The notes indicated that cranberry supplement was removed from the formulary several months ago.The 5/11/26 purposeful rounding program documentation revealed nine nursing (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff members received the following education: Risks and red flags: UTIs have increased over the last month, with many residents growing E. coli in urine cultures. This is often due to issues with perineal care. UTIs can be fatal for residents, and it is the staff's responsibility to prevent them whenever possible: assist with fluid intake - goal is 1200 milliliter (ml) minimum daily; toilet often and assist with thoroughly good hygiene - wipe front to back; assist with thorough perineal care as needed - ensure the resident and linens were completely clean; change briefs as soon as possible when wet or soiled - follow toileting program; and, cleanse the catheter tubing at least twice daily, preferably once per shift minimum unless the resident had requested to not be disturbed at night and with each bowel movement of incontinent episode. Teaching and training: Proper perineal care can prevent skin breakdown of perineal area, itching, burning, odor and infections. Perineal care was to be done after each incontinent episode and with each episode of toileting. Always follow the one swipe per wipe rule. Wipe front to back or away from the meatus. If your gloves become contaminated during perineal care, change gloves. One of the most important aspects of perineal care was checking for signs of infection, rash or skin breakdown. Observe the area as you clean it and report any skin abnormalities to the nurse.III. Staff interviewsThe corporate nurse consultant was interviewed on 5/27/26 at 10:25 a.m. She said the facility utilized the McGeer criteria for UTI determination.Licensed practical nurse (LPN) #1 was interviewed on 5/27/26 at 1:50 p.m. LPN #1 said residents received incontinence care at least every two hours by the certified nurse aide (CNA). She said staff knew when a resident required incontinence care because the resident would be restless, there would be an odor or if they were capable the resident would let the staff know they needed to be changed. LPN #1 said incontinence care was documented in the facility's documentation system, and it was important to provide timely incontinence care to prevent sores and mitigate falls. She said signs and symptoms of a UTI included confusion, possible redness and pain. LPN #1 said if she noticed a change of condition, such as a UTI, she would notify the charge nurse and they would initiate alert charting on UTI symptoms every shift. LPN #1 said Resident #16 had a history of UTIs and she believed the resident was just treated for a UTI three to four weeks ago.CNA #1 was interviewed on 5/27/26 at 2:45 p.m. CNA #1 said incontinence care was provided at least every two hours, but she said a few of the residents were on special precautions that indicated the resident should be checked and changed more frequently. CNA #1 said if the resident was unable to hit the call light to notify nursing staff about toileting, then staff should perform more frequent rounding for incontinence care. She said staff knew which residents required increased rounding because they were discussed in shift to shift report. CNA #1 said incontinence care was documented in the facility's documentation system, and it was important to perform timely incontinence care to prevent pressure wounds and skin breakdown. CNA #1 said signs and symptoms of UTI included irritability, pain in the bladder or a difference in urine color. She said if she noticed signs/symptoms of a UTI, or a change of condition, in one of her residents she would notify her nurse right away. CNA #1 said Resident #16 was currently on alert monitoring for UTI.Resident #16's physician was interviewed on 5/28/26 at 1:48 p.m. The physician said Resident #16 has had three UTIs over the last 12 months. She said what was so concerning about Resident #16's most recent UTI was that the resident was fairly asymptomatic when she was hospitalized , although she was very ill and definitely met criteria for sepsis. The physician said if the staff were documenting that they were changing and checking Resident #16 every two hours during awake periods there were many reasons the resident might have been having recurring UTIs, such as an anatomical reason that would require a urology evaluation. She said some women were more prone to UTIs even under the best of care.The physician said as a result of Resident #16's recurring UTIs, she had discussed unnecessary antibiotic therapy, antibiotic resistance and the increasing risk of multidrug-resistant organisms (MDROs). She said she used McGeer's criteria, and when Resident #16 had urinary symptoms she would check a UA and start antibiotic therapy. The physician said if the urine culture resulted negative, then she would stop the antibiotics. She said when the interdisciplinary team was in the period of figuring out if Resident #16 had a UTI they would place her (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the sepsis protocol and check her vital signs at least every shift to ensure she was not declining.CNA #2 was interviewed on 5/28/26 at 3:05 p.m. CNA #2 said if she noticed a resident appeared differently than they did at the start of her shift, such as a UTI, she would go talk to the nurse about it then measure the resident's vital signs. She said the potential negative outcome of not recognizing a change of condition such as a UTI was that the resident could decline faster.Registered nurse (RN) #2 was interviewed on 5/28/26 at 3:10 p.m. RN #2 said if she noticed a resident appeared differently than they did at the start of her shift, such as a UTI, she would perform an assessment then call the charge nurse. She said if the resident was on hospice, she would notify the hospice physician of the change. RN #2 said the potential negative outcome of not recognizing a change of condition in a resident with a UTI was that they could become septic.The assistant director of nursing (ADON) was interviewed on 5/28/26 at 3:35 p.m. The ADON said she also served as the facility's infection preventionist. The ADON said the facility has had an increase in UTIs - she said the facility typically averaged two to four UTIs per month, but this month they had seven. She said through her infection tracking process she determined the facility was seeing a trend in E. coli infections, as well klebsiella infections. The ADON said E. coli was typically found in bowel movements, or feces, but she did not think it was caused by poor incontinence care because the facility had consistent CNAs. She said she performed a weekly huddle with the CNA and nurses the week of 5/11/26 and educated the staff on the importance of proper incontinence care. The ADON said she had not noticed any concerns with incontinence care; however, she said she did not audit incontinence care.The ADON said the facility did not have residents with recurring UTIs very often, but Resident #16 did have recurring UTIs. She said she had discussed Resident #16 and her recurring UTIs in the daily stand-up meetings. The ADON said Resident #16 was septic from a UTI in early April 2026 and the facility had since initiated a toileting program involving checking and changing the resident every two hours. She said the facility had also initiated the sepsis protocol on Resident #16 to be hyperaware that she was not going septic again. The ADON said the facility used the McGeer's criteria but were quicker to order antibiotic therapy for concerns of UTI for Resident #16 due to her history of sepsis.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice for two (#3 and #14) of four residents reviewed of 16 sample residents. Specifically, the facility failed to ensure Resident #3 and Resident #14 received oxygen therapy in accordance with the physician's orders.Findings include:I. Professional referenceAccording to National Library of Medicine, National Center for Biotechnology Information, dated 2026, retrieved on 6/10/26 fromhttps://urldefense.proofpoint.com/v2/url?u=https-3A__www.ncbi.nlm.nih.gov_books_NBK551617_&d=Dw Oxygen therapy is a critical medical intervention designed to ensure adequate oxygen delivery to the body's cells, supporting essential functions and preventing life-threatening conditions. The absence of sufficient oxygen, or hypoxia, can result in severe complications such as organ dysfunction, brain damage, and cardiac arrest.According to the [NAME] Stroller Patient operating instructions, undated, retrieved on 6/10/26 from https://documentcloud.adobe.com/gsuiteijk0-ntegration/index.html?state=%7B%22ids%22%3A%5B%221zWB It read in pertinent To verify the level of liquid oxygen in the unit with the electronic liquid level gauge: Depress the push button (liquid level switch) on top of the unit for two seconds minimum. Read across the top of the light bar to indicate contents level and read the arc of LEDs, which indicates content level. Caution: The Stroller/Sprint (oxygen tank) is empty if only the last segment of the light bar is lit.II. Facility policy and procedureThe Oxygen Administration policy and procedure, revised 12/1/25, was provided by the nursing home administrator (NHA) on 6/1/26 2:37 p.m. It read in pertinent part, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Oxygen is administered under the orders of a physician, except in the case of an emergency. In such a case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. The residents' care plan shall identify the interventions for oxygen therapy, based upon the residents assessment and orders.III. Resident #3A. Resident statusResident #3 age [AGE], admitted to facility 4/4/23 and discharged [DATE]. According June 2026 computerized physicians orders (CPO) diagnoses include congestive heart failure, chronic respiratory failure with hypoxia and primary hypertension. According to the minimum data (MDS) assessment, dated 5/15/26, the resident had no memory deficits, she was independent with decision making and no inattention, disorganized thinking and no alterations in levels of consciousness per staff assessment. The assessment revealed the resident had shortness of breath while laying flat. The assessment did not document that the resident was receiving oxygen therapy. -However, the physician's order revealed the resident had been on oxygen therapy since November of 2025.B. Resident representative interview:Resident #3's representative was interviewed on 6/1/26 at 3:22 p.m. The representative said she found Resident #3's portable oxygen tank was empty several times, so she made it a habit of checking the tank every time she visited to make sure it was full. The representative said on 4/1/26 she visited Resident #3 and found her portable tank was empty. She said she placed her on the stationary oxygen concentrator that was kept in the resident's room. She said at that time, Resident #3 told her she was on four liters of oxygen and asked the representative if she still needed to be on that increased amount of oxygen. The representative said she had not been informed of the resident's change of condition or what prompted her to need an increase in liter flow of oxygen. The representative spoke with the nurse on duty and was told that Resident #3 had been off her oxygen and was found to have a desaturated oxygen level of 50% (normal oxygen saturation in a person should be between 95 and 100 percent). The representative said this led to the physician increasing the resident's oxygen liter flow to four liters per minute to stabilize the resident. C. Record reviewReview of the June 2026 CPO revealed the following physician's order:Continuous Oxygen at (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two liters per minute by nasal cannula. Do not wake the resident at night to check oxygen saturation levels but check the resident every two hours to ensure the resident is receiving the oxygen therapy per the order. Verify that the resident is wearing oxygen, and that the tank was full and the liter flow is correct, ordered on 11/20/25. Resident #3's oxygen care plan last revised 11/24/25 documented the resident had chronic respiratory failure and was at risk for complications related to poor oxygen absorption. The resident was on oxygen therapy. Interventions included administering medication/puffers as ordered, monitoring for effectiveness and side effects, monitoring for signs and symptoms of respiratory distress, reporting signs and symptoms ot the physician and providing oxygen at two liters of oxygen via nasal cannula continuously.A facility grievance/concern resolution form, dated 4/21/26, revealed that a certified nurse aide (CNA) had transferred the resident from her oxygen contractor unit to her portable unit and the resident was without oxygen long enough to cause her oxygen saturation level to drop significantly to 50%. The CNA thought the resident had only been off her oxygen for a couple of minutes. The form documented that the resident recovered quickly.-However, there was no documentation that the resident was titrated back to her prescribed oxygen rate of liter flow. IV. Resident #14A. Resident status Resident #14 age greater than 85 admitted to facility 5/20/26. According to the June 2026 CPO, diagnoses include chronic respiratory failure with hypoxia and dementia with agitation.According to the MDS assessment, dated 6/5/26, the resident had severely impaired cognition with a brief interview for mental status (BIMS) score of five out of 15. The assessment documented the resident was not receiving oxygen, -However, the resident was receiving oxygen therapy (see record review below).B. Record reviewThe June 2026 CPO revealed the following physician's order:Provide oxygen four liters continuously, ordered on 5/21/26.-However, the physician's order did not provide instructions for the delivery method or duration of use. The oxygen care plan, initiated 5/20/26, documented the resident had altered respiratory status and difficulty breathing. The focus documented the resident was on oxygen therapy. Pertinent interventions included monitoring for symptoms of respiratory distress and oxygen. -However, the oxygen intervention was incomplete and did not provide the oxygen setting liter flow, delivery method, duration or if humidification was needed. B. Observation and interviewsOn 6/1/26 at 10:47 a.m. Resident #14 was in the common area wearing oxygen via a nasal cannula. The oxygen portable tank's fill light indicator showed only one red light was illuminated, which indicated that it was empty (see the Stroller users manual above). CNA #4 was informed of the fill light indicator being on the last red light indicator and he checked the device immediately. CNA #4 was interviewed on 6/1/26 at 10:47 a.m. After being alerted Resident #14's tank needed to be filled, he checked the fill gauge. He said he would refill the oxygen as soon as he was able. CNA #4 said he could not leave the unit to fill her tank at that immediate time and had to wait until the other CNA returned from break to take over monitoring the residents on the unit.CNA #4 said that the portable oxygen tanks were supposed to be filled by the night shift staff. Morning shift staff were supposed to check the portable oxygen tank before transferring the resident from their in room concentrator to the portable tank for the day. CNA #4 said normally a full tank can last a few days. CNA #4 said he did not start his shift with the morning staff and had not arrived until approximately 10:47 p.m. and he was not aware that Resident #14's oxygen tank fill indicator was on the last red light indicator. CNA #5 was interviewed on 6/1/26 at 1:06 p.m. CNA #5 said the last red indicator light on the resident's portable oxygen tank meant the tank was empty.V. Additional staff interviewsThe assistant director of nursing (ADON) and director of nursing (DON) were interviewed on 6/1/26 at 6:08 p.m. The ADON said when the portable oxygen tank had at least one light lit the tank still had oxygen in the tank and would continue to supply the resident with the needed oxygen. She said she was not sure how the tank alerted when it was empty but would contact the oxygen provider for more information. -However the manufactures manual documented that the tank was empty when the fill indicator had only one light indicator lit (see above).

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practical physical, mental, and psychological well-being an prevevent re for two (#6 and #12) of five residents out of 16 sample residents. Specifically, the facility failed to develop individualized interventions related to Resident #6 and Resident #12 behavioral symptomatology for becoming aggressive towards other individuals (resident and visitors) when they did not like what was going on in their environment/surroundings; to prevent each of them from initiating an aggressive altercation directed towards other individuals.Findings include:I. Facility policy and procedureThe Dementia Care policy and procedure, revised 12/1/25, was provided by the nursing home administrator (NHA) on 6/1/26 at 5:27 p.m. It read in pertinent part, This facility will provide dementia treatment and services which may include, but is not limited to, ensuring adequate medical care, diagnosis, and supports based on diagnosis, ensuring the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choices, and safety and utilizing individualized, non-pharmacological approaches to care.Residents who display or are diagnosed with dementia will receive the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.Identify, address, and/or obtain necessary services for the dementia care needs of the residents.Develop and implement person-centered care plans that include and support the dementia care needs identified in the comprehensive assessment.Develop individualized interventions related to the resident's symptomology and rate of progression.Review and revise care plans that have not been effective and/or when the resident has a change in condition.Modify the environment to accommodate resident care needs and achieve expected improvements or maintain the expected stable rate of decline.II. Resident #6A. Resident statusResident #6, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnosis included Parkinson's disease, dementia, severe, with frontal lobe, cognitive communication deficit , executive function deficit and a history of aggressive behavior.The 3/18/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The MDS assessment indicated the resident did not have behaviors directed towards others. B. Record reviewA facility investigation, dated 11/25/25, documented staff observed Resident #6 and Resident #13 having a tug of war over a kleenex box. Resident #13 brought a box of tissues from her room to the dining room table and when Resident #6 saw the box on the table he thought it was his and proceeded to take possession of it. Resident #13 tried to stop Resident #6 from taking the box and he became upset.The investigation revealed that Resident #6 was confused and becoming increasingly upset when he was stopped by Resident #13 from taking her box of kleenex. In the struggle over the box Resident #6 reached out to grasping at Resident #13 and scratched Resident #13 causing her fragile skin to tear open. The investigation documented the staff responded to the interaction between Resident #6 and Resident #13 and separated both residents to ensure safety. The investigation documented Resident #6 was referred to a behavioral health provider.A facility investigation, dated 1/3/26, documented the activities director observed Resident #6 grabbed Resident #8's wheelchair and shaking it out of frustration to get Resident #8 to move out of his way.The investigation documented the staff responded to the interaction between Resident #6 and Resident #8 by separating the residents to ensure safety. Resident #6 was asked to speak to residents if he wanted them to move or if he wanted something from them; Resident #6 said he would try.A facility investigation, dated 4/12/26, documented another resident reports that Redient #6 was acting strange in the dining room. He witnessed Resident approached Resident #7 and his wife who (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were visiting in the dining room and started kicking their chairs and telling them they were talking too much. Resident #6 was getting more agitated Resident #6's aggressive behavior was making Resident #7 upset and making his wife feel fearful.A nursing staff was seated at the nurses station and heard Resident #6 yelling at Resident #7 and his wife. And just observed to see how things went. The CNA did not respond to intervene immediately. Until the resident witness went to report the incident to staff and get staff to deescalate the incident. The investigation documented Resident #6's care plan was reviewed. It indicated Resident #6 was seen by an in-house provider on 4/14/26, and the social services director (SSD) placed a request for behavioral health services to see the resident. Resident #6's behavior care plan, initiated 4/13/24 and revised 3/25/26, revealed the resident had a history of verbal aggression towards others, yelling at others, taunting, and non-verbal body language towards others, physical aggression including pushing, and has kicked others' wheelchairs. Pertinent interventions included redirecting the resident to an independent activity if he was showing behaviors in group settings.-Review of the care plan did not reveal the facility implemented effective person-centered dementia care interventions to prevent Resident #6's ongoing aggressive behavior directed towards others. C. Observations and interviewsResident #7 was interviewed on 5/27/26 at 11:50 a.m. Resident #7 said he remembered when Resident #6 came to their table on 4/12/26. He said Resident #6 made his wife uncomfortable.Resident #13 was interviewed on 5/27/26 at 3:23 p.m. Resident #13 said she got a scratch on her arm when Resident #6 grabbed her Kleenex box from the dining room table they were sharingResident #6 was interviewed on 5/27/26 at 3:32 p.m. Resident #6 was able to recall events in the past with some clarity. Resident #6 said his wife was recently admitted to the facility for short term rehabilitation, and he was spending his time with his wife on a different floor of the facility.Resident #8 was interviewed on 5/28/26 at 10:52 a.m. Resident #8 said Resident #6's grabbed his wheelchair started shaking it after Resident #6 got upset about watching what was on the television on 1/3/26. Resident #8 said he used to play card games with Resident #6. He said Resident #6 became upset if the other residents did not follow his rules.III. Resident #12A. Resident statusResident #12, over age [AGE], was admitted on [DATE]. According to the June2026 CPO, diagnosis included cognitive communication deficit, severe dementia with anxiety, and need for assistance with personal care.The 4/13/26 MDS assessment revealed the resident was severely cognitively impaired, with a BIMS score of zero out of 15. She required supervision or touch assistance with toileting and personal hygiene and eating.The MDS assessment revealed the resident wandered daily and exhibited physical behavioral symptoms, such as hitting, kicking, scratching, grabbing, pushing, and sexually abusive behavior toward others.B. Record reviewA facility investigation, dated 4/21/26, documented the staff observed Resident #12 grab a blanket from Resident #9 and hit her on the arm three times.The investigation documented the staff responded to the interaction between Resident #12 and #9. The certified nurse aides (CNA) intervened immediately and separated both residents to ensure safety. The investigation documented Resident #12 was assessed and had no no pain, discomfort, injury, and did not show any signs of fearfulness.The investigation documented Resident #12 was moved to her room while Resident #9 showed little to no reaction to the incident.The investigation documented Resident #12's care plan was seen by behavioral health services (BHS) and adjustments made in the times medications were administered. And Resident #12 will remain in a frequent rounding program.C. Observations and interviewsDuring a continuous observation of the secure memory care unit on 5/26/26, beginning at 11:45 a.m. and ending at 1:05 p.m., the following was observed:Resident #12 was screaming at the staff who were assisting her with bathing. The unidentified staff members said staff said Resident #12's yelling was normal for him. On 5/28/26 at 4:41 p.m. Resident #12 was going into other residents' rooms.The staff present on the unit did not intervene or provide Resident #12 with a person-centered activity to meet her dementia care needs.On 6/1/26 at 3:40 p.m. Resident #12 was going into other residents' rooms.The staff present on the unit did not intervene or provide Resident #12 with a person-centered activity to meet her dementia care needs.Resident #12's behavior care plan, initiated 1/5/26 and (continued on next page)

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Lemay Avenue Health and Rehab LLC	4824 S Lemay Ave Fort Collins, CO 80525

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 4/20/26, revealed the resident was at risk for wandering and elopement due to his diagnosis of unspecified dementia. The care plan documented Resident #12 often asked to go home and would usually attempt to follow a staff and visitors off the unit and attempt to open doors on the unit. The care plan revealed the resident had a history of being aggressive towards people in her surrounding area. The care plan documented the resident had a history of sitting at doorways and kicking/reaching out towards people when agitated. The care plan documented redirection was not generally effective and the staff should attempt to keep residents separate from others. Pertinent interventions included intervening as necessary to protect the rights and safety of others, approaching and speaking to the resident in a calm manner removing the resident from the situation, taking the resident to an alternate location as needed, praising the resident for any indication of the resident's progress/improvement in behavior and providing a program of activities that was of interest and accommodates residents' status. -However, the staff failed to monitor and engage Resident #12 in meaningful activities to minimize his wandering behaviors (see observations above).IV. Staff interviewsThe activities director (AD) was interviewed on 5/27/26 at 3:04 p.m. The AD said Resident #6 was unpredictable. The AD said one moment he would be fine, the next moment he could be mad. The AD said he especially got mad during movies or if he was interrupted.CNA #6 was interviewed on 5/28/26 at 2:43 p.m. CNA #6 said Resident #12 wandered and sometimes became verbally aggressive. CNA #6 said at times it was difficult to keep her separated from other residents. She said there had been some recent staff change over in the secured units resulting in more resident to resident altercations.CNA #6 said Resident #12 had a history of becoming agitated, reaching out towards others, kicking others or flailing at them.Licensed practical nurse (LPN) #3 was interviewed on 5/28/26 at 4:15 p.m. LPN #3 said Resident #12 provoked other residents in the secured unit.LPN #3 was interviewed again on 5/28/26 at 4:41 p.m. LPN #3 said Resident #12 has made behavioral improvements with the addition of Ativan (antianxiety medication). LPN #3 said Resident #12 continued to have aggressive behaviors, and it was hard to tell if it was because of a change in medication or something else.LPN #3 said the secured unit at the facility would benefit from more planned activities by decreasing the ratio of staff to residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide medications as ordered for one (#1) of three residents of 16 sampled residents.Specifically, the facility failed to have a physician's ordered medications available at the facility to administer to Resident #1.Findings include:I. Professional referenceAccording to the National Library of Medicine, Medline Plus, Valacyclovir, dated 2026, retrieved on [DATE] from https://medlineplus.gov/druginfo/meds/a695010.html Valacyclovir is used to treat certain viral infections including varicella infections including herpes zoster (shingles) and chicken pox. It is in a class of medications called antivirals. It works by stopping the spread of the herpes virus in the body.According to Skinlight, Shingles (Zoster), last revised [DATE], retrieved on [DATE] from https://skinsight.com/skin-conditions/zoster-shingles/?Imiw9cApl=1 Oral antiviral medication such as valacyclovir may help if given within 72 hours after shingles lesions first appear. These medicines do not cure shingles, but they can decrease the amount of time you have pain and a rash. Antiviral medications may also decrease your chance of getting posherpetic neuralgia and may decrease your risk of developing visual problems if you have shingles on the face.According to the Centers for Disease Control and Prevention (CDC), Pink Eye is Treatable, dated [DATE], retrieved on [DATE] from https://www.cdc.gov/conjunctivitis/treatment/index.html Epidemic Keratoconjunctivitis (EKC) is caused by adenoviruses and is highly contagious. EKC can spread by direct contact with an infected person and has been associated with equipment used during eye exams. EKG causes severe inflammation of the conjunctiva and cornea and can result in vision loss. A doctor can prescribe antiviral medication to treat more serious forms of pink eye (like infection caused by herpes simplex virus or varicella-zoster virus). Antibiotics will not improve viral pink eye; these drugs are not effective against viruses.II. Facility policy and procedure The Pharmacy policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 6:33 p.m. It read in pertinent part, It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.III. Resident #1 A. Resident statusResident #1, age greater than age [AGE], was admitted on [DATE] and expired on [DATE]. According to the computerized physician orders (CPO) diagnosis included impaired visual function, diabetes, hypertension and heart failure.According to the minimum data set (MDS) assessment, dated [DATE], the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required minimal assistance with activities of daily living. The resident's vision was impaired and he had corrective lenses.B. Record reviewReview of the [DATE] CPO revealed the following physician's order: Valacyclovir HCL oral tablet 500 milligrams (mg). Give one tablet by mouth three times a day for exposure to keratoconjunctivitis (a highly contagious viral infection that causes severe inflammation and sometimes vision-threatening corneal scarring), ordered [DATE].Review of the resident's electronic medical record (EMR) and progress notes revealed the prescribed valacyclovir antiviral medication was not administered because the pharmacy would not supply the medication due to no insurance coverage.The eye care visit note, dated [DATE], documented the assessment revealed keratoconjunctivitis to both eyes and keratitis (inflammation of the cornea) in both eyes. The note documented valacyclovir 500 mg capsule by mouth three times a day, doxycycline (antibiotic medication) 100 mg by mouth two times a day, moxifloxacin 0.5% eye drops, instill one drop in both eyes four times a day and tobramycin 0.3% eye drops, instill one drop in both eyes four times a day were ordered. The note documented to replace the bandage contact lens (a specialized, high-oxygen-transmissible contact lens placed over the cornea to protect the eye, relieve severe pain from exposed nerve endings, to accelerate the healing of the corneal surface), and replace once a month for long-term care therapy to provide comfort measures (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for hospice status.The nursing progress note, dated [DATE], documented the resident returned from an eye physician appointment with orders for doxycycline 100 mg twice per day and valacyclovir 500 mg three times a day for exposure to keratoconjunctivitis to the right eye. The note documented the nurse would follow up with the eye doctor tomorrow for an end date. The nursing progress note, dated [DATE], documented the hospice provider called back and said hospice did not cover the cost of the resident's prescribed eye medications. The nursing note, dated [DATE], documented the facility called the physician again as eye medication and valacyclovir were ordered and did not have a stop date. -Review of Resident #1's electronic medical record (EMR) did not reveal documentation indicating the eye doctor was informed that the resident was not receiving valacyclovir. On [DATE] a fax was sent to the eye doctor which documented all orders above were open ended. The fax documented if hospice did not cover the medications, the doctor needed to discontinue the medications.-There was no documentation that the facility made attempts to consult with the facility's medical director or the resident's primary care physician for alternative medication treatment when they could not get ahold of the resident's eye doctor.IV. Staff interviewsThe assistant director of nursing (ADON) and the chief nursing officer were interviewed on [DATE] at 6:40 p.m. The chief nurse office said they had issues with their pharmacy due to poor communication and they had to change pharmacy providers as a result of the communication issues. The ADON said Resident #1's community eye doctor had prescribed a series of medications to treat his eye infection and the resident's insurance would not cover the medication nor would the hospice provider. The ADON said they tried to get the resident's wife to pay for the medications after discovery of non coverage. The ADON said the wife agreed to the pay for the medications after several conversations.The ADON said the resident was started on all of the medications ordered by the eye doctor except for the valacyclovir. The ADON said the family had provided the other medications ordered by the eye doctor. The ADON said the valacyclovir was not covered by insurance and did not have an end date. The ADON said the main reason why the facility did not get the medication started was because it did not have an end date on the prescription.The ADON said nursing staff tried to contact the resident's eye doctor for other options for covered medication, but did not get a call back. The ADON said they did not consult with the facility's medical director for an alternative covered medication or make any attempts to have the facility purchase the medication so the resident could begin treatment for his diagnosed eye infection.The chief nursing officer said they took this issue to the quality assurance performance improvement (QAPI) committee. The chief nursing officer said the outcome was to change pharmacy providers, have the new pharmacy provide an increase in the amount of the types of medication available in the emergency back up mediation kit. The chief nursing officer said the new pharmacy assisted to train the nursing staff on the emergency back up medicine kit.V. Facility QAPI action planThe QAPI action plan, dated [DATE], documented the following:Identified concern: prescribed medications not available for administration over several doses, timed administration. Medication error: mediation not available from the pharmacy due to pharmacy transition, hospice policy and poor communication.Corrective actions taken on [DATE]: The facility DON or staff development coordinator (SDC) was to verify that the pharmacy received the mediation orders.Pharmacy to communicate availability of the prescribed medications. Audit the compliance of the administration records to ensure compliance with pharmacy services in relation to timely medication administration. Identify all affected residents and correct. Re-educate nursing staff on pharmacy and medication administration. Nursing leadership to audit medication administration practices for three months -The QAPI action plan failed to address management of how the facility will ensure timely administration of prescribed medications. as ordered, when the resident insurance did not cover the cost of the resident medication and how to proceed when the physician ordered medicine with no date. -The QAPI action plan failed to address how to proceed with timely medication administration when there were questions about the ordered medication and the prescribing physician failed to respond to facility communication attempts. There was no plan on how the medical director (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or other designated physician would get involved particularly in cases where the diagnosed condition was indicative of a need to start medications sooner than later for the best success in treatment outcome.