STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065171	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Health and Rehabilitation	1655 Eaton St Lakewood, CO 80214

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to ensure kitchen staff appropriately cleaned thermometers before and after use. Findings include:I. Improper cleaning of food thermometerA. Professional referenceAccording to The Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations, retrieved 9/2/25 from:, revealed in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch. Equipment, food-contact surfaces and utensils shall be cleaned before using or storing food temperature measuring devices. (4-602.11)B. Facility policy and procedureThe Food Temperatures policy, undated, was provided by the nursing home administrator (NHA) on 8/28/25 at 2:00 p.m. It read in pertinent part, To take temperatures, a clean, rinsed, sanitized and air-dried thermometer that is metal stem type. To take hot food temperatures, insert the thermometer at a 45-degree angle to the middle of the food item, taking care not to touch the container or bone if it has one. Wait for the thermometer to rise to the maximum temperature, read and record the temperature and then remove the thermometer from the food item and immediately clean and sanitize.C. ObservationsDuring a continuous observation of the lunch meal on 8/26/25, beginning at 11:30 a.m. and ending at 12:10 p.m., the following was observed:At 11:30 a.m. the cook (CK) was cleaning a thermometer to take a temperature before serving. He took an alcohol wipe out to clean the thermometer and he poked the thermometer through the middle of the alcohol wipe square and the packaging. He then ran the alcohol wipe and the packaging up and down the thermometer probe. He obtained the temperature of the beans and cleaned the thermometer probe by poking a hole through the middle of another alcohol wipe and moving it up and down the thermometer probe. At 11:32 a.m. the CK took the temperature of pureed quesadillas. He took an alcohol wipe out to clean the thermometer and he poked the thermometer through the middle of the alcohol wipe square. He then ran the alcohol wipe and the packaging up and down the thermometer probe. He obtained the temperature of the quesadillas and cleaned the thermometer probe by poking a hole through the middle of another alcohol wipe and moving it up and down the thermometer probe.At 11:35 a.m. the CK took he temperature of pureed beans. He took an alcohol wipe out to clean the thermometer and he poked the thermometer through the middle of the alcohol wipe square. He then ran the alcohol wipe and the packaging up and down the thermometer probe. He obtained the temperature of the beans and cleaned the thermometer probe by poking a hole through the middle of another alcohol wipe and moving it up and down the thermometer probe.At 11:37 a.m. the CK took the temperature of sour cream. He took an alcohol wipe out to clean the thermometer and he poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. He then ran the alcohol wipe and its packaging up and down the thermometer probe. He obtained the temperature of the sour cream and cleaned the thermometer probe by poking a hole through the middle of another alcohol wipe and moving it up and down the thermometer probe.-The CK failed to open the alcohol wipe diagonally, inserting the thermometer probe into the opening and cleaning the probe without the packaging touching the probe. D. Staff interviewsThe CK was interviewed on 8/26/25 at 11:40 a.m. The CK said (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	he was taught to poke the thermometer through the alcohol wipe packaging to disinfect the thermometer.The dietary manager (DM) and the NHA were interviewed together on 8/27/25 at 9:30 a.m. The DM showed how she was taught to clean a thermometer. She took an alcohol wipe out to clean the thermometer and she poked the thermometer through the middle of the alcohol wipe square. She then ran the alcohol wipe and its packaging up and down the thermometer probe. -The DM failed to open the alcohol wipe diagonally, inserting the thermometer probe into the opening and cleaning the probe without the packaging touching the probe.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 development and transmission of disease and infection on one of two units. Specifically, the facility failed to:-Ensure housekeeping staff performed appropriate hand hygiene when cleaning residents' rooms,-Ensure staff performed appropriate hand hygiene when performing incontinence care for Resident #23; and,-Ensure staff wore appropriate personal protective equipment (PPE) during high contact resident care for Resident #23 and Resident #4, who were on enhanced barrier precautions (EBP).Findings include: I. Failed to ensure housekeeping staff performed appropriate hand hygiene when cleaning residents' roomsA. Professional reference According to The Centers for Disease Control And Prevention's (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers (February 2024), retrieved on 9/2/25 from: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Recommendations to clean your hands include immediately before touching a patient, before performing an aseptic technique, before moving from work on a soiled body site to a clean body site, after touching a patient or patient's surroundings, after contact with body fluids and immediately after glove removal.B. ObservationsDuring a continuous observation on 8/26/25, beginning at 1:30 p.m. and ending at 1:50 p.m., the following was observed: Housekeeper (HK) #1 was cleaning resident room [ROOM NUMBER]. HK #1 began by putting gloves on her hands. She retrieved bottles of chemicals out of a housekeeping cart and set them inside the room. She removed her gloves and donned (put on) clean gloves without performing hand hygiene. HK #1 removed a dust pan from the housekeeping cart and set it up inside the room. She removed her gloves and donned clean gloves without performing hand hygiene. HK #1 removed a broom and mop from the housekeeping cart and set them up inside the room. She removed her gloves and donned clean gloves without performing hand hygiene. HK #1 sprayed a chemical solution onto a rag and wiped down the television remote on side A of the room and disposed of the rag in the cart. She removed her gloves and donned clean gloves without performing hand hygiene. She then sprayed the chemical onto a clean rag and wiped down the bedside table on side A before disposing of the rag in the cart. She removed her gloves and donned clean gloves without performing hand hygiene. HK #1 next sprayed a glass cleaner chemical onto a rag and wiped the mirror in the bathroom before disposing of the rag. She removed her gloves and donned clean gloves without performing hand hygiene. HK #1 then scrubbed the toilet with a brush and put it back into the cart. She removed her gloves and donned clean gloves without performing hand hygiene. HK #1 next sprayed the toilet with a chemical. She removed her gloves and donned clean gloves without performing hand hygiene. She swept the room and disposed of the contents in the dust pan. She removed her gloves and donned clean gloves without performing hand hygiene. She removed the fall mat on side A of the room and swept where the mat was. She removed her gloves and donned clean gloves without performing hand hygiene. She wiped down the toilet with a rag and disposed of the rag. She removed her gloves and donned clean gloves without performing hand hygiene. She got a clean rag and wiped the inside of the toilet and disposed of the rag. She removed her gloves and donned clean gloves without performing hand hygiene. She wiped the mirror with a clean rag and disposed of the rag. She removed her gloves and donned clean gloves without performing hand hygiene. HK #1 put away the glass cleaner. She removed her gloves and donned clean gloves without performing hand hygiene. She attached a clean mop head to the mop and mopped the bedroom. She disposed of the mop head. She removed her gloves and donned clean gloves without performing hand hygiene. She attached a clean mop head to the mop and mopped the bathroom. She disposed of the mop head. She removed her gloves and donned clean gloves without performing hand hygiene. She attached a new mop head to the mop and mopped the entryway of the room. She removed her gloves and donned clean gloves without performing hand hygiene. She swept the entryway of the room. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed her gloves. HK #1 said she was finished cleaning the resident's room. -HK #1 changed her gloves 18 times throughout the course of cleaning resident room [ROOM NUMBER], however, she failed to perform hand hygiene with each glove change, including after cleaning the toilet and prior to cleaning other areas of the room.II. Failed to ensure staff performed appropriate hand hygiene when performing incontinence care for Resident #23 A. Observation During a continuous observation on 8/26/25, beginning at 12:40 p.m. and ending at 1:30 p.m., the following was observed: At 1:15 p.m. the call light in Resident #23's room was turned on. At 1:18 p.m. certified nurse aide (CNA) #1 went into the room. CNA #1 donned clean gloves and began to check Resident #23's brief. She removed the soiled brief and performed perineal (area between the genitals) care on Resident #23. She put a clean brief on Resident #23. Without changing gloves and performing hand hygiene, CNA #1 pulled Resident #23's skirt over her legs and assisted her to sit up in bed. CNA #1 put shoes on Resident #23 and put a gait belt around her waist. CNA #1 transferred Resident #23 to her wheelchair. CNA #1 put Resident #23's oxygen cannula in her nose and secured the oxygen tubing behind her ears. CNA #1 then removed her gloves and, without performing hand hygiene, removed the bag of trash from the trashcan. CNA #1 put Resident #23's sweater on her and proceeded to wheel Resident #23 out of the room. CNA #1 stopped to throw away the trash and perform hand hygiene and then wheeled Resident #23 into the living room. -CNA #1 failed to change her gloves and perform hand hygiene after changing the resident's soiled brief and prior to touching the resident's clothing, shoes, a gait belt, the resident's oxygen nasal cannula and tubing and the handles of the resident's wheelchair.-Additionally, CNA #1 failed to don a gown prior to performing high-contact resident care for Resident #23, who had a wound on her left shin (see additional EBP failures below).III. Failed to ensure staff wore appropriate PPE during high-contact resident care for Resident #23 and Resident #4, who were on EBPA. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Frequently Asked Questions about EBP in Nursing Homes (6/28/24), retrieved on 9/2/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices). An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally-inserted central catheters (PICCs), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. The presence of an indwelling device is a major risk factor for being colonized with or acquiring a MDRO. Therefore, the safest practice would be to wear a gown and gloves for any care (such as dressing changes) or use (injecting or infusing medications or tube feeds) of the indwelling medical device.B. Facility policy and procedure The Enhanced Barrier Precautions policy and procedure, revised June 2024, was received from the nursing home administrator (NHA) on 8/28/25 at 2:00 p.m. It documented in pertinent part, EBP should be used during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their multi-drug resistant organism (MDRO) status. Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care.C. ObservationsDuring a continuous observation on 8/25/25, beginning at 12:15 p.m. and ending at 4:05 p.m., the following was observed: At 12:49 p.m. Resident #23 was sitting in her wheelchair in the living room. CNA #1 went up to Resident #23 and wheeled her into her room. There was a sign for EBP precautions on the door of Resident #23's room. CNA #1 put gloves on, took Resident #23's sweater off and assisted Resident #23 into bed. Resident #23 had a large bandage on her left shin. CNA #1 took Resident #23's shoes off and covered her up with a blanket. -CNA #1 failed to don a gown prior to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferring Resident #23 into bed. At 3:04 p.m. CNA #2 and CNA #3 went into Resident #23's room. CNA #3 put gloves on but no gown. CNA #2 did not put a gown or gloves on. CNA #2 sat Resident #23 up in bed and put socks on her feet. CNA #3 put a gait belt around Resident #23's waist. CNA #2 and CNA #3 transferred Resident #23 into her wheelchair. CNA #2 put on Resident #23's sweater and shoes and wheeled her into the living room. -CNA #2 and CNA #3 failed to wear appropriate PPE during high-contact resident care for Resident #23. On 8/26/25 at 11:30 a.m. registered nurse (RN) #1 was providing tube feeding for Resident #4. RN #1 gathered supplies and went into Resident #4's room. There was an EBP sign outside of Resident #4's room. RN #1 donned clean gloves and explained the procedure to Resident #4. RN #1 unclamped the feeding tube, administered warm water into the feeding tube, administered the feeding tube formula and administered more warm water to flush the tube. RN #1 clamped the tube closed and threw the supplies away. She cleaned out the syringe and removed her gloves. RN #1 washed her hands.-RN #1 failed to don a gown prior to performing Resident #4's tube feeding. IV. Staff interviews The environmental services director was interviewed on 8/26/25 at 2:00 p.m. The environmental services director said housekeepers should change their gloves when they were soiled while cleaning residents' rooms. She said gloves should be changed a minimum of five times during cleaning one room. She said hand hygiene should be performed after each glove removal. RN #1 was interviewed on 8/27/25 at 9:25 a.m. RN #1 said residents with bacteria in their urine, foley catheters, feeding tubes and wounds required EBP. She said EBP required wearing a gown and gloves when performing high-contact care. She said she was not sure if she should wear a gown when administering tube feeding formula to a resident's feeding tube and said she had not received any education about that. The infection preventionist (IP) was interviewed on 8/27/25 at 11:00 a.m. The IP said hand hygiene should be completed when entering the dining room, removing gloves, coming out of a resident's room and between handling room trays. She said gloves should be changed when moving from a dirty to clean area during care. She said this included after performing perineal care on a resident. She said the importance of hand hygiene was for infection control. The IP said residents with indwelling medical devices, including a gastric feeding tube, residents with wounds and residents with MDROs were placed on EBP. She said this meant staff should wear a gown and gloves during high contact resident cares such as showers, transfers and perineal care. She said Resident #23 was on EBP because of a wound. She said EBP included the administration of tube feedings and medications through a gastric feeding tube. She said the importance of following EBP was for infection control. She said RN #1 should have put on a gown before working with Resident #4's tube feeding. The director of nursing (DON) was interviewed on 8/27/25 at 11:20 a.m. The DON said hand hygiene should be completed after moving from a dirty task to a clean task during resident care and after glove removal. She said the importance of this was to prevent the spread of infection. She said wounds, foley catheters, intravenous catheters (IVs) and gastric feeding tubes qualified a resident to be placed on EBP. She said staff should wear a gown and gloves when providing care to these residents. She said the importance of this was to prevent infection.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and interviews, the facility failed to ensure money from personal funds accounts was managed accurately for one (#13) of five residents reviewed for personal funds accounts out of 34 sample residents.Specifically, the facility failed to notify Resident #13, who was Medicaid funded, or her legal representative, when the resident's personal funds account reached $200.00 less than the eligibility resource limit.Findings include:I. Record reviewA review of Resident #13's current trust account balance revealed the resident had $2,631.92 in her account, which was $631.92 over the allotted limit of $2,000.00 for Medicaid-funded residents.II. Staff interviewsThe financial coordinator and the nursing home administrator (NHA) were interviewed together on 8/27/25 at 9:30 a.m. The financial coordinator said she notified residents or residents' representatives when the residents' personal funds accounts reached $2,000. The financial coordinator said she was unaware that the residents or their representatives needed to be notified when their personal funds account reached $200.00 less than the eligibility resource limit. The financial coordinator said residents were at risk of losing their Medicaid-funded benefits when their personal funds account reached $2,000. The NHA said the facility had been in contact with Resident #13's representative to spend down the resident's personal funds account once the account reached the allotted limit. -However, the facility was unable to provide documentation to indicate communication with Resident #13's representative had taken place in regards to the account balance of the resident's personal funds account.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints for one (#10) of one resident out of 34 sample residents. Specifically, the facility failed to:-Obtain a physician's order that addressed Resident #10's medical symptoms; -Ensure ongoing safety risk assessments were completed for the use of restraints for Resident #10; and,-Ensure that the least restrictive measures attempted and proven unsuccessful for Resident #10 were documented. Findings include:I. Facility policy and procedureThe Restraint Assessment and Consent policy and procedure, revised October 2024, was provided by the director of nursing (DON) on 8/27/25 at 9:55 a.m. It read in pertinent part, A physical restraint free or least restrictive environment will be the standard for resident care. If restraints are present, the interdisciplinary team will make every effort to reduce and then eliminate restraints. Purposes for restraint use include resident safety, injury prevention and protection of a medical device. When evaluating restraints, a risk benefit of device use will be completed. The following will be documented on the evaluation/consent form:-Alternative measures tried prior to device use, with trial results;-Evaluation of self-release ability and potential movement or access to body restriction;-Observations of device effect on resident;-Identification of potential risks and benefits of device; and,-Medical symptoms. A physician's order will be obtained for restraints. This order will include the type and purpose of the restraint and duration of application, as well as a diagnosis for the restraint. If the restraint is determined to be appropriate, a long term care plan will be implemented, including a plan for interdisciplinary team restraint reduction. Restraints will be evaluated and reported on a monthly basis as part of the quality assurance process and with any potential change of condition. This evaluation is located on the back of the consent form. If a significant change of condition is identified, the restraint evaluation will be re-done.II. Resident #10A. Resident statusResident #10, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included cerebral palsy (a congenital disorder of movement and muscle mass) and depression.The 7/31/25 minimum data set (MDS) assessment revealed Resident #10 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment indicated a trunk restraint and limb restraints were used daily.B. ObservationsOn 8/24/25 at 9:00 a.m. Resident #10 was observed wearing a seatbelt and foot straps while seated in her wheelchair.On 8/25/25 at 10:30 a.m. Resident #10 was observed wearing a seatbelt and foot straps while seated in her wheelchair.On 8/26/25 at 1:18 p.m. Resident #10 was observed wearing a seatbelt and foot straps while seated in her wheelchair.C. Record reviewOn 10/14/24, a physical restraint evaluation and consent were completed. The evaluation documented Resident #10 was trialed without the use of foot straps, however both feet were not able to be positioned independently and the resident needed the staff to place both feet back on the foot pedals. It documented Resident #10 had an increased risk for injury without the foot straps.On 11/19/24, a physical restraint evaluation and consent were completed. The evaluation documented Resident #10 was trialed without the use of the wheelchair seatbelt however it was not successful. The evaluation documented the resident benefited and required a seatbelt for midline, upright positioning in her custom power wheelchair.-Review of Resident #10's electronic medical record (EMR) did not reveal the facility completed ongoing evaluations (after 11/19/24) to ensure the resident's use of the seatbelt and foot straps were still appropriate for use, including a trial without the straps and the seatbelt. -Review of Resident #10's EMR did not reveal documentation indicating less restrictive interventions were attempted prior to the use of the seatbelt and foot straps.Review of Resident #10's August 2025 CPO revealed the following physician's order:Apply a wheelchair seatbelt and foot straps when the resident is seated in her wheelchair. Staff need to release the straps every shift, as needed and at the request of the resident, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered 11/20/24.-However, the physician's order failed to identify the medical symptom the seatbelt and foot straps were used for. Resident #10's activities of daily living (ADL) care plan, revised 8/7/25, revealed the resident had impaired ADL function due to cerebral palsy. The care plan documented the resident used a motorized wheelchair with a seatbelt and foot straps, which she was unable to release. The seatbelt and foot straps were being used for positioning due to a diagnosis of cerebral palsy. Interventions included applying the seatbelt and foot straps when she was seated in her wheelchair and releasing the seatbelt and foot straps every shift, as needed and at the resident's request.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 8/26/25 at 1:15 p.m. LPN #1 said Resident #10 liked to stretch backwards and the seatbelt helped with positioning Resident #10 in her wheelchair correctly. LPN #1 said Resident #10 was unable to undo the straps herself. He said the staff only released the straps when she was getting out of her chair. The DON was interviewed on 8/27/25 at 9:32 a.m. The DON said per policy, the staff were supposed to release Resident #10 from her seatbelt and foot straps every two hours. She said Resident #10 requested the seatbelt and foot straps and the resident knew it was a restraint because Resident #10 was unable to release them herself. She said assessments needed to be completed every quarter for the restraints and that therapy usually completed the assessments. The DON said the restraints and the resident not being able to release the restraints had been documented in Resident #10's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure one (#69) of four residents reviewed for activities of daily living (ADLs) out of 34 sample residents received the necessary services to maintain good nutrition and personal care. Specifically, the facility failed to provide meal assistance for Resident #69. Findings include:I. Resident #69A. Resident statusResident #69, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, type 2 diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD) , essential hypertension (high blood pressure), and hypothyroidism (low thyroid function).The 8/13/25 minimum data set (MDS) assessment revealed Resident #69 had a memory problem and and was moderately impaired cognitive skills for daily decision making per staff assessment. She required maximum assistance of one staff member with meals and one-person assistance with transfers and personal hygiene. B. ObservationsDuring a continuous observation on 8/24/25, beginning at 11:30 a.m. and ending at 12:25 p.m., the following was observed: At 11:30 a.m. Resident #69 received her meal, which consisted of a pureed diet. The food was placed on the table, within her reach. Two unidentified certified nurse aides (CNA) were next to the resident and the other two residents who were at the same table. The unidentified CNAs assisted the other residents, but Resident #69 was not assisted. The staff encouraged the resident to eat, but they did not provide any physical assistance. Resident #69 had a third of a glass of milk and her plate remained full when she left the dining room at 12:25 p.m.During a continuous observation on 8/25/25, beginning at 11:25 a.m. and ending at 12:00 p.m., the following was observed: At 11:30 a.m. Resident #69 received her meal, which consisted of a pureed diet. The food was placed on the table, within her reach. An unidentified CNA was next to the resident and fed another resident who was at the table, but Resident #69 was not assisted. Resident #69 had three-quarters of a glass of milk and her plate remained full when she left. At 11:58 a.m. the unidentified CNA assisted Resident #69 out of the dining room and to a common area. C. Record reviewThe nutrition care plan, revised 7/4/25, revealed Resident #69 required a modified texture diet consisting of pureed foods with thin liquids, fortified foods, one-on-one assistance during meals and verbal cues to encourage swallowing after taking bites or sips to prevent pocketed food. The care plan indicated staff were to offer the resident one food item at a time.D. Staff interviewsCNA #4 was interviewed on 8/27/25 at 9:51 a.m. CNA #4 said Resident #69 was usually able to communicate with others during meals. CNA #4 said the staff set Resident #69 up at the table and prepared the resident's food. CNA #4 said when the resident was unable to eat, the staff provided some cueing assistance with reminders and occasionally physically helped her with her food. CNA #4 said Resident #69 did not eat well and often had a snack between meals. CNA #4 said if the resident refused to eat her meals, the staff could not force her to eat. Registered nurse (RN) #3 was interviewed on 8/27/25 at 11:01 a.m. RN #3 said Resident #69 had cognitive impairments, but was able to communicate at times. RN #3 said Resident #69 lost some weight lately, so the staff continued to try to assist her, but she repeatedly refused help.-However, observations revealed staff did not attempt to physically assist the resident with eating (see observations above).The medical director (MD) was interviewed on 8/27/2025 at 12:21 p.m. The MD said Resident #69 had impaired cognition and needed one-on-one assistance during her meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065171	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Health and Rehabilitation	1655 Eaton St Lakewood, CO 80214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 one (#56) of two residents out of 34 sample residents received proper respiratory care and services in accordance with professional standards of practice, the resident's care plan and the resident's choice. Specifically, the facility failed to:-Ensure Resident #56's continuous oxygen setting was set at the prescribed flow rate; and,-Ensure Resident #56 was provided with continuous oxygen supplementation per physician's orders.Findings include:I. Facility policy and procedureThe Oxygen Titration policy and procedure, reviewed 1/14/25, was provided by the nursing home administrator (NHA) on 8/28/25 at 2:00 p.m. via email. It read in pertinent part, Oxygen will be administered per physician orders and nursing evaluation. Evaluation of thecontinued need for oxygen will be based on diagnoses, history and clinical presentation,including titration results. Continuous oxygen orders will include the liter flow, route andfrequency for oxygen use, frequency of pulse oximetry, titration parameters and diagnosis. Oxygen titration orders will consist of the frequency of pulse oximetry and parameters for titration.II. Resident #56A. Resident statusResident #56, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbances, respiratory failure with hypoxia, chronic obstructive pulmonary disease and cognitive communication deficit.The 5/7/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The resident required maximum assistance with activities of daily living (ADL). The MDS assessment revealed that the resident required continuous oxygen at 2 liters per minute (LPM) with a nasal cannula.B. ObservationsOn 8/24/25 at 9:30 a.m. Resident #56 was observed sitting in her room. The resident's oxygen concentrator was set to 4.5 LPM.-However, Resident #56 oxygen flow rate was supposed to be 2 LPM, per physician's orders (see record review below).At 2:45 p.m. Resident #56 was observed sitting in her room. The resident's oxygen concentrator remained set at 4.5 LPM.On 8/25/25 at 9:55 a.m. Resident #56 was observed sitting in her room with her oxygen concentrator set at 4.5 LPM.At 1:20 p.m. the Resident #56's oxygen concentrator remained set at 4.5 liters LPM.At 3:01 p.m. Resident #36 was observed sitting in her wheelchair in the activity room. She was not wearing any supplemental oxygen.At 4:00 p.m. Resident #56 was taken to the dining room for dinner. She was not provided with any supplemental oxygen.On 8/26/25 at 9:00 a.m. Resident #56 was observed asleep in her room. The resident was not using any supplemental oxygen.At 11:24 am, the resident remained asleep in her room without supplemental oxygen.C. Record reviewThe respiratory care plan, dated 4/19/24, documented that the resident had a diagnosis of acute respiratory failure and was at risk for hypoxia. The interventions included the use of supplemental oxygen at 2 LPM continuously. Review of Resident #56's August 2025 CPO revealed the following physician's order:Oxygen at 2 LPM continuously via nasal cannula, ordered 4/19/24.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 8/26/25 at 11:25 a.m. LPN #1 said Resident #56 was prescribed 2 LPM of oxygen continuously via nasal cannula, per the physician's order. LPN #1 entered Resident #56's room and confirmed the resident was not wearing her nasal cannula and therefore was not receiving oxygen. LPN #1 checked Resident #56's oxygen saturation (level of oxygen in the blood), which read 91% (percent) on room air LPN #1 placed the oxygen on the resident via nasal cannula at 2 LPM.LPN #1 said it was the nurse's responsibility to ensure residents were on their appropriate oxygen liter flow rates. LPN #1 said he did not realize Resident #56 was not wearing the oxygen when he administered her morning medications.The director of nursing (DON) was interviewed on 8/26/25 at 12:50 p.m. The DON said each resident's oxygen should be checked three times per day to ensure the resident was receiving the correct amount of oxygen. She said it should be documented in the treatment administration records (TAR), along with the resident's oxygen saturation. The medical director (MD) was interviewed on 8/27/25 at 12:30 p.m. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MD said it was appropriate for Resident #56 to receive oxygen at 2 LPM via nasal cannula continuously. He said he would continue to monitor the resident to determine if her oxygen flow rate needed to be adjusted.