STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen and three of three nourishment rooms. Specifically, the facility failed to:- Ensure employees performed hand hygiene appropriately;- Ensure food was labeled, dated and stored appropriately; - Ensure dishes were washed and sanitized at the correct temperature,- Ensure equipment was stored properly; and,- Ensure the nourishment room refrigerators were clean and maintained at safe temperatures. Findings include:I. Ensure employees performed hand hygiene appropriatelyA. Professional referenceThe Colorado Retail Food Regulations, (3/16/24) and retrieved on 12/15/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)B. ObservationsOn 12/9/25 during continuous observation, beginning at 3:40 p.m. and ending at 3:45 p.m., the following was observed:Dishwasher #1 was wrapping utensils in napkins with bare hands. He had removed the utensils from a flat bin where the silverware was laying in all directions, and he proceeded to touch all areas of the utensils. Dishwasher #1 touched his face, removed and replaced his hat, touched other surface areas and continued to wrap utensils without washing his hands. On 12/9/25 during continuous observation, beginning 5:10 p.m. and ending 5:45 p.m., the following was observed:At 5:10 p.m. cook (CK) #2 prepared sandwiches wearing gloves. While CK #2 prepared the sandwiches he touched the box of plastic wrap, the outside of the bread bag and utensils without changing his gloves. CK #2 removed the gloves and washed his hands for 10 seconds. He then proceeded to donned (put on) gloves and went to the refrigerator, removed deli turkey and cheese, opened the packages and continued to make sandwiches without changing the gloves. At 5:25 p.m. dishwasher #1 was placing the crackers and condiments onto the meal trays. Dishwasher #1 wiped sweat off of his forehead and continued to set up the meal tray without washing his hands. On 12/10/25 at 12:25 p.m. restorative certified nurse aide (CNA) was assisting Resident #82 with her meal. The restorative CNA #1 was stopped assisting Resident #82, helped another resident pull up her pants and fix her shirt, she then immediately went back to feeding the resident. She stopped again and assisted another resident with setting up their plate. She then picked up a knife off of the floor. She proceeded to assist Resident #82 with eating without washing her hands. C. Staff interviewThe lead restorative CNA was interviewed on 12/10/25 at 5:15 p.m. The lead restorative CNA said anytime a resident was being assisted with eating, The CNA's hands should be clean. The lead restorative CNA said hand hygiene should be performed in between assisting residents. The lead (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	restorative CNA was interviewed a second time on 12/11/25 at 10:00 a.m. The lead restorative CNA said the restorative CNA #1 received education on handwashing on 12/10/25 (during the survey). The dietary manager (DM) was interviewed 12/11/25 at 4:23 p.m. The DM said staff should be washing hands between glove changes for 25 seconds. She said gloves should be changed and hands washed when residents or other surface areas were touched before continuing the task.II. Failed to ensure time and temperature controlled food was labeled, dated and stored appropriately. A. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 12/11/25 read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter 3-29).Except during preparation, cooking, or cooling, or when time is used as the public health control time/temperature control for safety food shall be maintained at 135 degrees fahrenheit (F) or above at 41 F or less. (3-501.16)B. ObservationsDuring the initial initial main kitchen tour on 12/8/25 at 8:45 a.m. the following was observed:-A refrigerator with a freezer compartment located near the walk-in refrigerator, off of the main kitchen, contained three unmarked, undated containers filled with juice-like liquids. -The reach-in refrigerator, located off of the main kitchen, contained nine 10 pound rolls of thawed ground meat, two sides of beef, and nine packages of pork which were not labeled or dated. -A second reach-in refrigerator, located in the main kitchen, had an outside reading of 59 F. There was no thermometer in the refrigerator. The refrigerator contained eggs, in their shells, sitting in a metal bin loosely wrapped with plastic wrap, a container filled with a yogurt-like substance and two bags of lettuce. None of these food items were labeled or dated. -A small refrigerator located in the dining room for the self-serve cereal showed the temperature log had not been filled out since 12/5/25. There was no thermometer in the refrigerator. There were several small milk containers. On 12/8/25 at 11:30 a.m. the following was observed in the Monarch unit nourishment refrigerator and freezer:-The temperature log had not been filled out since 12/5/25 and there was not a thermometer in the refrigerator.-Fourteen health shakes with no pull dates (date when removed from freezer).On 12/9/25 at 3:35 p.m. the following was observed in the walk-in refrigerator in the main kitchen:-A container of what appeared to be seafood salad was loosely wrapped with a plastic wrap in a mixing bowl with no label or date. -A bin of sliced tomatoes wrapped in plastic wrap with no label or date. On 12/10/25 at 2:35 p.m. the following was observed in the Monarch unit nourishment area:-Three turkey sandwiches wrapped in plastic wrap were sitting on the counter and were not dated. -Four plastic containers holding fruit-like food were sitting on the counter and were not labeled or dated. On 12/10/25 at 2:50 p.m. the following was observed in the [NAME] nourishment area:-A resident opened soy milk that did not have an open date marked on the container.-A cup of fruit that was not labeled or dated.-An opened container of hummus that was not labeled or dated. -Twelve health shakes were sitting on the counter. The temperature of one of the shakes was 68.2 degrees F. At 3:13 p.m. the following observations with the DM-On the Monarch unit the undated turkey and cheese sandwiches sitting directly on the counter the temperature was 72.5 degrees. At 3:22 p.m. the medication cart on the [NAME] unit had a supplement bin with no ice. The bin contained an opened pudding cup which was made in the kitchen. The temperature was taken with the DM and was 58 degrees F. Licensed practical nurse (LPN) #4 said she was unaware the pudding needed to have a holding temperature of 41 degrees and below. C. Staff interviewsCertified nurse aide (CNA) #12 was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	single-service and single use articles shall be stored in a clean dry location, where they are not exposed to splash, dust, or other contamination, and at least 6 inches above the floor. Clean equipment and utensils shall be stored in a self-draining position that allows air drying and covered or inverted. (4-903)B. ObservationsOn 12/9/25 at 3:30 p.m. the following was observed in the kitchen:-There were three stacks of different sized stainless steel pans in the clean dish storage area. The pans had water droplets on the edges of the pans and visible moisture on the sides when pans were lifted up. On 12/11/25 at 10:30 a.m. the following was observed in the main kitchen:-There were stainless steel pans that were stacked on top of each other with visible moisture on the sides when pans were lifted up. C. Staff interviewThe DM was interviewed on 12/11/25 at 10:30 a.m. The DM said the pans should be dried prior to being stacked. She said the dishwasher had a towel which should be used to dry equipment before it was stacked. V. Failure to maintain clean nourishment refrigerators.A. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 12/15/25 read in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch. Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. (4-601.11)B. ObservationsOn 12/8/25 at 8:45 a.m. in the main kitchen the refrigerator's freezer compartment had green fluid frozen on a shelf in the freezer. The refrigerator contained food debris and spilled liquid. On 12/8/25 at 11:30 a.m. the Monarch nourishment refrigerator had food debris scattered throughout the freezer compartment. The refrigerator had food debris on the door shelves. On 12/10/25 at 2:27 p.m. the Monarch unit's nourishment refrigerator had food debris scattered throughout the freezer compartment and food debris in the door shelves in the refrigerator.On 12/10/25 at 2:50 p.m. the [NAME] unit's nourishment refrigerator's freezer compartment had brown frozen liquid on the bottom shelf. The refrigerator drawers had food debris on the bottom of the drawers and discolored stains in the drawers. The door shelves contained food debris. On 12/10/25 at 3:00 p.m. the Columbine nourishment refrigerator's freezer compartment had food debris scattered throughout the freezer. Food crumbs were observed in the refrigerator.C. Staff interviewsThe DM was interviewed on 12/10/25 at 3:15 p.m. She said the housekeeping department was responsible for cleaning the refrigerator and freezer compartment which should entail removing the items. The MTD was interviewed on 12/10/25 at 3:45 p.m. The MTD said he was not sure who was responsible for cleaning out the nourishment refrigerators but thought it was either the nursing or nutrition department. He said housekeeping would clean the front of the refrigerator. The MTD stepped out to make a call and returned shortly after. He then said the housekeeping department was responsible for cleaning out the nourishment refrigerators. He said if staff spilled any food or liquid this should be cleaned immediately and housekeeping did a deeper clean weekly, taking items out of the refrigerator and freezer compartments. He said there was no log of the cleaning schedule.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to provide adequate outside ventilation by means of windows and/or mechanical ventilation in four of four shower rooms.Specifically, the facility failed to ensure the residents' shower room vents were functioning in four shower rooms. Findings include:I. Facility policy and procedureThe Resident Environmental policy, undated, was provided by the corporate consultant on 12/11/25 at 8:33 p.m. It read in pertinent part, It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two (resident bathrooms and service areas should be ventilated, as required by code).II. ObservationsOn 12/11/25 at 1:03 p.m., an environmental tour was conducted. The ventilation fan outlets in four out of four residents shower rooms were without a motor.The [NAME] unit did not have a window nor mechanical ventilation. The ventilation outlet on the Monarch unit was being repaired. The outlet was without a motor, and there was no switch to operate. The two shower rooms on the Columbine unit's ventilation outlet had no motor.A small square of single-ply toilet paper was placed against the vent in all four shower rooms. All the outlets were unable to hold the toilet tissue in place, indicating the fans did not function.III. Staff interviewAn environmental tour was conducted with the maintenance director (MTD) on 12/11/25 at 7:39 p.m. The MTD confirmed the exhaust fans in all four shower rooms were without a motor and not functioning. The MTD said the ventilation outlet had not been working since he became the maintenance director. The MTD said he did not know the reason the ventilation outlets were without a motor. The MTD said he would immediately work on getting a new motor for all four shower rooms.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality in two of two dining rooms. Specifically, the facility failed to:-Provide a meal in a timely manner and did not notify the residents of the delay,-Serve residents at a table at the same time, and-Provide residents on the Monarch who were sitting in the dining room waiting for their meal that was delayed, with a drink or diversion. Finding include:I. Facility policy and procedureThe Resident Rights policy statement, dated 2/21/25, was provided by the nursing home administrator (NHA) on 12/11/25 at 4:11 p.m. It read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence and be treated with respect, kindness, and dignity.II. Observations of the main kitchen and dining roomDuring a continuous observation on 12/8/25, beginning at 11:55 a.m. and ending at 12:30 p.m., in the main dining room the following was observed:At 12:00 p.m. several unidentified staff members assisted with the meal service. The staff members could be heard asking who the residents were in order to deliver the tray. A table with two residents who were seated at the same time were served at different times. The first resident was served at 12:00 p.m. and the second resident was served at 12:14 p.m. The first resident had finished the meal and left the table, leaving the second resident to eat by themself. Another table with two residents who were socializing were served at different times. The first resident was served at 12:05 p.m. The first resident ate and left the table before the second resident was served at 12:15 p.m. The second resident asked the staff twice when she would receive her meal. A table with three residents, had the first resident served at 11:58 a.m. the second resident was served at 12:05 p.m. and the third resident was not served until 12:11 p.m.During a continuous observation on 12/9/25, beginning at 4:40 p.m. and ending 6:20 p.m., the following was observed during the meal preparation and service in the main kitchen:During a continuous observation on 12/10/25, beginning at 11:35 a.m. and ending at 12:48 p.m., in the main dining room the following was observed:The dining room had approximately 15 tables. Several unidentified certified nurse aides (CNA) were passing drinks and taking meal orders. The first tray went to the dining room at 11:55 a.m. Throughout the meal different tables were served the meal at random, leaving residents at the same table with meal trays and others waiting. The first tray was served to a table with three residents. The resident with the first tray was at 11:55 a.m. The resident began to eat. At 12:09 p.m. the second resident received his meal. The minimum data set (MDS) coordinator who served the meal told the third resident it would be right up. At 12:14 p.m. the third resident received her meal. At 12:11 p.m. Resident #134 received her meal. Resident #134 asked Resident #164 if it was ok if she ate,. Resident #134 said yesterday she waited to eat until all of her tablemates were served their meals, and when they received their food hers was cold. Resident #164 told her to eat her meal. Resident #134 offered her tablemate some crackers to eat while she waited. At 12:14 p.m. Resident #164 flagged a CNA down and asked for her meal. At 12:30 p.m. Resident #164 received her meal. The posted dinner menu was seafood salad croissant, coleslaw, sliced tomatoes, crackers, and iced gelatin poke care.At 4:50 p.m. the dietary manager (DM) began to take the temperature readings of the food. The cold foods were not at serving temperature (41 degrees Fahrenheit or less). The seafood salad was 50.5 degrees Fahrenheit (F), the coleslaw was 56 degrees F, the pureed bread was 67.6 degrees F, the pureed was coleslaw 58 F and the sliced tomatoes were 46.2 F. The DM pulled the cold meal from the serving line and directed the dietary aides (DA) to put the meal in the freezer to reach serving temperatures. At 5:10 p.m. the cold items temperature were checked and it had not reached the correct serving temperatures. At 5:25 p.m. Resident #11 went to the kitchen window and asked what was taking so long. Dishwasher #1 told the resident it would be coming soon, however, no explanation was given.At (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	busy the staff was during that time and what staff was working because agency staff took longer to deliver the trays.VI. Staff interviewsThe DM was interviewed on 12/9/25 at 6:30 p.m. The DM said the cook (CK) #2 started prepping for the meal service at 1:30 p.m. on 12/9/25. She said the crab meat should have been cold enough to serve because it was in the refrigerator, taken out to prepare for the meal and put back in the refrigerator. The DM said the coleslaw was mixed up and left in the large mixing bowl in the refrigerator, however, the DM said the coleslaw should have been scooped into the serving cups prior to being put back in the refrigerator. The DM said the food was prepared the same day that it was going to be served and not prepared a day ahead of time. She said the practice was not to put the cold food items into large pans and that it should have been put into smaller pans and then refrigerated. She did not know why CK #2 deviated from the normal practice. The regional clinical resource was interviewed on 12/10/25 at 8:30 a.m. The regional clinical resource said all residents were spoken to after dinner to fill out grievances in regards to the late dinner meal which was served on 12/9/26. She said that they were looking more into the situation as to how they prevent this situation happening again. The DM was interviewed on 12/11/25 at 4:23 p.m. The DM confirmed the tables were not served at the same time. She said that she had requested the meal tickets to be given to the kitchen window in order of the tables, however that did not occur. She said the meal tickets were completed by the CNAs prior to the meals. The DM said the tickets were delivered to the kitchen prior to plating the meals. She said there was a DA who managed the dining room, however that position was eliminated and now the CNAs deliver the tickets to the kitchen. The DM said the DAs, who were working the tray line, were unable to see which residents had entered the dining room or which table they were at, so therefore the tickets needed to be in order. The DM said the goal was for everyone to be served at the table prior to moving to another table.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a comfortable and homelike environment for residents on three of four units.Specifically, the facility failed to:-Ensure residents were provided clean washcloths;-Ensure broken towel racks and window seals in residents room were fixed timely,-Ensure residents' rooms were clean; and,-Ensure the lights in the residents' shower room were fixed timely. Findings include:I. Facility policy and procedureThe Homelike Environment policy, revised February 2021, was provided by the nursing home administrator (NHA) on 12/11/25 at 4:11 p.m. It read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a clean, sanitary and orderly environment.II. Environmental tour and interviewEnvironmental tours were completed on 12/10/25 at 2:20 p.m. and on 12/11/25 at 5:05 p.m. The following was observed: Resident rooms #300, #301, #304, #400, #401, #404, #410, #500, #503, #506, #507, #702, #703, #704, #705, #706, #1103, #1104, #1106, #1108, #1208, #1307, #1404, #1406, #1410, #1503, #1506, #1510, #1603, #1605 and #1607 had broken towel racks and there were no towels in the resident rooms.Rooms #1308, #1407, and #1408 had two resident occupants and only one towel rack. The resident in room [ROOM NUMBER]B had a broken window seal. There was a trash bag left on the floor outside the bathroom.Resident room [ROOM NUMBER] was dirty, with the tile floor appearing hazy and muted. The light fixture in the main shower room of the [NAME] unit had broken loose from the mounting and was dangling from the ceiling. A jagged ring of cracked drywall surrounded the gaping hole where the fixture once sat, leaving the internal electrical box exposed. The glass cover hung suspended y by a pair of twisted, color-coded wires.III. Resident interview The resident in room [ROOM NUMBER]B said the broken window seal enabled ants to enter the room when it rained. She said they used paper towels and they only received wash towels when they asked for it. The resident said they have not had a towel rack for a while.IV. Staff interviewCertified nurse aide (CNA) #3 was interviewed on 12/10/25 at 2:14 p.m. CNA #3 said all nursing staff were responsible for ensuring the residents' rooms were clean and were stocked with towels each day. He said wash towels were provided to the residents who asked for them.The maintenance director (MTD) was interviewed on 12/11/25 at 5:00 p.m. The MTD said he was not aware most of the residents' rooms had broken and missing towel racks. He said he completed a facility-wide room audit of all towel racks and had placed an order for 45 towel racks. The MTD said she will begin installation of all the broken racks as soon as the order arrives at the facility. The MTD said nursing staff were to initiate work orders through the facility's electronic work order system for the replacement of towel racks when they were broken. He said the window seal in room [ROOM NUMBER] would be immediately fixed. The MTD said the maintenance department completed monthly audits of all equipment, and he could not tell the reason the towel racks were missed.The assistant director of nursing (ADON) was interviewed on 12/11/25 at 6:35 p.m. The ADON said the CNA's, together with all nursing staff, were responsible for providing towels for all residents. She said every resident's room should have a towel rack for the resident's towel.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure four (#44, #74, #62 and #82) of six residents reviewed for activities out of 53 sample residents received an ongoing program of activities , designed to meet the needs and interests, and promote physical, mental and psychosocial well-being.Specifically, the facility failed to offer and provide personalized and group activity programs for Resident #44, #74, #62 and #82. Findings include: I. Facility policy and procedure The Activities policy, revised 2025, was provided by the nursing home administrator (NHA) on 12/11/25 at 3:05 p.m. It read in pertinent part, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and shall include, but is not limited to: activity assessment to include resident's interest, preferences and needed adaptations, and social history. Activities will be designed with the intent to: enhance the resident's sense of well-being, belonging, and usefulness; create opportunities for each resident to have a meaningful life; promote or enhance physical activity, cognition, emotional health, self-esteem, dignity, pleasure, comfort, education, creativity, success and independence; reflect resident's interests, age, cultural, religious interests, and choice. Activities may be conducted in different ways, one-to-one programs or in a combination of large and small groups, Residents are encouraged, but not mandated, to participate in scheduled activities. Each resident's interest and needs will be assessed on a routine basis. Special considerations will be made for developing meaningful activities for residents with dementia and special needs. All staff will assist residents to and from activities when necessary. Activities can occur at any time and are not limited to formal activities provided by the activities staff and can include other facility staff members, volunteers, visitors, residents, and family members. The physician, in coordination with the comprehensive assessment, approves activity programs. II. Resident #44 A. Resident status Resident #44, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included senile degeneration of the brain, unspecified dementia, and chronic kidney disease. The 10/2/25 minimum data set (MDS) assessment revealed the resident had a severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. She was dependent on staff for bed mobility, oral and personal hygiene, toileting and dressing and she required a mechanical lift for transfers and bathing. The MDS assessment documented it was important to the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident to participate in group activities and also to do her favorite activities. B. Observations On 12/8/25 at 9:00 a.m. Resident #44 was seated in front of the nurses' station. The resident was not engaged in a meaningful activity. On 12/8/25 at 9:45 a.m. Resident #44 remained seated at the nurses' station. On 12/8/25 at 10:20 a.m. Resident #44 remained by the nurses' station. On 12/8/25 at 11:20 a.m. Resident #44 remained by the nurses' station. On 12/9/25 at 9:03 a.m. Resident #44 was sitting in the common area and was not engaged in any meaningful activity. On 12/9/25 at 9:45 a.m. Resident #44 was in the same position by the nurses' station. On 12/9/25 at 10:30 a.m. Resident #44 was still sitting in front of the nurses' station. There were no meaningful activities observed. On 12/9/25 at 11:30 a.m. Resident #44 was assisted to the dinner table. On 12/9/25 at 11:50 a.m. Resident #44 was awaiting her lunch. The staff did not communicate with the resident. On 12/10/25 at 9:00 a.m. Resident #44 was sitting in front of the nurses' station and there were no meaningful activities. On 12/10/25 at 10:15 a.m. Resident #44 remained in front of the nurses' station. On 12/10/25 at 11:00 a.m. Resident #44 was sitting in the front of the nurses' station. On 12/10/25 at 12:31 p.m. Resident #44 was served her meal. On 12/10/25 at 12:40 p.m. CNA #13 on duty assisted Resident #44 with her meal, but did not talk to the to Resident #44 while the resident ate her meal. On 12/10/25 at 12:48 p.m. Resident #44 was assisted to her room. She was sitting in the room without meaningful activity. On 12/11/25 at 8:30 a.m. Resident #44 was sitting in front of the nurses' station. The resident was not engaged in a meaningful activity. On 12/11/25 at 8:50 a.m. Resident #44 was sitting in front of the nurses' station. On 12/11/25 at 9:48 a.m. Resident #44 was sitting in front of the nurses' station. C. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activities care plan, dated 4/25/25, identified Resident #44 enjoyed singing activities, holiday parties, food-and-drink socials, games, arts and crafts, being around others, watching television or movies and listening to music. Pertinent interventions included encouraging activities designed to meet the interests of and support physical, mental, and psychosocial well-being, providing activity materials like books, magazines, newspapers, arts and crafts, television, and radio, in accordance with the resident's interests and supporting the resident's choices for preferences regarding customary routine and activities. The November 2025 activity participation record documented the resident was active daily in resting/relaxing and thinking. She had family visits/socializing and talked on the phone daily. The log documented she was invited to bingo/trivia or card games twice on 11/5/25 and 11/7/25, but she was sleeping. The log documented the resident participated in exercise group on 11/7/25, 11/14/25 and 11/20/25. There was no further documentation that indicated the resident was invited or participated in group activities per her preference. The December 2025 (12/1/25 to 12/11/25) participation record showed the resident had family visits, resting and relaxation. She attended exercise on 12/5/25. The participation record documented the resident attended arts crafts on 12/10/25. The log documented she was unavailable for religious activities on 12/5/25, 12/6/25 and 12/7/25. D. Staff interviews The activities director (AD) was interviewed on 12/11/25 at 2:00 p.m. The AD said Resident #44 did not participate in the activities program because she preferred not to. The AD said when residents were admitted to the facility, the staff obtained the resident's activity and religious preferences. The AD said he had not invited Resident #44 to any group activities. The AD said he did not know her preferences very well and that activities assistant #1 knew her better. He said he delivered the daily chronicle daily to Resident #44. AA #1 was interviewed on 12/11/25 at 2:25 p.m. AA #1 said Resident #44 preferred observing activities. AA #1 said Resident #44 required assistance to the activities. AA #1 said the resident liked musical activities. AA #1 said Resident #44 needed to be invited to each activity. AA #1 said when she was not participating in activities she was sitting by the nurses' station. III. Resident #74 A. Resident status Resident #74, age less than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included anoxic brain damage (due to lack of oxygen to the brain), quadriplegia, and attention deficit hyperactivity disorder (ADHD). The 10/2/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. The resident was dependent on staff with maximal assistance for transfers, dressing, and bathing. The MDS assessment documented it was important to the resident to do favorite activities and also to go outside and get fresh air. B. Observations (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/25 at 10:00 a.m. Resident #74 was awake in his bed. The television was on, but there was no sound. On 12/8/25 at approximately 2:00 p.m. Resident #74 was awake in his bed. The television screen saver was on. There were no meaningful activities for the resident. On 12/8/25 at 4:00 p.m. the resident was sitting in his wheelchair. He was sitting in front of the nurses' station, with no activity. On 12/9/25 at 9:03 a.m. Resident #74 was awake and lying in bed, with nothing to do. The television was not on. The resident was looking outside the door. On 12/10/25 at 9:02 a.m. Resident #74 was lying in bed awake. The television was not on. On 12/10/25 at 2:51 p.m. Resident #74 was lying in bed awake The television was not on. On 12/10/25 at 4:11 p.m. the resident was lying in bed. The television was on, however, the volume was low. On 12/11/25 at 8:41 a.m., Resident #74 was awake while lying in bed. The television was not on, and he had no meaningful activity. C. Record review The activity care plan, revised 10/21/25, documented Resident #74 was not able to communicate with words and was mostly bed bound. It documented Resident #74 was unable to participate in groups but enjoyed being read to, listening to music, being around animals, watching television and being around others. Pertinent interventions included encouraging activities designed to meet the interest of and support physical, mental, and psychosocial well-being encouraging independence and interaction in the community, encouraging autonomy and independence with preferred activity pursuits, providing activity materials like books, magazines, newspapers, television, radio, arts and crafts, in accordance with resident's interest and supporting the resident's choices for preferences regarding customary routine and activities. The care plan had additional interventions that included activities and book reading three times a week and daily chronicle every morning. -Review of the care plan did not address the resident's interest to go outside as identified on the MDS assessment. The November 2025 activity task documentation record did not document Resident #74's participation shows watching television and relaxation daily. The log documented the resident was sleeping on various days for group activities. The log documented the resident did not participate in group activities from 11/1/25 to 11/15/25. The December 2025 (12/1/25 to 12/11/25) activity task documentation record did not documented the resident participated in any group activities. The log documented the resident watched television daily and listened to music. Review of Resident #74's electronic medical record (EM)R revealed the last one-to-one activity that was provided to the resident was on 6/9/25. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interviews CNA #3 was interviewed on 12/11/25 at 12:30 p.m. CNA #3 said Resident #74 did not like activities but loved watching television, listening to music. CNA #3 said the resident had his own television streaming channels and playlists. CNA #3 said Resident #74 liked the bedroom door open. AA #1 was interviewed on 12/11/25 at 2:25 p.m. AA #1 said Resident #74 was on the one- to-one activity program. AA #1 said she visited Resident #74 every morning, set up music, a television show, or a movie, and Resident #74 participated in observing a flower arrangement as a monthly activity. -However, record review revealed the last time Resident #74 participated in a one-to-one activity was 6/9/25 (see record review above). AA #1 said the CNAs helped take some residents to the activities area. She said it was hard to monitor an activity while also inviting residents. The assistant director of nursing (ADON) and the regional clinical resource were interviewed together on 12/11/25 at 6:53 p.m. The ADON and regional clinical resource said the activity assistants, nurses or CNAs took the residents to an activity if a resident wanted to go. The ADON said if the resident refused to attend an activity, the staff discussed it at care conferences. The ADON said the activities staff conducted activity participation reviews quarterly. The ADON said it was essential that the staff interacted with residents by engaging and inviting them to activities. IV. Resident status A. Resident status Resident #62, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included hereditary and idiopathic neuropathy, displaced bicondylar fracture of the right tibia hemarthrosis (bleeding into a joint space causing pain), acute kidney failure, chronic respiratory failure with hypoxia, nutritional anemia, heart failure, and anxiety disorder. The 10/23/25 MDS assessment revealed Resident #62 was cognitively intact with a BIMS score of 15 out of 15. The resident was dependent on staff for activities of daily living and required maximum assistance for transfers, moderate assistance with toileting, and personal hygiene. The 10/30/25 MDS assessment revealed it was very important for the resident to listen to music, keep up on the news, attend religious services, participate in group activities and go outside for fresh air. B. Resident interviews and observations Resident #62 was interviewed on 12/10/25 at 11:25 a.m. Resident #62 she did not participate in any activities and only watched television in her room. Resident #62 said the staff used to assist her into her wheelchair, however they stopped. The resident said she could not remember the last time the facility staff had assisted her to an activity. Resident #62 was interviewed again on 12/10/25 at 3:14 p.m. She said she had not been invited to Bingo that was currently going on. She said the facility staff had not informed her of the event and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expressed that she would have been interested in getting out of bed to attend the activity. During a continuous observation on 12/10/25, beginning at 1:06 p.m. and ending at 3:10 p.m., the following was observed: At 1:15 p.m., Resident #62 was in bed. There was a group ice cream social in the activity room on the Columbine unit. The resident said she was not invited to this activity. At 1:33 p.m. an unidentified CNA entered the resident's room to pick up her lunch tray. The CNA did not offer to assist the resident with any activity. At 2:00 p.m. the resident remained in her bed and occasionally closed her eyes. At 2:30 p.m. AA #1 walked down the hallway and spoke to a resident about an upcoming Bingo activity scheduled for 3:00 p.m. At 3:10 p.m. the resident remained in her bed and no staff members assisted the resident to Bingo During a continuous observation on 12/11/25, beginning at 10:04 a.m. and ending at 2:00 p.m., the following was observed: At 10:04 a.m. Resident #62 was lying flat on her back with her arms at her sides, staring at the ceiling. At 10:30 a.m. the resident closed her eyes. At 11:00 a.m. Resident #62 was awake and remained in her bed while the word puzzle activity was ongoing. At 1:15 p.m. the resident remained in her bed, and no staff members invited her to the ongoing coloring and aromatherapy activity. C. Record review The activities care plan, initiated on 10/29/25, revealed Resident #62 would benefit from small, supportive group activities and independent leisure in her room. Interventions included assisting the resident to and from activity locations as needed, assisting the resident with in-room activities as required with peers that had similar interests, encouraging the resident to socialize and encouraging her to attend activities of her interest. The activities participation log for November 2025 and December 2025 (12/1/25 to 12/11/25) was provided by the AD on 12/11/25 at 3:26 p.m. It documented the following: The resident participated in watching television, resting and relaxation 22 times. -Review of the logs did not reveal the resident was involved in one-to-one activities. -Review of the logs did not reveal small group activities, independent leisure, in-room activities or assistance to and from activities were offered. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Resident #82 A. Resident status Resident #82, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included degenerative disease of the nervous system, unspecified dementia, chronic respiratory failure and a history of falling. The 6/24/25 MDS assessment revealed the resident was severely cognitively impaired and unable to participate in a BIMS assessment. The assessment revealed that the resident accepted care, and it was very important for the resident to be around animals and listen to music. B. Observations On 12/9/25 at 2:15 p.m. Resident #82 was sitting in her wheelchair at the [NAME] nurses' station. At 3:25 p.m. the resident was sitting at the nurses station. Several unidentified staff members walked past the resident and did not engage with her. At 5:00 p.m. the resident was assisted to the dining area for diner. On 12/10/25 at approximately 10:18 a.m. an unidentified CNA assisted the resident to a tree planting activity. The CNA turned around and brought the resident back to the nurses' station. The unidentified CNA said the resident would not be interested in the tree planting activity. However, the CNA did not ask the resident. The CNA left the resident at the nurses' station. Resident #82 sat in her wheelchair at the nursess station. C. Record review The activities care plan, revised 3/28/25, identified Resident #82's activities preferences included observing her environment, watching television and movies, listening to music, being read to and being around others. Pertinent interventions included assisting the resident and from activity locations as needed, assisting the resident with in-room activities as required and encouraging the resident to attend an activity of her interest. Review of the November 2025 activities participation revealed the resident participated in family visits and watching television during the month. There was no further documentation indicating the resident participated in activities during the month. VI. Staff interviews CNA #8 was interviewed 12/10/25 at 2:05 p.m. CNA #8 said the AD and assistants were responsible for carrying out the activities programs. She said Resident #62 preferred getting up early during the day and refused any assistance to get up later in the afternoon. CNA #8 said she had not seen Resident #62 being offered activities in her room. She said the resident only watched television in her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AD was interviewed on 12/11/25 at 2:25 p.m. The AD said Resident #62 liked to stay in her room. He said Resident #62 was not currently participating in any one-on-one activities in her room. The AD said the AA should be reminding the residents of upcoming activities and encouraging them to attend. The AD said the activities department should be doing more to engage participation in the activities program for those residents who required assistance to and from activity programs. He said he would conduct an audit of all the resident activity preferences and initiate one-on-one preferred activities for those residents who were unable to attend daily activities. He said he would ensure the AAs remind the residents and assisted them to the activities location with the help of the CNAs. The AD said most of the residents would not know if there was an activity going on without being informed. The AD said the staff should return and offer the activity again, even when they had refused the first time.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for five of 10 residents reviewed on the secured unit out of 53 sample residents. Specifically, the facility failed to keep five resident beds in a safe position to prevent accident hazards. Findings include:I. Professional reference According to Effects of Bed Height on Balance during INgress and Egress from a Hospital Bed, (8/9/24) retrieved on 12/18/25 from https://pmc.ncbi.nlm.nih.gov/articles/PMC12439613/#:~:text=Additionally%2C%20optimizing%20hospital%20b When a bed is set too high, the process of getting into it becomes difficult; patients may attempt to pull themselves up, which can cause instability and increase their chances of falling.II. Observations and interviewsOn 12/8/25 at 12:12 p.m. the bed in room [ROOM NUMBER] was elevated with the mattress surface level at approximately four feet.On 12/8/25 at 2:33 p.m. the resident bed in room [ROOM NUMBER] was elevated with the mattress surface level at approximately four feet. On 12/9/25 at 2:55 p.m. the bed in room [ROOM NUMBER] was elevated with the mattress surface level at approximately four feet.On 12/9/25 at 3:08 p.m. two beds in room [ROOM NUMBER] were elevated with the mattress surface level at approximately four feet.On 12/9/25 at 4:26 p.m. the bed in room [ROOM NUMBER] remained in the elevated position. The resident who resided in room [ROOM NUMBER] walked to the bed, reached up and climbed into bed.The resident then began opening a clean brief while she sat sitting on top of the bed. Her legs were dangling approximately one foot above the floor. Certified nurse aide (CNA) #10 was notified of the residents position. CNA #10 walked into the room promptly and said the resident's bed should not be up that high. CNA #10 used the electronic bed remote to lower the bed until the resident's feet were able to touch the floor.On 12/10/25 at 2:49 p.m. beds in rooms #408, #410 and #401 were elevated with the mattress surface level at approximately four feet.On 12/10/25 at 6:00 p.m. the clinical resource consultant observed the bed position in rooms #309, #401 A and B and #410 A and B. The clinical resource consultant said the beds were too high.III. Staff interviewsCNA #11 was interviewed on 12/10/25 at 3:07 p.m. CNA #11 said the staff placed the beds in an elevated position so the residents would not transfer themselves and use them. She said some of the residents were a fall risk and most of them had dementia which could lead to falls. CNA #11 said because many residents had dementia, the nursing staff brought residents to a common area during the day. CNA #11 said if a resident was tired, the CNA would bring the resident to their room and then lower the bed in order for the resident to sleep. CNA #11 said Resident #72 tried to transfer herself to her bed often. CNA #12 was interviewed on 12/10/25 at 3:31 p.m. CNA #12 said nursing staff should keep the beds lowered and make sure they were locked. She said residents on the secured unit wandered and elevating beds could create a potential safety issue. CNA #12 said she had observed residents climb up onto high beds before. CNA #2 was interviewed on 12/10/25 at 3:48 p.m. CNA #2 said staff maintained resident beds in an elevated position unless a resident wanted to go to bed, at which point staff lowered the beds. CNA #2 said she had previously observed the resident who resided in room [ROOM NUMBER] wandered into another residents' room and the resident was found lying on an elevated bed. CNA #2 said the beds should be low because the resident could climb into high beds.Licensed practical nurse (LPN) #1 was interviewed on 12/10/25 at 4:12 p.m. LPN #1 said nursing staff were told to keep some beds elevated so the residents did not get back into bed.LPN #1 said that Resident #72's bed should be maintained in an elevated position to keep other residents from using the bed.The ADON was interviewed on 12/10/25 at 7:00 p.m. The ADON said the CNAs had good intentions leaving beds elevated She said the CNAs thought leaving the beds elevated would prevent residents from self-transferring into bed. The ADON said elevated beds were an accident hazard. The ADON said education was being provided to the CNAs to maintain resident beds at a safe level.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and record review, the facility failed to ensure certified nurse aides (CNA) received at least 12 hours of annual in-service training that also included dementia management training and resident abuse prevention training to ensure continued competence for three out of five certified nurse aides (CNA) reviewed.Specifically, the facility failed to ensure CNA #3, CNA #4, and CNA #5 received 12 hours of continuing education annually. Findings include:I. Facility policy and procedureThe In-Service Training policy, revised in 2001, was provided by the corporate consultant on 12/11/25 at 8:33 p.m. It read in pertinent part, All staff must participate in initial orientation and annual in-service training.Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment.Completed training is documented by the staff development coordinator, or his or her designee, and should include the date and time of the training, the topic of the training, the method used for training, a summary of the competency assessment, and the hours of training completed.II. Training record reviewFive randomly selected CNA training records were reviewed on 12/11/25. Of the five CNAs reviewed, CNA #3, CNA #4 and CNA #5 did not receive 12 hours of annual training. The corporate consultant said CNA #3 (hired 10/8/24), CNA #4 (hired 5/22/24) and CNA #5(hired 11/30/23) did not have 12 hours of training.III. Staff interviewsThe staff development coordinator was interviewed on 12/11/25 at 4:40 p.m. The staff development coordinator said she was responsible for ensuring that all CNAs completed the mandatory 12 hours of in-service training. The staff development coordinator said she did not have a timeline for checking staff competencies but would immediately begin checking regularly to ensure each staff member complied with the policy.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to inform residents of the possible outcome of their noncompliance with nutritional supplements for one (#62) out of three residents reviewed for weight loss out of 53 sample residents. Specifically, the facility failed to inform Resident #62 of the risks of significant weight loss. Findings include:I. Facility policy and procedureThe Resident Rights policy, revised on 2/2021, was provided by the nursing home administrator (NHA) on 12/11/25 at 3:51 p.m. It revealed in pertinent part, The resident would be notified of his or her medical condition and of any changes in his or her condition and would be informed of, and participate in, his or her care planning and treatment.II. Resident #62A. Resident statusResident #62, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician order (CPO), diagnoses included hereditary and idiopathic neuropathy, displaced bicondylar fracture of the right tibia hemarthrosis (bleeding into a joint space causing pain), acute kidney failure, chronic respiratory failure with hypoxia, nutritional anemia, heart failure and anxiety disorder.According to the 10/23/25 minimum data set (MDS) assessment Resident #62 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff for activities of daily living and required maximum assistance for transfers, moderate assistance with toileting, and personal hygiene.B. Resident's observation and interviewDuring a continuous observation on 12/8/25, beginning at 12:46 p.m. and ending at 12:56 p.m. the following was observed: Resident #62's lunch was The resident was observed poking at her food with a knife but did not take any bites. She picked up a small package and attempted to open it without success. The resident looked malnourished and pale, and her mouth was dry. The resident said she had lost a significant amount of weight since her admission to the facility. She said she did not eat her meals because she did not want to be obese. She said she either skipped dinner or had applesauce most of the time. She said the staff had not discussed the risks of significant weight loss with her.C. Record reviewThe nutrition care plan, revised on 11/12/25, revealed the resident was at nutritional risk related to varied oral intake, diagnoses of hypothyroidism, a history of significant weight loss, anticipated weight fluctuations related to fluid status, diuretic use, and heart failure. Interventions included dietary supplements as ordered, honoring to food preferences, notifying the physician and representative of significant weight changes, providing vitamins and minerals, ensuring a registered dietitian (RD) reassessed as indicated and obtaining weights weekly for four weeks and monthly thereafter if stable.The physician progress note, dated 12/3/25, documented that the resident had lost close to 40 pounds and was very unmotivated to perform daily activities, including eating. The physician documented that if this trend continued, it likely indicated she was approaching the end of life.The 12/3/25 interdisciplinary team (IDT) progress note documented the snack box, fortified food at all meals and the Magic cup (frozen nutritional supplement) were discontinued due to the resident's refusals.The 12/5/25 nutritional narrative weight loss note documented the resident weighed 144 pounds (lbs) on 11/4/25. The resident currently weighed 114.2 lbs on 12/5/25. The resident was noted to have lost 11.9 lbs in three weeks and would be placed on weekly nutritional at risk (NAR) meeting list due to continued weight loss.-Review of Resident #62's electronic medical record (EMR) did not reveal documentation that indicated the facility provided the resident with education regarding the risks of weight loss. III. Staff interviewsRegistered nurse (RN) #2 was interviewed on 12/10/25 at 2:46 p.m. RN #2 said she had worked With Resident #62 since her admission. She said the resident had lost a lot of weight since admission due to the refusal of her nutritional supplements. RN #2 said the resident consumed 0 to 25 percent of the dietary nutritional supplements, resulting in continued weight loss. RN #2 said she had not offered education on the effects of the resident's non-compliance with the dietary nutritional supplements.RN #1 was interviewed on 12/10/25 at 3:05 p.m. RN #1 said she was the unit manager and was aware of Resident #62's significant weight loss. She said she had consulted the resident's (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician regarding the considerable weight loss, suggested reviewing the resident's chart and asked the physician to consider an appetite stimulant. RN #1 said the physician denied her request and wrote a note indicating the resident's weight was unavoidable. RN #1 said she had not discussed or provided education to the resident of the possible effects of her continued non-compliance with dietary nutritional supplements.The dietary manager (DM) was interviewed on 12/10/25 at 3:25 p.m. The DM said she first tried the food approach then introduced Magic cup, Medpass 2.0 (oral nutritional supplement) and a snack box. She said the resident continued to lose weight due to non-compliance with the nutritional supplements. The DM said she recommended Remeron (a medication that can be used to stimulate the appetite) to help boost the resident's appetite, but the resident's physician denied the request on 12/5/25.The DM said she discussed her weight loss concerns with Resident #62, but did not document them or any education provided in the resident's EMR.The RD was interviewed on 12/10/25 at 3:35 p.m. The RD said Resident #62 refused most of her nutritional supplements and did not consume enough of her meals. She said Resident #62 had been placed on weekly weights to monitor her status. The RD said the IDT had met to discuss the significant weight loss and had implemented several interventions. She said however, the resident had been non-compliant with the interventions recommended by the IDT.She said that she had not provided education to the resident regarding the possible health effects of her non-compliance with the nutritional supplements, which resulted in the continued decline of her weight.VI. Facility follow upThe NHA provided documentation of education on 12/12/25 at 5:13 p.m. The documentation indicated the ADON provided education to Resident #62 on 12/11/25 regarding the possible outcome of the resident's continued non-compliance with the nutritional supplement and her refusal of tray meals.The documentation included a physician's order that initiated on 12/11/25. The physician's order prompted the staff to document a progress note every shift on the resident's compliance, non-compliance, or refusals with nutritional supplements. The physician's order also prompted the staff to document interventions attempted, and different approaches tried to promote the resident's compliance with interventions to improve her nutritional status.An additional physician's order was initiated on 12/11/25 at 11:20 a.m. for mirtazapine (Remeron) oral tablet 7.5 milligrams, one tablet by mouth at bedtime for appetite stimulation.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect two (#111 and #66) of eight residents from abuse out of 53 sample residents.Specifically, the facility failed to protect Resident #111 and Resident #66 from physical abuse from each other. Findings include:I. Facility policy and procedureThe Abuse, Neglect, and Exploitation policy, undated, was provided by the nursing home administrator (NHA) on 12/10/25 at approximately 4:00 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, intimidation, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.II. Incident of physical abuse between Resident #111 and Resident #66 on 10/18/25A. Facility investigationThe facility abuse investigation was provided by the NHA on 12/10/25 at approximately 4:00 p.m.The facility investigation documented on 10/18/25 at 6:15 p.m. certified nurse aide (CNA) #9 witnessed Resident #111 and Resident #66 facing each other and making hand-to-hand, swatting gestures at each other's hands and arms and making contact. The investigation documented CNA #9 immediately intervened by separating the residents and redirecting each resident in separate directions. CNA #9 notified the nurse on duty of the interaction. No injuries were reported at the time of the incident. -However, record review revealed Resident #111 sustained a skin tear to the back of her left hand (see record review below).The investigation documented both residents were interviewed after the incident. Both residents were unable to answer questions when interviewed. The investigation documented staff were reminded of the importance of monitoring resident interactions in common areas. B. Resident #1111. Resident statusResident #111, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included severe unspecified dementia with other behavioral disturbances (cognitive decline with behavioral issues like agitation, wandering, depression) and cognitive communication deficit (difficulty talking or understanding due to impaired thinking skills).The 10/22/25 minimum data set (MDS) assessment identified Resident #111 was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. The resident walked independently and required set up assistance with eating and substantial/maximal assistance with showering and dressing.C. Record reviewResident #111's psychosocial/behavioral care plan, revised 10/20/25, revealed Resident #111 exhibited behaviors of striking out, grabbing others and verbal aggression toward others. Pertinent interventions included to encourage and supply the resident with activities of her interest and offering to remove her from areas of high traffic and stimulation. The care plan directed staff to observe Resident #111 and ensure the resident stayed away from residents she had known altercations with.The 10/18/25 nursing progress note at 6:15 p.m. documented at 6:15 p.m. Resident #111 and Resident #66 were both being physically aggressive towards each other. No injuries were noted at the time. The two residents were separated. Resident #111 was assessed and found to have a skin tear on the back of her left hand. The residents were placed on 72-hour charting checks following the altercation with no further physical aggression noted.C. Resident #661. Resident statusResident #66, age [AGE], was admitted on [DATE]. According to the December 2025 CPO, diagnoses included vascular dementia (a decline in thinking skills from reduced blood flow to the brain often from strokes or chronic high blood pressure) and muscle weakness.The 9/9/25 MDS assessment identified Resident #66 was severely cognitively impaired with a BIMS score of seven out of 15 and used a wheelchair. The MDS assessment identified Resident #66 had vocal symptoms such as screaming and making disruptive sounds.2. Record reviewResident #66's psychosocial/behavioral care plan, revised (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/20/25, revealed Resident #66 exhibited behaviors of physical aggression with other residents. Pertinent interventions included encouraging and supplying the resident with activities of her interest and to offer to remove her from areas of high traffic and stimulation, observing Resident #66 and ensuring the resident stayed away from residents she had known altercations with.D. ObservationsOn 12/10/25 at 4:00 p.m. Resident #111 was yelling Get your (explicit language) out of here in the main common area where multiple residents were located. Resident #111 had furrowed eyebrows, pressed lips, and her stare was fixed in the direction of the residents in front of her. She was leaning forward with her walker and her head and neck were also extended forward. Her elbows were slightly outward and her hands were clenched onto her walker. An unidentified CNA came up to her, put her hand on her shoulder and looked at her, redirecting her attention to the CNA. Resident #111 dropped her elbows, her hands relaxed on the walker, her eyes and eyebrows relaxed and her mouth was no longer pursed as she turned her head away from the residents and focused on the CNA. The CNA assisted her in walking toward a more spacious area of the room. III. Staff interviewsCNA #2 was interviewed on 12/11/25 at 5:17 p.m. She said she was not present for the altercation on 10/18/25, but she was told that Resident #111 and Resident #66 were cussing at each other and swatting at each other's hands and wrists. She said before the altercation, staff kept eyes on residents and made sure they were safe. She said after the altercation, they ensured the Resident #111 and Resident #66 did not sit together in the common area or in the dining room. CNA #2 said Resident #66 would start cussing if other residents around her were cussing. She said Resident #111 was not aggressive but was also known to cuss or yell. CNA #2 said if staff saw either resident start to become agitated, they redirected them with an activity or snack and made sure they kept their distance.CNA #1 was interviewed on 12/11/25 at 5:20 p.m. CNA #1 said Resident #111 was known to yell and cuss. She said in general, they kept Resident #111 closer to the CNAs or nurses to keep focus on her because she could get grumpy easily. CNA #1 said Resident #66 seemed to get overstimulated with loud environments but was easy to redirect.Licensed practical nurse (LPN) #5 was interviewed on 12/11/25 at approximately 5:30 pm. LPN #5 said Resident #111 and Resident #66 had behaviors and needed to be closely watched to ensure altercations did not occur.CNA #9 was interviewed on 12/11/25 at approximately 5:40 p.m. CNA #9 said she witnessed the altercation between Resident #111 and Resident #66. CNA #9 said she was coming out of the shower room with a different resident when she saw Resident #111 walking with her walker toward Resident #66, who was in a wheelchair. She said Resident #111 shuffled next to Resident #66 and both residents began swatting their hands at each other. She said she did not know which resident initiated the aggressive behavior. She said the residents made physical contact with each other's hands. CNA #9 said she separated Resident #111 and Resident #66. CNA #9 said Resident #111 was taken to the dining room and Resident #66 returned to her room. She said a skin tear was later discovered on Resident #111's hand. She said it was unknown whether the skin tear occurred from Resident #111's bracelets or from contact with Resident #66. CNA #9 said it was the first time she had seen Resident #111 and Resident #66 in an altercation. She said the residents occasionally yelled at each other, but had not previously been physically aggressive toward one another. CNA #9 said after the incident, staff kept the residents separated as much as possible to avoid further issues.Registered nurse (RN) #3 was interviewed on 12/11/25 at 5:45 p.m. RN #3 said he recalled there was an incident between Resident #111 and Resident #66. RN #3 said he did not witness the altercation between Resident #111 and Resident #66. He said he assessed the residents after the altercation and found some superficial skin tears on Resident #111 which appeared to be recent and could have occurred during the altercation. RN #3 said Resident #66 did not have any injuries. RN #3 said before the incident, staff used the resident's care plans to understand their likes and dislikes in order to help keep them calm. RN #3 said after the incident, staff implemented safety checks for 72 hours. RN #3 said the residents were observed and remained separated if they were exhibiting behaviors to avoid conflict.The assistant director of nursing (ADON) was interviewed on 12/11/25 at 6:30 p.m. The ADON said prior to the incident, to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent resident-to-resident altercations, staff observed all residents closely and were quick to react to potential escalations. She said if staff sensed agitation in the residents, they would redirect them and ensure there was distance between those residents. The ADON said when the incident with Resident #111 and Resident #66 occurred, she ensured the residents were separated and had assessments completed. She said there were no injuries at the time of the incident but upon later assessment, the nurse noticed a skin tear on Resident #111's hand. The ADON said the facility was taking measures to ensure no further abuse occurred. She said the facility met to review the incident with the psychologist and primary care provider (PCP) and it was determined the incident was a spontaneous event. The ADON said after the incident, staff were more aware of the need to observe interactions between Resident #111 and Resident #66. The NHA was interviewed on 12/11/25 at 7:00 p.m. The NHA said the facility had concluded the physical abuse between Resident #111 and Resident #66 was substantiated

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#93) of three residents out of 53 sample residents received the proper treatment and assistive devices to maintain vision.Specifically, the facility failed to:-Follow up after an eye appointment for Resident #93; and,-Assist Resident #93 to make an appointment for cataract surgery. Findings include:I. Facility policy and procedureThe Hearing and Vision Services policy, undated, was provided by the nursing home administrator (NHA) on 12/11/25 at 4:00 p.m. It read in pertinent part, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. Staff should refer any identified need for hearing or vision services/appliances to the social worker/social service designee. Once vision or hearing services have been identified, the social worker/social service designee will assist the resident by making appointments and arranging for transportation.II. Resident #93A. Resident statusResident #93, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included dry eye syndrome of the bilateral lacrimal glands (tear glands do not produce enough tears), dementia and depressive episodes. The 12/4/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 13 out of 15. She required supervision when walking and transferring. The MDS assessment did not identify the resident having vision difficulty or requiring glasses.-However, Resident #82 had difficulty seeing (see interviews below).B. Resident interviewResident #93 was interviewed on 12/8/25 at 11:20 a.m. Resident #93 said she could not see out of her left eye. She said she had an eye appointment at least a month ago and she was told she needed cataract surgery. She said the facility had not followed up to arrange for the surgery. Resident #93 said she could not obtain new glasses until the cataract was repaired. Resident #93 was interviewed again on 12/10/25 at 5:25 p.m. Resident #93 said it was hard to live with the vision issues because she had difficulty seeing things up close. She said she used to read novels and was not able to do this anymore because of her vision difficulty. Resident # 93 said not being able to see made her feel depressed.C. Record reviewResident #93's care plan identified the resident had eyeglasses to assist with vision. The vision care plan directed staff to monitor for changes in Resident #93's ability to perform daily activities and mobility, to monitor for dilated pupils, double vision, grey or milky eye color, and blurred or hazy vision, to monitor Resident #93's eyes for irritation, redness, and increased dryness and to report these symptoms to the physician.A social services progress note, dated 9/11/25,documented Resident #93 requested assistance to schedule cataract surgery. The note documented the social services assistant (SSA) contacted the hospice provider for consent and the request was forwarded to transportation to schedule. The note documented the SSA was to follow up as needed.A physician's progress note, dated 10/24/25, documented Resident #93 was to receive eye drops in both eyes four times a day for her left eye cataract.The nursing progress note, dated 10/27/25, documented Resident #93 returned from her medical appointment. Per the transporter, Resident #93's eye physician said she was approved to have surgery and would send a message to her primary physician who would contact the facility to coordinate the cataract surgery. -Review of Resident #93's electronic medical record (EMR) did not reveal any additional documentation that the facility had attempted to schedule Resident #93's cataract surgeryD. Staff interviewsCertified nurse aide (CNA) #2 was interviewed on 12/10/25 at 3:48 p.m. CNA #2 said she did not know whether or not Resident #93 had vision issues, but she believed Resident #93 did have cataracts.Licensed practical nurse (LPN) #1 was interviewed on 12/10/25 at 4:12 p.m. LPN #1 said she thought Resident #93 went to an appointment a couple months ago to have her eye surgery, but recently learned the resident just received approval for the surgery at that appointment. LPN #1 said Resident #93 sometimes complained about dry eyes and received eye drops to help with that.The SSA was interviewed on 12/10/25 at 4:16 p.m. The SSA said (continued on next page)

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Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93 had been concerned about her vision. She said in September 2025, Resident #93 had a cataract evaluation and was then sent for a referral for the B Scan (an ultrasound test that creates an image of the internal eye and checks for underlying issues that could affect surgical outcomes) on 9/26/25. She said the facilty resent the referral on 10/16/25 and the B scan appointment was scheduled for 10/27/25. She said the transportation coordinator called and set up the appointments and should therefore be aware of when appointments need to be made.The social services director (SSD) was interviewed on 12/11/25 at 12:17 p.m. The SSD said the eye care center had received the referral and was contacting the incorrect facility to set up the surgical appointment. The SSD said that after the B Scan was completed and the doctor gave approval for Resident #93 to receive cataract surgery, the facility should have followed up with the eye care center after about a week to make sure a surgical appointment was scheduled. The SSD said it was the responsibility of the scheduler to make sure follow up and appointments were created. The SSD said the facility created an appointment for Resident #93's surgery that day (12/11/25), during the survey. The scheduler was interviewed on 12/11/25 at 1:00 p.m. The scheduler said she received a referral from the facility's eye doctor, which she then sent to eye care center for follow-up related to Resident #93's cataract She said the eye care center referred Resident #93 for further testing. She said when the testing was completed, the eye care center was supposed to contact the scheduler to coordinate the date of surgery. The scheduler said the eye care center did not contact her, so she assumed there had been an issue related to testing. She said she did not follow-up with the eye care center. The scheduler said she later learned Resident #93's testing was completed on 10/27/25 and the resident could have been scheduled for surgery at that time. She said the eye care center never contacted the scheduler to inform her that Resident #93 completed the tests. The scheduler said she was ultimately responsible to make sure all appointments were getting scheduled and she should have called and checked in with the eye care center sooner to coordinate the cataract surgery appointment for Resident #93. LPN #3 was interviewed on 12/11/25 at 1:13 p.m. LPN #3 said she would contact the facility's scheduler to coordinate an appointment if the physician determined the appointment was neededThe assistant director of nursing (ADON) was interviewed on 12/11/25 at 2:00 p.m. The ADON said the scheduler was responsible for scheduling appointments in a timely manner. The ADON said the scheduler should have followed up with the eye care center within two weeks of the testing when she had not been contacted by the eye care center to arrange the surgery.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.Specifically, the facility failed to:-Ensure housekeeping staff followed proper cleaning procedures for cleaning and disinfecting resident rooms and high-frequency touched areas; and ,-Ensure housekeeping staff performed hand hygiene and glove changes appropriately. Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures (5/4/23) was retrieved on 12/18/25 fromhttps://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_\ Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.Common high-touch surfaces include: bedrails; IV (intravenous) poles; sink handles; bedside tables; counters; edges of privacy curtains; patient monitoring equipment (keyboards, control panels); call bells; and, door knobs.According to the CDC's Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 12/18/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, To protect themselves and their patients from deadly germs, all healthcare personnel should understand proper hand care and cleaning techniques. Hand hygiene, which protects both staff and patients, involves cleaning hands by washing with soap and water, using antiseptic hand rubs (such as alcohol-based foams or gels), or performing surgical hand antisepsis. Cleaning your hands reduces the potential spread of deadly germs, including those resistant to antibiotics, to patients. It also lowers the risk of healthcare personnel becoming colonized or infected by germs acquired from patients. Because some healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep everyone safe, maintaining healthy skin is a common challenge.According to the CDC Hand Sanitizer Guidelines and Recommendations (3/12/24), retrieved on 12/18/25 from https://www.cdc.gov/clean-hands/about/hand-sanitizer.html,Germs are everywhere. They can get onto hands and items we touch during daily activities and make us sick. Cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you.There are important differences between washing hands with soap and water and using hand sanitizer. Apply the gel product to the palm of one hand (read the label to learn the correct amount). Cover all surfaces of hands. Rub your hands and fingers together until they are dry. This should take around 20 seconds. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.II. Facility policy and procedureThe Cleaning and Disinfecting Resident Rooms policy, revised September 2022, was provided by the nursing home administrator (NHA) on 12/11/25 at 4:11 p.m. It read in pertinent part, Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current CDC disinfection recommendations and the OSHA Bloodborne Pathogens Standard.Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (urinary catheters) or the vascular system (intravenous catheters) are considered critical items and must be sterile when used, based on acceptable sterilization procedures. Sterilization destroys all viable microorganisms to prevent disease transmission associated with the use of that item.The Hand Hygiene policy, revised October 2023, was provided by the NHA on 12/11/25 at 3:51 p.m. It read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors.III. ObservationsDuring a continuous observation on 12/11/25, beginning at 9:03 a.m. and ending at 9:43 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., housekeeper (HK) #1 was cleaning resident room [ROOM NUMBER] on the Columbine unit.HK #1 donned (put on) a new pair of gloves without performing hand hygiene. HK #1 entered resident room [ROOM NUMBER] with a bottle containing a purple-colored disinfectant solution labeled (BNC-15) and began spraying the entire surface of the sink area. HK #1 picked up articles from the floor around the resident's bed. She started rearranging personal items on the resident's bedside table. HK #1 returned to her cart, removed her gloves and donned a new pair of gloves without performing hand hygiene. HK #1 retrieved a blue rag from her cart, sprayed the purple-colored disinfectant solution (BNC-15) on the sink area, waited three to four minutes while she arranged resident items on the sink counter. She began cleaning the area around the sink, the mirror surface, and the sink faucet.HK #1 removed her gloves and put on a pair of gloves without performing hand hygiene. She retrieved a bleach germicidal spray bottle and sprayed the inside of the toilet bowl and the surrounding surfaces. HK #1 went to her cart, took off her gloves and donned a new pair of gloves. She picked up a toilet brush, a blue cleaning rag and began scrubbing the toilet. HK #1 wiped from top to bottom of the toilet and returned to her cart. She put the toilet brush and the cleaning rag back onto the cart and took off her gloves.-HK #1 failed to disinfect the toilet brush after use.-HK # failed to clean the side rails in the resident bathroom.HK #1 returned to her cart, removed her gloves, applied hand sanitizer, and immediately put on a pair of gloves. HK #1 picked up a trash can from bed A and placed it on top of the surface of the resident's sink that she had already cleaned. She emptied the trash can, applied a new liner, and placed it by the resident's bed. HK #1 returned to her cart, picked up a mop pad and a stick and started mopping the floor around the resident's bed without changing her gloves.-HK #1 failed to disinfect high-touch areas such as the resident's call lights and door knobs-HK #1 failed to ensure that already cleaned surfaces were not re-contaminated. HK #1 returned to her cart, picked up a broom and a dustpan and swept a portion of the room after she completed mopping the floor.-HK # did not sweep the entire floor prior to moping.During a continuous observation on 12/11/25, beginning from 10:07 a.m. to 10:30 a.m. HK #2 was observed cleaning resident room [ROOM NUMBER].At 10:07 a.m. HK #2 donned gloves without performing hand hygiene. HK #2 entered room [ROOM NUMBER] and began rearranging and picking up objects from the floor. HK #2 emptied the trash can and replaced the bags. HK #2 returned to her cart, changed her gloves and did not perform hand hygiene. HK #2 picked up a plastic container with a cleaning brush from her cart, together with a bleach germicidal cleaner. She sprayed the toilet bowl and placed the bottle on the floor in the resident's bathroom, closer to the toilet. HK #2 rearranged the resident's bedside table and repositioned the resident's bed. She picked up a cup of juice from the resident's bedside table with her right hand and her left hand held a dirty rag. She placed the cup of juice on another table, closer to the window, and continued cleaning the bedside table. After cleaning the bedside table, she used the same gloves to place the juice cup back where it was initially.-HK #2 failed to clean and disinfect the residents call light, grab bar and door knobs-HK #2 failed to change gloves and perform hand hygiene between dirty and clean surfaces.IV. Staff interviewsHK #1 was interviewed on 12/11/25 at 9:45 a.m. HK #1 said she applied hand sanitizer when she finished cleaning the bathroom and when she completed cleaning room [ROOM NUMBER].HK #1 said she should have used the hand sanitizer each time she changed gloves. She said she forgot to the clean high-touch areas such as doorknobs, resident call lights, and grab bars in the resident's toilet. HK #1 said that as soon as she placed the trash can on the clean surface, she knew it was not right and should have cleaned it again. She said she would remember to change her gloves more often in between tasks and also perform hand hygiene.The infection preventionist (IP) was interviewed on 12/11/25 at 4:37 p.m. The IP said gloves should be changed between tasks, and hand hygiene should be performed each time gloves were changed when cleaning resident rooms. She said high-touch areas such as resident call lights, grab bars in residents' bathrooms and door knobs needed to be cleaned each day and when visibly soiled. The maintenance director (MTD) was interviewed on 12/11/25 at 5:05 p.m. He said the HKs should know when to perform hand hygiene and change gloves during cleaning tasks. He said high-touch areas included door knobs, call lights, light (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	switches, bedside tables, nightstands and bed remotes. He said high touch areas should be disinfected daily. He said HK #2 should have changed her gloves and performed hand hygiene before touching the resident's juice cup.The MTD said he would immediately retrain housekeeping staff on the correct process for cleaning resident rooms and provide on-the-spot hand hygiene training.