STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065150	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Care Center	1330 Sidney Ave Sterling, CO 80751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to document resuscitation choices accurately in the medical record for one (#1) of three residents out of eight sample residents. Specifically, the facility failed to:-Ensure Resident #1's Medical Orders for Scope of Treatment (MOST) form was completed accurately; and,-Ensure Resident #1's MOST form matched the resident's wishes and the physician's order for a do not resuscitate (DNR) code status.Findings include: I. Facility policy and procedure The Advanced Directives policy, revised February 2024, was provided by the director of nursing (DON) on 12/9/25 at 2:05 p.m. It read in pertinent part, The facility recognizes advance directives, every attempt will be made to honor the resident's wishes unless to do so would violate the state or federal law. The advance directive and cardiopulmonary resuscitation (CPR) decisions will be reviewed in writing on admission and annually, when requested by the resident, or as needed.II. Resident #1 A. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included dementia, type 2 diabetes mellitus, paroxysmal atrial fibrillation (irregular heart beat), essential hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery (build up of fats, cholesterol and other substances along the walls of the heart arteries), dysphagia (difficulty swallowing food or liquids) and osteoporosis. The 9/9/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental score (BIMS) score of zero out of 15. She required moderate assistance with toileting, showering and personal hygiene. She required supervision with oral hygiene and set up assistance with eating. B. Record reviewReview of Resident #1's November 2025 CPO revealed the resident's physician's orders for cardiopulmonary resuscitation were DNR, ordered 9/4/25, which indicated the resident/resident's representative did not wish for the resident to receive CPR. Review of Resident #1's Medical Orders for Scope of Treatment (MOST) form, which was signed upon the resident's admission to the facility on 9/4/25, revealed the following:Section A, (for CPR preferences) was marked yes for CPR, which indicated the resident/resident's representative wished for the resident to receive CPR. -However, the physician's order indicated the resident was a DNR (see physician's order above).Below the Yes for CPR box were directions indicating selecting Yes required choosing Full Treatment for medication interventions in Section B. -However, Section B on Resident #1's MOST form was marked Comfort-focused treatment and the primary goal was to maximize comfort. -Although the MOST form directions indicated section B should have been marked full treatment with the primary goal to prolong life by all medically effective means, Resident #1's MOST form was marked incorrectly and emphasized comfort focused treatment. -Review of Resident #1's comprehensive care plan did not indicate Resident #1's CPR wishes. Review of Resident #1's 9/6/25 initial psychosocial assessment indicated her CPR status was DNR. Review of Resident #1's 9/10/25 care conference indicated her CPR status was DNR. Review of Resident #1's 11/29/25 hospital transfer form indicated her CPR status was see MOST form.-However, Resident #1's MOST form was marked that the resident wished to receive CPR, which did not match the resident's physician order which indicated the resident was a DNR status.The 11/29/25 nurse progress note revealed Resident #1 had increased difficulty breathing and was seen by the nurse practitioner on 11/28/25 with new orders for nebulizer treatments only. At lunch on 11/29/25, Resident #1 started having increased difficulty breathing and then vomited. The nurse assisted Resident #1 to her room, cleaned her up and administered duo-neb (a nebulizer breathing medication) treatment without positive effects and Zofran for nausea. Vital signs were obtained and were within normal limits except oxygen saturations were 87 %to 90 % on 2 liters of oxygen per minute. A call was placed to the on-call provider who gave the order to send Resident #1 to the hospital for an evaluation. The responsible party and the DON were notified. The responsible party wanted an update once she was evaluated at the hospital. Resident #1 was transported at this time by the facility bus and accompanied by the driver and the receptionist. Resident #1 was actively vomiting on departure, respirations were very labored and the color around her mouth was pale. She was responsive when spoken to. A call was placed to the hospital emergency room and a report was given.The 11/29/25 hospital emergency room report revealed Resident #1 came from a nursing facility by van for shortness of breath and vomiting. The nurse at the nursing facility reported she had vomited brown liquid and was not responding upon arrival to the emergency room. Resident #1 was brought into a bed where she began to become unresponsive and immediately started vomiting what appeared to be feculent material. The resident had a

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain accurately documented medical records for two (#1 and #2) of three residents reviewed out of three sample residents.Specifically, the facility failed to ensure Resident #1 and Resident #2 wound assessments were documented accurately and include weekly measurements to reflect progression of the wounds in the residents medical records. Findings include:I. Facility policy and procedureThe skin and wound care management policy, undated, was provided by the director of nursing (DON) on 10/28/25 at 10:18 a.m. It read in pertinent part, The purpose of this procedure was to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record. The date and time the wound care was given, the position in which the resident was placed, any change in the resident's condition, all assessment data such as wound bed color, size, and drainage. Obtained when inspecting the wound. If the resident refused the treatment and the reason why. Notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice.II. Resident #1 A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged on 10/16/25. According to the October 2025 computerized physician orders (CPO), the diagnoses included pulmonary embolism (sudden blockage of a lung artery, usually caused by a blood clot), type two diabetes, atrial fibrillation (irregular heart rhythm where the chambers of the heart beat chaotically and out of sync with the lower chamber), muscle weakness and needing assistance with personal care. The 7/18/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 15 out of 15. She required substantial or maximal assistance with lower body dressing and putting on and taking off footwear.B. Record reviewA review of Resident #1's treatment administration record (TAR) revealed the following treatment orders:-Wound care to the back of the left heel. Cleanse with in-house wound cleanser, apply medihoney to wound bed and secure with adhesive foam dressing. Change daily and as needed every day. Order date 8/5/25. -Wound care to the weeping areas of the bilateral lower extremities. Apply absorbent pads to bilateral lower extremities, secure with ACE bandage and change four times a day and as needed. Order date 8/5/25 and discontinued date 9/10/25. -Wound care to the bilateral lower extremities. Cleanse legs with wound cleanser, apply Dermaphor to dry skin on legs, apply DermaSyn/Ag (an antimicrobial wound gel) to eschar and slough area wound beds only, cover with Telfa, secure with ACE wrap, every day. Ordered 9/10/25. Skin/wound notes documented on for the month of August, September and October of 2025 to date revealed wound assessments were completed for Resident #1. The note documented open areas to the bilateral lower extremities. The skin/wound notes provided no additional information.The skin/wound notes failed to document an assessment of the wounds with measurements, the wound progression and treatment effectiveness. The notes only provided the location of the wounds to the resident's bilateral lower extremities. The facility failed to ensure skin assessments were focused and detailed.III. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the October, 2025 CPOs, diagnoses include cellulitis of the left lower limb, sepsis, muscle weakness and difficulty walking. The 10/2/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required partial to moderate assistance with lower body dressing and putting on and taking off shoes and socks.B. Record reviewA review of Resident #2's TAR revealed the following treatment orders:-Wound care. Cleanse wound area, pat dry, apply xeroform to areas on left leg, heel, and foot/toes, apply ABD (highly absorbant wound dressing), wrap with Kerlix then ACE wrap. Order date 5/2/25.A skin/wound note documented on for the month of August, September and October of 2025 to date revealed wound assessments were completed for Resident #1. The note documented a left lower leg vascular wound. The skin assessment did not include any additional information. The skin/wound notes failed to document an assessment of the wounds with measurements, the wound progression and treatment effectiveness. The notes only provided the location of the wound to the left lower extremity. The facility failed to ensure skin assessments were focused and detailed. IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 10/27/25 at 3:44 p.m. LPN #1 said skin assessments were done once per week. She said skin assessments should include the wound measurements and other wound details. LPN #1 said she was wound care certified. She said she was recently hired by the facility for the position of wound nurse. She said each wound should have a