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	03/26/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#11) of four residents out of 36 sample residents remained free from accidents.Resident #11 was admitted to the facility on [DATE] with diagnoses including parkinsonism, dementia, muscle weakness, a history of falls, and dysphagia (difficulty swallowing). On 1/28/26, Resident #11 sustained an unwitnessed fall from her electronic reclining chair. The facility recommended unplugging the resident's chair to prevent her from using the remote control due to cognitive impairments. The director of nursing (DON) said on 3/26/26, at some time before the fall on 2/14/26, the resident's electric chair was plugged back in (see interview below). On 2/14/26, the resident used the remote to the electronic reclining chair and sustained an additional unwitnessed fall. The resident was transferred to the hospital where she received staples to the laceration on her head and sustained a small hematoma (brain bleed).Specifically, the facility failed to ensure Resident #11's fall interventions were consistently implemented to prevent a fall with major injury. Findings include:I. Facility policy and procedureThe Fall Management policy, dated 3/1/26, was provided by the nursing home administrator (NHA) on 3/26/26 at 6:10 p.m. The policy revealed in pertinent part, Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Complete a thorough analysis of fall - time of day, location of fall, causative factors. Identify whether the interventions were in place at the time of the fall. Educate and communicate implemented interventions to direct care staff via verbal report.II. Resident #11A. Resident statusResident #11, age [AGE], was admitted to the facility on [DATE]. According to the March 2026 computerized physician orders, diagnoses included a history of falls, diagnosis of Parkinson's disease and dementia. The 2/21/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident used a manual wheelchair. The resident required substantial assistance with personal hygiene, toileting, transferring and walking. The MDS assessment documented Resident #11 had sustained two falls since admission to the facility with injuries. B. Record reviewThe activities of daily living (ADL) care plan, initiated 12/21/25, revealed Resident #11 had an ADL self-care performance deficit related to Parkinson's disease and dementia. Pertinent interventions included providing assistance with mobility in a wheelchair, providing one-person maximum assistance with transfers and encouraging the resident to use the call light for assistance. The fall care plan, dated 1/6/26, documented Resident #11 was at risk for falls related to a previous fall with fracture and dementia. Pertinent interventions included anticipating and meeting the resident's needs (initiated 12/21/25), assessing the resident's needs for adaptive devices (initiated 12/21/25), ensuring the resident's call light was in place (initiated 12/21/25), encouraging the resident to use her call light (initiated 12/21/25), ensuring there was adequate lighting in place (initiated 12/21/25), ensuring the resident was wearing appropriate footwear when ambulating (initiated 12/21/25), placing a fall mat next to the resident's bed when in bed (initiated 2/6/26), providing therapy as needed (initiated 12/21/25), placing the electric recliner with a manual recliner for safety (initiated 2/16/26) and reviewing past falls (initiated 12/21/25). -However, the facility (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	failed to ensure the staff were educated regarding the unplugging of the electric reclining chair to ensure it remained unplugged to prevent an additional fall. The facility investigation, dated 1/28/26 was provided by the NHA on 3/26/26 at approximately 2:00 p.m. The investigation documented Resident #11 sustained an unwitnessed fall in front of her electric reclining chair on 1/28/26. Resident #11 was assessed by the nurse and no injuries were reported, however the physician ordered the facility to send the resident to the hospital for an evaluation. The resident was transported to the hospital at 6:20 p.m. According to the emergency room physician progress notes, Resident #11 was monitored in the emergency department and received one liter of normal saline fluid intravenously for dehydration. The physician reported Resident #11 appeared more awake, alert and discharged back to the facility at 8:10 p.m. The resident's representative was notified and stayed with the resident at the emergency department until discharge. The facility investigation, dated 2/14/26, was provided by the NHA on 3/26/26 at approximately 2:00 p.m. The investigation documented Resident #11 sustained an unwitnessed fall on 2/14/26 at 11:20 a.m. The resident was found lying on the floor on her right side with her head partially under the bedside table next to her with the legs of the table slightly under her right side. The residents' recliner was elevated in the fully upright position. The resident had blood coming from the right side of her head. The investigation documented the licensed practical nurse (LPN) reported it appeared the recliner button was inadvertently pushed by the resident, and the recliner raised her up and she fell out of the chair and hit her head on the bedside table. Resident #11 stated she did not know exactly what happened and how she fell out of her chair. The investigation documented emergency medical services (EMS) were called, and the resident was transported to the emergency room. Resident #11 was assessed by a physician who reported the resident sustained a mechanical fall from her recliner and sustained a laceration to the right side of her head that required staples. A computed tomography (CT - imaging test) scan was completed. The emergency department physician reported the CT scan showed a mixed subdural chronic hematoma (a brain bleed from a previous event) and an acute (portion that was two millimeters without any effacement - a new brain bleed). The resident was monitored in the emergency room with her daughter present for another five hours and 35 minutes. The investigation documented the resident was determined to be neurologically stable and discharged back to the facility.III. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 3/25/26 at 12:33 p.m. CNA #4 said Resident #11 required two-person assistance with transfers from the bed to the reclining chair. CNA #4 said she reported any concerns regarding care of Resident #11 to the nurse.The director of nursing (DON) was interviewed on 3/26/26 at 3:44 p.m. The DON said Resident #11 had sustained two falls since admission. The DON said Resident #11 had an unwitnessed fall on 1/28/26, where she was found in front of her electric reclining chair. The DON said the resident was assessed by a nurse, EMS was notified, and the resident was transported to the emergency department. The DON said the resident returned to the facility after a few hours with no injury. The DON said the facility implemented an intervention of unplugging the resident's electric reclining chair.-However, the facility failed to ensure the electric reclining chair was unplugged and the resident sustained an additional fall from the chair on 2/14/26, related to the resident using the remote (see record review above). The conversation between the facility staff and the resident about unplugging the electric reclining chair was not documented in the resident's electronic medical record (EMR).The DON said Resident #11 sustained another fall on 2/14/26, where she was found on the floor by the chair with her head bleeding. The DON said the resident was transported to the hospital and assessed by the emergency physician. The DON said a CT scan was completed and sutures were placed on the right side of the Resident #11's head. The DON said the CT scan was reviewed by the medical director (MD) who determined the CT scan showed no long-lasting concerns. The DON said the resident's electric recliner was replaced on 2/15/26 with a manual recliner. The DON said the facility conducted a root cause analysis of the fall on 2/14/26. The DON said the facility determined Resident #11 used the electric reclining chair, which was plugged back in since 1/28/26. He said he thought the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	housekeeping staff might have plugged the chair in again when it should have remained unplugged after Resident #11 sustained the fall on 1/28/26. The DON said the electric reclining chair should have been removed from Resident #11's room after the residents' fall on 1/28/26 and replaced with the manual recliner. The MD was interviewed on 3/26/26 at 4:50 p.m. The MD said he had reviewed Resident #11's hospital records from 2/14/26. He said the CT scan finding was not enough to cause any long lasting problems.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#30 and #11) of 11 residents out of 36 sample residents received the nutritional care and services necessary to maintain their highest practicable level of well-being.Resident #30 was admitted to the facility on [DATE] with a diagnosis of dementia. Upon admission, the resident weighed 141.5 pounds (lbs) and was not identified to have nutritional concerns. On 12/10/25, the resident weighed 134.5 lbs, indicating a 7 lbs weight loss. The facility failed to address the residents' weight loss. On 12/17/25, the resident weighed 131 lbs, which indicated the resident sustained a 7.4% (10.5 lbs) weight loss in 30 days, which was considered severe. Per interviews with the registered dietitian (RD), the facility failed to identify the resident's weight loss until 1/30/26. However, Resident #30 continued to lose weight. On 2/26/26, the resident weighed 121.5 lbs, which indicated a 14.13% (20 lbs) weight loss, which was considered severe. The facility failed to implement a nutritional intervention until 2/6/26, approximately two months after the resident began losing weight. Resident #11 was admitted on [DATE] with diagnoses of Parkinson's disease and dementia. Upon admission, Resident #11 weighed 119 lbs. On 12/30/25 the resident weighed 117 lbs. On 2/4/26, the resident weighed 107 lbs, indicating a 18.9% (22 lbs) weight loss from 12/21/25 to 2/23/26, a period of two months, which was considered severe. The facility failed to address and implement nutritional interventions until 2/20/26, approximately two weeks after the resident sustained weight loss. Specifically, the facility failed to timely implement person-centered nutritional interventions for Resident #30 and Resident #11, who experienced severe weight loss.Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation, on 3/23/26 to 3/26/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/13/26. I. Situation of harm Resident #30 sustained a 7.4% (10.5 lbs) weight loss from 11/16/25 to 12/17/25 and 14.13 % (20 lbs) from 11/16/25 to 2/26/26, which was considered severe. The facility failed to identify the resident's weight loss and implement person-centered nutritional interventions for approximately two months after the resident began losing weight. Resident #11 sustained a 18.9% (22 lbs) weight loss from 12/21/25 to 2/23/26, which was considered severe. The facility failed to identify the resident's weight loss and implement person-centered nutritional interventions for approximately two weeks. II. Facility plan of correction On 3/26/26 at 10:47 a.m. the director of nursing (DON) provided a corrective action plan the facility implemented in response to residents' weight loss. The corrective action plan documented the following: A. Identification of concern The facility identified there were concerns regarding weight loss on 3/1/26. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	B. Corrective action for affected residents included the following: -Reviewed weights for identified residents, reweights completed by 3/6/26 by certified nurse aide (CNA) leaders. -Notification of the provider and the RD regarding identified residents was completed on 3/6/26 by the assistant director of nursing (ADON). -Notified the corporate team of the concerning weights on 3/6/26 during the weekly weight meeting. -Checked the last calibration of the weight scale on 3/5/26 with the ADON and the maintenance assistant. Discussed community order weights to complete calibration, or a company coming into the community every three months. C. Identification of other residents having the potential to be affected: The facility identified all residents had the potential for deficient practice. D. Address measures or systemic changes to ensure the deficient practice will not recur: -Education was provided to the interdisciplinary team (IDT) on the weight management process completed by a registered nurse (RN) quality mentor on 3/6/26. -Education was provided to CNA staff on the weight management program by the CNA team lead. -Each resident would be weighed upon admission and weekly or per provider orders. The nursing management team would review triggered weight changes daily (Monday through Friday) in the clinical morning meeting. -Any concerning weights would be addressed with the RD. -Weekly IDT would complete a weight meeting and review any residents with weight concerns. Residents reviewed would be written on the weight log, and progress note entered into the EMR. The RD would review abnormal weights and review high-risk residents monthly and all residents quarterly. The team would implement interventions as needed, and the resident's care plan would reflect the resident's weight concerns and interventions. E. Plan to monitor for sustained compliance The DON/designee would audit abnormal weights weekly for 12 weeks, audits would be written on the weekly weight log. Any abnormal weights would be addressed with the RD. -The DON/designee would report findings from the audits to the QAPI (quality assurance and performance improvement) Committee monthly for 90 days. The QAPI committee would identify any trends and take corrective action as needed. The first weight meeting was on 3/6/26 with the IDT and the RD. The RN quality mentor joined and provided additional education. Supplement orders were entered in the residents' electronic medical records (EMR). Education was provided to the team by the RN quality mentor on 3/6/26. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The facility documented the date of compliance was 3/13/26. III. Facility policy and procedure The Weight Management policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 3/26/26 at 8:25 a.m. It read in pertinent part, Residents are monitored for weight change on a regular basis. Results are reviewed and analyzed by the facility for interventions as appropriate. Residents identified with weight change will be assessed by the interdisciplinary team (IDT), and further interventions will be implemented to minimize the risk for further weight change where possible and to promote weight stability. Residents identified at risk for weight change will have interventions implemented to minimize the risk for additional weight change included in their plan of care. This may include supplements, RD evaluation, and assisted dining. The director of nursing or designee will analyze results for trends and patterns in residents identified with weight changes and report findings to the QAPI committee for review and recommendations. IV. Resident #30 A. Resident status Resident #30, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included left femur fracture, chronic kidney disease, atrophy of the thyroid, essential hypertension, need for assistance with personal care and unspecified dementia. The 1/9/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The MDS assessment documented Resident #30 had no issues swallowing and could eat independently, without any setup assistance or verbal cues. The resident was 70 inches tall and weighed 134 lbs. The MDS assessment documented Resident #30 had not experienced any significant weight loss. B. Observations and representative interview Resident #30's representative was interviewed on 3/24/26 at 9:11 a.m. The representative said she noticed Resident #30 had been losing weight, but did not know why. The representative said when she visited the facility, she encouraged Resident #30 to eat, and Resident #30 would eat the majority of her meals. The representative was observed asking Resident #30 if she had eaten yet, but Resident #30 did not answer. The representative said some days Resident #30 did not talk much. The representative said Resident #30 appeared sleepy. On 3/24/26, from 12:12 p.m. to 12:36 p.m., Resident #30 was continuously observed. Resident #30 was in the dining room for lunch. An unidentified staff member set a plate of spaghetti in front of Resident #30 and asked her if she wanted her food cut up. Resident #30 did not respond and the staff (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	member walked away. Resident #30 sat in front of the plate for a few minutes without eating. Resident #30's representative then assisted Resident #30 and cut up the spaghetti into smaller bites. Resident #30 ate around 25% of her meal and left the dining room. C. Record review The nutrition care plan, initiated 11/24/25, identified Resident #30 was at risk for nutrition problems as a result of leaving more than 25% of her meals uneaten. The interventions included monitoring weights as ordered, offering food alternatives, providing the diet as ordered, monitoring food intakes and the RD was to evaluate as needed. The weight loss care plan, initiated 2/23/26, revealed Resident #30 had unplanned weight loss as a result of having poor oral intake. Pertinent interventions included alerting the RD if intake was poor for greater than 48 hours, providing supplements, monitoring oral intake and monitoring weekly weights. Resident #30's weights were documented in the EMR as follows: -On 11/16/25, the resident weighed 141.5 lbs; -On 12/10/25, the resident weighed 134.5 lbs; -On 12/17/25, the resident weighed 131 lbs; -On 1/9/26, the resident weighed 134 lbs; -On 2/11/26, the resident weighed 127 lbs; -On 2/26/26, the resident weighed 121.5 lbs; -On 3/8/26, the resident weighed 123 lbs; and, -On 3/11/26, the resident weighed 118.5 lbs. -The resident sustained a 7.4% (10.5 lbs) weight loss, which was considered severe, from 11/16/25 to 12/17/25, in one month. -The resident sustained a 14.13% (20 lbs) weight loss, which was considered severe, from 11/16/25 to 2/26/26, in three months. -The facility failed to obtain an admission weight for four days after the resident was admitted to the facility. Resident #30's March 2026 CPO revealed the following physician's orders: Regular diet with regular consistency and thin liquids, ordered 11/12/25 and discontinued on 2/6/26. Regular diet with mechanical soft texture, thin liquids and fortified meals, ordered 2/6/26. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Mighty shakes two times a day, ordered 2/20/26. -The facility failed to implement a nutritional intervention until 2/6/26, which was approximately two months after the resident first sustained severe weight loss. The 11/12/25 mini nutritional assessment documented Resident #30 had a normal nutritional status. On 11/13/25, Resident #30's cognition was moderately impaired with a BIMS score of nine out of 15. The 1/5/26 mini-nutritional assessment documented Resident #30 was at malnourished nutritional status based on a measurement taken of her calf. On 1/5/26, Resident #30's cognition was severely impaired with a BIMs score of four out of 15. -However, despite the facility identifying the resident was malnourished, the facility failed to implement any person-centered nutritional interventions. D. Staff interviews The RD was interviewed on 3/26/26 at 9:04 a.m. The RD said Resident #30 had multiple risk factors for nutritional concerns, such as diagnoses of dementia, a recent bone fracture and a low body mass index. The RD said Resident #30's decline in weight was a result of poor oral intake due to dementia and difficulty staying engaged during meals. The RD said the direct care staff assisted in keeping the resident engaged during meals. The RD said she became involved in Resident #30's care on 1/30/26, when the significant weight loss had been identified. -However, Resident #30 sustained a 7.4% (10.4 lbs) weight loss from 11/16/25 to 12/17/25, which was considered significant. The RD said no interventions were in place prior to the significant weight loss that she identified on 1/30/26, although the weights had been trending down since admission. The RD said she added the resident to the fortified food program on 2/6/26 and added supplements at the end of February 2026. The DON was interviewed on 3/26/26 at 10:47 a.m. The DON said he did not think the facility had implemented enough interventions to prevent weight loss for all residents in the facility, which was why he enacted a PIP (performance improvement plan) on 3/1/26. The DON said since enacting the action plan, many residents had stopped losing weight, and some had gained weight. The medical director (MD) was interviewed on 3/26/26 at 12:20 p.m. The MD said Resident #30's weight change within her first month of admission was very significant and should have warranted intervention. The MD said the facility had not been doing a good job of managing residents' weights. The MD said the facility recently identified systemic weight loss in the facility and was taking action to correct the issue with a QAPI and IDT approach. The MD said the facility had made progress in the management of residents' weights, but was still developing successful systems. The activities director (AD) was interviewed on 3/26/26 at 4:14 p.m. The AD said she would sometimes help out as a CNA in the facility and was familiar with Resident #30. The AD said Resident #30's eating habits varied, based on her cognition level at the time. The AD said some days, Resident #30 was more distracted at mealtimes and needed frequent redirection from staff to eat. CNA #5 was interviewed on 3/26/26 at 4:15 p.m. CNA #5 said in recent weeks, Resident #30 needed (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	increased cuing and encouragement to eat her food because she became distracted. CNA #5 said she often checked Resident #30's meal tickets and had observed only 25% of the meal had been eaten. V. Resident #11 A. Resident status Resident #11, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included Parkinson's disease, dementia, muscle weakness and dysphagia (difficulty swallowing). The 2/26/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. Resident #11 required substantial assistance with personal hygiene, toileting, bed mobility, wheelchair assistance, transfers and eating. The MDS assessment revealed Resident #11 was 65 inches tall and weighed 98 lbs., was on a mechanically altered diet and had difficulty or pain with swallowing. B. Record review The activities of daily living (ADL) care plan, initiated 12/21/25, documented Resident #11 had deficits related to Parkinsonism and dementia and Resident #11 required partial to moderate assistance with eating. The nutrition care plan, revised 3/10/26, documented Resident #11 had a swallowing problem related to coughing or choking during meals or swallowing medication. Pertinent interventions included providing assistance with meals using the hand over hand technique as needed. The poor oral intake care plan, initiated 1/6/26, revealed Resident #11 was at risk for poor fluid intake related to Parkinson's disease and dementia. Pertinent interventions included encouraging fluid as tolerated. The unplanned/unexpected weight loss care plan, initiated 3/14/26, revealed Resident #11 had recent weight loss related to an acute illness and poor food intake. Pertinent interventions included alerting the RD if the resident's intake was low for over 48 hours, providing supplements as ordered, alerting the RD if the resident was not consuming supplements as ordered, notifying the RD and the physician for weight loss, monitoring meal intake and monitoring weekly weights. The nutrition care plan, initiated 3/14/26, documented Resident #11 was malnourished related to her declining health status and leaving greater than 25% of her meals. Pertinent interventions included monitoring for symptoms of swallowing difficulties and providing Mighty Shake twice and a day and Boost Breeze twice a day. Resident #11's weights were documented in the EMR as follows: -On 12/21/25, the resident weighed 119 lbs; -On 12/24/25, the resident weighed 117.2 lbs; -On 12/30/25, the resident weighed 117 lbs; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 1/5/26, the resident weighed 116 lbs; -On 1/15/26 the resident weighed 114 lbs; -On 2/4/26 the resident weighed 107.5 lbs; -On 2/9/26, the resident weighed 106.5 lbs; -On 2/16/26, the resident weighed 101.5 lbs; -On 2/23/26, the resident weighed 97 lbs; -On 2/26/26, the resident weighed 97.5 lbs; -On 3/2/26, the resident weighed 98.5 lbs; -On 3/5/26 the resident weighed 97.8 lbs; -On 3/9/26 the resident weighed 97.5 lbs; and, -On 3/16/26 the resident weighed 96.5 lbs. -The resident had a 18.9% (22 lbs) weight loss from 12/21/25 to 2/23/26, a period of two months, which was considered severe. A review of Resident #11's March 2026 CPO revealed the following physician's orders: -Magic cup (frozen nutritional supplement), offer two times per day with lunch and dinner, ordered on 2/20/26. -Regular diet, pureed texture, regular/thin, fortified meals, ordered on 2/18/26. -Boost Breeze supplement (oral nutritional supplement), offer two times each day, ordered on 3/7/26. A nutrition progress note, dated 2/23/26, documented Resident #11 had lost 5% in 30 days. The note documented the resident's body mass index was 16.7 (indicating the resident was underweight). The note documented Resident #11's meal intake was between 0% to 25%, Resident #11 received Mighty Shake supplement three times each day, Magic cup supplement two times each day and fortified meals had recently been added. The note documented Resident #11 was being followed by the IDT. -However, review of Resident #11's EMR revealed the facility did not implement a nutritional intervention until 2/18/26, which was approximately two weeks after the resident sustained significant weight loss. A nursing progress note, dated 2/24/26, documented the resident weighed 97 lbs. The note documented Resident #11's diet texture changed and the resident was eating at a table in the dining room with meal assistance provided. The note documented the physician and the pharmacist had been notified of Resident #11's weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The nursing progress note, dated 2/27/26, documented Resident #11 weighed 97.5 lbs pounds The IDT progress note, dated 3/6/26 at 3:33 p.m., documented a nutrition review meeting was held to review Resident #11's weights, skin, nutrition plan and interventions. The note documented interventions including fortified meals and Magic Cup supplements twice daily. The note documented a new intervention to add an eight ounces Boost Breeze supplement two times each day.D. Staff interviews CNA #4 was interviewed on 3/25/26 at 12:33 p.m. CNA #4 said Resident #11 needed help with eating her pureed meal and the resident liked the magic cup supplement.CNA #4 said Resident #11 was offered Boost and Mighty Shake supplements between meals, but sometimes did not drink the supplements when offered. CNA #4 said she reported Resident #11's meal intake to the nurse. The RD was interviewed on 3/26/25 at 9:20 a.m. The RD said the facility had implemented a plan to address weight loss in the last two months. She said there had been further improvement in weight loss after initiating meetings to review weekly weights. The RD said she began participating in virtual phone meetings weekly to review weight and skin concerns with the dietary manager and a nurse. The RD said the facility began weighing all residents weekly and she began reviewing residents for any changes, including weight loss of 5% or more and she documented the information in the residents' care plans. The RD said Resident #11 was at high risk as her weight had been under 100 lbs since February 2026. The DON was interviewed on 3/26/26 at 10:59 a.m. the DON said Resident #11's weight loss was related to her diagnosis of Parkinson's disease, dementia, weakness and poor oral intake. The DON said there were recent improvements with the facility's nutritional practices related to assessment for residents' weight loss, including the initiation of facility audits, weekly weight monitoring for all residents and specific multidisciplinary review of residents with any documented weight loss. The DON said adjustments had been made to individualized care plans, including for Resident #11. The DON said interventions for Resident #11 included fortified foods, Mighty Shake supplements twice a day and chocolate milk at meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen.Specifically, the facility failed to ensure: -Food was held at the correct temperature;-Hand hygiene was conducted during meal service and dishwashing; -The kitchen was clean and sanitary; and, -Food was labeled and stored correctly in the walk-in refrigerator, freezer, reach-in refrigerator, and dry storage area. Findings include:I. Failure to hold food at the correct temperatureA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 3/31/26. It revealed in pertinent part, Time/Temperature control for safety food, hot and cold holding at 135 degrees F (Fahrenheit) or higher and 41 degrees F and lower. (Chapter 3)B. Facility policy and procedureThe Food Wholesomeness policy and procedure, revised December 2021, was provided by the nursing home administrator (NHA) on 3/26/26 at 8:25 a.m. It read in pertinent part, Cold foods are kept between 34 to 41 degrees F prior to serving and frozen foods are kept at 0 degrees F or below.C. ObservationsDuring a continuous observation on 3/24/26, beginning at 5:00 p.m. and ending at 6:01 p.m., the following was observed during the meal service in the main kitchen:At 5:00 p.m. the kitchen staff began serving room trays. A tray of small souffle cups with sour cream in them was sitting on a metal cart next to the service line. The tray of souffle cups were not sitting on ice. At 5:22 p.m. the tray of sour cream remained sitting on the cart and the souffle cups have been put on trays and sent out to the residents. At 5:54 p.m. the assistant dietary manager prepared the test tray for the five surveyors and used one of the souffle cups of sour cream. At 6:01 p.m. the five surveyors evaluated the test tray and the temperature of the sour cream was 74 degrees F. D. Staff interviews The assistant dietary manager was interviewed on 3/25/26 at 2:46 p.m. She said the souffle cups of sour cream should have been on ice. She said any dairy products should be on ice during meal service. II. Failure to perform hand hygiene appropriately during meal service and dishwashingA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 3/31/26. It revealed in pertinent part, The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20/25 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. Facility policy and procedureThe Food Wholesomeness policy and procedure, revised December 2021, was provided by the NHA on 3/26/26 at 8:25 a.m. It read in pertinent part, Food is handled properly with frequent handwashing and proper sanitation guidelines.Handwashing signs are posted above handwashing sinks and employees have handwashing techniques reviewed regularly and at orientation.C. ObservationsOn 3/23/26 at 11:50 a.m. an unidentified dietary staff member entered the kitchen, did not wash or sanitize her hands, prepared a plate, and then wiped her nose with the back of her hand. She then immediately came out of the kitchen and served the plate to a resident.On 3/23/26 at 11:59 a.m. the same unidentified dietary staff member entered and exited the kitchen using the door handle to enter and pushing the door to exit the kitchen. The dietary staff member did not sanitize or wash their hands before continuing to serve the residents' meals.During a continuous observation on 3/24/26, beginning at (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5:00 p.m. and ending at 6:01 p.m., the following was observed during the meal service in the main kitchen:At 5:00 p.m. cook (CK) #3 began preparing room trays.At 5:10 p.m. CK #3 s moved the room tray cart around the kitchen while wearing gloves. Without changing gloves or performing hang hygiene, CK #3 continued to prepare the room trays. At 5:15 p.m. CK #3 walked away from the service line to talk to another dietary staff member. During this time, CK #3 touched multiple different surfaces (preparation tables, meal trays and the reach-in refrigerator) without changing her gloves. At approximately 5:22 p.m. the kitchen staff began to serve the residents who were in the dining room. CK #3 was still wearing the same gloves that she was wearing when she touched multiple items in the kitchen. At 5:31 p.m. an unidentified dietary staff member came into the kitchen and grabbed silverware and a napkin, she did not wash her hands. At 5:41 p.m. CK #3 touched three premade cheeseburgers with her gloved hand (the same pair of gloves as before).At 5:44 p.m. DA #1, who was washing dishes at the three-compartment sink went from dirty dishes to clean dishes without washing his hands. D. Staff interviewsDA #1 was interviewed on 3/25/26 at 2:40 p.m. He said he was unsure if he needed to wash his hands when going from dirty dishes to clean dishes. He said he was recently hired. The assistant dietary manager was interviewed on 3/25/26 at 2:46 p.m. She said the staff should be changing their gloves any time they change tasks or touch other surfaces. She said staff should wash their hands when they change their gloves. She said the staff should wash their hands when they go from dirty dishes to clean dishes. She said that CK #3 should not have touched the cheeseburgers. III. Failure to ensure the kitchen was clean and sanitaryA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 3/31/26. It revealed in pertinent part, Physical facilities shall be cleaned as often as necessary to keep them clean. Plumbing fixtures such as handwashing sinks, toilets, and urinals shall be cleaned as often as necessary to keep them clean. Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. Refuse, recyclables, and returnables shall be removed from the premises at a frequency that will minimize the development of objectionable odors and other conditions that attract or harbor insects and rodents. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. (Chapter 4, 5 and 6)B. Facility policy and procedureThe Food Wholesomeness policy and procedure, revised December 2021, was provided by the NHA on 3/26/26 at 8:25 a.m. It read in pertinent part, Kitchen and serving areas are clean at all times. A cleaning schedule is followed and initialed when tasks are done. Rags are stored in clean areas and when in use, in proper sanitation and soap solutions. Foods are stored under cleanable conditions.C. ObservationsOn 3/23/26 at 8:44 a.m. an environmental tour of the kitchen and dishroom was conducted, the following was observed:-Two wet towels were on the preparation tables, one of the towels was next to a staff member who was cutting cake. -The floor leading from the dish room to the door that went outside had a large strip where the tiles were pulled up. The threshold of the door that went outside of the building was crumbling leaving enough space underneath the door to see directly outside. -The cove base was missing in the dishroom.-The large trash can in the food preparation area did not have a lid on it. -The large mixer was not covered, not in use and had sleeves of styrofoam bowls sitting on top of the mixer. On 3/24/26 at 5:00 p.m. the following was observed:-DA #1 was wiping the counter and wiping the debris off the counter onto the plate dolly, which was full of clean plates being used for meal service. The plate dolly was not covered and was open to air. -The plate dolly had large amounts of food debris on it, on all sides. -The large trash can was overflowing with trash and did not have a lid on it-The floor underneath the three-compartment sink was warped and the tile was coming up.There were small holes in the grout where the tiles were coming up around the drain on the floor. Where the floor meets the wall, the wall was crumbling and peeling. -The large mixer was not covered and had the sleeves of styrofoam bowls on top of it. D. Staff interviewsCK #3 was interviewed on 3/25/26 at 2:38 p.m. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She said that the plate dolly got cleaned during the evening shift. She said that the day shift used it and the evening shift cleans it. The assistant dietary manager was interviewed on 3/25/26 at 2:46 p.m. She said the plate dolly was cleaned two times a day and whenever it needed to be. She said sanitizer towels should be kept in the sanitizer buckets when they were not being used. She said that the large mixer never had a cover on it due to daily use. She said that they did not have a current cleaning checklist but they were working on making one. IV. Failure to ensure foods were labeled and stored appropriately in the walk-in freezer, walk-in refrigerator, reach-in refrigerator and dry storage area. A. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), was retrieved on 3/31/26. It revealed in pertinent part, Food packaged in a food establishment shall be labeled, label information shall include: the common name of the food, or absent a common name, an adequately descriptive identity statement. Food shall be protected from contamination by storing the food in a clean, dry location, where it is not exposed to splash, dust, or other contamination and at least six inches above the floor. Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. (Chapter 3)B. Facility policy and procedureThe Food Wholesomeness policy and procedure, revised December 2021, was provided by the NHA on 3/26/26 at 8:25 a.m. It read in pertinent part, Foods not in original containers are labeled and dated with opening and suggested to have a use by date. Foods are stored under cleanable conditions.C. ObservationsOn 3/23/26 at 8:44 a.m. the following was observed in the main kitchen:In the dry storage area a box of hot dog buns was sitting directly on the floor. In the reach-in refrigerator:-A bowl of chopped hard-boiled eggs was not dated.-A small container of pre-poured sauces in souffle cups were not labeled or dated. In the walk-in refrigerator:-A shallow pan of pre-poured sauces in souffle cups were not labeled or dated. -Two personal lunch boxes that were not labeledIn the walk-in freezer:-Approximately four boxes of frozen vegetables were sitting directly on the floorIn the second dry storage area there were two cans of stewed tomatoes with fist-sized dents and one can of jellied cranberry sauce with a dent on the side right by the top of the can, they were sitting with all of the other canned goods. On 3/25/26 at approximately 2:30 p.m. the following was observed in the main kitchen:In the reach-in refrigerator, a small container of pre-poured souffle cups were labeled as tarter sauce however, when the container was pulled down there was a couple of souffle cups that did not have dates on them and were sour cream. D. Staff interviewsThe assistant dietary manager was interviewed on 3/25/26 at 2:46 p.m. She said the souffle cups were normally dated on the lids and the containers the staff put them in normally would have the description of what was in the souffle cups and dated. She said boxes of food should never be stored on the floor. She said staff normally would inspect the canned goods and would put the dented cans in the dietary manager's office so they could be reimbursed for them.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on observations, record review and interviews, the facility failed to ensure residents' personal funds accounts were managed adequately for the facility and accessible to the residents for three (#7, #27 and #44) of three residents out of 36 sample residents. Specifically, the facility failed to ensure residents were educated on how to access their money on the weekends. Findings include: I. Resident interviewsResident #7 was interviewed on 3/23/26 at 2:40 p.m. He said the person who handled the money was not always at the facility. He said he was not aware of any times on the weekends when he could pull out his money. Resident #7 was interviewed a second time on 3/25/26 at 1:04 p.m. He said he normally went to the business office manager or the front desk to pull out his money. He said he could not get money out on the weekends.Resident #27 was interviewed on 3/25/26 at 1:07 p.m. She said she was not able to pull money out of her account on the weekends. Resident #44 was interviewed on 3/25/26 at 1:11 p.m. He said he had to pull money out before the weekend if he had any plans to go anywhere on the weekend. II. ObservationsDuring the survey process, a sign listing banking hours was not observed in the facility. III. Staff interviewsThe wound care nurse was interviewed on 3/26/26 at 11:12 a.m. She said she did work on weekends. She said when she did work on the weekends, the issue of pulling money out had not come up. She said during the week the residents would go to the front office. She said she was unsure of what the process was for the weekends. Licensed practical nurse (LPN) #2 was interviewed on 3/26/26 at 11:15 a.m. She said she did work on the weekends and during the week the residents usually went to the business office manager to pull out their money. She said she was unsure of the process of how residents accessed their money on the weekends. The business office manager was interviewed on 3/26/26 at 1:05 p.m. He said he was unsure if the residents had ever been educated on how to access their money on the weekends. He said he thought the residents were told when they first admitted to the facility. He said the facility did not have their banking hours posted anywhere. He said the residents were able to access their money on the weekend by going to the receptionist at the front desk. He said the facility had a receptionist seven days a week. He said the receptionist had access to the petty cash box. He said he was unsure if all of the staff knew the weekend process of how residents access their money. He said residents should be aware of how to access their funds on the weekends. The nursing home administrator (NHA) was interviewed on 3/26/26 at 1:22 p.m. She said the residents should be able to access their funds on the weekends. She said the facility would post their banking hours and would educate residents during resident council meetings. She said that all of the staff should know the process of how residents access their funds on the weekends because a resident can ask any staff member.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure three (#45, #58 and #27) of five residents were kept free from abuse out of 36 sample residents. Specifically, the facility failed to:-Protect Resident #45 and Resident #58 from physical by Resident #80; and,-Protect Resident #27 from physical abuse by Resident #21. Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 3/23/26 at 11:21 a.m. It read in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. Each facility assesses each potential resident prior to admission. This assessment includes a behavior history. Persons with a significant history or high risk of violent behavior are carefully screened and assessed for appropriateness of admission. If a resident experiences a behavior change resulting in aggression toward other residents, the community will implement interventions for protection of the alleged assailant and other residents. The facility conducts further assessment and arranges for appropriate psychiatric evaluation for further screening. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization, can then be implemented. II. Incident of physical abuse by Resident #80 towards Resident #45 on 11/2/25 A. Facility investigation The facility's investigation, dated 11/2/25, was provided by the NHA on 3/25/26 at 10:00 a.m. The investigation documented the following: On 11/2/25 certified nurse aide (CNA) #7 witnessed Resident #80 strike Resident #45 on the back with her hand. CNA #7 separated the residents and then notified the NHA. The nurse assessed both residents for injury and none were noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #80 was placed on a one-to-one observation initially and then 15-minute checks. Resident #45 and Resident #80's care plans were updated and their physicians were notified of the incident. Resident #45 was checked frequently and the residents were immediately separated from each other. The investigation documented Resident #45 was interviewed by the social services director (SSD). It was documented due to the resident's cognitive impairment she stated she had never been hit before and she had never hit anyone. Resident #45 did not recall any one yelling or talking to her that day or prior. Resident #45 self-propelled herself throughout the halls of the facility in her wheelchair. The investigation documented Resident #80 was interviewed by the SSD. It documented the resident had no recollection of the incident and stated she did not hit anyone. Resident #80 struggled to focus on the conversation and talked about birds in the hall. It documented the SSD attempted a second interview with Resident #80 to obtain further information. The resident did not remember the incident. The investigation documented CNA #7 was interviewed by the SSD. CNA #7 said she was walking onto the 100 hallway near the tubroom. CNA #7 said she observed Resident #80 sitting in her wheelchair behind Resident #45, who was also sitting in her wheelchair. CNA #7 said Resident #80 yelled that she needed to go to the doctor. The investigation documented Resident #45 ignored Resident #80 and then Resident #80 leaned forward and hit Resident #45 with a closed fist in the back. The investigation documented CNA #7 removed Resident #80 from the situation and took the resident to the dining room. It documented Resident #80 continued to yell out that she needed to go to the doctor. CNA #7 continued to redirect the resident by reminding her it was Sunday multiple times. CNA #7 said Resident #45 did not say anything about the incident during or after Resident #80 hitting her. The investigation revealed Resident #80 had episodes of yelling out and had entered other residents' rooms while yelling. The investigation documented the facility substantiated the abuse. B. Resident #45 (victim) 1. Resident status Resident #45, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included dementia with agitation, encephalopathy (disease, damage, or malfunction to the brain), depression, hyperthyroidism and hypertension (high blood pressure) . The 2/22/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. She required maximal assistance with all activities of daily living (ADL). 2. Resident #45's representative interview Resident #45's representative was interviewed on 3/25/26 at 10:36 a.m The representative said he did recall the incident between Resident #45 and Resident #80. The representative said the residents were never roommates. He said they had rooms near each other. The representative said Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#80 moved rooms to be farther away from Resident #45 as part of the intervention. The representative said Resident #45 did not recall the event due to her cognitive impairment and did not seem upset because she did not remember the incident. 3. Record review The elopement care plan, revised 6/17/25, revealed Resident #45 wandered related to impaired safety awareness. The care plan documented Resident #45 wandered but did not exit-seek. Pertinent interventions included distracting the resident by offering her pleasant diversions, structured activities, food, conversation, television or a book. The care plan documented Resident #45 preferred conversations with staff and other residents. The dementia care plan, revised 6/17/25, revealed Resident #45 had impaired cognitive function as evidenced by her BIMS score related to dementia. Pertinent interventions included cueing, reorienting the resident, task segmentation, offering the resident simple choices and providing supervision as needed. The social services progress note, dated 11/3/25 at 11:23 a.m., documented the SSD interviewed Resident #45. It documented Resident #45 had no recollection of the incident with Resident #80. It documented the resident was in a pleasant mood, smiling and wanting to hold hands with the SSD. It documented Resident #45 was at her baseline with confusion. The risk management review note, dated 11/4/25 at 7:57 a.m., documented the root cause for the incident between Resident #45 and Resident #80 was due to dementia and Resident #45 was blocking the hallway with her wheelchair. It documented treatment was required. It documented interventions included assessment and observation of Resident #45 for possible injury and/or psychosocial upset. It documented referrals were made to social services and the physician recommended monitoring Resident #45. A nursing progress note on 11/4/25 at 8:03 a.m. documented Resident #45 was involved in a resident-to-resident contact incident on 11/2/25. It documented there was no delayed injury or psychosocial effects noted. A social services progress note, dated 11/4/25 at 2:07 p.m., documented the SSD interviewed Resident #45. It documented the resident reported feeling safe in the community, and she was having a good day. It documented the resident remained at her baseline with confusion. C. Resident #80 (assailant) A. Resident status Resident #80, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included dementia with other behavioral disturbance, type two diabetes and excoriation disorder. The 9/9/25 MDS assessment revealed Resident #80 had severe cognitive impairments with a BIMS score of zero out of 15. The assessment revealed Resident #80 needed partial to moderate assistance with most of her ADLs. The assessment further revealed that Resident #80 had both physical and verbal symptoms directed towards others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review The trauma-informed care plan, initiated 9/6/25, revealed Resident #80 had significant family trauma. The care plan documented the trauma she experienced may have contributed to her problematic behaviors, such as trust in others. Pertinent interventions included assessing the resident's need for additional therapeutic services, reinforcing participation in structured activities, and allowing time for Resident #80 to share feelings. The behavior care plan, initiated 9/5/25, revealed Resident #80 had behaviors of yelling at staff and other residents, and physical aggression, and attention-seeking behaviors possibly due to pain, confusion and other residents being in her way. Pertinent interventions included intervening as necessary to protect the rights and safety of others, diverting attention with tasks or activities, monitoring behaviors to identify underlying causes and one-on-one as needed while awake and line-of-sight while in bed. A nursing progress note dated 9/4/25 at 7:14 p.m. documented Resident #80 was in the lobby with other residents. The note documented she was yelling and screaming and using profanity at the other residents. The note documented she was not easily redirected. A nursing note, dated 11/4/25 at 8:07 a.m., documented that Resident #80 was the aggressor of a resident-to-resident contact on 11/2/25. The note documented that Resident #80 had been on one-to-one supervision while she was in her wheelchair. The note documented Resident #80 had not had any other aggressive behavior. D. Staff interviews CNA #2 was interviewed on 3/26/26 at 9:07 a.m. CNA #2 said Resident #45 frequently showed signs of wandering and went into other residents' rooms. CNA #2 said she redirected the resident when she was trying to go into other rooms. CNA #2 said Resident #45 also yelled out and made disruptive sounds. CNA #3 was interviewed on 3/26/26 at 9:10 a.m. CNA #3 said if she witnessed a resident-to-resident altercation, she would separate the residents to allow them time to calm down from the situation. CNA #3 said once she separated the residents and ensured their safety, she would notify the nurse on duty, the director of nursing (DON) and the NHA immediately. CNA #3 said she did not witness the incident between Resident #45 and Resident #80 on 11/2/25, but was working that day and heard about it. CNA #3 said Resident #80 had previously exhibited behaviors of yelling, hitting, and making accusations. CNA #3 said the resident had accused her of taking her food tray, but the tray was right in front of her on the table. CNA #3 said Resident #80 exhibited ticking behaviors, such as touching or fidgeting with other residents' wheelchairs and reaching out to tap a resident on their arm with her finger as a way to get their attention. The DON, the NHA and the SSD were interviewed together on 3/26/26 at 3:00 p.m. The NHA said she was notified for any reports of abuse. The NHA said the facility initiated an investigation immediately after notification of an allegation of abuse. The DON said staff were educated on abuse at the time of hire and annually. The NHA said all staff had received training on abuse in April 2025. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	well as the police. The facility investigation documented that Resident #80 was in a previous physical abuse allegation on 11/2/25 (see incident above). The facility investigation documented the SSD interviewed Resident #58 (alleged victim) on 11/17/25 at 10:50 a.m. about the incident with Resident #80. Resident #58 said he did not remember the incident and could not recall how he had gotten the scratch on the back of his neck. When the SSD asked if another resident had ever hurt him, Resident #58 told her no. When the SSD asked him if he was ever afraid or worried that something might happen to him or someone else he shook his head indicating no. The facility investigation documented Resident #80 was interviewed on 11/17/25 at 11:11 a.m. The investigation documented Resident #80 had a hard time maintaining focus and attention to the conversation due to her cognitive impairment. Resident #80 could not recall seeing Resident #58 in the lobby and she could not recall being upset with any other residents. The SSD interviewed the CNA that witnessed the incident between Resident #58 and Resident #80 on 11/21/25. The CNA said Resident #80 was speaking loudly to the other residents in the front lobby like she normally did. She said that both Resident #80 and Resident #58 were in the front lobby area. The CNA observed Resident #80 lean forward and grab Resident #58's ear. The CNA reported she thought that Resident #80 was trying to get Resident #58's attention. The CNA reported she separated the residents immediately. The CNA said that Resident #58 looked confused and wide-eyed but once he was away from Resident #80, he went back to his normal self. The CNA reported that Resident #58 did not verbalize being afraid. The CNA mentioned that Resident #80 was far from the nurses and CNAs that were taking care of her that day and felt that it would have been more efficient if Resident #80 stayed closer to the nurses' station down her hall. The facility substantiated the allegation of physical abuse. The occurrence was witnessed by staff, Resident #58 had an injury to the back of his neck which was consistent with the CNAs account. B. Resident #58 (victim) 1. Resident status Resident #58, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included Alzheimer's disease, dementia and sensorineural hearing loss bilateral (gradual hearing loss in both ears). The 1/9/26 MDS assessment revealed Resident #58 had severe cognitive impairment with a BIMs score of three out of 15. The MDS assessment documented that Resident #58 did not have any aggressive behaviors, wandering or rejection of care. The MDS assessment documented that Resident #58 was dependent on staff for most of his ADLs. 2. Resident #58's representative interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not remember Resident #80 grabbing Resident #58. The NHA, the DON and the SSD were interviewed together on 3/26/26 at 3:35 p.m. The SSD said that Resident #80 was seen grabbing Resident #58's ear from behind and she scratched his neck. She said after that happened, the facility did a medical workup on Resident #80 to see if she had a fracture on her left arm. She said Resident #80 would often complain of pain. Resident #80 was unable to verbalize what was bothering her due to her cognitive ability. She said that activities would not hold her attention for long, she said even with one-on-one activities she would lose interest. The SSD said that Resident #80's behaviors would start out of the blue. She said the resident did not have any signs of when she would become agitated. IV. Incident of physical abuse by Resident #21 towards of Resident #27 on 2/25/26 A. Facility investigation The facility's investigation, dated 2/25/26, was provided by the NHA on 3/26/26 at 10:13 a.m. The investigation documented Resident #27 reported Resident #21 had grabbed her arm as she went outside to smoke. The investigation documented Resident #21 was in the lobby of hall 400, six feet from the door to the smoking area. Resident #27 attempted to go outside when Resident #21 grabbed her arm and told her she would not go out the door. The investigation documented Resident #27 told Resident #21 several times to leave her alone before she was able to get away from him. Resident #27 reported Resident #21 continued to reach out to grab her and yelled, There goes the waterboy. The investigation documented Resident #27 said she did not know who Resident #21 was talking to and there were no witnesses to the event. The facility investigation documented Resident #27 had no injuries. It documented the resident said she felt safe and the facility would escort Resident #27 to the smoking area to prevent further altercations. The facility investigation documented Resident #21 had no memory of the event with Resident #27. The facility documented Resident #21 had a history of being confused and believed he was working at his prior job as a prison guard. It documented Resident #21 made homicidal statements, which he later described as a joke. The facility investigation documented Resident #21 would be on 15-minute checks, and behavioral health services would be notified. The investigation documented Resident #21 would be removed from the common areas if he became agitated. The facility investigation substantiated the abuse of Resident #27 by Resident #21. B. Resident #27 (victim) 1. Resident status Resident #27, age less than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included diabetes mellitus type two, mild asthma, chronic kidney disease, adult failure to thrive, bipolar two disorder and myoneural disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/29/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #27 was able to walk independently with intermittent use of a wheelchair on days when she felt muscle weakness. 2. Observations On 3/25/26 at 12:40 p.m. Resident #27 was sitting on a bench, smoking a cigarette in the smoking area. On 3/26/26 at 4:13 p.m. Resident #27 was walking into the 100 and 400 hallway common area from the smoking area outside. She walked down the hall independently. -Resident #27 did not have an escort or supervision, as identified as an intervention in the facility investigation (see facility investigation above). 3. Resident interview Resident #27 was interviewed on 3/23/26 at 4:40 p.m. Resident #27 was lying in bed and said she had been outside in the smoking area smoking for most of the day. She said she remembered the altercation with Resident #21. She said Resident #21 did not want her to go outside, but she handled the situation by herself. Resident #27 said she felt like the staff had not done anything to prevent the incident from happening again. 2. Record review Resident #27's behavior care plan, initiated 10/20/25, revealed the resident had a behavior problem related to not adhering to posted smoking times. - However, the care plan revealed no interventions for Resident #27 to be escorted out to the smoking area to prevent an altercation with Resident #21 as mentioned in the facility investigation (see facility investigation above). C. Resident #21 (assailant) 1. Resident status Resident #21, age [AGE], was admitted on [DATE] and discharged to the hospital on 3/23/26. According to the March 2026 CPO, diagnoses included diabetes mellitus type 2, unspecified dementia of unspecified severity with behavioral disturbance, insomnia, and depression. The 2/12/26 MDS assessment revealed the resident had a severe cognitive impairment, with a BIMS score of zero out of 15. Resident #21 used a wheelchair and was able to self-propel. 2. Record review A behavioral monitoring for antidepressant medication progress note, dated 2/19/26, documented a behavioral outburst from Resident #21. It documented Resident #21 had verbal aggression with staff, residents, and visitors. The progress note documented Resident #21 was confused and believed he worked in a prison or he was in Vietnam. The note documented Resident #21 became physically (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain proper storage of medications for three out of three medication carts and one of three medication storage rooms.Specifically, the facility failed to:-Label insulin pens with the date they were opened;-Label inhalers with the date they were opened;-Discard opened medications for residents who had been discharged ; and,-Discard expired medications Findings include:I. Professional referenceAccording to the manufacturer Arkray USA, inc, revised 2019, Performing a Control Solution Test, retrieved on 3/30/26 from,https://cdn.boundtree.com/btm/products/Bound_Tree_Arkray_Assure_Prism_Multi_Control_Solution_Dir Check the expiration dates printed on the bottle. When you first open a control solution bottle, record the discard date (date opened plus [3] months) in the space provided on the label. Out of range results may occur due to the following factors . When the control solution is past its discard date.According to the manufacturer Biocon Biologics, 2023, Patient Information-Storing the Insulin Glargine yfgn pen, retrieved on 3/30/26 from, https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=3ac85ebb-5594-59c8-77fd-df254329d151&ty Only use your pen for up to 28 days after its first use. Throw away the Insulin Glargine yfgn pen you are using after 28 days, even if it still has insulin left in it.According to the manufacturer [NAME] Lily, 2026, Highlights of Prescribing Information, retrieved on 3/30/26 from, https://pi.lilly.com/us/humalog-pen-pi.pdf, When stored at room temperature, Humalog (insulin lispro) can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time.According to the manufacturer GlaxoSmithKline, 2017, Highlights of Prescribing Information, retrieved on 3/30/26, from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/204275s012lbl.pdf, Discard [NAME] Ellipta six weeks after opening the foil tray or when the counter reads 0, whichever comes first.II. Facility policy and procedureThe Medication Storage policy, revised November 2020, was provided by the nursing home administrator (NHA) on 3/26/26 at 11:21 a.m. It read in pertinent part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. III. Observations and interviewsOn 3/24/26 at 2:15 p.m. the 200 hall medication cart was observed with licensed practical nurse (LPN) #5. The following was observed:-A used Ellipta inhaler for Resident #42 was not labeled with the date it was opened. LPN #5 said she did not know how long the medication was good for after it was opened. LPN #5 placed the medication back into the cart.-A used insulin lispro pen for Resident #15 with an opened date of 1/21/26. LPN #5 said the insulin pen was expired based on the opened date on the pen. LPN #5 said insulin pens were good for 30 days after they were opened, and an expired insulin pen could be less effective.- A used insulin lispro pen for Resident #27 was not labeled with the date it was opened. On 3/24/26 at 2:34 p.m. the medication cart that was used for the 100 and 400 hallway was observed with LPN #4. The following was observed:-Two nitroglycerine 0.4mg vials labeled with the name of a resident who had been discharged on 3/3/26.-A used insulin lispro pen for Resident #76 was not labeled with the date it was opened. LPN #4 labeled the pen with the date 3/23/26. LPN #4 said she assumed the insulin was opened the day before because she had not opened it, and she knew the facility had gotten a new shipment of medication the day before.-A used insulin glargine pen for Resident #41 was not labeled with the date it was opened. LPN #4 labeled the insulin pen with the date 3/23/26. LPN #4 said she labeled the pen based on the same (continued on next page)

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	065150	A. Building B. Wing	03/26/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assumption as the insulin lispro for Resident #76On 3/24/26 at 2:46 p.m. the medication storage room for the 100 and 400 hallway was observed with LPN #4. The following was observed:-A Tuberculin Purified Protein 5 TU (tuberculin units) per 0.1 milliliter (ml) vial with an opened date of 2/9/26. LPN #4 said she thought the medication might be expired. LPN #4 placed the medication back into the medication refrigerator. On 3/24/26 at 3:15 p.m. the 300 hallway medication cart was observed with LPN #3. The following was observed:-An open glucometer test control solution labeled 11/29/25. LPN #3 said testing the glucometers was a night shift nurse's duty, and she did not know how long the solution was good for after opening. LPN #3 said she would have to ask the director of nursing (DON) how long the medication can be used for after it is opened. LPN #3 placed the solution back into the medication cart.IV. Staff interviewsThe clinical resource nurse was interviewed on 3/24/26 at 3:15 p.m. The clinical resource nurse said she had discarded the unlabeled insulin pens. The DON was interviewed on 3/25/26 at 10:40 a.m. The DON said LPN #4 should have discarded the unlabeled insulin pens instead of labeling them herself. The DON said LPN #4 had not opened the medications, which meant she did not know with certainty when the medications were opened. The DON said glucose control solutions should be used within 30 days of opening, and the glucose control solutions should have been discarded.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide tube feeding management according to professional standards for one (#6) of one resident reviewed out of 36 sample residents.Specifically, the facility failed to:-Ensure the correct tube feeding formula was administered;-Ensure tube placement before tube feed administration; and-Provide flushes and water administration according to the physician's orders. Findings include:I. Facility policy and procedureThe Enteral Tube Feeding via Continuous Pump policy, revised 2/23/24, was provided by the nursing home administrator (NHA) on 3/26/26 at 11:04 a.m. It read in pertinent part, Steps in the procedure: 1. Place the equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. 2. Wash hands and dry thoroughly. 3. Wear clean gloves. 4. Position the head of the bed at 30 degrees to Fahrenheit (F) 45 degrees F (semi-Fowler's position) for feeding, unless medically contraindicated. 5. Check the label on the enteral formula against the physician's order. 6. Attach enteral feeding pump set to bag and prime tubing. Clamp tubing. 7. Clamp enteral tube. Remove the plug. 8. Verify placement of the tube per current professional standards. 9. If anything suggests improper tube positioning, do not administer feeding or medication. Notify the charge nurse or physician. 10. When correct tube placement has been verified, flush tubing with at least 30 ml (milliliter) warm water (or prescribed amount). 11. Remove the syringe and clamp tubing. Initiate Feeding.II. Resident #6A. Resident StatusResident #6, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician's orders (CPO), diagnoses included unspecified severe protein-calorie malnutrition, alcohol dependence, Alzheimer's disease, and benign prostatic hyperplasia (non-cancerous enlargement of the prostate).The 1/5/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 of 15. The MDS documented Resident #6 had pain or difficulty swallowing. Resident #6 received greater than 51% of his food and 501 ml of his fluid intake via a feeding tube.B. Record reviewReview of Resident #6's CPO revealed the following orders for his tube feed management:-Resident is to be NPO (nothing by mouth), only tube feeds, ordered 3/10/26.-Administer 250 ml of water after nutrition administration four times a day for hydration, ordered 12/11/25. -Jevity 1.5 calorie (cal)/fiber oral liquid nutritional supplement 270 ml enterally four times a day, ordered 10/16/25. Resident #6's tube feeding management care plan, initiated 10/2/25, revealed the resident had dysphagia (difficulty swallowing). The care plan documented the resident had poor fluid intake related to the resident's NPO status. Pertinent interventions included to administer the tube feeding and water flushes per the physician's order and to give water through the gastric tube per the physician's orders.III. Observations and interviewsOn 3/24/26 at 4:32 p.m., licensed practical nurse (LPN) #3 administered a tube feeding to Resident #6. LPN #3 said she had opened the tube feed formula bottle at 10:00 a.m. the same morning. The tube feed formula bottle read Glucerna 1.2 cal with carbsteady. -However, the physician's orders were for Jevity 1.5 cal formula tube feed.LPN #3 connected the tube feeding to Resident #6's gastric tube and pressed start on the tube feeding pump.-However, LPN #3 did not ensure the gastric tube was in place before administering the tube feeding. LPN #3 did not flush the gastric tube with 30 ml of water or administer 250 ml of water per the physician's order prior to administering the tube feed.On 3/25/26 at 10:01 a.m. LPN #2 administered tube feed to Resident #6. LPN #2 flushed Resident #6's gastric tube with 250 ml of water before administering the formula. LPN #2 said Resident #6 was not allowed to eat or drink by mouth, and his only hydration was water administered through the gastric tube. LPN #2 said Resident #6's physician orders included administration of 250 ml of water before and after tube feeding.-However, the physician's order was to administer 250 ml of water after tube feeding.IV. Staff interviewsLPN #3 was interviewed on 3/25/26 at 11:18 a.m. LPN #3 said after the observation on (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/24/26 at 4:32 p.m. she recognized something was not correct with the tube feeding. LPN #3 said she checked the physician's orders and discovered the order was for Jevity 1.5 cal. LPN #3 said she went into Resident #6's room, discontinued the incorrect tube feed formula, and then administered the correct tube feed formula per the physician's orders. LPN #3 said she should have double-checked the label on the tube feed formula bottle before administration to Resident #6.The director of nursing (DON) was interviewed on 3/25/26 at 11:18 a.m. The DON said he did not know LPN #3 had administered the incorrect tube feeding. The DON said LPN #3 should have notified someone after the error. The DON said tube feeds should be flushed with water before and after tube feed formula administration to prevent the gastric tube from clogging. The DON said the tube placement should be assessed before nutrition administration.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, record review and interviews, the facility failed to ensure residents, family members and legal representatives had full access to review the results of the facility's most recent survey findings that included the survey results, certifications, complaint investigations and plans of correction in effect for the past three years.Specifically, the facility failed to ensure three years of survey and investigation findings were available for the public, and where individuals wishing to examine survey results did not have to ask to see them. Findings include: I. Resident interviewsThree residents (#12, #14 and #59) who were identified as alert and oriented by facility and assessment were interviewed on 3/25/26 at 10:15 a.m. Resident #12, Resident #14 and Resident #59 said they did not know where to find the results of recent survey findings.II. Observations and staff interviewThe facility's survey results binder was not located in an area where individuals could examine results on 3/25/26 at 10:50 a.m. The nursing home administrator (NHA) provided a survey results binder on 3/25/26 at 11:00 a.m. The NHA said she had removed the binder from the facility's lobby the previous day in order to ensure the binder was up to date with previous survey findings. -The survey results binder provided was found to contain results from the recertification survey on 3/7/24 and one complaint survey 6/30/25. The binder failed to include the facility's last three years of complaint findings.The NHA said the complaint investigations and plans of correction for the past three years should have been included in the binder.