STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065152	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that clean linens were provided to residents on a daily basis. Specifically, the facility failed to ensure clean hand towels and washcloths were provided to residents.Findings include:I. ObservationsObservations made throughout the survey (from 2/23/26 to 2/26/26) revealed there were no towel racks inside the residents' bathrooms. On 2/23/26 at 3:38 p.m. room [ROOM NUMBER] B had no hand towels or washcloths.On 2/23/26 at 5:43 p.m. room [ROOM NUMBER] A and B had no hand towels or washclothsOn 2/25/26 beginning at 2:27 p.m., the following observations were made:-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths;-room [ROOM NUMBER] had no hand towels or washcloths; and,-room [ROOM NUMBER] had no hand towels or washcloths.On 2/26/26 at 9:24 a.m. the linen closet on the first floor was observed with certified nurse aide (CNA) #7. The linen closet contained 20 washcloths and 15 hand towels. On 2/26/26 at 9:28 a.m. the linen closet on the second floor was observed with licensed practical nurse (LPN) #1. The linen closet was locked with a combination padlock. There were approximately 15 washcloths and hand towels inside the linen closet. On 2/26/26 at 3:04 p.m. the closets of room [ROOM NUMBER] bed A and bed B and room [ROOM NUMBER] bed A and bed B did not have towel racks in the closets. room [ROOM NUMBER] A and B both had a broken towel rack in the closet. II. Resident interviewsResident #55 was interviewed on 2/23/26 at 4:27 p.m. Resident #55 said that linen towels were not passed out. She said that at times, the facility had run out of bath towels. She said the bathroom had paper towels, but she said she did not like to use paper towels for her face. Resident #67 was interviewed on 2/23/26 at 5:30 p.m. Resident #67 said she was newly admitted to the facility and that she did not have any cloth linens in her room. She said the bathroom had only paper towels to dry her hands.Resident #52 was interviewed on 2/23/26 at 5:45 p.m. Resident #52 said the bathroom only had paper towels. She said that she did not get linen towels unless she asked for them.Resident #53 was interviewed on 2/25/26 at 2:35 p.m. Resident #53 said she did not have linen towels. She said that she had to use paper towels. The resident's son was present in the room and confirmed that Resident #53 did not have linen towels in her room or the bathroom.Resident #60 was interviewed on 2/25/26 at 2:45 p.m. Resident #60 said there were no towels provided. She said that the bathroom only had paper towels. She said that she had to ask for a linen towel and then she kept the towel on her bed, as there was no other place to put the towel. Resident #56 was interviewed on 2/25/26 at 2:47 p.m. Resident #56 said there were no towels provided. She said once she received a towel, she would hold onto it. Resident #60 was interviewed a second time on 2/26/26 at 3:05 p.m. Resident #60 said there were not towel racks in the closet. Resident #67 was interviewed a second time on 2/26/26 at 3:10 (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. Resident #67 said there were no towel racks in the closet. III. Resident group interviewFive residents (#2, #7, #24, #56 and #58) who were identified by the facility and assessment as interviewable, were interviewed together as a group on 2/25/26 at 10:00 a.m.The residents said they only had paper towels for drying their hands in their bathrooms. They said they had to ask for linen towels, but the staff did not go around and pass out towels. IV. Staff interviewsCertified nurse aide (CNA) #7 was interviewed on 2/26/26 at 9:24 a.m. CNA #7 said the linens were kept locked up in the linen closets. He said that the towels were locked up because residents would take too many towels. He said that if the residents asked, then the staff would give a hand towel and a washcloth to the resident. He said that the facility was low on towels. Certified nurse aide (CNA) #6 was interviewed on 2/26/26 at 9:32 a.m. CNA #6 said the residents had to ask for towels. He said there was a cart with towels, however, the residents were not allowed to get the towels themselves. Licensed practical nurse (LPN) #1 was interviewed on 2/26/26 at 9:30 a.m. LPN #1 said the towels were locked up on the second floor. She said the residents had to ask for towels, as they were not passed out. The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 2/26/26 at 2:30 p.m. The DON said the residents' towels racks were in their closets. She said the towels were replaced as used on a daily basis.-However, observations with the ADON revealed there were no towel racks in all resident's closets (see observation below).-However, according to resident interviews, there were no towel racks inside the closets and they did not receive hand towels unless they asked for them (see interviews above).V. Facility follow-upOn 2/26/26 at 3:15 p.m., the closets in room [ROOM NUMBER] and room [ROOM NUMBER] were observed with the ADON, who verified there were no towel racks in the residents; closets or in the bathroom. The resident who resided in room [ROOM NUMBER] told the ADON there were no towel racks in the closets or the bathroom.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the environment were free of accidents and hazards for one (#11) of two residents reviewed for accidents out of 41 sample residents and three of three emergency crash carts. Specifically, the facility failed to:-Ensure Resident #11 was assessed to determine if he was safe to smoke independently after an incident of unsafe smoking; and,-Ensure medical grade power strips were readily available in the crash carts (a specialized, mobile, and organized unit of trays and drawers on wheels containing essential life-saving equipment and medications). Findings include: I. Failed to ensure Resident #11 was assessed to determine if he was safe to smoke independently after an incident of unsafe smoking A. Facility policy and procedure The Resident Smoking policy and procedure, revised 6/12/25, was provided by the nursing home administrator (NHA) on 2/26/26 at 4:53 p.m. It read in pertinent part, Smoking is not allowed inside the facility under any circumstances. Any smoking related behavior, restrictions, or concerns shall be noted on the care plan. In the event a staff member observes a resident who is unsupervised smoking in a manner that is unsafe to themselves or others, that employee will immediately redirect the resident and inform the nurse, who is to inform the social services director (SSD) or designee, and then document the observations for review. A new smoking assessment will be performed. B. Resident #11 1. Resident status Resident #11, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes and chronic obstructive pulmonary disease. The 2/7/26 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented the resident had no behaviors. 2. Resident interview An interview with Resident #11 was attempted on 2/23/26 at 9:38 a.m. Resident #11 declined to be interviewed. 3. Observation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/23/26 from 9:38 a.m. to 10:21 a.m., Resident #11 was observed in his room awake without a sitter present, despite staff interviews indicating the resident was supposed to have a sitter present due to his smoking behaviors (see interviews below). 4. Record review The smoking care plan, revised 5/2/25, revealed Resident #11 smoked cigarettes and electronic cigarettes and was an independent smoker. Interventions, dated 6/24/25, included to notify the charge nurse immediately if it was suspected that the resident had violated the facility's policies, inform the resident of the smoking policy/rules and regulations and conduct a smoking assessment quarterly and as needed. The smoking safety screen, dated 12/18/25, revealed: The resident was able to safely store his own smoking materials, followed facility policies regarding smoking and was safe to smoke independently and unsupervised. A nursing note, dated 1/17/26, revealed that Resident #11 was found in the basement conference room with a friend and the staff believed he had been smoking. The staff reminded him about the safety risks and the facility policy regarding smoking inside the building. Resident #11 did not appear receptive at the time and stated that he had opened a window. The resident was redirected back to his room and was cooperative with the staff. Ongoing monitoring was to continue. -Review of Resident #11's electronic medical record did not reveal documentation to indicate a new smoking safety screen was conducted after the incident on 1/17/26. C. Staff interviews Registered nurse (RN) #2 was interviewed on 2/25/26 at 4:30 p.m. She said Resident #11 had behaviors of verbal aggression towards staff, illicit drug usage and attempting to smoke cigarettes in his room. She said he had a sitter due to his smoking associated behaviors of attempting to smoke in his room and expressing verbal aggression when staff tried to redirect him. RN #2 said she could not recall the last time the resident had attempted to smoke in the building, but said he was not compliant with the staff reminding him of the facility's policies. She said when Resident #11 made attempts to smoke indoors, the staff reported the incident to the director of nursing (DON). Certified nurse aide (CNA) #5 was interviewed on 2/25/26 at 4:49 p.m. CNA #5 said he took shifts with other staff members to provide a sitter for Resident #11. CNA #5 said Resident #11 had a sitter related to his smoking associated behaviors of attempting to smoke in his room and expressing verbal aggression when staff tried to redirect him. SSD #2 was interviewed on 2/26/26 at 1:01 p.m. SSD #2 said smoking safety screens were completed at the time of admission, quarterly, with a change of condition, when there were behavioral issues around smoking and a failure to follow the facility's smoking policies. SSD #2 said Resident #11 was an independent smoker, but he could be defiant regarding following facility policies. She said she was not notified by nursing of the incident on 1/17/26 when the resident was smoking in the basement. SSD #2 said Resident #11 had a sitter related to allegations of inappropriate behaviors towards others. She said if she had known about the smoking incident on 1/17/26, she would have immediately completed a new smoking safety screen. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 2/26/26 at 3:12 p.m. The DON said social services conducted smoking safety screens at admission, quarterly, changes of condition and as needed. The DON said observations of unsafe smoking behaviors and refusal to follow smoking policies would trigger a new smoking safety assessment. She said if smoking related behaviors were observed, the staff would report that to the interdisciplinary team (IDT). The DON said that Resident #11 had a sitter due to an incident of unsafe smoking in January 2026 (see record review above). She said she investigated the incident and determined no new smoking safety assessment was required because Resident #11 was not observed actively smoking. The DON said she did not document her investigation or interviews because she brought it to the attention of the IDT and it was social services responsibility to document an investigation into the allegation. II. Failed to ensure medical grade power strips were readily available in the crash carts A. Observations The facility's three crash carts were observed on 2/25/26. The following was found: At 3:50 p.m. there was a commercial power strip found in the crash cart in the basement. The power strip was not a medical grad power strip. At 3:55 p.m. there was no power strip found in the crash cart on the first floor. At 4:00 p.m. there was a commercial power strip in the crash cart on the second floor. The power strip was not a medical grade power strip. The suction machine functioned appropriately. The facility's crash carts were observed again with the maintenance director (MTD) on 2/26/26. The following was found: At 11:12 a.m. the commercialized power strip in the basement crash cart was replaced with a medical grade power strip by the MTD. At 11:14 a.m. a medical grade power strip was placed in the first floor crash cart by the MTD. At 11:16 a.m. the commercialized power strip in the second floor crash cart was replaced with a medical grade power strip by the MTD. B. Staff interviews The MTD was interviewed on 2/26/26 at 11:16 a.m. The MTD said it was important to use medical grade power strips in the emergency crash carts because the commercial power strips had 20 amperes (amps; the standard unit for measuring electric current). He said the more amps, the more heat could be trapped and could cause a fire. The MTD said the medical grade power strips had 15 amps and created less heat, which decreased the risk of fire. The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 2/26/26 at 4:50 p.m. The ADON and the DON said the night nurses checked the crash carts nightly, the respiratory nurse checked them at least daily and the ADON checked the crash carts daily as a part of her morning rounds. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said she would expect to see a medical grade power strip stocked in the facility's crash carts so the power strip had enough power to handle the emergency equipment. C. Facility follow-up The MTD replaced the commercial power strips with medical grade power strips during the tour of the facility's crash carts on 2/26/26 beginning at 11:12 a.m. -However, the commercial power strips were not replaced with medical grade power strips in the crash carts until the concern was brought to the attention of the facility during the survey.

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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. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of two medication carts.Specifically, the facility failed to ensure residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened.Findings include:I. Facility policy and procedureThe Medication Labeling and Storage policy, dated February 2023, was provided by the nursing home administrator (NHA) on 1/26/26 at 9:23 p.m. It read in pertinent part, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: medication name (generic and/or brand); prescribed dose; strength; expiration date, when applicable; resident's name; route of administration; and, appropriate instructions and precautions.II. ObservationsOn 2/26/26 at 8:48 a.m. the second floor medication cart was observed with licensed practical nurse (LPN) #1. The following items were found:There was one umeclidinium-vilanterol (Anoro Ellipta) inhalation aerosol powder breath activated 62.5-25 micrograms (mcg) per actuation (mcg/act) inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the resident's name or the date the medication was opened for Resident #62.There was one fluticasone-umeclidinium-vilanterol (Trelegy Ellipta) inhalation aerosol powder breath activated 100-62.5-25 mcg/act inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the date the medication was opened for Resident #67.There was one bottle of Systane long-lasting ophthalmic (eye) drops stored in an appropriately labeled medication box. -However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #60.On 2/26/26 at 10:08 a.m. the back hall medication cart on the first floor was observed with registered nurse (RN) #3. The following items were found:There was one dimethyl fumarate (Tecfidera) delayed release (DR) 240 milligram (mg) oral medication stored in an appropriately labeled medication box. -However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #24.There was one GenTeal severe 0.3 percent (%) ophthalmic gel stored in an appropriately labeled medication box.-However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #51.There was one umeclidinium-vilanterol (Anoro Ellipta) inhalation aerosol powder breath activated 62.5-25 mcg/act inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the resident's name or the date the medication was opened for Resident #61.There was one Albuterol sulfate hydrofluoroalkane (HFA) inhalation aerosol solution 108 (90 base) mcg/act inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the resident's name or the date the medication was opened for Resident #40.There was one Morphine sulfate immediate release (IR) 20 milligram per milliliter (mg/ml) oral solution stored in an appropriately labeled medication box. -However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #4.III. Staff interviewsLPN #1 was interviewed on 2/26/26 at 8:48 a.m. LPN #1 said medications should be labelled inside their respective boxes. She said it was important for the medications to be labelled inside the boxes in case the box was damaged by water or other liquids in the medication cart.RN #3 was interviewed on 2/26/26 at 10:08 a.m. RN #3 said the medications should be labelled inside their respective boxes so the medications did not get mixed up if the boxes were destroyed.The assistant director of nursing (ADON) was interviewed on 2/26/26 at 11:27 a.m. The ADON said she would have expected to see the medications labelled (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside their medication boxes, because any medication could go in any medication box. She said this could cause a medication error.The director of nursing (DON) and the ADON were interviewed together on 2/26/26 at 4:50 p.m. The DON said it was important for medications to be labelled inside their respective boxes because the medication inside could become separated from its box. She said an unlabelled medication without its box could potentially cause a medication error, since the nursing staff would not know who the medication belonged to.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable in taste. Specifically, the facility failed to ensure resident food was palatable in taste and temperature.Findings include: I. Facility policy and procedure The Resident Food Preferences policy, dated July 2017, was provided by the nursing home administrator (NHA) on 2/26/26 at 9:23 p.m. It read in pertinent part, The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. The facility's quality assessment and performance improvement (QAPI) committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc. II. Resident group interview A group of five residents (#2, #7, #24, #56 and #58) who were assessed by the facility to be interviewable, were interviewed together on 2/25/26 at 10:30 a.m. Resident #7 said the vegetables were often overcooked and she did not believe the meals were nutritious. She said she had voiced her concern about the food needing to be served hotter, but she had not received much of a response from the facility. Resident #56 said the room trays served on the second floor were barely warm at all. She said the biggest complaint she had heard from the other residents was regarding the small portion sizes and residents still feeling hungry after a meal. III. Additional resident interviews Resident #57 was interviewed on 2/23/26 at 12:18 p.m. Resident #57 said the food was so-so, and his food was too salty. Resident #55 was interviewed on 2/23/26 at 2:20 p.m. Resident #55 said the food needed help, and it did not taste homemade. Resident #17 was interviewed on 2/23/26 at 2:31 p.m. Resident #17 said some food was good and some food was bad. She said today's (2/23/26) lunch was not good. She said she only ate the rice. She said she was not able to describe what was not good about the food. Resident #17 said she wished the facility offered condiments more often and more consistently. Resident #34 was interviewed on 2/23/26 at 2:45 p.m. Resident #34 said the food needed more flavor and was served cold. Resident #16 was interviewed on 2/23/26 at 3:10 p.m. Resident #16 said the food was served cold, he did not think the food had enough flavor and he did not enjoy eating any of the meals. Resident #37 was interviewed on 2/23/26 at 3:23 p.m. Resident #37 said he had been to other facilities and this facility's food was the worst food. He said today's (2/23/26) lunch was bad. He (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the rice was gummy and the stir fry should have had soy sauce. He said when he ordered from the always available menu, it was not good. He said he ordered a hamburger as a substitute meal and the burger meat was dry. He said he could tell if the food was sitting out for a while and the facility did not offer condiments, such as tomatoes and mustard. Resident #24 was interviewed on 2/24/26 at 9:01 a.m. Resident #24 said his biggest concern at the facility was the food. He said the food was served cold and the meals were either bland or too salty. Resident #30 was interviewed on 2/24/26 at 10:32 a.m. Resident #30 said the food was terrible. Resident #30 said she was unable to talk more about the food. Resident #7 was interviewed on 2/24/26 at 12:09 p.m. Resident #7 said the meals could be warmer and she said she would like to be offered condiments. She said the lunch served on 2/23/26 could have used soy sauce as a condiment. IV. Observations On 2/25/26 at 11:25 a.m. the lunch menu was observed on the wall in the dining room. It revealed the lunch being served was braised turkey roast, rice pilaf, creamed spinach, spice cake and coffee or tea and juice. During the lunch meal service on 2/25/26 from 11:53 a.m. to 1:30 p.m., the following was observed: At 12:41 p.m. dietary aide (DA) #1 asked an unidentified resident how his lunch tasted. The resident said the spinach was off and did not taste right. At 1:25 p.m. an unidentified resident told the assistant director of nursing (ADON) that lunch was horrible. V. Test tray A test tray for a regular diet was evaluated by five surveyors immediately after the last resident had been served their lunch tray on 2/25/26 at 1:30 p.m. The test tray consisted of braised turkey roast with gravy, rice pilaf, spinach and spice cake. The braised turkey roast was served with a white gravy and was salty with a temperature of 117 degrees Fahrenheit (F). The turkey was dry and the gravy was very salty. The rice pilaf looked like plain rice and had a temperature of 118.9 degrees F. The rice pilaf was bland and tasted like plain rice. The creamed spinach looked like plain spinach, was dark green and wet and had a temperature of 120 degrees F, which was not palatable. The spinach was not creamy or cheesy. VI. Record review The recipe for the creamed spinach (see test tray observation above) was reviewed on 2/25/26 at 11:28 a.m. The creamed spinach indicated the ingredients included butter, flour, salt, nutmeg and (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spinach. The October 2025 food committee minutes revealed hamburgers were cooked differently with each cook and french fries needed to be cooked longer. The January 2026 resident council meeting minutes revealed residents wanted and agreed to discussing all dietary topics at the food committee meeting that followed right after resident council. One resident in particular had questions regarding menu, preferences and snacks. -However, a request for the January 2026 food committee meeting minutes revealed a food committee meeting did not take place in January 2026 (see NHA interview below). The February 2026 resident council meeting minutes revealed all residents were invited to attend the upcoming food committee meeting on 2/17/26. -However, a request for the February 2026 food committee meeting minutes revealed a food committee meeting did not take place in February 2026 (see NHA interview below). VII. Staff interviews Cook (CK) #1 was interviewed on 2/25/26 at 12:41 p.m. CK #1 said he did not have the ingredients on 2/25/26 to make creamed spinach, so the spinach was frozen spinach with nothing added to it. He said the rice was made with chicken broth, garlic and rice. -However, according to the recipe, CK #1 should have added butter, flour, salt and nutmeg into the creamed spinach. Certified nurse aide (CNA) #2 was interviewed on 2/25/26 at 4:51 p.m. CNA #2 said residents complained about how the food tasted. CNA #2 said she never offered to have the residents who complained fill out a grievance form because she tried to solve the problem in real time or told the nurse of their concerns. The NHA was interviewed on 2/26/25 at 5:26 p.m. The NHA said the facility did not have a dietary manager (DM). The NHA said she had an assistant DM and a registered dietitian (RD). The NHA said she lost her most recent DM the week prior to the survey (week of 2/16/26). The NHA said she knew there were resident concerns about how the food tasted. The NHA said she did not know the recipes were not followed by the dietary staff. The NHA said the gravy should not have tasted overly salty. The NHA said if the menu said creamed spinach and rice pilaf, the creamed spinach should have looked creamy and the rice pilaf should have revealed visible ingredients besides rice.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.Specifically, the facility failed to ensure necessary maintenance repairs were communicated and completed in a timely manner in the kitchen area.Findings include:I. ObservationsDuring a walkthrough of the kitchen on 2/25/26 from 11:28 a.m. to 11:53 a.m., the following was observed: -The wall behind the toaster was observed with visible burned marks. The wallpaper was observed peeling in multiple areas. There were sections of wallpaper observed missing above the toaster near the ceiling. -There were six holes observed in the wall to the right of the spice rack on the same wall as the toaster.-There were multiple areas of chipped paint observed on the ceiling along two pipes adjacent to the wall where the toaster was located. -There were multiple chipped paint marks observed on the ceiling along one pipe which was adjacent to the pipe line next to the wall where the toaster was located. -There were approximately twenty to thirty brown spots observed on the ceiling above the oven and stove. -The swamp cooler system located on the ceiling above the preparation table was observed with duct tape on one side. -The wall above and below the three-compartment sink was observed with multiple stains. At 11:33 a.m., the following was observed in the dishwasher room: -The vent to the right of the dishwasher was observed with an exposed sheetrock sheet measuring approximately six to eight inches in length.-There was a hole observed on the right side of the same vent. -There was missing tile observed on the wall and to the right of the dishwasher. -The vent above the dishwasher was observed with missing screws and was loose.-There were multiple areas of chipped paint marks observed above the sink. II. Staff interviews [NAME] (CK) #1 was interviewed on 2/25/26 at 11:50 a.m. CK #1 said if he needed anything repaired, he told the dietary manager (DM). He said he did not log if there were any repairs needed. CK #1 and dietary aide (DA) #2 were interviewed together on 2/26/26 at 4:00 p.m. CK #1 and DA #2 both said they did not know the last time the walls and ceiling in the kitchen were cleaned. DA #2 said he thought it was at least a month ago (January 2026), if not longer. The MTD was interviewed on 2/26/26 at 3:50 p.m. while touring the kitchen. The MTD said he had worked at the facility since October 2025. The MTD said he was responsible for the building's maintenance. The MTD said he tracked maintenance requests using a software system. The MTD said each department's management was responsible for informing him of maintenance requests in their departments. The MTD said there was not a dietary manager (DM) as of 2/20/26. The MTD said prior to 2/20/26, the DM did not inform him of any maintenance requests prior to leaving the facility. The MTD said the items identified on the kitchen tour, such as the holes in the wall, chipped paint and stains on the wall and ceilings, were not in his work order software system and they should be fixed.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#69) of two residents reviewed for personal property out of 41 sample residents was able to retain their personal belongings. Specifically, the facility failed to receive consent from Resident #69 or his responsible party before disposing of his personal belongings after the resident was discharged to the hospital.Findings include:I. Resident #69A. Resident statusResident #69, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included quadriplegia and systemic lupus. The [DATE] minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. B. Record reviewA nursing note, dated [DATE], revealed Resident #69's physician assessed him and found that the resident had phimosis (a condition where the foreskin could not be retracted) which required medical intervention. The physician ordered that the resident be transferred to the hospital. A social services note, dated [DATE], revealed the social services director (SSD) had a phone meeting with the resident's representative about his condition and discussed whether readmission would be plausible. The resident was going to start dialysis.A social services note, dated [DATE], revealed the SSD contacted the resident's representative regarding finding Resident #69's missing electronic tablet in the facility's lost and found. The representative asked if the resident's items were still in his room and the SSD informed the sister that his room had been cleaned out. The SSD said she would reach out to the director of nursing (DON) to find out if the items had been stored by someone, as the SSD was not aware of any discussions that might have happened between the family and other management. The SSD spoke with the admission director who said she had left Resident #69's representative a voicemail on [DATE] letting her know that since the resident had not been readmitted to the facility, his items would be packed up and stored. The admissions director told the SSD that the items had been packed up on [DATE] and stored in the facility's basement. The SSD spoke with the maintenance director who said that the items had been disposed of on [DATE] after storing the items for over the 30-day period (57 days). The SSD contacted both the resident's representatives on [DATE] and advised them of the disposal of many of the resident's personal items. The representatives were upset when provided with this information. A social services note, dated [DATE], revealed that the SSD called the resident's representatives back and let them know that his electric wheelchair, electronic tablet, and television had been found. When the SSD tried to discuss arrangements to pick up the items, the family discontinued the call. A social services note, dated [DATE], revealed the SSD spoke with the resident's representative and told her that she had 14 days to pick up his remaining items. The representative said she would pick up his belongings. -Review of Resident #69's electronic medical record (EMR) between [DATE] and [DATE] revealed there were no progress notes indicating the resident's representatives were notified to come and pick up the resident's belongings.-Review of the resident's EMR revealed there were no progress notes documented to indicate an initial call was made by the admissions director to the resident's representatives advising them of the potential that the resident's items would be disposed of in 30 days. II. Staff interviewsSSD #1 was interviewed on [DATE] at 1:00 p.m. SSD #1 said she had been the one to have a phone conference with Resident #69's representatives in [DATE] regarding the resident returning to the facility from the hospital. She said, at that time, she thought he was going to be readmitted to the facility, so there was not a conversation regarding storing his personal belongings. SSD #2 was interviewed on [DATE] at 1:18 p.m. SSD #2 said she had made the follow-up calls to Resident #69's representatives in February 2026. She said the admissions director did not usually make progress notes when she called families. SSD #2 said the facility would notify the families that items would be stored for 30 days and then disposed, of but the notification to Resident (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#69's representatives was a verbal notification. III. Facility follow-upOn [DATE] at approximately 3:00 p.m., SSD #2 provided an addendum to the facility's policy on discharge to include residents' personal items left in the facility. The policy outlined that all personal items would be packed, labeled, inventoried, and stored by the facility in a secure area of the basement. The social services department would make the verbal notification to the family and document a progress note. After 14 days, the social services department would send a reminder letter with the specific timeframe for pick up of residents' belongings. After the 30 days timeframe expired, the social services department would call the family to remind them about picking up the belongings and inquire about when items would be picked up. If the family wanted items to be disposed of or donated, a written letter would document this and the family would sign it.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to consider resident and family group views and act upon grievances and recommendations.Specifically, the facility failed to provide the residents the opportunity to share views, grievances, and recommendations to dietary related issues in the resident council meetings.Findings include:I. Facility policy and procedureThe Grievance policy, undated, was provided by the nursing home administrator (NHA) on 2/26/26 at 4:53 p.m. It read in pertinent part, All grievances, complaints, or recommendations stemming from resident or family groups will be considered. Actions on such items will be responded to in writing, including a rationale for the response.II. Resident group interviewFive alert and oriented residents (#24, #2, #7, #56 and #58) who regularly attended the resident council meetings and were deemed interviewable by assessment and the facility were interviewed together on 2/25/26 at 10:30 a.m. The residents were identified as alert and oriented through facility and assessment.The group of residents said the facility did not include dietary concerns in the resident council meetings and instead had a separate food committee meeting, but it had been several months since the facility had provided the residents with the opportunity to have a food committee meeting. Resident #24 said the dietary concerns brought up in the resident council meetings were redirected to the food committee meeting. He said any food concerns brought up in the resident council meeting were not addressed by staff. III. Record reviewA review of the resident council meeting minutes, dated December 2025, revealed the resident council meeting was cancelled due to a COVID-19 outbreak in the facility. A review of the resident council meeting minutes, dated 1/7/26, revealed all concerns regarding dietary were deferred to the food committee. A review of the resident council meeting minutes, dated 2/11/26, revealed all concerns regarding dietary were deferred to the food committee on 2/17/26.-However, the facility was unable to provide documentation that a food committee meeting took place on 2/17/26.A review of the food committee meeting notes revealed the food committee meeting had not been conducted since 10/25/25. IV. Staff interviewsSocial services director (SSD) #2 was interviewed on 2/26/26 at 1:01p.m. SSD #2 said she facilitated the resident council meetings and the facility had a process for addressing grievances identified in the resident council. SSD #2 said that dietary issues brought up in the resident council meetings were redirected to the food committee and the food committee meeting was run by the dietary manager. She said that the facility did not currently have a dietary manager and SSD #2 was not sure when the facility last had a food committee meeting. She said concerns brought up in the food committee meetings would be taken to the grievance official, the NHA. The NHA was interviewed on 2/26/25 at 2:35 p.m. The NHA said that the facility had not had a dietary manager since the previous week (the week of 2/16/26) and prior to that, the dietary manager was sporadically running the food committee meetings. The NHA said any food concerns brought up in the food committee meeting should be handled the same way as concerns brought up in resident council meetings, with a written concern form. She said she did not have any food committee meeting minutes from November 2025, December 2025, January 2026 or February 2026 and she could not say if the dietary manager was holding the food committee meetings during those months.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide ongoing programs to support choices of activities and engaging programming based on the comprehensive assessment and care plan that were designed to meet the interests of and support the physical, mental, and psychosocial well-being of two (#46 and #55) of three residents reviewed for activities out of 41 sample residents.Specifically, the facility failed to offer and provide personalized meaningful activity programs for Resident #46 and Resident #55 as documented in their care plans.Findings include:I. Resident #46A. Resident statusResident #46, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO) diagnoses included unspecified dementia, mood disturbance and anxiety. The resident was in hospice care.The 2/18/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. The resident was dependent on staff assistance for all activities of daily living (ADL) . The 3/14/21 MDS assessment revealed it was very important to the resident to listen to music, have animals around, keep up with the news and do her favorite activities. It was somewhat important to her to have books and magazines to read. B. Observations: On 2/23/26 at 12:10 p.m. Resident #46 was sitting in the dining room for lunch. Staff were assisting the resident with eating. There was no conversation being conducted with the resident while staff was assisting her with eating. During a continuous observation on 2/24/26, beginning at 1:58 p.m. and ending at 3:58 p.m. Resident #46 was lying in bed. There was no music playing in the resident's room or any other type of meaningful activity. During a continuous observation on 2/25/26, beginning at 1:29 p.m and ending at 4:30 p.m. Resident #46 was again lying in bed. The resident did not have any meaningful activity while she was in her room. There was no music or television (TV) playing on the resident's side of the room. The resident's roommate had the TV on, however, Resident #46 laid in bed holding the daily chronicle (facility daily bulletin) folded in a square. At 4:07 p.m. the business office manager entered Resident #46's room. The business office manager greeted Resident #46 and said she was in the room to check on the resident's bird. The business office manager remained in the room for only a few minutes. Resident #46 asked the business office manager to stay and visit, as she wanted some company. However, the business office manager said she could not stay and left the room. -No staff members from the care or activities teams were observed to come to the resident, per her request, to provide a one-on-one activity for her or to keep the resident company after the staff member left. C. Record reviewReview of Resident #46's activities care plan, updated 1/30/26, revealed the resident liked to watch TV, enjoyed visiting, her bird and reading the daily chronicle. Pertinent interventions were to assist the resident to activities of interest, encouraging the resident to participate in individual activities as desired. The activity assessment, dated 1/23/26, revealed Resident #46 liked to spend time in her room and attend group activities of her interest. She enjoyed religious prayer, arts and crafts, singing, parties, knitting and socializing. The assessment indicated that for attending the group activities, she needed more attention and encouragement. Review of Resident #46's activity participation record (from 1/29/26 to 2/26/26) revealed the resident participated in independent activities and also received supplies for independent activities. However, there was no documentation of what independent activities the resident was provided with.There was no documentation in the resident's participation record regarding group activities. II. Resident #55A. Resident statusResident #55 was admitted to the facility on [DATE]. According to the February 2026 CPO, diagnoses included depression, difficulty walking and chronic pain.The 1/26/26 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. The resident was independent with ADLS. The 4/18/26 MDS assessment revealed it was very important for the resident to get fresh air when the weather was good and to participate in her favorite activities.B. Resident interview Resident # 55 was interviewed on 2/23/26 at 2:30 p.m. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #55 said she had not been able to go on any facility bus rides or shopping trips to buy certain personal items because she used a wheelchair for mobility and the facility's bus had a wheelchair lift that had been broken for a long time. The resident did not remember how long the lift had been broken for. She said she would really like to go on some of the outing activities. C. Record reviewReview of Resident #55's care plan, updated on 12/30/25, revealed Resident #55 was independent with activities, however she liked the community outings. Pertinent interventions included inviting and assisting the resident to activities of choice. Review of Resident #55's activity participation record (from 1/25/26 to 2/26/26) failed to reveal documentation to indicate the resident had participated in any activity outings. III. Staff interviewsThe activities director (AD) was interviewed on 2/25/26 at 11:41 a.m. The AD said she was newly hired to the facility. She said she was familiar with Resident #46. The AD said the resident liked to attend group activities, but she needed assistance to get to the activities. She said Resident #46 was receiving hospice care services. She said the activity department had staff coverage seven days a week, and that they were responsible for inviting the residents to group activities. She said Resident #46 received the facility's daily chronicle every day and enjoyed religious activities and coloring. The AD said the resident was not on a one-to-one activity program but she would benefit from one. She said sensory stimulation would also benefit the resident, however, other than hand massages, this had not been tried with her. She said she had not gotten in touch with hospice volunteers for the resident to see if they could provide visits. She said the business office manager should have informed activities staff that Resident #46 wanted to visit rather than just leaving the room after the resident requested her to stay (see observations above). The AD said she scheduled trips to the local store weekly. She said the facility had a van, however, the wheelchair lift was broken. She said Resident #55 could not climb the stairs of the bus and therefore was unable to go on the activity outings to the store or scenic trips. She said the facility had made attempts to repair the bus, but the bus was still broken. She said she had not looked into the possibility of using a sister facility's bus or the local city wheelchair bus so Resident #55 could attend outings. The AD confirmed that Resident #55 had requested to attend outings. The maintenance director (MTD) was interviewed on 2/25/26 at 4:20 p.m. The MTD confirmed the facility's wheelchair lift on the bus was broken. He said the attempts to repair the ramp had failed. The MTD said he could always borrow the buses from the facility's sister communities if needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received treatment treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#67) of two residents reviewed out of 41 sample residents.Specifically, the facility failed to:-Ensure physician's orders were obtained for Resident #67's insulin pump and that the insulin pump was being appropriately monitored; -Ensure Resident #67's blood glucose (sugar) levels were being monitored; and,-Ensure Resident #67 received a carbohydrate-controlled diet, per her request.Findings include:I. Professional referenceAccording to the American Diabetes Association's Check Your Blood Glucose - Diabetes Testing And Monitoring retrieved on 3/4/26 from https://diabetes.org/living-with-diabetes/treatment-care/checking-your-blood-sugar, The logging of your blood glucose results is vital. When you bring your log to your health care provider, you will have a good picture of your body's response to your diabetes care plan.II. Facility policy and procedureThe Insulin Therapy policy, dated March 2025, was provided by the nursing home administrator (NHA) on 2/26/26. The policy read in pertinent part, The facility is to routinely assess residents who self manage their insulin therapy for their ongoing willingness and ability to do so safely and effectively. Residents who manage their glucose monitoring and/or insulin administration are routinely assessed for their ongoing willingness and ability to do so safely and effectively.III. Resident #67A. Resident statusResident #67, age [AGE], was admitted on [DATE], post hospitalization for vertigo and continued dizziness. According to the February 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic neuropathy, and chronic obstructive pulmonary disease (COPD). Per the admission assessment, the resident was cognitively intact.B. Resident observations and interview On 2/23/26 at 4:30 p.m. Resident #67's arm was observed with an attached Dexcom freestyle glucometer (blood sugar monitor that continuously monitors blood sugar levels) and an insulin pump attached to her left arm. The resident said she was newly admitted to the facility. She said she was a diabetic and she had to watch the carbohydrates that she ate. She said she was receiving a regular diet and not a carbohydrate controlled diet. She said she had been requesting a carbohydrate controlled diet, but nobody was listening to her. She said she had an insulin pump and a glucometer and the results went directly to her phone. She said she had had these devices for a while and was able to manage them.On 2/23/26 at 5:20 p.m. Resident #67 received her dinner meal tray; however, she did not receive a carbohydrate controlled meal. The resident's meal tray ticket documented the resident was on a regular diet.Resident #67 was interviewed again on 2/24/26 at approximately 10:00 a.m. Resident #67 said she had changed her insulin pump earlier in the morning. She said the dexcom freestyle glucometer would read directly to her phone. She said the insulin pump would then automatically dispense the appropriate amount of insulin into her body. She said that none of the nurses from the facility had asked to see her blood sugar. levels She said that it was important for her to watch what she ate in order to keep her blood sugars in a manageable range. On 2/24/26 at 5:30 p.m. Resident #67 received cheese ravioli for dinner and a piece of cake, which was not a carbohydrate controlled diet. Resident #67 was interviewed a third time on 2/25/26 at 10:00 a.m. Resident #67 was being assisted to therapy by the physical therapy assistant. She said she did not receive the carbohydrate diet again for breakfast. She said she had not been receiving the controlled carbohydrates as she requested and needed because of her diabetes since she was admitted to the facility. C. Record reviewThe 2/19/26 hospital records revealed Resident #67 was discharged from the hospital to the facility with the following physician's orders:Insulin aspart 100 units/milliliter (ml) solution pump. Inject into the skin continuously via Omnipod (insulin pump) as directed. The discharge hospital records additionally indicated the resident should eat a carbohydrate controlled diet with a maximum of 25 percent (%)to 50% of the calories to come from carbohydrates for each meal. -Review (continued on next page)

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Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #67's February 2026 CPO failed to reveal the resident had a physician's order for the insulin pump. -The February 2026 CPO failed to reveal that the resident had a physician's order to monitor the resident's blood glucose levels and the use of the dexcom glucometer. -The February 2026 CPO failed to reveal physician's orders to monitor the resident's insulin pump for any dysfunction or complications. -Review of the February 2026 CPO revealed the resident had a physician's order for a regular diet (not a carbohydrate controlled diet). -There was no documentation in Resident #67's EMR to indicate the facility had attempted to obtain appropriate monitoring orders from the physician (see DON interview below).The at-risk review note, dated 2/20/26, documented staff were to monitor Resident #67's blood glucose levels, insulin pump functionality , and observe for signs and symptoms of low or high blood sugar levels. -However, review of Resident #67's electronic medical record (EMR) did not reveal documentation to indicate the facility was monitoring the resident's blood glucose levels, insulin pump or signs and symptoms of low or high blood sugar levels. A review of Resident #67's meal tray ticket on 2/25/26 revealed the resident's diet order had been changed from a regular diet to a carbohydrate controlled diet (during the survey). IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 2/25/26 at 9:56 a.m. LPN #1 said she was the admitting nurse when Resident #67 was admitted to the facility on [DATE]. She said the resident was admitted from the hospital due to vertigo. LPN #1 confirmed Resident #67 had a diagnosis of diabetes and that she had an insulin pump which she managed on her own. She said the blood glucose levels went to the resident's phone. She said she had not asked to see the resident's phone to monitor her blood sugar levels, however, she said she had not worked since the resident was admitted to the facility. LPN #1 reviewed Resident #67's EMR and confirmed that there was no documentation in the resident's EMR related to the resident's blood sugars. She additionally confirmed, after reviewing the resident's EMR, that there was no physician's order to monitor Resident #67's blood sugars or a physician's order for the resident's insulin pump. LPN #1 said she would have another nurse call the physician for the orders. Registered nurse (RN) #2 was interviewed on 2/26/26 at 1:00 p.m. RN #2 said she had phoned the physician for the insulin pump and blood glucose monitoring physician's orders for Resident #67. She said she had not seen the physician's order on the hospital discharge record for the carbohydrate controlled diet and the physician ordered a regular diet. RN #2 said Resident #67 managed the insulin pump and the freestyle glucometer herself and was planning on only being at the facility for a few weeks, therefore, she thought it was okay that the monitoring orders were not in the February 2026 CPO. The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 2/26/26 at 2:10 p.m. The ADON confirmed there were no physician's orders for the blood glucose monitoring and the insulin pump in Resident #67's EMR. She said a physician's order for both devices obtained on 2/25/26 (during the survey). The DON said she had attempted to call the physician for orders however, had not received. -However, review of Resident #67's EMR did not reveal any documentation of the DON's attempts to call the physician (see record review above). The ADON said she was responsible for reviewing residents' EMRs after they were admitted to the facility to ensure all physicians orders were in place; however, she had not reviewed Resident #67's EMR yet. V. Facility follow-upA second review of Resident #67's EMR on 2/25/26 revealed physician's orders had been obtained for monitoring the resident's blood sugar levels and the insulin pump. Additionally, a blood sugar value of 370 mg/dl (milligrams per deciliter) was recorded in the EMR on 2/25/26 at 11:30 a.m.-However, the physician's orders were not obtained for monitoring the insulin pump and recording the resident's blood sugar levels until the concern was brought to the facility's attention during the survey.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide necessary services consistent with professional standards of practice to promote healing of pressure injuries and prevent of additional pressure injuries for one (#46) of two residents out of 41 sample residents. Specifically, the facility failed to:-Ensure Resident #46, who had pressure injuries, was repositioned and provided incontinence care in a timely manner; and,-Ensure staff consistently implemented care planned pressure injury prevention interventions for Resident #46.Findings include:I. Professional referenceAccording to Basic Nursing third edition; [NAME] S. Treas, [NAME], [NAME] H. [NAME] (2022), page 1214-1215, Healthy people regularly shift position to maintain comfort. However, many patients are unable to move without assistance. They require a change of position at least every two hours to prevent skin breakdown, muscle discomfort. People who are immobile are more prone to pressure injury as a result of reduced circulation, impaired oxygen exchange to the tissues and edema.According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.p on 2/10/22, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.II. Resident #46A. Resident statusResident #46, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included unspecified dementia, mood disturbance and anxiety. The 2/18/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. The resident was dependent on staff assistance for all activities of daily living (ADL).The MDS assessment indicated the resident was at risk for developing pressured injuries and had at least one unhealed pressure injury. B. ObservationsOn 2/23/26 at 11:50 a.m. Resident #46 was being assisted to the dining room. The resident's feet were resting on her wheelchair foot pedals, however, she did not have the protective boots on her feet. She was not wearing shoes and her sock feet were resting directly on her foot pedals.During a continuous observation on 2/24/26, beginning at 1:58 p.m. and ending at 5:20 p.m., the following was observed:At 1:58 p.m. Resident # 46 was sleeping on her back in bed.At 2:33 p.m. the resident continued to be in the same position, lying on her back with no repositioning. There were no positioning wedges observed in the room, and the resident did not have protective boots on her feet. The resident's heels were resting directly on the mattress. At 3:58 p.m. Resident #46 continued to lay on her back in bed with no repositioning offered by staff.At 5:20 p.m. the resident continued to lay on her back in bed. There had been no staff members in the resident's room to offer her repositioning with wedges or place protective boots on her feet. During a continuous observation on 2/25/26, beginning at 1:29 p.m. and ending at 4:30 p.m. the following was observed:At 1:29 p.m. Resident #46 was laying in bed on her back with her head slightly raised., There were no positioning wedges offloading the resident. At 2:35 p.m., the resident continued to lay on her back in bed with her head slightly raised.-No staff members had entered the room to provide incontinence care and repositioning to the resident. At 4:22 p.m. registered nurse (RN) #1 and RN #2 entered Resident #46's room to provide wound care for the resident. The nurses proceeded to uncover the resident in order to perform wound care. The resident's heels did not have protective boots on and her heels were lying directly on the mattress. RN #2 proceeded to open the resident's brief and perform wound care on the resident's sacrum pressure wound while RN #1 assisted. The stage 3 pressure injury on the resident's sacrum was cleaned with normal saline, patted dry, and medihoney ointment (wound treatment) was applied and the wound was covered with a dressing, per the physician's order. RN #2 began to close the resident's brief after finishing the wound care on the resident's sacrum. When prompted, RN #2 changed Resident #46's brief and said the resident was wet. After changing the resident's brief, RN #1 proceeded to perform the wound care on the resident's right heel. The unstageable pressure injury on the resident's right heel was cleaned with normal saline and covered with a dressing, per the physician's order. Before leaving the resident's room, RN #1 put Resident #46's protective boots on the resident. The resident allowed the application of the boots.On 2/26/26 at 8:30 a.m. Resident #46 was in the dining room for breakfast. The resident did not have protective boots on her feet. Resident #46's heels were resting directly on the wheelchair foot pedals. C. Record ReviewReview of Resident #46's pressure injury care plan, updated 1/28/26, identified the resident had a deep tissue injury to the right heel and a stage 3 pressure ulcer to the sacrum. Pertinent interventions included monitoring the wounds per facility protocol with offloading, treatment orders, applying heel protecting boots and offloading heels while the resident was in bed and applying heel protecting boots while the resident was up in her chair as well to prevent pressure injuries and encouraging and assisting the resident with turning and repositioning frequently while in bed, and as tolerated.The nurse progress note, dated 1/28/26, revealed the development of a new pressure injury on the resident's right heel. The progress note documented new interventions included heel offloading by pillows/heel protectors to prevent further pressure injuries and putting the resident on a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repositioning schedule.-However, observations revealed staff were not consistently offloading the resident's heels or providing timely repositioning to the resident (see observations above). The nurse progress note, dated 2/10/26, revealed the resident developed a new sacral pressure injury and the wound care physician had determined that it was an unavoidable pressure injury. Per the progress note, the facility initiated frequent rounding to reinforce skin care and repositioning as tolerated, maintaining pressure-relief interventions, including low air-loss mattress, heel offloading boots, pillows, and positioning wedges for side-lying/offloading as tolerated by the resident, encouraging oral intake and supplements as tolerated, continuing frequent repositioning attempts with gentle re-approach due to refusals,and honoring resident preferences and comfort-focused goals.The wound tracking evaluation, dated 2/17/26, revealed Resident #46 had a stage 3 pressure injury on the sacral area with dimensions of 4 centimeters (cm) by 3 cm by 0 cm, initiated on 2/9/26, and a closed unstageable right heel with dimensions of 3 cm by 4 cm by 0 cm, initiated on 1/28/26. D. Staff interviews: Registered nurse (RN) #3 was interviewed on 2/26/26 at 10:22 a.m. RN #3 said Resident #46 had a pressure injury on her sacrum and one on her right heel. She said the resident was at high risk for pressure injuries due to immobility and incontinence. She said Resident #46 was to be checked on frequently. She said the resident was to have the foot protection boots and was to be repositioned when she was in bed. RN #2 was interviewed on 2/26/26 at 10:30 a.m. RN #2 said the repositioning requirements for Resident #46 had been added to the medication administration records (MAR), in order to ensure the resident was being repositioned. RN #2 said the staff had been in-serviced about the importance of residents being repositioned every two hours. She said if Resident # 46 refused repositioning, staff should document the refusal. The assistant director of nursing (ADON) was interviewed on 2/26/26 at 11:09 p.m. The ADON said she was the wound care nurse and she completed wound care rounds with the wound care physician. She said the wound care physician measured the residents' wounds, and made any changes to wound treatments in the physician's orders. The ADON said Resident #46's wounds were classified as unavoidable due to her comorbidities. She said the resident should have the interventions of the heel protectors on her heels at all times and staff should be repositioning the resident every two hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received necessary respiratory care and services per professional standards of practice for two (#24 and #67) of three residents reviewed for respiratory care out of 41 sample residents.Specifically, the facility failed to:-Ensure the physician's order matched the resident's preference for oxygen administration for Resident #24; and,-Ensure there was a physician's order for oxygen use for Resident #67.Findings include: I. Facility policy and procedure The Oxygen Administration policy, dated October 2010, was provided by the nursing home administrator (NHA) on 2/26/26 at 9:23 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident and assemble the equipment and supplies as needed. II. Resident #24 A. Resident status Resident #24, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD - restrictive airflow caused by inflammation), multiple sclerosis (MS - autoimmune disease of the central nervous system) and neuromuscular dysfunction of the bladder (loss of normal bladder control caused by MS). The 1/28/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #24 was dependent on staff for activities of daily living (ADL), including dressing, showering, toileting and ambulating. He required set-up assistance for oral hygiene and was independent with eating. The 1/28/26 MDS assessment revealed Resident #24 required the use of oxygen therapy. B. Observations On 2/23/26 at 5:04 p.m. Resident #24 was in the dining room. The resident was not connected to a continuous oxygen source. On 2/24/26 at 9:00 a.m. Resident #24 was sitting in his powered wheelchair in his room. He was not connected to a continuous oxygen source or wearing a nasal cannula. On 2/24/26 at 5:18 p.m. Resident #24 was in the dining room. He was not connected to a continuous oxygen source. On 2/25/26 at 8:04 a.m. Resident #24 was in the dining room. The resident was not connected to a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuous oxygen source. On 2/25/26 at 11:17 a.m. Resident #24 was independently transporting himself in his powered wheelchair around the hallways on the first floor of the facility. He was not connected to a continuous oxygen source. -However, the resident's physician's order for oxygen indicated the resident was to be on continuous oxygen (see physician's orders below). C. Resident interview Resident #24 was interviewed on 2/24/26 at 9:00 a.m. Resident #24 said he used oxygen when he was lying down because he could not breathe when he was lying down. He said he particularly needed the oxygen when he took a nap or slept at night. -However, the resident's physician's order for oxygen indicated the resident was to be on continuous oxygen, not just when he was lying down (see physician's orders below). D. Record review Review of Resident #24's February 2026 CPO revealed the following physician's order: Continuous oxygen at 2 to 5 liters per minute (LPM) via nasal cannula to keep oxygen saturation between 88 to 92 percent (%), every shift, ordered 2/5/26. Resident #24's comprehensive care plan, initiated 6/2/22, revealed the resident had ordered supplemental oxygen related to COPD and chronic respiratory failure with hypoxia. Pertinent interventions included the resident preferred to wear supplemental oxygen at night, monitoring for signs/symptoms of respiratory distress and reporting to the physician as needed: respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color, offering incentive spirometer (a handheld device designed to strengthen lungs and open airways by encouraging slow, deep breaths) per physician's order and evaluating lung function and utilizing oxygen settings per physician's orders. E. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/25/26 at 11:05 a.m. LPN #1 named registered nurse (RN) #2 as the facility's respiratory RN. She said a resident with a physician's order for continuous oxygen should wear oxygen continuously, but she said a lot of the residents had their own preferences regarding their oxygen. RN #1 was interviewed on 2/25/26 at 2:30 p.m. RN #1 said a continuous oxygen order meant the resident should wear their oxygen continuously, but she said Resident #24's physician's order indicated to keep his oxygen saturations between 88% to 92%. She said Resident #24's oxygen saturation was last documented as 93%, so that was why the resident was not using the continuous oxygen. RN #1 said the moment Resident #24 was in bed, he would wear the oxygen. RN #1 spent a few minutes looking in Resident #24's electronic medical record (EMR), but was unable (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	find documentation that the physician had been notified that Resident #24 did not wear the oxygen continuously as ordered. RN #2 was interviewed on 2/25/26 at 2:35 p.m. RN #2 said she did not think the physician had been notified that Resident #24 did not wear his oxygen continuously as ordered. She said the physician knew the resident did not wear the oxygen continuously because the resident smoked cigarettes, and he was unable to smoke while he wore oxygen. RN #2 said since Resident #24's oxygen order said oxygen saturations should be maintained at 88% to92%, she interpreted the order to mean that the resident did not require continuous oxygen if his oxygen saturations were within the physician ordered parameters. She said she would update the order to read at night and would notify the physician. The director of nursing (DON) was interviewed on 2/25/26 at 2:39 p.m. The DON said Resident #24's oxygen order should specify that he needed continuous oxygen at night. She said the facility could update the order to make it consistent with the resident's preferences. The DON said Resident #24 did not need to wear the oxygen if his oxygen saturations were within the physician ordered parameters. RN #2 was interviewed again on 2/25/26 at 4:46 p.m. RN #2 said she spoke with the physician and together they determined the therapeutic oxygen flow for Resident #24 was 3 LPM. She said the physician agreed to the order specifying that Resident #24 wore the oxygen continuously while in bed. F. Facility follow-up A second review of Resident #24's February 2026 CPO on 2/25/26 revealed the following physician's order: Oxygen at 3 LPM via nasal cannula continuously while in bed, every shift, ordered 2/25/26. -However, the physician's order was not changed to reflect Resident #24's preferences for wearing continuous oxygen the concern was brought to the facility's attention during the survey. The DON was interviewed again on 2/26/26 at 4:50 p.m. The DON said she saw Resident #24's updated oxygen order, and she thought the updated physician's order was more appropriate to match the resident's preferences. She said she did not think the physician's order needed to include oxygen monitoring parameters. III. Resident # 67 A. Resident status Resident #67, age [AGE], was admitted on [DATE] According to the February 2026 CPO diagnoses included type 2 diabetes mellitus with diabetic neuropathy, and chronic obstructive pulmonary disease (COPD). According to the resident's Level I Pre-admission Screening and Resident Review (PASRR) assessment, the resident was cognitively intact. B. Observations (continued on next page)

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Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/23/26 at 4:30 p.m. Resident #67 was sitting in bed. She was wearing a nasal cannula and her oxygen was set to 3 liters per minute (LPM). On 2/25/26 at 11:23 a.m. Resident #67's oxygen was set to 2.5 LPM. C. Record review A review of Resident #67's February 2026 CPO on 2/25/26 revealed the resident had no physician's order for oxygen therapy. The progress note, dated 2/20/26, documented Resident #67 was started on oxygen at 2 LPM via nasal cannula. D. Staff interview LPN #1 was interviewed on 2/25/26 at 9:56 a.m She said Resident #67 was on oxygen therapy for her diagnosis of COPD. She confirmed oxygen was considered a medication and required a physician's order to administer it. After reviewing Resident #67's physician's orders, LPN #1 said she was not able to locate the physician's order for the resident's use of oxygen. E. Facility follow-up A second review of Resident #67's February 2026 CPO on 2/26/26 revealed a physician's order for oxygen administration was obtained on 2/25/26 at 10:46 a.m. -However, the physician's order for Resident #67's oxygen administration was not obtained until the concern was brought to the facility's attention during the survey.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans, and resident preferences for one (#37) of two residents out of 41 sample residents. Specifically, the facility failed to: -Ensure a complete and thorough pain assessment was completed that identified Resident #37's history of pain and its treatment, history of addiction, characteristics of pain and the impact of pain on the resident's quality of life; -Identify Resident #37's goals for pain management and acceptable level of pain; -Identify Resident #37's locations of pain; and, -Ensure Resident #37's location of pain was consistently identified when administering pain medication to the resident.Findings include: I. Facility policy and procedureThe Pain Management policy, revised June 2022, was provided by the nursing home administrator (NHA) on 2/26/26 at 6:46 p.m. It read in pertinent part, The facility will evaluate and identify residents experiencing pain, evaluate the existing pain and the use, determine the type and severity of the pain and develop a care plan for management consistent with the resident's goals and preferences. The care plan is implemented and evaluated for its effectiveness. The staff monitors and documents the resident's response to pain management interventions. Pain screening is conducted upon admission, quarterly and annually thereafter using the pain evaluation. The goal of the pain management system is to effectively and consistently identify and treat pain.II. Resident #37 A. Resident status Resident #37, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included chronic pain syndrome, malignant neoplasm of rectum and rectosigmoid junction (cancer located in the lower part of the large intestine where the colon meets the rectum), obesity, major depressive disorder, peripheral vascular disease (a circulatory condition that reduces blood flow to the arms or legs), chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes it difficult to breathe due to airflow blockage), unilateral inguinal hernia (a condition where tissue pushes through a weak spot in the abdominal muscles on one side of the groin), osteoarthritis, spinal stenosis (narrowing of the spaces within the spine), acute kidney failure, benign prostatic hyperplasia (BPH - noncancerous enlargement of the prostate gland that can cause urinary problems) and hypoxemia (lower-than-normal levels of oxygen in the blood). The 1/20/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was independent with eating, oral hygiene, toileting and personal hygiene. He required partial assistance with showering. The assessment revealed Resident #37 did not have a pain management regimen. He took pain medication as needed and received non-medication interventions for pain. He had pain in the past five days of the look back assessment period. The assessment revealed the resident's pain occasionally occurred and occasionally made it difficult to sleep and occasionally limited his day to day activities because of pain. A numeric scale was completed for pain intensity and his worst pain was a 3 on a scale of 0 to 10. The resident said his pain intensity was described as mild.B. Resident interview Resident #37 was interviewed on 2/23/26 at 3:23 p.m. Resident #37 said he had been prescribed oxycodone (opioid pain medication) for the last eight years due to surgery he had on his neck. He said he used to ride his bike five to ten miles a day but could no longer do so because of the pain. He said his physician wanted to discontinue all oxycodone orders. He said he used to be on oxycodone 20 milligrams (mg) three times a day and now he was on oxycodone 10 mg every 12 hours. Resident #37 said if the physician stopped prescribing his oxycodone he had ways of obtaining oxycodone. He said he knew people on the street and that was what he had been doing since his physician changed his oxycodone order. He said yesterday, 2/22/26, he bought two 5 mg oxycodone tablets on the street in addition to the oxycodone administered by the facility. Resident #37 said he experienced pain where his hernia was located as well as abdominal pain. He said he had abdominal surgery because his intestines were twisted. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #37 lifted his shirt and showed the surgical scar that was vertically along his abdomen, extending from a few inches above his belly button to a few inches below his belly button. He said his physicians and nurses asked him if he knew he had a hernia and he said he knew because he was reminded of it all day because of the pain. Resident #37 said he additionally had pain in both knees. He said he had cancer and the chemotherapy damaged the ligaments in his knees. He said his current pain level was a 6 out of 10 and increased to an 8 on some days. He said his goal for pain management was to have a pain level of 0. He said his goal was to be able to return to his previous lifestyle as much as possible. C. Record review Resident #37's pain care plan, revised 9/29/25, revealed he had acute pain related to an abdominal incision from a colon resection, history of cervical spine fusion, carpal tunnel syndrome, spinal stenosis and COPD. Interventions included administering analgesia (pain relief) as ordered, monitoring and recording pain characteristics every shift and as needed, monitoring and reporting to nurse any signs and symptoms of non-verbal pain, and notifying the physician if interventions were unsuccessful or if the current complaint was a significant change from the resident's past experience of pain. -The care plan did not include non-pharmacological interventions, monitoring for pain medication effectiveness, and monitoring for side effects of opioid (a class of natural, man-made, or semi-synthetic chemical compounds that interact with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals) use. The 10/6/25 pain assessment revealed Resident #37 had pain in the last five days. He had a pain management regime, he took pain medication as needed and he received non-medication interventions for pain. The assessment documented the resident's pain rarely occurred, rarely interfered with therapy activities and rarely interfered with his day-to-day activities. A numeric scale was completed for pain intensity and his worst pain was a 3 on a scale of 0 to 10. -However, the treatment, side effects and effectiveness of pain medications sections were left blank for the scheduled pain medication regimen. The administration patterns, side effects and effectiveness sections were left blank. The non-medication interventions and effectiveness section was left blank. The 1/7/26 pain assessment revealed Resident #37 had had pain in the last five days. He took pain medication as needed and he received non-medication interventions for pain. The assessment documented his pain occasionally occurred, occasionally interfered with sleep and occasionally interfered with his day-to-day activities. A numeric scale was completed for pain intensity and his worst pain was a 3 on a scale of 0 to 10. -However, the administration patterns, side effects and effectiveness sections were left blank for pain medication as needed. The non-medication interventions and effectiveness section was left blank.Resident #37's February 2026 CPO revealed the following physician's orders: Oxycodone 5 mg. Take one tablet by mouth every four hours as needed for moderate to severe pain, ordered 9/28/25 and discontinued 1/16/26. Oxycodone 5 mg. Take one tablet by mouth every six hours as needed for moderate to severe pain for 14 days, ordered 1/16/26 and discontinued 2/10/26.Oxycodone 5 mg. Take one tablet by mouth every eight hours as needed for moderate to severe pain, ordered 1/16/26 and discontinued 2/10/26. Oxycodone 5 mg. Take one tablet by mouth every 12 hours as needed for a pain level of 5 to 10, ordered 2/10/26. Cymbalta 60 mg. Take one capsule by mouth one time a day for pain, ordered 9/29/25 and stopped 10/9/25. Cymbalta 60 mg. Take one capsule by mouth one time a day for pain and depression, ordered 10/9/25. Gabapentin 300 mg. Take two capsules by mouth at bedtime for pain, ordered 9/29/25. Acetaminophen. Take 1000 mg by mouth every six hours as needed for pain. Maximum dose is less than 3000 mg, ordered 12/5/25. Document nonpharmacological interventions attempted prior to pain medication using the key provided every shift. Repositioning, reassurance, distraction, exercise, rest, deep breathing exercises, massage, guided imagery, laughter, socialization, aromatherapy or other, ordered 9/28/25.Evaluate pain utilizing the 0 to 10 pain scale as appropriate for the resident every shift for pain management, ordered 9/28/25. -Review of Resident #37's electronic medical record (EMR) did not reveal documentation indicating if the non-pharmacological pain interventions were effective.The 1/1/26, 1/2/26, 1/3/26, 1/5/26, 1/7/26, 1/8/26, 1/10/26, 1/14/26, 1/16/26, 1/17/26, 1/24/26, 1/25/26, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/26, 1/31/26, 2/6/26, 2/7/26, 2/14/26, 2/21/26 and 2/24/26 nurse notes revealed Resident #37 was administered oxycodone 5 mg. The 1/9/26 and 1/30/26 nurse notes revealed the resident was administered acetaminophen 1000 mg. -However, there was no documentation indicating where the pain was located when the oxycodone 5 mg or acetaminophen 1000 mg were administered between 1/1/26 and 2/24/26. - A review of Resident #37's EMR revealed the non-pharmacological interventions were not determined as a personalized pain management intervention for the resident. The 12/9/25 physician notes revealed Resident #37 had a history of spinal stenosis, cervical spondylotic myeloradiculopathy (age-related spinal cord compression), myelopathy (spinal cord compression causing nerve symptoms) and degenerative disc disease of the cervical spine. Treatment had included decompression, discectomy (surgical disc removal), laminectomies (spinal decompression surgery), and spinal fusion. The resident had peripheral neuropathy (nerve numbness that causes pain) due to and not concurrent with chemotherapy, as well as baseline neuropathy related to cervical and lumbar spine conditions. Chemotherapy and radiation had been completed in October 2020, with chemotherapy discontinued due to neuropathy. The resident had ulnar neuropathy at the elbow of the left upper extremity (nerve damage or irritation affecting the elbow and arm). Additionally, the resident had chronic bilateral knee pain, including osteoarthritis of the right knee and chronic left knee pain. Pain had been reported as fairly well controlled with acetaminophen (Tylenol) 1000 mg every six hours as needed, duloxetine (Cymbalta) 60 mg daily, gabapentin 600 mg at bedtime, and oxycodone 5 mg every four hours as needed. The resident had been scheduled to see pain management on 12/22/25. He had additionally been scheduled for surgery on the left arm and wrist on 1/27/26, with plans to continue coordination of care with orthopedics. Therapies and supportive care had been continued as indicated.The 1/16/26 physician note revealed there was an update from the pain management clinic indicating the resident was discharged from the pain management clinic due to a toxicology screen in December 2025 being positive for methamphetamine (often called meth or crystal meth, is a potent and highly addictive synthetic stimulant drug that affects the central nervous system). The urinalysis was reviewed with the resident and was positive for methamphetamines. It was reported that the office would be discharging the resident from their practice due to this result. The resident was educated that he continued to receive oxycodone as needed; however, due to the positive drug screen and for his safety, the medication would need to be gradually weaned. The resident voiced understanding. He communicated to multiple people at the office he would find oxycodone off the street if needed. The resident was educated on the risk of overdose, death or injury by using drugs purchased on the street. The 1/21/26 physician's social worker note revealed Resident #37 said pain management dropped him and he would no longer receive pain medication after 1/30/26 due to him popping hot (testing positive for methamphetamine in a toxicology screen). The resident reported he was unsure what the plan was to manage his pain starting at the beginning of next month (February 2026). He reported he did not understand the reason pain management discharged him. Shortly after stating that, he mentioned this was discussed with his physician during their visit as well as informed risk regarding taking certain medications while utilizing illicit drugs. The 2/10/26 physician note revealed Resident #37 reported pain in his hands, knees and from hernias. His pain control was unclear. He was likely using methamphetamine and likely using opioids he got from the street. Concurrent use of methamphetamine and opioids was not safe and they would continue to wean the resident off oxycodone. The plan was to decrease oxycodone to 5 mg every 12 hours as needed.-However, the facility failed to ensure other non-opioid medications were implemented in place of the oxycodone medication that was being weaned in order to ensure Resident #37 was able to achieve effective pain management without the opioid medication. III. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 2/26/26 at 10:47 a.m. CNA #4 said today (2/26/26) was her first day working in the facility. She said if a resident reported pain, she asked the resident where the pain was located and reported the pain to the nurse. CNA #4 said she was not sure if CNAs documented pain at this facility, but some facilities had CNAs document pain in their daily (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charting. CNA #4 said she met Resident #37 this morning and he was not happy. She said he did not report any pain to her. She said she did not know what helped his pain go away or what made his pain worse. CNA #5 was interviewed on 2/26/26 at 11:03 a.m. CNA #5 said if a resident reported pain to him, he asked the resident to rate their pain and where they experienced pain. He said he told the resident he informed the nurse. He said he asked the nurse if they could assess the resident due to what the resident reported to him. He said he did not document if a resident reported pain to him. CNA #5 said he was familiar with Resident #37. He said he had pain in his back and legs. CNA #5 said pain medication helped the resident and sometimes something cold to drink or coffee helped alleviate his pain. He said Resident #37 talking to his family or friends on the phone helped him with his pain. Licensed practical nurse (LPN) #1 was interviewed on 2/26/26 at 11:30 a.m. LPN #1 said pain assessments were completed when the residents were admitted , quarterly and as needed. She said pain was documented on an assessment form in their EMRs. She said the pain assessment documented where a resident's pain was located, the intensity of the pain, what medications were used for pain before, what worked for relieving the pain and what did not work to help the resident get to baseline. She said she asked what non-pharmacological interventions worked for pain relief. She said she asked what their baseline goal level for pain was and what their acceptable pain level was. LPN #1 was familiar with Resident #37. She said he had pain and he complained about pain a lot. She said he had pain in his hands, wrists and his lower back. She said sometimes he had a headache. She said his goal was to be pain free or a 0 out of 10 pain level. She said he did not complain about pain everyday but approximately 75% of the time, he complained about pain. She said he had pain since she started working at the facility in December 2025. She said too much exertion made his pain worse, such as going outside and therapy. LPN #1 said if Resident #37 used his wheelchair too much, his pain in his hands would hurt. She said he never asked for pain medications for his knees or abdominal incision, she said it was mostly for his hands and wrists. The director of nursing (DON) was interviewed on 2/26/26 at 5:00 p.m. The DON said pain assessments were completed when the residents were admitted , quarterly and as needed. She said pain was documented on an assessment form in their EMRs. She said the assessment covered where the pain was located, the intensity of the pain, what worked for treating the pain and what did not work to help the resident get to baseline. She said she asked what non-pharmacological interventions worked for pain relief. She said she asked what their baseline goal level for pain was and what their acceptable pain level was. The DON said she was familiar with Resident #37. She said he had pain in his hands due to carpal tunnel syndrome. She said he rarely complained about pain. The DON said he was mostly outside of the building smoking. She said his pain management was to not have any pain. She said he had been in pain since he was admitted to the facility. She said his physician was not a facility physician and the physician decreased his pain medications. IV. Facility follow up The NHA provided the following information on 2/27/26 at 3:57 p.m., after the survey exit. Per the NHA, the documentation provided revealed the facility's diligence in monitoring Resident #37's pain, offering pain medication as needed and non-pharmacological interventions each time he voiced his pain concerns. According to the documentation, it was effective in managing his pain levels at those times. The documentation included the 2/10/26 physician's progress note indicating the resident tested positive for methamphetamines, the resident admitted to using methamphetamine and buying oxycodone off the street (see record review above). He said he typically took 10 mg more oxycodone than what he received from the physician. The 1/7/26 pain assessment for Resident #37 was provided which highlighted the resident's pain frequency as occasional. Resident #37's January 2026 MAR was provided and highlighted that nonpharmacological interventions were utilized, the resident's pain was evaluated every shift and acetaminophen and oxycodone were administered when requested by the resident.-However, the documentation did not indicate Resident #37's pain assessment was complete, identify what the resident' pain management goals were, identify all pain locations or indicate the location of pain was identified when administering pain medication to Resident #37.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#30) of three residents reviewed for ancillary services out of 41 sample residents received dental services timely. Specifically, the facility failed to: -Ensure Resident #30 was provided timely emergency dental services after reporting tooth pain; and, -Ensure Resident #30 was offered routine dental care.Findings include: I. Facility policy and procedure The Dental Services policy and procedure, revised December 2016, was provided by the nursing home administrator (NHA) on 2/26/26 at 6:46 p.m. It read in pertinent part, Routine and 24-hour emergency dental services are provided to the residents through a contract agreement with a licensed dentist that comes to the facility monthly, referral to the resident's personal dentist, referral to community dentist or referral to other health care organizations that provide dental services. Selected dentists must be available to provide follow up care. Failure of a dentist to provide follow up services will result in the facility's right to use its consultant dentist to provide the resident's dental needs. Social services representatives assist residents with appointments, transportation arrangements and for reimbursement of dental services under the state plan, if eligible. All dental services provided are recorded in the resident's medical record.II. Resident #30 A. Resident status Resident #30, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included osteoarthritis, chronic pain syndrome, hyperlipidemia, polyneuropathy, insomnia, major depressive disorder, generalized anxiety disorder and post traumatic anxiety disorder. The 1/19/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required a wheelchair. She was independent with eating, oral hygiene, toileting, showering, and personal hygiene. The MDS assessment indicated the resident had no dental issues. B. Resident interview and observation Resident #30 was interviewed on 2/24/26 at 10:32 a.m. Resident #30 said she had to have a tooth pulled on 2/25/26. She said she needed to see a dentist because it had been a while. During the interview, Resident #30 was observed visibly in pain on her right side of her face, specifically her cheek and jawline. She had her head titled down to her right shoulder while being interviewed. When asked if she was in pain, Resident #30 said she was in pain and on a pain scale of zero to 10, zero being no pain, her pain level was currently an 8. Resident #30 asked to end the interview because of her pain, and she did not want to talk. There was a white caked substance observed on her upper front teeth. C. Record review The informed consent for dental, audiology and optometry services revealed Resident #30 signed the consent on 12/1/25. The 12/9/25 physician progress note revealed that Resident #30 was asked not to return to the dental office where she was previously seen due to behaviors related to obtaining local anesthesia during the last visit. The physician's referral included an order for an external dental exam, Xrays and prophy (a routine preventative cleaning for healthy gums or gingivitis) at the nursing facility. The timeframe to complete the order was one week. The 1/15/26 social services progress note revealed Resident #30 was on the schedule to see the dentist on 1/6/26, however, Resident #30 was out of the facility so the appointment was to be rescheduled. -The appointment was scheduled for 1/6/26, 28 days after the physician referred Resident #30 to be seen by the facility dentist (see physician's progress note above). The 2/10/26 dental emergency evaluation form revealed Resident #30 had pain on her upper right and lower right side of her mouth. The pain level was a 7 out of 10 and the pain had been present for seven days. There were no antibiotics or pain medication prescribed. The 2/12/26 nurse note revealed Resident #30 was seen by the dentist in the morning for a recent complaint of pain in her gums and mouth. The dentist ordered oral antibiotics. The 2/13/26 nurse note revealed Resident #30 started her first dose of antibiotics and was compliant with the treatment. There were no side effects noted. The resident said she had pain on her gums that goes on and off. Resident #30 was on scheduled pain medication. The 2/18/26 social services note revealed Resident (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#30 was evaluated on an emergency basis due to dental pain. The dentist determined the affected tooth was infected and recommended extraction. Nursing reported Resident #30 recently completed a course of antibiotics for the infection and her pain was being managed. She was scheduled for an oral surgery consultation and treatment on 2/25/26 at 12:30 p.m. Social services director (SSD) #1 notified the physician of the upcoming appointment. Social services remained available for support and services as needed. -However, the social services note was completed one week after the dental emergency form was completed by nursing (see 2/10/26 dental emergency form above). The 2/19/26 social services note revealed Resident #30 had been on the dentist schedule for 2/9/26, however, the resident was not seen and would be rescheduled for the dentist's next visit to the facility. -The appointment was scheduled on 2/9/26, 62 days after the physician referred Resident #30 to be seen by the facility dentist (see physician's progress note above). The 2/22/26 at 12:43 p.m. nurse note revealed Resident #30 complained about pain around her right ear, below her right jaw and neck. There was no complaint of gum pain or oral pain. During the assessment, there was a complaint of swelling or redness on her gum or mouth. Resident #30 said the pain came with mild to moderate intensity. The physician was notified through the on-call nurse. Resident #30 was taking scheduled pain medications. Diclofenac gel applied to the affected pain area and the resident was waiting for a new order from the physician to treat the pain. The 2/22/26 at 6:01 p.m. nurse note revealed there was a faxed physician's order received for naproxen (medication to treat pain) and the resident was notified of the new medication. IV. Staff interviews SSD #1, SSD #2, and the social services assistant (SSA) were interviewed together on 2/26/26 at 1:19 p.m. SSD #1 said when a resident requested dental services, social services sent a referral to the dentist after obtaining consent from the resident or responsible party. The SSA said the dentist provided social services with a list of residents to be seen at the next on-site dental visit. The SSA said the dentist came to the facility every other month.The SSA said residents were seen by the dentist annually or quarterly, depending on their insurance coverage. SSD #1 said if a resident had a specific dental need or emergency, the facility figured out a way for the resident to be seen by a dentist sooner, regardless of insurance coverage. SSD #1 said residents could be seen at the dentist's next scheduled visit to the facility, unless the situation was considered an emergency.The SSA said the dentist provided the list of residents to be seen on the day of the visit to the facility and sometimes one week prior to their visit. The SSA said during the dentist's February 2026 visit to the facility, the dentist did not see all residents on the list because he ran out of time. SSD #1 and the SSA said the dentist usually was able to see all of the residents who were scheduled to be seen. SSD #1 said if a resident complained of tooth pain, an emergency dental form was completed by the dentist. She said nursing was responsible for notifying the physician and the responsible party. SSD #1 said she used the emergency form to send to the dentist to schedule an appointment. SSD #1 said residents referred for oral surgery could usually be seen the same day.SSD #1 said she was familiar with Resident #30. She said she had received an email on 12/1/25 from the physician requesting a referral to the in-house dentist. SSD #1 said consent was obtained from Resident #30 and she was added to the next dentist visit to the facility. SSD #1 and the SSA said there needed to be better communication with the physician to confirm dental visits. SSD #1 said she did not know how the referral for Resident #30 had been made in December 2025 and did not know when Resident #30 was last seen by a dentist. SSD #1 said she was unaware the referral had been made to the facility dentist because Resident #30 had been discharged from the physician's dental provider.SSD #1 was interviewed a second time on 2/26/26 at 4:17 p.m. SSD #1 said she contacted the oral surgeon's office and learned Resident #30 did not attend her scheduled oral surgery appointment on 2/25/26. SSD #1 said she contacted the dental provider for clarification on why the resident was not seen for oral surgery on 2/25/26. She said the provider told her they told Resident #30 not to go to the appointment as the procedure would have resulted in an out of pocket expense for the resident and the dental provider did not contract with the oral surgeon. SSD #1 said the dental provider said the original referral to the oral surgeon was sent by the dentist (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before realizing the provider was not within their network. SSD #1 said the dental provider informed her of one contracted provider and they required a full set of dental Xrays before scheduling the procedure. SSD #1 said she followed up with Resident #30 to review the updated plan. She said Resident #30 told her she was contacted by her provider, understood the new plan and agreed to the new plan. SSD #1 said the resident reported no current oral discomfort and expressed she was comfortable waiting to schedule her oral surgery. SSD #1 said the dental provider said they planned to schedule Resident #30's oral procedure in March 2026. -However, SSD #1 did not know the appointment was cancelled or why the appointment was cancelled until the first interview on 2/26/26 at 119 p.m. (see interview above). SSD #1 was interviewed on 2/26/26 at 4:17 p.m. SSD #1 said, based on the date the consent for dental services was signed by the resident in December 2025, Resident #30 should have been offered dental services sooner than what was offered.

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	065152	A. Building B. Wing	02/26/2026

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure meals were served according to the resident's preferences for one (#37) of five residents out of 41 sample residents. Specifically, the facility failed to offer food choices according to Resident #37's preferences.Findings include: I. Facility policy and procedure The Resident Food Preferences policy, revised July 2017, was provided by the nursing home administrator (NHA) on 2/26/26 at 9:23 p.m. It read in pertinent part, Staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. The food services department will offer a variety of foods at each scheduled meal. II. Resident #37A. Resident status Resident #37, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included chronic pain syndrome, malignant neoplasm of rectum and rectosigmoid junction (cancer located in the lower part of the large intestine where the colon meets the rectum), obesity, major depressive disorder, peripheral vascular disease (a circulatory condition that reduces blood flow to the arms or legs), chronic obstructive pulmonary disease, (COPD - a long-term lung disease that makes it difficult to breathe due to airflow blockage) unilateral inguinal hernia (a condition where tissue pushes through a weak spot in the abdominal muscles on one side of the groin), osteoarthritis, spinal stenosis (narrowing of the spaces within the spine), acute kidney failure, benign prostatic hyperplasia (BPH - noncancerous enlargement of the prostate gland that can cause urinary problems) and hypoxemia (lower than normal levels of oxygen in the blood). The 1/20/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was independent with eating, oral hygiene, toileting and personal hygiene. He required partial assistance with showering. B. Resident interview Resident #37 was interviewed on 2/23/26 at 3:23 p.m. Resident #37 said the facility did not give him the food he wanted for meals. He said for breakfast, he hated oatmeal and the facility always gave him oatmeal for breakfast. He said he wanted cold cereal and the facility never offered cold cereal. He said he hated turkey and they served him turkey. Resident #37 said the way the facility provided meals made him want to leave the facility because no one was listening to him. He said when the kitchen served him meals that he did not order, he would go without eating or he would leave the building to eat somewhere else. He said he talked to the male nurses in his unit about not receiving the food he wanted and the nurses said there was nothing they could do about it. C. ObservationsDuring a continuous breakfast observation on 2/24/26, beginning at 8:03 a.m. and ending at 8:30 a.m., Resident #37 was observed in the dining room. An unidentified staff member brought him breakfast. Resident #37's breakfast consisted of pancakes, bacon and oatmeal. Resident #37 said he did not want oatmeal, however, the unidentified staff member did not offer the resident a replacement and left the oatmeal sitting on the dining room table. During a facility tour on 2/25/26 at 11:20 a.m., the meal menu, the alternative menu and the snack menu was observed in the elevator closest to the dining room and posted on a bulletin board in the main hallway near the lobby.-However, the menus posted did not have an alternative menu listed for breakfast. During a continuous observation on 2/25/26, beginning at 11:58 a.m. and ending at 1:30 p.m., the lunch preparation was observed in the main kitchen. Resident #37's meal ticket did not reveal his dislike for turkey. He was served the posted lunch meal of braised turkey roast, rice pilaf, creamed spinach and spice cake. D. Record review The nutrition care plan, initiated and revised on 10/1/25, revealed Resident #37 was at potential nutrition and hydration risk due to a history of intussusception (a serious medical emergency where part of the intestine slides into another part, telescoping and causing a blockage), surgical aftercare following digestive surgery, absence of other specified parts of the digestive tract, hypoxemia, COPD, MDD, osteoarthritis, obesity, iron deficiency, (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anemia, hydronephrosis, hypercalcemia, acute kidney failure and neoplasm of the rectum. Interventions included providing and serving diet as ordered, administering medications as ordered, encouraging fluids as needed, encouraging healthy choices, inviting the resident to activities that involved food and fluids, monitoring for dysphagia and monitoring for malnutrition. -However, the care plan did not indicate Resident #37's likes and dislikes. The 10/8/25 food preferences assessment documented that Resident #37 did not like turkey. The assessment said no turkey sandwiches or hot turkey. The 11/11/25 food preference assessment revealed he did not like turkey and cabbage. -However, Resident #37's dietary meal ticket did not indicate the resident did not like turkey and observation during the survey revealed the resident received turkey roast for lunch on 2/25/26 (see observations above).III. Staff interviews [NAME] (CK) #1 was interviewed on 2/25/26 at 12:25 p.m. CK #1 said certified nurse aides (CNA) were responsible for completing the resident's meal ticket on behalf of the resident. CK #1 said CNAs took lunch and dinner orders and residents were served whatever was on the breakfast menu for breakfast. CK #1 said the way a resident was served something different than what was on the breakfast menu was when the dietary manager (DM) updated the meal ticket with the resident's preferred breakfast meal. CNA #2 was interviewed on 2/25/26 at 4:51 p.m. CNA #2 said the night shift CNAs were responsible for completing the resident's meal ticket on behalf of the resident for the following day's lunch and dinner meals. She said if the resident was not in their room when the night shift CNA asked residents what they wanted for lunch and dinner, the day shift CNA was responsible for completing the remaining incomplete tickets. She said breakfast meals were not ordered on behalf of the resident. CNA #2 said if the resident did not want what was on the menu, she was responsible for offering a substitution. She said sometimes residents did not like anything on the menu so she tried to offer what they wanted or asked the resident what they wanted to eat. CNA #2 said residents could change their mind and let the day CNA know by 10:00 a.m. She said if the resident changed their mind after 10:00 a.m. the resident had to tell the kitchen staff. CNA #2 said residents were served cold cereal based on their likes and dislikes. She said the cold cereal showed up on the breakfast meal ticket as a like. CNA #2 said there were residents who received hot cereal who did not like hot cereal. She said she tried to double check to make sure the residents received what they wanted. CNA #2 said she was familiar with Resident #37. She said he did not like turkey. She said he did not eat lunch (on 2/25/26) because he was served turkey. She said he was easily frustrated when he was not served what he preferred. CNA #2 said Resident #37 always asked for cold cereal. She said she had to remind the kitchen of his likes and dislikes because he was not always served cold cereal. The NHA was interviewed on 2/26/25 at 5:26 p.m. The NHA said the facility did not have a DM. The NHA said she had an assistant DM and a registered dietitian (RD). The NHA said she lost her most recent DM the week prior to the survey (week of 2/16/26). The NHA said the DM was responsible for completing the food preferences assessment for residents. The NHA said once the food preferences assessment was completed, the DM manually entered the likes and dislikes to the resident's meal tickets. She said since she did not have a DM, the RD was responsible for completing the assessments and entering the likes and dislikes to the residents' meal tickets. The NHA said breakfast orders were not taken for residents and if they wanted something different than what was on the menu, it would show up on their meal ticket as a like or dislike. The NHA said she was familiar with Resident #37 and she did not know his likes and dislikes. The NHA said she did not know Resident #37's meal ticket did not match his likes and dislikes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.Specifically, the facility failed to ensure suction equipment was maintained in a sanitary manner.Findings include:I. Professional referenceAccording to the Healthcare Sterile Processing Association, August 2023, retrieved on 3/4/26 from https://myhspa.org/wp-content/uploads/2023/08/Fundamentals-of-sterile-storage.pdf, Healthcare facilities must take action to create an environment that properly protects sterile packages. This includes securing a proper sterile storage environment and developing policies and procedures to help ensure sterile packages are safely stored and handled. If items are not properly protected or something unexpectedly happens, stored items may become contaminated. Providing the appropriate sterile storage environment and training personnel about proper handling and other essential sterile storage practices is critical for ensuring that the items remain sterile and ready for patient care.II. ObservationOn 2/25/26 at 4:00 p.m. there was a Yankauer suction tip (a firm, plastic suction catheter designed to remove oral secretions) observed attached to the suction machine on the second floor crash cart. The Yankauer was not inside its sterile packaging.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 2/25/26 at 4:00 p.m. LPN #1 said she did not know what to turn the suction machine to in an emergency. She said a Yankauer suction tip was not supposed to be attached to the suction machine, because the Yankauer should be stored in a sterile container and might accidentally be used.The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 2/26/26 at 4:50 p.m. The ADON said part of the night nurse's duties when checking the crash carts was to check that the suction machine worked properly. The DON said while it might be considered best practice to have a Yankauer suction tip attached to the suction machine so it was readily available in an emergency, she did not think the Yankauer should be attached to the suction machine due to infection risk.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interviews, the facility failed to have an adequately equipped call system to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff area. Specifically, the facility failed to ensure all parts of the call light system were functioning properly in the common bathroom near the main dining room and the day room on the first floor.Findings include:I. Resident interviewResident #38 was interviewed on 2/23/26 at 1:00 p.m. Resident #38 said he was newly admitted to the facility and had gone to the bathroom in the common bathroom in the basement, near the dining room. He said he pulled the cord to call staff for help. He said the help never came as he waited for more than 20 minutes. Resident #38 said he used his cell phone and called a family member to ask for the facility to be called to come and help him. II. Observations and staff interviewOn 2/23/26 at 5:14 p.m. the bathroom call light was turned on in the common resident bathroom in the basement , next to the dining room. There was no call light above the door. There was a digitalized hanging monitor which displayed the room numbers when the call light was pulled. -However, the common bathroom did not display any notification when the call light in the bathroom was pulled. On 2/25/26 at 3:00 p.m. the lounge common area had a sign outside titled Day Room on the first floor. There were two residents sitting in the lounge watching television. The call light cord for the Day Room was clipped to the wall. -However, when the call light for the Day Room was pushed, it did not light up above the door outside the Day Room. Additionally, the big digitized hanging monitor which indicated which room the call lights were on was not displaying that the call light in the Day Room had been pushed. At 3:15 p.m. the call light was pushed a second time and the light above the door did light up. -However, the big digitized hanging monitor still did not display that the call light in the Day Room had been pushed. The computer at the nurses desk was logged out. Registered nurse (RN) #1 said the call lights which were pulled would register on the computer monitor, along with the big digitized sign. -However, RN #1 said she did not know how to log into the computer to visualize the rooms which had pulled the call light cords. III. Additional staff interviewsCertified nurse aide (CNA) #1 was interviewed on 2/23/26 at 5:33 p.m. CNA #1 said each floor had their own call light board to notify staff of call light activations.The nursing home administrator (NHA) was interviewed on 2/23/26 at 5:33 p.m. The NHA said the facility was not aware of the call light issue and was calling maintenance to look into the issue. She said the call light in the common area bathroom in the basement should have notified the staff on the first floor of the call light's activation.The NHA was interviewed again on 2/23/26 at 5:37 p.m. The NHA said the call light in the common area bathroom near the dining room in the basement registered in the call light in the system and notified the staff at the nurses' station, but not on the digitalized hanging monitor on the first or basement floors. She said she was closing the bathroom in the basement until maintenance resolved the issue.The maintenance director (MTD) was interviewed on 2/25/26 at 4:19 p.m. The MTD said the bathroom call light in the basement was fixed. He said it worked, however, it did not translate to the display board which was downstairs in the dining room. He said it also did not go upstairs, but he had fixed the problem. He said the call light now displayed on the big digitized board and on the computer.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to have adequate outside ventilation by means of a window or mechanical ventilation or a combination of the two for two out of three common bathrooms and two resident bathrooms, affecting eight residents.Specifically the facility failed to ensure the ventilation fans were clean and in good repair.Findings include:I. ObservationsOn 2/23/26 at 10:00 a.m. the 2nd floor was odorous.On 2/23/26 at 2:30 p.m. the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER] had strong odors of a combination of urine and feces. There were no windows in the bathroom and the ventilation fan could not be heard. The ventilation fan cover had dust built up on it. The bathroom was shared by four residents.On 2/24/26 at 12:48 p.m. the shared bathroom in room [ROOM NUMBER] had strong odors of a combination of urine and feces. The ventilation fan cover had dust built up on it. The bathroom was shared by four residents.On 2/24/26 at 1:00 p.m. the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER] continued to have strong odors of combination of urine and feces. On 2/24/26 at 1:30 p.m. the men's public bathroom on the second floor had strong odors of a combination of urine and feces. There were not any windows in the bathroom and the ventilation fan could not be heard. On 2/24/26 at 1:33 p.m. the women's public bathroom on the second floor had strong odors of a combination of urine and feces. There was a window in the bathroom; however, it was high up on the wall and blocked off by a bathtub with bars built up above the bathtub lip, which did not allow access to the window to open it. The ventilation fan could not be heard. On 2/25/26 at 2:30 p.m. the maintenance director (MTD) observed the men's and women's public bathrooms on the second floor and found that the ventilation fans were not working. The MTD observed room [ROOM NUMBER] and room [ROOM NUMBER]'s shared bathroom and found that the ventilation fan was not working. The MTD observed that the ventilation fan cover in room [ROOM NUMBER] was dirty and the ventilation fan was not working properly. The ventilation fan was pulling in a little air, however, it was not working at full strength.II. Staff interviewThe MTD was interviewed on 2/25/26 at 2:30 p.m. The MTD confirmed the second floor had urine odors. He said the bathrooms all had individual ventilation fans. He said he checked the ventilation fans monthly. The MTD said the women's public bathroom on the second floor had a window, however, he said he had to close the window up because when it was opened, it would make the hallway cold. The MTD said because the bathrooms did not have windows, the ventilation fans needed to work properly. He said he would get the ventilation fans replaced.