STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065179	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hildebrand Care Center	1401 Phay Ave Canon City, CO 81212

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper storage of medications for four of four medication storage carts.Specifically, the facility failed to:-Date residents' insulin pens and inhalers with the date they were opened;-Label residents' medications the resident's name; -Discard insulin vials and epinephrine (used to treat life threatening conditions, including allergic reactions) medication that had expired; and,-Ensure loose pills in a medication cart were discarded.Findings include:I. Professional referenceAccording to the manufacturer, Viatris, How to Use a Wixela Inhub (inhaler used to treat asthma and lung disease), 2021, retrieved on [DATE] from https://www.wixelahcp.com/-/media/Project/Common/WixelahcpCom/PDF/[NAME]-2020-0047_V4_US_How-t Take Wixela Inhub out of the foil pouch just before you use it for the first time. Write the pouch opened and use by dates on the label. The use by date is one month from the date you opened the pouch for your first dose.According to the manufacturer, GlaxoSmithKline (inhaler used to treat lung disease) [DATE], Patient Information Incruse Ellipta, retrieved on [DATE] from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Incruse_Ellipta/pdf/INCRUSE Safely throw away Incruse Ellipta in the trash six weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler.According to the manufacturer Biocon Biologics, 2023, Patient Information-Storing the Insulin Glargine yfgn pen, retrieved on [DATE] from, https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=3ac85ebb-5594-59c8-77fd-df254329d151&ty Only use your pen for up to 28 days after its first use. Throw away the Insulin Glargine yfgn pen you are using after 28 days, even if it still has insulin left in it.According to the manufacturer [NAME] Lilly and Company, 2023, Instructions for Use Humalog Insulin Lispro injection, retrieved on [DATE] from, https://pi.lilly.com/us/humalog-vial-ifu.pdf, Throw away all opened vials after 28 days of use, even if there is insulin left in the vial.II. Facility policy and procedureThe Storage of Medications policy, undated, was provided by the nursing home administrator (NHA) on [DATE] at 12:53 p.m. It read in pertinent part, The nursing staff shall be responsible for maintaining medication storage and preparation in a clean, safe and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.III. Observations and interviewsOn [DATE] at 2:15 p.m., the River Walk medication cart was observed with licensed practical nurse (LPN) #1. The following medications were found:-The second drawer of the medication cart contained 35 loose pills at the bottom of the drawer. LPN #1 said the drawer should have been cleaned and should not contain a large amount of loose pills. -A used Wixela 250/50 micrograms (mcg) inhaler for Resident #64 was not labeled with the date it was opened. LPN #1 said inhalers should be labeled with the date opened.-A used Incruse Ellipta inhaler 62.5 mcg for Resident #64 was not labeled with the date it was opened.-A used Wixela inhaler 500/50 mcg for Resident # 52 was not labeled with the date it was (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opened.-A used Umeclidinizam/Vilanterol Ellipta inhaler 62.5/25 mcg for Resident #22 was not labeled with the date it was opened.-An unopened Epinephrine 0.3 milligram (mg) per 0.3 milliliters (ml) auto injector labeled with Resident #11's name, with an expiration date of [DATE]. LPN #1 removed the medication from the cart and said it should have been discarded in [DATE].-An used vial of insulin glargine pen for Resident #28 was not labeled with the date it was opened. LPN #1 said insulin should always be labeled with the date opened.On [DATE] at 2:52 p.m. the Aspen medication cart was observed with LPN #2. A used Ayr saline nasal gel was not labeled with a resident's name. LPN #2 said the nasal gel should be labeled with the resident's name. On [DATE] at 3:16 p.m. the Pikes Peak medication cart was observed with LPN #3. The following medications were found:-A used Trelegy Ellipta inhaler 100/62.5 mcg for Resident #9 was not labeled with the date it was opened. -Two used Trelegy Ellipta inhalers 200/62.5/25 mcg for Resident #56 were not labeled with the date they were opened. LPN #3 said the inhalers should be labeled with the date they were opened.On [DATE] at 3:43 p.m. the Mystic Mountain medication cart was observed with LPN #4. The following medications were found:-A used insulin lispro kwik pen 100 units per ml did not have a resident label attached. LPN #4 said the insulin pen should have a resident's label attached. -A used insulin lispro vial 100 units per ml for Resident #20 which was labeled with a date opened [DATE]. LPN #4 said the insulin should have been discarded on [DATE].IV. Staff interviewsThe director of nursing (DON) was interviewed on [DATE] at 4:05 p.m. The DON said the medication cart which contained 35 loose pills should have been cleaned more frequently and there never should be that many loose pills in a medication cart. The DON said the insulin and inhalers without dates opened should have been labeled with the date they were opened. The DON said the epinephrine should have been discarded in [DATE] and the insulin pen opened on [DATE] should have been discarded 28 days after it was opened. The DON said the nasal gel and the insulin pen should have had resident identification labels.The pharmacist was interviewed on [DATE] at 12:10 p.m. The pharmacist said that dry inhalers (such as the Wixela and Ellipta inhalers) should have been labeled with the date they were opened. The pharmacist said if the epinephrine and inhalers were used beyond manufacturer's recommendations, they could be less effective.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, records review and interviews, the facility failed to adequately monitor the resident for unnecessary psychotropic medications needed to provide effective and person-centered care for one (#7) of five residents reviewed for use of psychotropic medication out of 51 sample residents. Specifically, the facility failed to ensure the physician's order for Resident #7's as needed (PRN) lorazepam (antianxiety medication) was reevaluated and a rationale was provided by the physician to justify the continued use of the psychotropic medication beyond the 14-day limit.Findings include:I. Facility policy and procedureThe Antipsychotic Medication Use policy was provided by the director of nursing (DON) on 9/25/25 at approximately 10:00 a.m. The policy read in pertinent part, All antipsychotic medications will be used within the regulation guidelines for psychotropic medications or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order.II. Resident statusResident #7, age greater than 80, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), the resident's diagnoses included dementia, anxiety and depression.The 9/9/25 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.The MDS assessment indicated the resident was receiving antianxiety medications.III. Record reviewReview of Resident #7's September 2025 CPO revealed the following physician's order:Lorazepam 0.5 milligrams (mg), give 0.5 mg by mouth every two hours as needed for anxiety or shortness of breath, ordered 8/18/25.-The physician's order for the PRN lorazepam was prescribed indefinitely instead of for 14 days as required and did not include a rationale for extending the medication usage beyond 14 days. Review of Resident #7's psychotropic medication care plan, revised 9/4/25, revealed the resident received psychotropic medications for depression, anxiety, hallucinations, and insomnia. Interventions included giving medications as ordered by the physician and monitoring for side effects (sleepiness or fatigue, dizziness, dry mouth, nausea, tremors, headaches, constipation) and effectiveness, alerting the physician if side effects and/or ineffectiveness developed, monitoring for the need for the continued use of psychotropic medications or the potential for alternate approaches, reporting changes in mood/behavior to the nurse, monitoring for target behaviors, including distressing expressions that caused the resident mental anguish, unamendable impulsivity that interfered with delivery of care and/or impacts physical/mental health and saddened/apathetic expressions and utilizing non-pharmacological interventions, such as pain management modalities, assuring the resident she was safe and her needs would be met, distraction and redirection.Review of Resident #7's September 2025 medication administration record (MAR) revealed the resident received a dose of PRN lorazepam on 9/13/25 at 8:00 p.m. -However, the physician's order for the PRN lorazepam should have been reevaluated by the physician on 9/1/25 (14 days after it was initially ordered on 8/18/25) and a new physician's order obtained for the medication or a rationale documented by the physician for the continued use of the medication beyond 14 days.A review of Resident #7's progress notes revealed no documentation to indicate the physician had reevaluated the resident's PRN lorazepam in order to justify the use of the medication beyond the 14-day limit for PRN psychotropic medications. IV. Staff interviewsThe DON was interviewed on 9/25/25 at 5:00 p.m. The DON said she was not aware that PRN psychotropic medications should only be prescribed for 14 days and then reevaluated for continued use unless the physician documented a rationale for ordering the medication for longer than 14 days. The DON said she was new to the facility and had just begun in her current role approximately two weeks prior to the survey. The pharmacist was interviewed on 9/25/25 at 12:15 p.m. The pharmacist said she was aware of the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regulation that PRN antianxiety medications could only be prescribed for 14 days. The pharmacist agreed that the physician should have documented a note which indicated a rationale for why Resident #7 was receiving the PRN lorazepam beyond 14 days. She confirmed there was no physician rationale for the use of the medication beyond 14 days documented in Resident #7's medical record.

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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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for two (#10 and #39) of five residents reviewed for accidents out of 51 sample residents.Specifically, the facility failed to ensure Resident #10 and #39 were transferred appropriately and according to their plan of care.Findings include: I. Facility policy and procedure The Safe Lifting and Movement of Residents policy, revised July 2017, was received from the director of nursing (DON) on 9/24/25. It read in pertinent part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include the following: -Resident's preferences for assistance; -Resident's mobility (degree of dependency); -Resident's size; -Weight-bearing ability; -Cognitive status; Whether the resident is usually cooperative with staff; and, -The resident's goals for rehabilitation, including restoring or maintaining functional abilities. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. Safe lifting and movement of residents is part of an overall facility employee health and safety. II. Resident # 10 A. Resident status Resident #10, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, hypertension and muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/5/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The resident required substantial assistance with activities of daily living (ADL). B. Observations On 9/24/25 at 9:10 a.m. there was a sign observed hanging on the wall in Resident #10's room. The sign indicated Resident #10 was a two-person transfer using the transfer pole. The sign indicated staff were to use a safety gait belt during the resident's transfers. C. Resident interview Resident #10 was interviewed on 9/24/25 at 9:10 a.m. Resident # 10 said approximately a month prior (August 2025) she was sitting in her lounge chair. She said that the certified nurse aide (CNA) transferred her from the chair without a gait belt. She said she was transferred incorrectly as the CNA transferred her alone. She said when the CNA transferred her, she twisted and hurt her knee. She said she went to the hospital for an Xray which did not reveal an injury. She said she had to take pain medications to help with the discomfort in her knee. Resident #10 said it was a new agency staff CNA who did not know what she was doing. The resident said since the incident, there were extra gait belts in her dresser drawer and there was a sign on the wall to describe how she was to be transferred. D. Record review Review of Resident #10's fall care plan, revised 7/29/25, identified the resident had a potential for falls/injury related to cognitive deficit, decreased mobility, poor safety awareness and weakness. Pertinent interventions included assisting the resident with a transfer pole (at bed and recliner) and using a gait belt with transfers. The physician's order, dated 7/31/25, revealed the resident was a two-person assistance with a pivot disc (mobility device that rotates to assist with twisting/turning) for transfers. The nurse progress note, dated 8/9/25, documented Resident #10 stated she was not feeling well. She reported increased left knee pain. Voltaren gel (topical ointment used to treat pain) was applied to her left knee A new physician's order, dated 8/11/25, revealed the resident was a two-person assistance for transfers and indicated staff were not to use the pivot disc. The facility investigation, dated 8/11/25, revealed that on 8/8/25 Resident #10 was transferred with one person with a gait belt when the resident's transfer status and physician's order indicated the resident was a two-person assistance transfer with a gait belt. The CNA failed to follow the transfer procedures for the resident which was a pivot disc. The investigation documented the CNA said she did the transfer alone, as other staff were busy and the resident was ready for bed. The investigation revealed staff were educated on how to transfer the resident properly and to use gait belts during the transfer. E. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physical therapist (PT) was interviewed on 9/24/25 at 3:10 p.m. The PT said the rehabilitation department completed assessments on the residents for proper transfer techniques. She said Resident #10 was a two-person transfer with a pivot disc before the incident on 8/8/25, but she had not liked the pivot disc. She said the resident was now a two-person transfer with a gait belt and the transfer pole. The DON was interviewed on 9/24/25 at approximately 5:00 p.m. The DON said staff were trained on proper transfer techniques. She said the agency staff the facility used at times received information on each resident when they worked, including resident transfer statuses. The DON said Resident #10 should not have been transferred with only one CNA. She said the CNA should have waited until another CNA or nurse was located to assist with the transfer. She said if a CNA or nurse needed help with a transfer, there was support from administration nurses and therapists who could assist. II. Resident #39 A. Resident status Resident #39, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included dementia, muscle weakness and chronic kidney disease. The 7/7/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. She required substantial/maximal assistance with toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene, sitting to lying and lying to sitting on the side of the bed. She was dependent on staff assistance with sitting to standing and chair/bed to chair transfers. B. Record review The mobility care plan, revised 6/27/25, documented Resident #39 had impaired functional mobility related to decreased cognition and weakness. Interventions included an orange name plate and banner to alert staff of the resident's high fall risk status, utilizing bed bars for bed mobility/transfers with sheep skin over the bed bars to reduce risk of injury and padded flooring in the resident's room to prevent injury. The functional care plan, initiated 7/9/25, documented Resident #39 would have opportunities to participate in her functional abilities tasks to her highest functional level over the next three months. Interventions included the resident needed two-person staff assistance with a gait belt for transfers. The 9/4/25 facility investigation was provided by the nursing home administrator (NHA) on 9/24/25 at 9:30 a.m. The report revealed that on 9/4/25 Resident #39 was transferred with one-person assistance with a gait belt by CNA #2, when the resident's transfer status and physician's order indicated the resident was a two-person assistance transfer with a gait belt. The investigation documented a second staff person was present in the room during the transfer, however, CNA #2 did not wait for assistance. Resident #39 was assessed by registered nurse (RN) #1 and no injuries were noted. CNA #2 was interviewed by the facility on 9/4/25 and stated that she transferred Resident #39 by herself using a gait belt. She said she did not follow the proper procedure of using two-person assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 was interviewed by the facility on 9/5/25 and said she did not recall the incident and stated everyone took good care of her. She recalled no issues with her transfers. The conclusion of the facility's investigation revealed CNA #2 displayed a lack of professionalism and did not follow facility transfer procedures. The nursing progress note, dated 9/5/25 at 1:51 p.m., documented Resident #39's representative was called and notified that Resident #39 had been transferred by one-person staff assistance instead of two-person staff assistance by an agency CNA. The representative was notified the resident had no injuries. C. Staff interviews CNA #3 was interviewed on 9/25/25 at 3:24 p.m. CNA #3 said Resident #39 was a two-person assistance transfer with a gait belt. CNA #3 said Resident #39 had a sign posted in her room that instructed staff that she was a two-person assistance transfer with a gait belt. CNA #3 said if she was the only person in the room of a resident who required two people for transfers, she would pull the call light until another staff member came in to assist her with the resident transfer.RN #2 was interviewed on 9/25/25 at 4:51 p.m. RN #2 said Resident #39 was a two-person assistance for all transfers. RN #2 said one person should not try to assist the resident. RN #2 said two-person assistance was for Resident #39's safety and the safety of staff. RN #2 said agency staff had a binder that they had to review when working. RN #2 said the binder included residents who were a two-person assistance for transfers. RN #2 said if CNAs were not familiar with a resident, all they had to do was just ask another staff member. RN #2 said the incident of the one-person transfer for Resident #39 could have been prevented. The DON and the assistant director of nursing (ADON) were interviewed together on 9/25/25 at 5:23 p.m. The ADON said Resident #39 was a two-person assistance transfer with a gait belt. The ADON said an agency CNA was assigned to provide care for Resident #39 on 9/4/25 The ADON said Resident #39 was getting back into bed after breakfast and the second CNA who was in the room to assist with the transfer went to shut the door. She said while the second CNA was shutting the door, the agency CNA lifted Resident #39 using the gait belt and moved her to the bed by herself. The ADON said the agency CNA knew Resident #39 was a two-person assistance for transfers. The ADON said the agency CNA did not indicate why she decided to do the transfer by herself. The ADON said the agency CNA was pulled into her office for questioning and then was sent home and had not been allowed to return to the facility. The ADON said Resident #39 did not fall or sustain any injuries on 9/4/25. The ADON said she did not provide any new education to the staff on the floor regarding transfers following the improper transfer with Resident #39.