| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065189 | A. Building<br>B. Wing | 04/09/2026 |

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| Peaks Care Center, The | 1440 Coffman St<br>Longmont, CO 80501 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, record review 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 dietary staff washed their hands and changed single-use glove use appropriately during meal service;-Ensure meat was thawed according to safe food handling practices;-Ensure staff wore hair nets during food preparation; -Ensure the microwave was maintained in good repair and safe condition; and,-Ensure staff maintained sanitary conditions in the kitchen when eating at a food preparation table. Findings include:I. Hand hygieneA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, were retrieved on 4/16/26. It revealed in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands.(2-301.15)B. Facility policy and procedureThe Food Preparation and Service policy, revised November 2022, was provided by the nursing home administrator (NHA) on 4/9/26 at 4:33 p.m. It revealed in pertinent part, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint) so that hair does not contact food.C. ObservationsDuring a continuous observation of the lunch meal on 4/8/26, beginning at 11:30 a.m. and ending at 12:49 p.m., the following was observed in the kitchen:At 11:35 a.m. cook (CK) #1 began assembling meal plates for residents. At 12:13 p.m. CK #2 wore oven mitts over single-use gloves to remove the pot roast from the oven, placed the pot roast in the hot holding area, and removed the oven mitts.At 12:13 p.m. while wearing the same single-use gloves, CK #2 worked at the grill preparing burgers. CK #2 then turned and moved to the cold preparation area and began preparing a sandwich. CK #2 prepared a ham and cheese sandwich with the same gloved hands. CK #2 reached into a bag of chips while wearing the same pair of gloves, picked up chips with his gloved hand, and placed the chips on a plate and served them to the resident.At 12:14 p.m. CK #2, while wearing the same gloves he opened cans of tomato soup.At 12:15 p.m. CK #2, while wearing the same gloves, flipped burgers and handled buns on the grill.At 12:16 p.m. CK #2, while wearing the same gloves, he picked up a meal ticket.At 12:16 p.m. CK #2, while wearing the same gloves, he used the microwave and heated food.At 12:17 p.m. CK #2, while wearing the<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | same gloves, he picked up a clean plate.At 12:17 p.m. CK #2, while wearing the same gloves, he removed a hamburger from the grill, picked up the hamburger bun with his gloved hand, placed the hamburger on a bun on the plate, and served the plate to a resident.At 12:18 p.m. CK #2, while wearing the same gloves, he picked up a meal ticket.At 12:18 p.m. CK #2, while wearing the same gloves, he picked up cheese from the bag and placed it on the bun with his gloved hand.At 12:19 p.m. CK #2, while wearing the same gloves, he picked up a bottle of mayonnaise and spread it on the bun for the burger.At 12:20 p.m. CK #2, while wearing the same gloves, picked up ham and placed the ham on a cutting surface. CK #2 held the knife in his right hand and held the ham with his left hand to cut the ham. CK #2 then picked up the ham with his gloved hands, placed the ham on a slice of bread, and served the plate to a resident. The gloves were wet from moisture on the outside when CK #2 placed the food on the plate.At 12:22 p.m. CK #2 removed his single-use gloves and donned (put on) a new pair of gloves without performing hand hygiene.At 12:25 p.m. CK #2, while wearing the same gloves, worked at the grill and prepared a ham and cheese sandwich.At 12:26 p.m. CK #2, while wearing the same gloves, picked up a meal ticket and placed it in the preparation area, removed his gloves, and donned another pair of gloves without performing hand hygiene.At 12:27 p.m. CK #2 plated food to be served to three residents.At 12:31 p.m. CK #1 removed his gloves and donned a new pair of gloves without performing hand hygiene.At 12:31 p.m. CK #1, while wearing the same gloves, picked up a meal ticket, plated food, and served the plate to a resident.At 12:32 p.m. CK #1 removed his gloves, picked up meal tickets, and brought the meal tray cart into the kitchen.At 12:33 p.m. CK #1 donned a new pair of gloves without performing hand hygiene and handled food and a plate.At 12:34 p.m. CK #1 plated pot roast with carrots and potatoes, added gravy, covered the plate, and placed the plate on a cart.At 12:35 p.m. using the same gloved hands CK #2 placed raw hamburger meat, buns, and cheese with his gloved hands on the grill to begin preparing a hamburger. At 12:36 p.m. CK #2, while wearing the same gloves, picked up onions, pickles, and lettuce with his gloved hands and placed the items on the hamburger, placed a plate cover over the plate, and placed the plate on a cart.At 12:37 p.m. CK #2, while wearing the same gloves, dropped a bun on the floor while preparing a hamburger, picked up the bun from the floor by the top portion, discarded the bun, did not change gloves, and continued preparing a hamburger.At 12:40 p.m. CK #2, while wearing the same gloves, picked up a plate, placed a grilled cheese sandwich on the plate, and served the plate to a resident.At 12:41 p.m. CK #2, while wearing the same gloves, picked up a quesadilla from the grill, placed the quesadilla on a cutting board, and cut the quesadilla with a knife with his gloved hands.At 12:42 p.m. CK #2, while wearing the same gloves, used a towel from the sanitizer bucket to wipe the food preparation area. CK #2 did not change gloves and did not perform hand hygiene. CK #2 then picked up a tortilla, placed the tortilla on the grill, and added cheese with his gloved hands. At 12:45 p.m. CK #2 discarded his gloves, washed his hands for 10 seconds and donned a new pair of gloves.D. Staff interviews The dietary manager (DM) was interviewed on 4/8/26 at 2:45 p.m. The DM said the staff working in the kitchen were expected to wash their hands anytime they changed tasks and when there was risk for cross contamination. The DM said gloves were worn when handling food and must be changed during service and between tasks. The DM said she reminded the dietary staff to wash their hands and multiple in-services had been completed on hand hygiene. The DM said the staff must perform hand hygiene when moving from dirty to clean tasks. The DM said hand hygiene was important to prevent spread of bacteria and residents from getting sick. CK #3 was interviewed on 4/8/26 at 3:57 p.m. CK #3 said he had worked at the facility for almost a year and was ServSafe certified (food safety certificate). He said he last took the food safety course about four years ago. CK #3 said he received hand hygiene and infection control training when he started working at the facility. He said there was an upcoming training. CK #3 said he washed his hands every time he entered the kitchen and when he changed single-use gloves. CK #3 said he always wore gloves when he handled food and cleaned and should change them after each task. CK #3 said he changed his gloves after completing each task. CK #3 said after making a hamburger he washed his hands and donned a new pair of gloves before<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | moving to the cold bar to prepare a sandwich. CK #3 said if he touched his face, clothing or another surface he discarded gloves, washed hands and donned new gloves.The registered dietitian (RD) was interviewed on 4/9/26 at 1:25 p.m. The RD said employees working in the kitchen were required to wear gloves while serving food. The RD said staff should have washed their hands and put on new gloves if gloves became contaminated or after completing a task. The RD said when staff left the kitchen and returned, they were required to wash their hands and put on new gloves. II. Thawing frozen foodA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, were retrieved on 4/16/26. It revealed in pertinent part, Time/temperature control for safety food shall be thawed: under refrigeration that maintains the food temperature or completely submerged under running water. (3-501.13)B. Facility policy and procedureThe Food Preparation and Service policy, revised November 2022, was provided by the NHA on 4/9/26 at 4:33 p.m. It revealed in pertinent part, Foods are not thawed at room temperature. Appropriate thawing procedures include thawing in the refrigerator in a drip-proof container, completely submerging the item in cold running water (70 degrees Fahrenheit or below), thawing in a microwave oven and then cooking and serving immediately, or thawing as part of a continuous cooking process.C. ObservationsOn 4/6/26 at 9:10 a.m. frozen American goulash was in a container and placed inside the convection steamer with the door open, and the steamer was not turned on. The outside of the metal pan had a visible layer of white frost and ice buildup. D. Staff interviewsCK #2 was interviewed on 4/6/26 at 9:18 a.m. CK #2 said the goulash was frozen and he put it in the steamer to prepare it for that day's lunch.The DM was interviewed on 4/8/26 at 2:45 p.m. The DM said frozen food was pulled from the freezer three days in advance for meal preparation and placed in the refrigerator to thaw. The DM said meats were stored on the bottom rack of the upright cart in the refrigerator after they were pulled from the freezer. The DM said staff could use the steamer and microwave when thawing or reheating frozen food. The DM said the planned menu item for that day was herbed roasted chicken, however due to supply issues, the facility prepared goulash as a backup. The DM said she removed the pan of goulash from the freezer that morning at approximately 9:00 a.m. and handed it to CK #2. The DM said CK #2 should not have left the steamer door open and should have closed it and started cooking the goulash. The DM said she would have placed the goulash in the oven at 350 degrees Fahrenheit (F), and slowly cooked it until it reached an internal temperature of 165 degrees F. The DM said CK #2 used the steamer instead to keep the food moist. The DM said CK #2 had not been trained on proper thawing practices and said CK #2 was resistant to learning new skills but was a good CK. The DM said she had guided staff on proper handling of frozen food. The DM said dietary staff were trained annually and received monthly in-service education. The DM said proper thawing was important due to bacterial growth and the risk of residents becoming ill.CK #3 was interviewed on 4/8/26 at 3:57 p.m. CK #3 said to thaw frozen meat it was removed from the freezer, kept in its original packaging and placed in pans under cold running water. CK #3 said if the meat was frozen solid, he left it out in the open for a few hours and then placed it in the walk-in refrigerator. CK #3 said the next day he took it out and prepared it. CK #3 said he was trained in thawing through ServSafe and he had not received thawing training at the facility.CK #3 said for cooked goulash he reheated it in the oven at 350 degrees Fahrenheit (F) for about one hour until the internal temperature reached 165 to 170 degrees F. CK #3 said he only used the steamer for thin chicken breast for about 15 minutes before cooking it in the oven. CK #3 said he would not use the steamer for goulash because he was not trained to use that method and it was not appropriate for thawing and reheating that type of food. CK #3 said he used a thermometer to check food temperatures. CK #3 said if food was undercooked, he placed it back in the oven for about 15 minutes. CK #3 said if food was overcooked, he offered the resident an alternative.The RD was interviewed on 4/9/26 at 1:25 p.m. The RD said frozen food items should be placed in the refrigerator for 24 to 48 hours to thaw. The RD said the food could then be thawed under cool running water and reheated in the oven until it reached 165 degrees F. The RD said she inspected the kitchen monthly with the DM. The RD said they reviewed food temperatures, cleanliness, equipment function and tray<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | accuracy. III. Hair netsA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, were retrieved on 4/16/26. It revealed in pertinent part, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (2-402.1)B. Facility policy and procedureThe Food Preparation and Service policy, revised November 2022, was provided by the NHA on 4/9/26 at 4:33 p.m. It revealed in pertinent part, Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint) so that hair does not contact food.C. ObservationsOn 4/7/26 at 2:18 p.m. five staff members were in the kitchen including the dietary manager (DM), cook (CK) #2, and three unknown dietary staff. The DM wore a hair net that covered only the upper portion of the hair and hair below the hair net remained uncovered. CK #2 wore a hat, and the other three staff members did not wear hair nets and their hair was exposed.On 4/8/26 at 8:41 a.m. dietary aide (DA) #2 was in the kitchen assisting with breakfast and did not have a hair net on and went to get one and put it on.D. Staff interviewsThe DM was interviewed on 4/8/26 at 2:45 p.m. The DM said staff were required to wear hair nets whenever they were in the kitchen. The DM said there was a sign outside the kitchen door that reminded them to wear it and hair nets are always available for staff.DA #1 was interviewed on 4/8/26 at 3:22 p.m. DA #1 said the facility required her to wear a hair net in the kitchen and when working with or preparing food. DA #1 said staff trained her to keep her hair back in a hair net. DA #1 said hair nets were used to keep food sanitary and prevent hair from getting into food. DA #1 said if someone forgot to wear a hair net they would be reminded to wear it. DA #1 said hair nets were available at all times.CK #3 was interviewed on 4/8/26 at 3:57 p.m. CK #3 said the facility required him to wear a hair net anytime he entered the kitchen. CK #3 said hair nets kept food sanitary and prevented hair from getting into food. CK #3 said when he first started working at the facility there were issues with hair in food, and staff trained employees to wear hair nets. CK #3 said if someone forgot to wear a hair net they would be reminded to wear it. CK #3 said hair nets were available at all times.The RD was interviewed on 4/9/26 at 1:25 p.m. The RD said she expected all employees to always wear a hair net in the kitchen. The RD said she ensured employees understood the importance of hair nets in preventing contamination through in-service training. IV. Kitchen equipment maintenanceA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations (revised 3/16/24), was retrieved on 12/22/25. It revealed in pertinent part, Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: finished to have a smooth, easily cleanable surface. Multiuse food contact surfaces shall be:smooth, free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections, free of sharp internal angles, corners and crevices, finished to have smooth welds and joints. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. (Chapter 4)B. ObservationsOn 4/6/26 at 9:07 a.m. it was observed that the interior right side wall of the microwave had peeling paint that extended from the bottom to the top of the wall with bubbling present.On 4/8/26 at 3:25 p.m. the DM unplugged the microwave and said she would get another one.C. Staff interviewsThe DM was interviewed on 4/8/26 at 2:45 p.m. The DM said she would replace the microwave because she did not want bubbling paint to contaminate the food. The DM said they did not use that microwave that often and said another microwave was available and in fully operating condition. V. Maintain the kitchen in a sanitary conditionA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, were retrieved on 4/16/26. It revealed in pertinent part, Food employees shall eat, drink, or use any form of tobacco only in designated areas where the contamination of exposed food; clean equipment, utensils, and linens; unwrapped single-service and single-use articles; or other items needing protection cannot result. (2-401.11)B. ObservationsOn 4/7/26 at 2:18 p.m. DA #1 sat at the food preparation table in the (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | kitchen and ate lunch.C. Staff interviews The DM was interviewed on 4/8/26 at 11:53 a.m. The DM said when there was leftover food, staff received the food and ate at a designated area away from the kitchen. The DM said when the kitchen was busy, staff ate in the kitchen. The DM said DA #1 had just come on shift and was eating lunch at that time. The DM was interviewed again on 4/8/26 at 2:45 p.m. The DM said employees were not allowed to eat in the kitchen or in the food preparation areas and were expected to eat in the employee lounge. The DM said she monitored by being present in the kitchen throughout the day. The DM said eating in the kitchen could cause crumbs on hands or around the mouth and increased contamination risk. The DM said she spoke with DA #1 and provided education.The RD was interviewed on 4/9/26 at 1:25 p.m. The RD said she had seen staff eat in the kitchen and said this was not appropriate due to infection control concerns. The RD said when she observed staff eating in the kitchen, she told them the facility expectations to eat at a designated area. The RD said she would inform the DM when staff ate in the kitchen. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure four (#5, #9, #47 and #61) of four residents out of 39 sample residents were provided services that met professional standards of quality. Specifically, the facility failed to: -Ensure staff obtained a physician's order specifying personalized settings for air mattresses for Resident #5, Resident #9, Resident #47 and Resident #61; and, -Ensure staff maintained air mattresses according to the manufacturer's recommendations for Resident #5, Resident #9, Resident #47 and Resident #61.Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel (NPIAP), Prevention and Treatment of Pressure Ulcers and Injuries(3/17/26), retrieved on 4/16/26 from https://www.guidelinecentral.com/guideline/23835, It is good practice for organizations to maintain an inventory of, or access to, a range of full body support surfaces appropriate to the clinical context. The inventory should be maintained, stored and used in accordance with manufacturer recommendations. It is good practice to use a full body support surface or integrated bed system that appropriately accommodates the weight, height, size and body mass distribution of the individual. II. Facility policy and procedure The Use of Support Surfaces policy and procedure, revised 2024, was provided by the nursing home administrator (NHA) on 4/9/26 at 4:42 p.m. It read in pertinent part, Support surfaces will be utilized in accordance with manufacturer recommendations including considerations for contraindications. The director of nursing (DON) will maintain a list of support surfaces used in the facility, including product specifications. Arrangements will be made with rental vendors for obtaining this information. A schedule for inspection and replacement will be established accordingly. For powered devices, or those requiring air, the licensed nurse will check each shift and as needed for proper functioning and inflation.III. Manufacturer's instructions According to the Compass Healthcare's Meridian Medical Ultra-Care Series, user manual: pp 7-8, retrieved on 4/16/26 from https://compasshealthbrands.com/itemFiles/APM%20User%20Guide.pdf, Check to see if a suitable pressure is selected by sliding one hand between the air mattress and the foam base (or bed frame if there is no foam base) to feel the patient's buttocks. User should be able to feel the space in between and the acceptable range is approximately 25 to 40 millimeters (one inch to one and a half inches). The static mode provides a stable surface that makes it easier for the patient to transfer or reposition. IV. Resident #5A. Resident status Resident #5, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included congestive heart failure (CHF), peripheral vascular disease and chronic respiratory failure with hypoxia. The 3/10/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident used a walker. She required supervision with eating, toileting and showering. She required set up assistance for oral hygiene and personal hygiene. B. Resident observation On 4/9/26 at 9:12 a.m. Resident #5's air mattress was observed. The air mattress was labeled Meridian Medical. The air mattress had a control panel which included an adjustable firmness dial located on the left side, labeled from soft to firm. There was a green switch labeled power and an orange switch labeled static. Both switches were illuminated. Above the power and static switches were two indicators labeled normal pressure and lower pressure. The normal pressure indicator was illuminated with a green light. The low pressure indicator was not illuminated. The adjustable firmness dial was set to the second blue block of the dial on the left side. C. Record Review Review of Resident #5's April 2026 CPO revealed the following physician's order: Apply an air mattress and check settings every shift for wound healing and prevention. Monitor settings, ordered 3/25/26.-However, the physician's order did not indicate what settings the mattress should be set on. The 3/23/26 nurse progress note revealed Resident #5 admitted to hospice care services with a diagnosis cerebrovascular disease with related diastolic CHF. An air mattress was provided by hospice and in place. -However a review of Resident #5's (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | electronic medical record (EMR), including the hospice notes, did not reveal an assessment or documentation of what the air mattress settings should be for Resident #5.-There was no documentation in the resident's EMR to indicate the resident's mattress was being monitored and maintained on a routine basis. V. Resident #9 A. Resident status Resident #9, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dementia, type 2 diabetes mellitus, emphysema, stage 4 chronic kidney disease and pressure ulcer of the sacral region.The 1/19/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident used a wheelchair. He required setup assistance with eating. He required partial assistance with oral hygiene and substantial assistance with toileting and personal hygiene. B. Observation On 4/8/26 at 12:04 p.m. Resident #9's air mattress was observed. The air mattress was labeled Meridian Medical. The air mattress had a control panel which included an adjustable firmness dial located on the left side, labeled from soft to firm. There was a green switch labeled power and an orange switch labeled static. Both switches were illuminated. Above the power and static switches were two indicators labeled normal pressure and lower pressure. The normal pressure indicator was illuminated with a green light. The low pressure indicator was not illuminated. The adjustable firmness dial was set to the middle of the dial. C. Record review Review of Resident #9's April 2026 CPO revealed the following physician's order: Apply an air mattress and check settings every shift for wound healing and prevention. Monitor settings, ordered 12/25/25.-However, the physician's order did not indicate what settings the mattress should be set on. The skin care plan, initiated 12/1/25 and revised 2/12/26, revealed Resident #9 was at risk for skin breakdown due to incontinence, decreased mobility, and terminal diagnosis with end of life focus. Interventions included applying an air mattress and checking settings.-However, the care plan did not indicate what settings the air mattress should be set on. -A review of Resident #9's EMR, including hospice notes, did not reveal an assessment and documentation of what the air mattress settings should be for Resident #9.-There was no documentation in the resident's EMR to indicate the resident's mattress was being monitored and maintained on a routine basis. VI. Resident #47 A. Resident status Resident #47, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included hypertensive heart disease, atherosclerotic heart disease, senile degeneration of the brain, restlessness and agitation. The 3/6/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of five out of 15. She used a wheelchair. She required partial assistance with eating and required substantial assistance with personal hygiene. She was dependent on oral hygiene, toileting, and showering, B. Observation On 4/8/26 at 12:01 p.m. Resident #47's air mattress was observed. The air mattress was labeled Meridian Medical. The air mattress had a control panel which included an adjustable firmness dial located on the left side, labeled from soft to firm. There was a green switch labeled power and an orange switch labeled static. Both switches were illuminated. Above the power and static switches were two indicators labeled normal pressure and lower pressure. The normal pressure indicator was illuminated with a green light. The low pressure indicator was not illuminated. The adjustable firmness dial was set to the fifth blue block on the left side of the dial. C. Record Review Review of Resident #47's April 2026 CPO revealed the following physician's order: Apply an air mattress and check settings every shift for wound healing and prevention. Monitor settings, ordered 2/20/26.-However, the physician's order did not indicate what settings the mattress should be set on. -A review of Resident #47's EMR, including hospice notes, did not reveal an assessment and documentation of what the air mattress settings should be for Resident #47.-There was no documentation in the resident's EMR to indicate the resident's mattress was being monitored and maintained on a routine basis. VII. Resident #61 A. Resident status Resident #61, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dementia, spinal stenosis (narrowing of the spinal canal that caused pressure on the spinal cord and nerves), peripheral vascular disease (slow progressive circulation disorder involving narrowed or blocked vessels) and pressure-induced deep tissue damage of right heel. The 2/27/26 MDS assessment (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | revealed the resident was severely cognitively impaired with a BIMS score of seven out of 15. The resident used a wheelchair. He required partial supervision with eating. He was dependent on oral hygiene and toileting. B. ObservationOn Resident #61's air mattress setting was observed. The brand was Genesis III, The control panel included an adjustable firmness dial located on the left side, labeled from softer to firmer, with weight indicators ranging from 75 pounds (lbs) to 500 lbs. 75 lbs was on the soft setting and 500 lbs was on the firmer setting. The firmness dial on Resident #61's was set near the 225 lb setting. The power indicator and the lower pressure indicator lights were on. The normal pressure indicator light was not on. -However, record review revealed Resident #61 weighed 180 lbs, indicating the air mattress was not at the correct setting. C. Record review Review of Resident #61's April 2026 CPO revealed the following physician's order: The 9/25/26 behavior note revealed an air mattress was present on Resident #61's bed.Apply an air mattress and check settings every shift for wound healing and prevention. Apply an air mattress as indicated for wound healing and prevention. Monitor settings. Ordered 10/9/25. -However, the physician's order did not indicate what settings the mattress should be set on.-A review of Resident #61's EMR did not reveal an assessment and documentation of what the air mattress settings should be for Resident #61.-There was no documentation in the resident's EMR to indicate the resident's mattress was being monitored and maintained on a routine basis. VIII. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/9/26 at 9:46 a.m. LPN #1 said nurses were responsible for checking residents' air mattress settings. She said she knew to check based on a physician's order. LPN #1 said when a resident first had an air mattress delivered, the durable medical equipment (DME) company set up the air mattress according to the hospice care service company's order. She said the hospice care services company was responsible for routine maintenance and taking care of any issues with the mattress. She said she knew a resident's mattress was set on the right setting by touching the mattress and making sure the mattress did not touch the bed frame. She said residents had air mattresses for comfort and for residents who had wounds or did not eat well. LPN #1 said she was familiar with Resident #5, Resident #9, Resident #47 and Resident #61. She said the residents' air mattress settings were based on her touching their mattress and making sure the mattress did not touch the bed frame. The DON was interviewed on 4/9/26 at 12:49 p.m. The DON said nurses were responsible for checking residents' air mattress settings. She said the nurses knew they should check the settings because there was a physician's order to check the mattress every shift. The DON said nurses knew the air mattress settings based on the resident's weight. The DON said not every air mattress they had in the facility had settings based on weight. She said the settings for the other air mattresses should be based on the manufacturer's recommendations. The DON said she asked the hospice care services company for the manufacturer's manual for the air mattress that was not based on residents' weights, but she was unable to receive a copy of the manual. The DON said nurses checked the air mattress settings based on feel and they should make sure they did not feel the bar of the resident's bed frame. The DON said the DME company would come out to fix air mattresses as needed but they did not perform general maintenance of the air mattresses. The DON said residents had an air mattress for comfort, to prevent skin breakdown and for residents who were compromised. The DON said she was familiar with Resident #5, Resident #9, Resident #47 and Resident #61. She said the residents' air mattress settings were based on the nurses' touch to the residents' air mattresses during their shifts. -However, Resident #61's air mattress indicated the settings should be based on the resident's weight (see above) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure staff provided respiratory care consistent with professional standards of practice for three (#57, #52 and #5) of five residents reviewed for oxygen services out of 39 sample residents. Specifically, the facility failed to:-Ensure there was a physician's order in place for Resident #57's continuous positive airway pressure (CPAP) machine and routine maintenance of the CPAP; and,-Ensure there were appropriate oxygen orders in place for Resident #52 and Resident #5.Findings include:<br><br>I. Professional reference<br><br>According to Nursing Skills, Open Resources for Nursing (Open RN); Ernstmeyer K, [NAME] E, editors. Eau [NAME] (WI): [NAME] Valley Technical College; published 2021, accessed on 4/14/26 from https://www.ncbi.nlm.nih.gov/books/NBK593208/,<br><br>Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. (Chapter 11)<br><br>Devices such as high flow oxymasks, CPAP, BiPAP (bilevel positive airway pressure), or mechanical ventilation may be initiated by the respiratory therapist or provider to deliver higher amounts of inspired oxygen. (Chapter 11)<br><br>Manage oxygen therapy and equipment: If the patient is already on supplemental oxygen, ensure the equipment is turned on, set at the required flow rate, correctly positioned on the patient, and properly connected to an oxygen supply source. If a portable tank is being used, check the oxygen level in the tank. Ensure the connecting oxygen tubing is not kinked, which could obstruct the flow of oxygen. Feel for the flow of oxygen from the exit ports on the oxygen equipment.<br><br>II. Facility policy and procedure<br><br>The Oxygen Administration policy, dated 2025, was provided by the nursing home administrator (NHA) on 4/9/26 at 1:00 p.m. It read in pertinent part:<br><br>Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.<br><br>Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia (low levels of oxygen in the body's tissues).<br><br>Oxygen is administered under orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.<br><br>Personnel authorized to initiate oxygen therapy include physicians, registered nurses (RN), licensed practical nurses (LPN) and respiratory therapists.<br><br>The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | assessment and orders, such as, but not limited to:<br><br>-The type of oxygen delivery system;<br><br>-When to administer, such as continuous or intermittent and/or when to discontinue; and,<br><br>-Equipment setting for the prescribed flow rates.<br><br>Staff shall perform hand hygiene and don (put on) gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include:<br><br>-Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated;<br><br>-Keep delivery devices covered in plastic bag when not in use;<br><br>-Cleaning and care of equipment shall be in accordance with facility policies for such equipment; and,<br><br>-The equipment needed for oxygen administration will depend on the type of delivery system ordered.<br><br>Types of delivery systems include:<br><br>Nasal Cannula – Oxygen is administered through plastic cannulas in the nostrils. Effective for low oxygen concentrations less than 40%. Requires humidification at flow rates greater than 4 liters per minute (LPM).<br><br>CPAP Mask – This mask is part of a system that allows a resident to receive continuous positive airway pressure (CPAP), with or without an artificial airway. The system is comprised of a mask, tubing, and a machine that generates a constant flow of air pressure. Machines have different settings.<br><br>III. Resident #57<br><br>A. Resident status<br><br>Resident #57, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included obstructive sleep apnea.<br><br>The 3/20/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. He used a walker and wheelchair for mobility. He had no impairment of upper or lower extremities and was independent with activities of daily living (ADL).<br><br>The MDS assessment did not indicate the resident used a CPAP.<br><br>B. Observations and resident interview<br><br>On 4/6/26 at 3:29 p.m. Resident #57 said he wore a CPAP at night. He said the staff did not clean it, but they brought water for it. The mask was observed on top of the bedside table next to the CPAP machine and was not contained in a storage bag.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/7/26 at 12:30 p.m. the CPAP mask was observed on the bedside table next to the machine, lying on top of a lamp base and was not contained in a storage bag.<br><br>On 4/8/26 at 9:30 a.m. the CPAP mask was on the bedside table next to the machine, lying on top of a lamp base and was not contained in a storage bag.<br><br>On 4/9/26 at 10:00 a.m. the CPAP mask was on the bedside table next to the machine, lying on top of a lamp base and was not contained in a storage bag.<br><br>Cross-reference F880 for failure to maintain appropriate infection prevention and control.<br><br>C. Record review<br><br>A review of Resident #57's April 2026 CPO revealed no physician's orders for the CPAP machine or instructions for maintenance and cleaning of the equipment.<br><br>The respiratory/oxygen care plan, initiated 3/17/26, indicated Resident #57 was at risk for complications related to a compromised respiratory system related to obstructive sleep apnea (OSA). Interventions included administering oxygen as ordered, administering medications as ordered, educating the resident to use breathing techniques: purse lips, cough and deep breathing and notifying the physician of increased complaints of difficulty in breathing.<br><br>-The care plan did not include the use of the CPAP machine or the cleaning/maintenance of the equipment.<br><br>Review of the 3/13/26 hospital note indicated Resident #57 had OSA and the resident was to continue use of the CPAP machine at night, per his home settings.<br><br>D. Oxygen representative interview<br><br>The oxygen company's representative was interviewed on 4/9/26 at 9:18 a.m. The oxygen company's representative said when a resident was on oxygen their company provided routine visits to change tubing and cannulas and they also provided the bags to store the cannula/mask in if the resident was not wearing the oxygen. He said if a resident brought a CPAP from home he would check in with them to see if any equipment was needed. He said he was not notified by the facility that Resident #57 had a CPAP.<br><br>E. Staff interview<br><br>The director of nursing (DON) was interviewed on 4/9/26 at 9:26 a.m. The DON said she did not know Resident #57 had a CPAP machine when he was admitted to the facility. She said when a resident had a CPAP machine brought from home, physician's orders for the CPAP machine and routine cleaning/maintenance of the equipment were to be entered into the resident's electronic medical record (EMR) and the care plan would be updated as well. She said the physician's orders for Resident #57's CPAP machine were missed being added to the resident's EMR on his admission to the facility.<br><br>F. Facility follow-up<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/9/26 at 9:47 a.m. a review of Resident #57's April 2026 CPO revealed the DON had entered the following physician's orders related to the resident's CPAP machine:<br><br>Humidifier cleaning: Cleaning to be done weekly. Cleanse the humidifier with warm soapy water, rinse thoroughly and dry with a clean cloth or allow to air dry. One time a day every Monday for CPAP maintenance, ordered 4/9/26.<br><br>Humidifier water: Empty the distilled water each morning from the CPAP machine. After cleaning, refill with distilled water. One time a day for CPAP maintenance, ordered 4/9/26.<br><br>Mask/nasal pillow cleaning: Masks and nasal pillows must be cleaned in the morning. Clean CPAP using warm water and a cloth daily. One time a day, ordered 4/9/26.<br><br>Tube cleaning: Clean tube with mild detergent that is not anti-bacterial in warm water. Dry the interior of the hose, connect it to the CPAP machine and allow it to run for approximately 15 minutes or until moisture has evaporated. One time a day every Monday for CPAP maintenance, ordered 4/9/26.<br><br>Additionally, the resident's care plan was updated as follows:<br><br>Apply CPAP as ordered. Ensure settings are as physician ordered, initiated 4/9/26.<br><br>-However, the physician's orders for the CPAP machine and the care plan for the CPAP machine were not entered into Resident #57's EMR until the concern was brought to the facility's attention during the survey.<br><br>IV. Resident #52<br><br>A. Resident status<br><br>Resident #52, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included chronic respiratory failure with hypoxia.<br><br>The 3/25/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. She used a walker and wheelchair for mobility. She had impairment of one lower extremity and required partial to moderate assistance with ADLs.<br><br>The assessment indicated the resident required oxygen therapy.<br><br>B. Observations and resident interview<br><br>Resident #52 was interviewed on 4/6/26 at 3:39 p.m. Resident #52 said she always wore oxygen and it should be set at a flow rate of 2 LPM. Observation of the resident's oxygen concentrator revealed it was set at a flow rate of 2 LPM.<br><br>On 4/7/26 at 10:00 a.m. the resident's oxygen concentrator was set at a flow rate of 2 LPM.<br><br>On 4/8/26 at 9:00 a.m. the resident's oxygen concentrator was set at a flow rate of 2 LPM.<br><br>C. Record review<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #52's April 2026 CPO revealed the following physician's order:<br><br>The respiratory/oxygen care plan, initiated 3/17/26, revealed Resident #52 was at risk for complications related to a compromised respiratory system related to chronic respiratory failure. Interventions included administering oxygen as ordered, administering medications as ordered, educating the resident to use breathing techniques: purse lips, cough and deep breathing and notifying the physician of increased complaints of difficulty in breathing.<br><br>Oxygen via nasal cannula, titrate to 90% continuously, ordered 3/10/26.<br><br>-However, the physician's order did not indicate a flow rate that the oxygen was to be set on.<br><br>The 3/10/26 hospital note revealed Resident #52 had chronic hypoxic respiratory failure and was on oxygen at 2 LPM per nasal cannula at baseline.<br><br>D. Staff interviews<br><br>LPN #4 was interviewed on 4/9/26 at 9:00 a.m. LPN #4 said Resident #52's oxygen order did not indicate a continuous LPM flow rate and she would not know what the oxygen was supposed to be set on when the order read that way. She said if a resident's oxygen saturation level (measure of oxygen in the blood) were to drop below 90%, she would notify the physician for further orders.<br><br>The DON was interviewed on 4/9/26 at 9:41 a.m. The DON said Resident #52's oxygen order was an incorrect order. She said the facility did not use titration orders and nursing was to use the facility's oxygen template. She said upon the resident's admission to the facility, the nurse did not enter the correct physician's order for oxygen into the resident's EMR.<br><br>E. Facility follow-up<br><br>On 4/9/26 at 9:42 a.m. the DON entered the following physician's order related to oxygen into Resident #52's April 2026 CPO:<br><br>Oxygen 2 LPM via nasal cannula to keep saturations greater than (>)89% continuously, ordered 4/9/26.<br><br>-However, the physician's order for Resident #52's oxygen flow rate was not updated until the concern was brought to the facility's attention during the survey.<br><br>V. Resident #5<br><br>A. Resident status<br><br>Resident #5, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included congestive heart failure (CHF), peripheral vascular disease and chronic respiratory failure with hypoxia.<br><br>The 3/10/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The resident used a walker. She required supervision with eating, toileting and showering. She required set up assistance for oral hygiene and personal hygiene.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The MDS assessment indicated Resident #5 was not receiving oxygen therapy.<br><br>B. Resident interview and observations<br><br>Resident #5 was interviewed on 4/7/26 at 9:38 a.m. Resident #5 was sitting on the side of the bed and did not have an oxygen nasal cannula in her nose. An oxygen concentrator was observed next to the wall where the resident's bathroom was located. Resident #5 said she did not know why the oxygen concentrator was there because she did not use oxygen.<br><br>Resident #5 was observed on 4/7/26 from 12:05 p.m. to 1:07 p.m in the dining room. She was not receiving oxygen.<br><br>Resident #5's room was observed on 4/9/26 at 9:12 a.m. An oxygen concentrator was observed to still be next to the wall where the resident's bathroom was located.<br><br>C. Resident's representative interview<br><br>Resident #5's representative was interviewed on 4/8/26 at 9:18 a.m. The resident's representative said she was a nurse and Resident #5 had a physician's order for oxygen as needed. The resident's representative said the order was as needed because when she had visited Resident #5, the resident looked like her oxygen was low. The resident's representative said she had asked the facility staff to take the resident's vital signs and her oxygen saturation level was low. She said when Resident #5's oxygen saturation level was low, the facility used the oxygen concentrator.<br><br>D. Record review<br><br>A review of Resident #5's April 2026 CPO revealed the following physician's orders:<br><br>Oxygen via nasal cannula at 2 LPM to 3 LPM continuously to maintain oxygen saturation greater than 89%, ordered on 3/9/26 and discontinued on 4/9/26 (during the survey).<br><br>May take oxygen off for short intermittent times to refill portable oxygen tanks, ordered on 3/9/26.<br><br>-However, observations revealed Resident #5's oxygen was not being administered continuously, per physician's orders.<br><br>Head of bed elevated, resident is unable to lay flat due to shortness of breath, ordered 3/9/26.<br><br>The respiratory and oxygen care plan, initiated 6/11/25 and revised 4/9/26, revealed Resident #5 was at risk for complications due to a compromised respiratory system related to chronic respiratory failure with hypoxia. Interventions included administering medications as ordered, administering oxygen as ordered, educating the resident to use breathing techniques, elevating the head of the bed due to shortness of breath, encouraging the resident to be out of bed as tolerated and monitoring vital signs as ordered.<br><br>E. Staff interviews<br><br>LPN #1 was interviewed on 4/9/26 at 9:46 a.m. LPN #1 said nursing staff was responsible for ensuring residents had oxygen per the physician's orders. She said she was familiar with Resident #5.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | She said the resident had oxygen in case she needed it as a comfort measure. She said the physician's order in the resident's EMR said 2 LPM continuously, but it should read 2 LPM as needed. She said she would change the physician's to reflect Resident #5's actual oxygen needs.<br><br>The DON was interviewed on 4/9/26 at 12:49 p.m. The DON said nursing staff was responsible for ensuring residents had oxygen per the physician's orders. She said she was familiar with Resident #5. She said Resident #5 had oxygen off and on due to her CHF. The DON said the resident had retained a lot of fluid at one point and required oxygen continuously. The DON said Resident #5's representative wanted her to have oxygen available as needed. The DON said the resident sometimes used oxygen at night. She said if Resident #5 was using oxygen as needed, the physician's order should reflect that.<br><br>The DON looked at Resident #5's April 2026 CPO during the interview and said it was as needed and said the order was changed today, 4/9/26. The DON said she did not know it had changed after LPN #1 realized the order was incorrect.<br><br>F. Facility follow-up<br><br>On 4/9/26 at 12:07 p.m. the following physician's order related to oxygen was entered into Resident #5's April 2026 CPO:<br><br>Oxygen via nasal cannula at 2 LPM to 3 LPM as needed to maintain oxygen saturation greater than 89%.<br><br>-However, the physician's order for Resident #5's oxygen was not updated to oxygen as needed until the concern was brought to the facility's attention during the survey. |

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| | 065189 | A. Building<br>B. Wing | 04/09/2026 |

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| Peaks Care Center, The | 1440 Coffman St<br>Longmont, CO 80501 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide proper storage for medications for four of five medication carts and one of three medication storage rooms. Specifically, the facility failed to:-Ensure eye drops, inhalers and Tuberculin Purified Protein Derivative (PPD) vials were labeled with the date they were opened;-Ensure glucometer test strips and glucose control solutions were labeled with the date they were opened; and,-Ensure glucometer test strips and glucose control solutions were discarded when expired.Findings include:I. Professional referenceAccording to the manufacturer Catalent Pharma Solutions Xalatan(R) latanoprost ophthalmic solution package insert, , revised [DATE], and retrieved on [DATE] from https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf,Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees Celsius (77 degrees Fahrenheit - F) for six weeks.According to the manufacturer, GlaxoSmithKline Highlights of Prescribing Information, 2017, accessed on [DATE], from https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/209482s016lbl.pdf, Discard Trelegy Ellipta (inhaler) six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first. According to the manufacturer, [NAME] True Metrix Control Solution, [DATE], accessed on [DATE] fromhttps://imgcdn.[NAME].com/CumulusWeb/Click_and_learn/truemetrix_control_solution_ifu_2015-03.pdf, Write date first opened on bottle. Discard bottle after expiration date printed on the bottle label or three months after the date written on the bottle, whichever comes first.According to the manufacturer, [NAME] Professional Monitoring Blood Glucose Test Strips, date not available, accessed on [DATE] fromhttps://imgcdn.[NAME].com/CumulusWeb/Click_and_learn/truemetrixpro_test_strips_ifu_960297_and_96 Write the date opened on the test strip vial label when removing the first test strip. Discard all unused test strips in the vial after either the date printed on the test strip vial label or four months after the date opened, whichever comes first.According to the manufacturer, JHP Pharmaceuticals Aplisol Tuberculin Purified Protein Derivative, Diluted, accessed on [DATE] from https://www.fda.gov/media/74862/download?attachment, Vials in use more than 30 days should be discarded due to possible oxidation and degradation, which may affect potency.II. Facility policy and procedureThe Medication Storage policy, dated 2025, was provided by the nursing home administrator (NHA) on [DATE] at 4:42 p.m. p.m. It read in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.III. Observations and interviewsOn [DATE] at 3:24 p.m. the Sunlight Hall medication cart was observed with licensed practical nurse (LPN) #1. The following was observed:One opened bottle of Xalatan eye drops for Resident #61 with no open date.One opened Trellegy inhaler for Resident #56 with no open date. LPN #1 said the inhaler could be used until the medication was complete. LPN #1 said she used to write open dates on all of the medications, but she was told it was not necessary anymore. Two opened bottles of blood glucose test strips without open dates. LPN #1 said the test strips were good until the expiration date on the bottle.On [DATE] at 3:39 p.m. the Sunlight Hall medication storage room was observed with LPN #1. The following was observed:One opened level one glucose monitoring control solution and one opened level two glucose monitoring control solution with open dates that read [DATE]. LPN #1 said the control solution was good until the expiration date on the bottle.One opened Tuberculin PPD 5 TU (tuberculin units) per 0.1 milliliter (ml) vial without an open date. LPN #1 (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | said the vial was good until the expiration date, or until the medication was completed, whichever came first. On [DATE] at 3:53 p.m. the Frontier unit medication cart B was observed with RN #1. The following was observed:One opened container of glucose test strips was not labeled with the date opened. RN #1 said the test strips were good until the expiration date on the container.On [DATE] at 3:59 p.m. the Frontier unit medication cart A was observed with RN #2. The following was observed:Two opened containers of glucose test strips were not labeled with the date opened. On [DATE] at 4:28 p.m. the Red Cloud unit medication cart was observed with LPN #2. The following was observed:Three opened containers of glucose test strips, one container each for Resident #78, Resident #66 and Resident #40, not labeled with the date opened.On [DATE] at 11:23 a.m. the Frontier nurses' station was observed with RN #2. The following was observed:One opened level one glucose control monitoring solution without an open date. RN #2 said the solution should be labeled with an open date.On [DATE] at 11:58 a.m. the shared nurses' station for the Red Cloud unit and the Castle Peak unit was observed with LPN #1. The following was observed:Two opened containers of glucose test strips not labeled with the date opened. IV. Additional staff interviewThe director of nursing (DON) was interviewed on [DATE] at 1:02 p.m. The DON said there was a misunderstanding among the nursing staff about what medications needed to be labeled with an open date. The DON said the facility used to label every medication with an open date until their pharmacy representative said they did not need to date over-the-counter medications. The DON said patient-specific medications and glucometer supplies still needed to be labeled. The DON said the glucose test strips were good for 30 days after opening and the glucose monitoring control solutions were good for 90 days after opening. She said both would be ineffective if used past their expiration dates. The DON said the Tuberculin PPD should have an open date on it, because using it past its expiration date could result in a false test result. The DON said the Trellegy inhaler was only good for about 30 days and would be ineffective if used after its expiration date. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain infection control procedures designed to provide a safe and sanitary environment to prevent the development and transmission of diseases on three of four units and in one of two dining rooms.Specifically, the facility failed to:-Ensure staff wore the appropriate personal protective equipment (PPE) while providing care to -Resident #59, who was on enhanced barrier precautions (EBP);-Ensure staff offered residents hand hygiene before meals; and,-Ensure oxygen cannulas and CPAP (continuous positive airway pressure - a machine used to treat breathing issues while sleeping) masks were stored in a sanitary manner.Findings include:<br><br>I. Failed to ensure staff wore the appropriate PPE while providing care to Resident #59, who was on EBP<br><br>A. Professional reference<br><br>According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), (4/2/24), retrieved on 4/13/26, from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html,<br><br>Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs.<br><br>Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high-contact resident care activities.<br><br>EBP may be indicated for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO.<br><br>B. Facility policy and procedure<br><br>The Enhanced Barrier Precautions policy, revised August 2022, was provided by the nursing home administrator (NHA) on 4/9/26 at 4:42 p.m. It read in pertinent part,<br><br>Enhanced barrier precautions (EBP) are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (MDRO) to residents.<br><br>EBP employs targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply.<br><br>Examples of high-contact resident care activities requiring the use of gown and gloves 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 (any skin opening requiring a dressing).<br><br>C. Observations and staff interview<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/8/26 at 3:47 p.m. a sign posted on Resident #59's door indicated she was on EBP. The resident had an indwelling urinary catheter. Certified nurse aide (CNA) #8 was observed transferring Resident #59 from her wheelchair to her bed, using a hands-on slide board transfer method. CNA #8 reached for a PPE gown and Resident #59 told CNA #8 she did not need a gown because the gowns were only for infections like influenza, and staff did not wear the gowns for her care. CNA #8 shrugged, donned (put on) gloves and continued with the resident's care without putting on a gown.<br><br>-CNA #8 failed to don the appropriate PPE for high-contact resident care.<br><br>On 4/8/26 at 4:49 p.m. registered nurse (RN) #1 was observed in Resident #59's room performing urinary catheter care. RN #1 donned gloves, disconnected the catheter bag from the tubing, and connected a syringe to the tubing. RN #1 pressed the catheter bag tubing between her knee and the bed, which kept the tip of the tubing suspended in the air. RN #1 irrigated the catheter with a medicated solution, then reconnected the tubing. After the care was completed, RN #1 said she was not sure where to place the catheter bag tubing during the procedure, so she used her knee to keep the tubing from touching the bed. RN #1 said she should have worn a gown to irrigate the resident's urinary catheter, but she had forgotten to do so because she did not usually work with Resident #59.<br><br>II. Failed to ensure staff offered residents hand hygiene before meals<br><br>A. Professional reference<br><br>According to the CDC's, Hand Hygiene For Patients, (2/27/24), retrieved on 4/14/26 from https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html?utm_source=chatgpt.com, Patients and visitors should clean their hands before preparing or eating food, before touching your eyes, nose, or mouth, after using the restroom, after blowing your nose, coughing or sneezing, after touching hospital surfaces.<br><br>B. Observations<br><br>During a continuous observation on the Castle Peak unit on 4/6/26, beginning at 12:35 p.m. and ending at 12:48 p.m., the following was observed:<br><br>A meal tray cart was observed in the hall of the Castle Peak unit with residents' meal trays. There was no hand sanitizer or hand wipes observed on the cart. An unidentified staff member was delivering meal trays to residents' rooms and did not offer hand hygiene to residents.<br><br>On 4/6/26 at 12:26 p.m. a room tray was delivered to room [ROOM NUMBER] by an unidentified CNA. The unidentified CNA did not offer the resident in room [ROOM NUMBER] hand hygiene prior to the resident eating.<br><br>During a continuous observation on the Red Cloud unit on 4/6/26, beginning at 12:29 p.m. and ending at 12:40 p.m. CNA #1 was observed delivering meal trays to the residents. The meal trays were on a two-shelf cart. There were no hand wipes observed on the cart. CNA #1 went into room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] with the resident's meal trays.<br><br>-However, CNA #1 failed to offer hand hygiene to the residents in the rooms prior to the meal being served.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/6/26 at 12:45 p.m. the main dining room was observed. There were no hand wipes or hand sanitizer observed on any dining tables.<br><br>During a continuous observation of the main dining room on 4/7/26, beginning at 12:05 p.m and ending at 1:07 p.m., the following was observed:<br><br>Staff were delivering lunch meals to residents seated at the tables. Resident #59 self-propelled a manual wheelchair into the dining room, and sat in front of a table. Resident #59 was not offered hand hygiene before being served her lunch.<br><br>Resident #5, Resident #61 and Resident #47 were observed at a table for residents who needed feeding assistance. None of the residents were offered hand hygiene prior to being served their lunch.<br><br>C. Resident interviews<br><br>Resident #4 was interviewed on 4/7/26 at 12:30 p.m. Resident #4 said when meal trays were delivered to the rooms, hand hygiene was not offered to the residents, but would be appreciated.<br><br>Resident #31 was interviewed on 4/7/26 at 12:39 p.m. Resident #31 said when meal trays were delivered to the rooms, staff did not offer hand hygiene, just the paper napkin that the silverware was wrapped in.<br><br>Resident #30 was interviewed on 4/7/26 at 12:41 pm. Resident #30 said when meal trays were delivered to the rooms, staff did not offer hand hygiene. Resident #30 said residents got nothing to clean their hands other than the paper napkin on the tray.<br><br>III. Failed to ensure oxygen cannulas and CPAP masks were stored in a sanitary manner<br><br>A. Observations<br><br>On 4/6/26 at 3:29 p.m. Resident #57's CPAP mask was observed lying on the bedside table next to the machine and on top of a lamp base. The CPAP mask was not contained in a storage bag.<br><br>At 3:56 p.m. an oxygen concentrator was observed sitting by the window in room [ROOM NUMBER]. The oxygen concentrator was not running and had oxygen tubing and a nasal cannula attached. The oxygen tubing and nasal cannula were lying coiled on the floor and not contained in a storage bag.<br><br>On 4/7/26 at 8:28 a.m. the oxygen concentrator in room [ROOM NUMBER] was not running and the tubing and nasal cannula were coiled and lying underneath the handle of the concentrator. There was no storage bag for the oxygen tubing and nasal cannula when not in use.<br><br>At 12:30 p.m. Resident #57's CPAP mask was lying on the bedside table next to the machine on top of a lamp base and was not contained in a storage bag.<br><br>On 4/8/26 at 9:12 a.m. the oxygen concentrator in room [ROOM NUMBER] was not running and the tubing and nasal cannula were coiled and lying underneath the handle of the concentrator. There was no storage bag for the oxygen tubing and nasal cannula when not in use.<br><br>-At 9:30 a.m. Resident 57's CPAP mask was lying on the bedside table next to the machine on top of a<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | lamp base and was not contained in a storage bag.<br><br>On 4/9/26 at 10:00 a.m. Resident #57's CPAP mask was lying on the bedside table next to the machine on top of a lamp base and not contained in a storage bag.<br><br>B. Resident interview<br><br>Resident #57 was interviewed on 4/6/26 at 3:29 p.m. Resident #57 said he wore a CPAP at night and the staff did not clean it. He said staff had not provided a way to store the mask when it was not being used.<br><br>C. Oxygen representative interview<br><br>The oxygen representative was interviewed on 4/9/26 at 9:18 a.m. The oxygen representative said when a resident was on oxygen, their oxygen company provided routine visits to change oxygen tubing and nasal cannulas. The oxygen representative said the oxygen company also provided the bags to store CPAP masks and the oxygen tubing and nasal cannulas if the resident was not wearing the oxygen. He said the facility must notify the company when a resident had an oxygen order so appropriate supplies could be provided. He said he did not know that Resident #57 had a CPAP.<br><br>D. Staff interview<br><br>CNA #6 was interviewed on 4/9/26 at 9:56 a.m. CNA #6 said she knew Resident #57 used a CPAP but she did not know oxygen cannulas or CPAP masks needed to be stored in a bag when not in use to prevent cross contamination.<br><br>IV. Additional staff interviews<br><br>The infection preventionist (IP) and the director of nursing (DON) were interviewed together on 4/9/26 at 10:00 a.m. The IP said if a resident was on EBP and staff were transferring the resident with a slide board or providing urinary catheter care, the staff should wear PPE, which included gloves and gowns.<br><br>The DON said if a resident was on EBP, staff should wear a gown and gloves for performing activities, such as slide-board transfers or urinary catheter care.<br><br>The IP said staff should encourage and help residents to sanitize their hands at meal times.<br><br>The DON said staff were expected to offer hand hygiene to residents prior to eating in the dining rooms and when room trays were delivered.<br><br>The DON said oxygen nasal cannulas were to be stored in a plastic bag when the resident was not wearing the oxygen and the oxygen tubing and nasal cannula were not to be lying on the floor or stored under the handle of the oxygen concentrator because that could cause cross contamination. She said CPAP masks were to be cleaned routinely and stored in a plastic bag when not in use to prevent cross contamination. |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to document resuscitation choices accurately in the medical record for one (#16) of one resident out of 39 sample residents. Specially, the facility failed to ensure Resident #16's medical orders for scope of treatment (MOST) form matched the physician's order for cardiopulmonary resuscitation (CPR).Findings include:I. Resident #16A. Resident statusResident #16, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included fracture of unspecified part of neck of left femur and asthma.The [DATE] minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of nine out of 15. She required set-up assistance with eating and oral hygiene and partial to moderate assistance with toileting hygiene and dressing. B. Record reviewResident #16's MOST form, which was located in a binder at the nurses' station and uploaded into the resident's electronic medical record (EMR), revealed that the form was signed on [DATE] by Resident #16's representative. The MOST form was additionally signed by the director of nursing (DON) on [DATE]. Review of Resident #16's MOST form revealed the resident/resident's representative wished for no CPR with selective treatment, including intravenous (IV) antibiotics and fluids. Additional wishes for the resident documented on the form included the resident wished to not be intubated (tube placed in the windpipe to keep airway open) and to avoid intensive care. The [DATE] CPO revealed a physician's order which indicated that Resident #16's code status (preference for CPR or no CPR should the resident's heart stop beating)was to receive CPR, ordered [DATE]. -However, the [DATE] CPO did not match with the directive on the MOST form, which indicated the resident wished to have no CPR, effective [DATE] (see MOST form above). A care conference progress note, dated [DATE], revealed the care conference was attended by Resident #16's representative, the social services director (SSD), and the assistant director of nursing (ADON). The progress note documented that a new MOST form was completed for Resident #16.-The note did not reveal that the resident's preferences for code status were changed.The care plan, initiated [DATE], revealed Resident #16's code status was CPR.-However, Resident #16's MOST form was updated on [DATE] to indicate the resident did not want CPR. II. Staff interviewsCertified nurse aide (CNA) #7 was interviewed on [DATE] at 4:23 p.m. CNA #7 said she had worked at the facility for one month and had six years of CNA experience. CNA #7 said if she had found Resident #16 and the resident had stopped breathing, she would have checked if the resident was on oxygen, ensured it was working, checked the resident's oxygen levels, obtained an oxygen concentrator if needed and notified the nurse right away. CNA #7 said the residents' code statuses could be found in the residents' EMRs and in the care plans. CNA #7 said Resident #16 was a full code status with CPR, based on the resident's EMR. CNA #7 said she had not seen a situation where the resident's EMR indicated CPR while the MOST form indicated no CPR, but she would have still provided care and kept the resident comfortable regardless of code status.Registered nurse (RN) #3 was interviewed on [DATE] at 4:36 p.m. RN #3 said if she had found Resident #16 unresponsive, she would have checked the resident's vital signs if the resident had no pulse and was not breathing. RN #3 said if there were no vital signs, she would have called the physician, applied oxygen or increased the oxygen and followed the physician's directions. RN #3 said Resident #16's code status could be found in the resident's EMR. RN #3 said she would follow the most recent MOST form if there was conflicting information.RN #5 was interviewed on [DATE] at 4:50 p.m. RN #5 said she had worked at the facility for one year. RN #5 said if she found Resident #16 unresponsive, she would have checked the resident's heart rate, vital signs and oxygen. RN #5 said that if the resident had no pulse and was not breathing, she would have checked the resident's code status and the medication administration record (MAR). RN #5 said Resident #16's code status could<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | be confirmed in the EMR RN #5 said Resident #16 was a full code status, according to the resident's EMR. RN #5 said she would have followed the most recent MOST form if there was conflicting information and she would have notified the DON to determine why the physician's orders for code status had not been updated.The SSD was interviewed on [DATE] at 12:40 p.m. The SSD said nursing staff typically ensured that the residents' MOST forms, physician's orders for code status and EMRs matched. The SSD said the MOST form for Resident #16 was changed on [DATE] and the resident's representative, the DON and the SSD participated. The SSD said Resident #16's MOST form was coded as DNR (do not resuscitate) with selective treatment. The SSD said if there was a discrepancy in the EMR, she would have reviewed the MOST form during the care conference and discussed with the DON to resolve it.The DON was interviewed on [DATE] at 1:50 p.m. The DON said the facility ensured residents' code status was consistent between the MOST form, the physician's orders, and the residents' EMRs through care conference review. The DON said the staff members completing the clinical care conference, including the DON and the SSD, were responsible for updating the MOST form. The DON said staff were expected to follow the MOST form when there was conflicting code status information in the chart. The DON said care conferences were conducted quarterly to monitor and identify discrepancies. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide adequate positioning and contracture management for residents to maintain their highest practicable level of functioning for two (#59 and #15) of three residents out of 39 sample residents.Specifically, the facility failed to: -Ensure staff were appropriately monitoring the use of a resistance band that was requested by Resident #59 to keep her left leg safely positioned on her wheelchair leg rest; and,-Ensure hand splints were provided in a timely manner for Resident #15, who had Swan neck deformities (a condition causing the middle knuckles of the hand to bend inward and the end knuckles to bend outward, creating an S-shape) in both hands.Findings include:I. Facility policy and procedureThe Resident Mobility and Range of Motion policy, revised July 2017, was provided by the nursing home administrator (NHA) on 4/9/26 at 4:42 p.m. It read in pertinent part, Residents will not experience an avoidable reduction in range of motion (ROM). Residents with a limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain mobility unless a reduction in mobility is unavoidable. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility, including: pain, skin integrity issues, muscle wasting and atrophy, gait and balance issues that may lead to falls or fractures, contractures or other complications that could cause or contribute to immobility, impaired ROM or injury from falls. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.II. Failed to ensure staff were appropriately monitoring the use of a resistance band that was requested by Resident #59 to keep her left leg safely positioned on her wheelchair leg [NAME]. Resident statusResident #59, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician's orders (CPO), diagnoses included spastic hemiplegia affecting the left side, multiple sclerosis, lesion of the left upper limb ulnar nerve (impairment to a nerve in her arm), gait and mobility impairment, spinal stenosis, and flexion deformity of the left and right ankle and toes.The 3/18/26 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 #59 used a wheelchair for mobility and was dependent on staff assistance for showers and transfers in and out of her wheelchair. Resident #59 had range of motion impairments to one upper extremity and both lower extremities. The MDS assessment documented Resident #59 needed substantial assistance with lower-body dressing.B. Resident observations and interviewsOn 4/6/26 at 12:23 p.m. Resident #59 was in her room, sitting in her manual wheelchair. Resident #59's left leg was tied to her wheelchair leg rest with a bright orange exercise resistance band around her calf. Resident #59 said she had a contracture of her left leg, which prevented her from bending her knee and caused the leg to point inward toward the midline of her body. Resident #59 said she used the resistance band because her left leg extended past her wheelchair leg rest and the resistance band was necessary to prevent her left leg from getting caught in the middle of the leg rests. Resident #59 said the facility did not have the right assistive devices for her.On 4/8/26 at 10:33 a.m. Resident #59 was observed with her left calf tied to her manual wheelchair. Resident #59 said she preferred the resistance band because she could hardly feel it on her leg and the assistive devices that physical therapy provided her were too bulky, which prevented her from getting her wheelchair under the dining room tables.On 4/8/26 at 3:47 p.m. Resident #59 was sitting in her wheelchair in the doorway to her room. Resident #59's left leg was tied to her wheelchair with the resistance band. Resident #59's feet touched the floor and she appeared to be sliding to the front of her wheelchair. Resident #59 said she (continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was not able to position herself and she hoped staff would come help her reposition soon because she could not move independently in her current position.On 4/9/26 at approximately 4:15 p.m. Resident #59 was in her room, sitting in her wheelchair with the resistance band tied around her left calf. Resident #59 attempted to take the resistance band off her leg, but she could not reach any part of the band. Resident #59 then attempted to pull her pant leg up to bring the band closer to her hand. Resident #59 could not reach the band, and the band started to roll up. Resident #59 said she had a pair of scissors in her room, and if she needed to get the band off, she would have to find the scissors to cut the band off.C. Record review-Review of Resident #59's April 2026 CPO revealed no physician's orders to use a resistance band to assist Resident #59 in positioning her lower extremities. -The April 2026 CPO did not include physician's orders to monitor the use of the resistance band for skin breakdown or circulatory issues.The skin care plan, initiated 10/20/23, documented Resident #59 was at risk for skin breakdown.The activities of daily living (ADL) care plan, initiated 10/23/23 and revised 1/9/26, documented the use of a Velcro strap to keep Resident #59's left leg positioned properly to reduce the risk for injury. The care plan documented the resident could remove the Velcro strap without assistance, but indicated the resident refused to follow recommendations provided by therapy.-However, the care plan failed to document that the resident chose to use a resistance band to strap her leg to the chair instead of the Velcro strap.The assistive devices care plan, initiated 11/22/23, documented Resident #59 required assistive devices for mobility and positioning.The contracture care plan, initiated 4/25/25 and revised 1/2/26, revealed Resident #59 had a contracture related to a chronic disease process. Interventions included for Resident #59 to work with the therapy department for evaluation and treatment.-However, the care plan did not include the use of the resistance band for positioning Resident #59's leg.A nursing progress note, dated 6/2/25, documented Resident #59 used a resistance band to support her leg position on the foot rest. The physical therapy progress note, dated 10/8/25, documented Resident #59 reported using a resistance band to fixate her left leg onto her wheelchair pedal.The physical therapy recertification note, dated 1/18/26, documented Resident #59 had contractures at the hips, knees, and ankles. The note documented Resident #59 needed substantial assistance due to a high risk for injury to her left leg and decreased safety awareness. The note documented Resident #59 was provided with the proper positioning devices and modifications for positioning in her wheelchair.-Review of Resident #59's electronic medical record (EMR) failed to reveal documentation to indicate the following:-The medical condition the resistance band was being used to treat;-Identify who was allowed to apply the resistance band; -Where and how the resistance band was to be applied and used; -The type of specific direct monitoring and supervision provided during the use of the resistance band, including documentation of the monitoring; and,-The identification of how the resident's needs would be met during use of the resistance band, such as for re-positioning, meals, using the bathroom and hygiene. -Additionally, the resident's EMR failed to include documentation of the development and implementation of interventions to prevent and address any risks related to the use of the resistance band.The physical therapy progress note, dated 4/6/26, documented Resident #59 was educated on wheelchair positioning recommendations and the use of a wedge to position her legs instead of tying her leg to the leg rest. The note documented Resident #59 requested her leg be tied to the wheelchair at the end of the physical therapy session.D. Staff interviewsCertified nursing assistant (CNA) #5 was interviewed on 4/8/26 at 2:20 p.m. CNA #5 said Resident #59 usually had the CNAs tie her leg to the wheelchair with the resistance band. CNA #5 said she assumed physical therapy had approved the use of the resistance band for positioning because Resident #59 had been using it for positioning for the past few months. CNA #5 said Resident #59 needed help to get dressed and had diminished sensation in her legs.CNA #8 was interviewed on 4/8/26 at 2:41 p.m. CNA #8 said she was Resident #59's CNA. CNA #8 said the previous shift put the resistance band on Resident #59's leg and she did not know how long it had been on.Registered nurse (RN) #1 was interviewed on 4/8/26 at 3:55 p.m. RN #1 said she was Resident #59's nurse. RN #1 said she did not know Resident #59's leg was tied to (continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | her wheelchair. RN #1 said nurses should check residents' assistive devices at least once a shift for skin breakdown.The director of rehabilitation was interviewed on 4/9/26 at 12:43 p.m. The director of rehabilitation said she had recently learned Resident #59 had staff tie her leg to her wheelchair instead of using the wedge or Velcro strap provided by the physical therapy department. The director of rehabilitation said the use of the resistance band to align Resident #59's leg was okay if Resident #59 could remove the band herself and if it was not tied too tightly or left on for prolonged periods of time. The director of rehabilitation said if nursing staff applied the resistance band to Resident #59's leg, then nursing staff were also responsible for monitoring safety and performing skin checks. The director of rehabilitation said she was not aware Resident #59 could not remove the resistance band herself.The director of nursing (DON) was interviewed on 4/9/26 at 2:16 p.m. The DON said the therapy department managed all assistive devices, but nursing staff could apply, remove and monitor braces, splints, and other assistive devices with a physician's order. The DON said for residents with assistive devices, the nursing staff were expected to assess the resident at least twice a day for skin breakdown and circulation issues. The DON said if the equipment became ill-fitting or broke, nursing staff were expected to notify the rehabilitation department. The DON said she was aware Resident #59 used a resistance band to tie her leg to the leg rest of her wheelchair. The DON said she was told Resident #59 could remove the band herself and alternatives to the band had been offered. The DON said nursing staff should follow a physician's order to monitor Resident #59's skin and a care plan to use the resistance band for positioning. The DON said she did not see any current care plans or physicians' orders for the resistance band in Resident #59's EMR. The DON said she would add the resistance band to the resident's care plan and get the physician's orders to monitor Resident #59's use of the resistance band.III. Failed to ensure hand splints were provided in a timely manner for Resident #15, who had Swan neck deformities in both handsA. Professional ReferenceAccording to [NAME] and [NAME] C. [NAME], Managing Swan Neck and Boutonniere Deformities, copyright 2020, accessed on 4/16/26 from https://asht.org/sites/asht/files/images/International/Sept%202025/08%20Managing%20Swan%20Neck%20ar Swan neck and Boutonniere finger deformities result from extensor tendon imbalances. They can present acutely, most commonly in the setting of trauma (sharp laceration, blunt avulsion, burns) or as a progressive deformity. Corrective splinting is generally the first line of treatment of Swan neck and Boutonniere deformities of the fingers. Complete correction of Swan neck and Boutonniere deformities is difficult to achieve, but the function and esthetics of the interphalangeal joints of the fingers can be greatly improved with splinting and operative interventions. Swan neck deformities are first treated with splinting. Before any tendon rebalancing to correct a Swan neck or Boutonniere deformity, passive range of motion must be optimized. Hand therapy is important for all patients with these injuries. Corrective splinting, range of motion exercises, and education are essential elements of the patient's care. Early recognition and treatment of extensor tendon injuries is best to prevent extensor tendon imbalances and resultant swan neck and boutonniere deformities. Once established, these deformities can require prolonged courses of splinting and, less commonly, surgery for correction.B. Resident statusResident #15, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included type two diabetes, coronary heart disease, macular degeneration of the right eye, bipolar disorder and a history of falling.The 3/5/26 MDS assessment revealed the resident was cognitively intact, with a BIMS score of 15 out of 15. Resident #15 needed substantial assistance with his ADLs and needed set-up assistance with feeding. The MDS assessment indicated Resident #15 had Swan neck deformities in both of his hands.C. Resident observations and interviewsOn 4/6/26 at 3:01 p.m. Resident #15 was lying flat in bed. Both of his hands were concave at the knuckles, with the fingers extended out. Resident #15 said he had some pain in his hands from the deformity, but he did not want pain medication. Resident #15 said he could not bend his fingers, but would receive hand splints today (4/6/26) to help correct the deformity. He said he had worked with the therapy department for the past six weeks to get the hand splints.On 4/7/26 at 3:18 p.m. (continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #15 was lying flat in bed, taking a nap. The hand splints were observed in a basin on the opposite side of the room.On 4/8/26 at 10:30 a.m. Resident #15 was lying flat in bed. Resident #15 said the splints had arrived, but he had not gotten to wear them yet. Resident #15 said someone from the therapy department needed to put the splints on his hands.On 4/8/26 at 2:08 p.m. Resident #15 was lying flat in bed. Resident #15 said he had not seen anyone from the therapy department yet.D. Record reviewThe contracture care plan, initiated 4/7/25, identified Resident #15 had Swan neck contractures in both his hands. Interventions included offering Resident #15 orthotics and physical therapy and notifying the physician of any changes.The assistive devices care plan, revised 3/10/26, documented Resident #15 required assistive devices such as splints for his Swan neck contractures and occupational therapy would assist him with the splints.The plan of treatment for rehabilitation, dated 4/7/25, documented Resident #15 had not left his bed since his transition from rehabilitation to long-term care. The note documented that as a result, Resident #15 was functioning significantly below his baseline and would be referred to occupational therapy.-However, the plan of treatment did not address the swan neck deformities.The plan of treatment for rehabilitation, dated 12/8/25, documented Resident #15 said his goal was for his hands to work. The plan of treatment addressed the Swan neck deformity and included short-term and long-term goals to increase the range of motion in Resident #15's fingers. The note revealed Resident #15 was functioning at a higher level compared to his presentation on the day the note was written. The note documented a referral was placed for orthotics recommendation to an orthotics clinic.The occupational therapy progress notes, from 1/29/26 to 2/25/26, documented the facility contacted the orthotics clinic to assess Resident #15. The note documented Resident #15's hand and finger function were limited by the need for splinting.The occupational therapy progress note, dated 4/6/26 and written by occupational therapy assistant #1, documented Resident #15's splints had arrived at the facility. C. Staff interviewsOccupational therapy assistant #1 was interviewed on 4/6/26 at 3:01 p.m. Occupational therapy assistant #1 said he did not know when Resident #15 developed the Swan neck deformities in his hands. Occupational therapy assistant #1 said the therapy department had been treating the deformities with diathermy (electromagnetic current therapy), which had improved the condition marginally. Occupational therapy assistant #1 said Resident #15 was currently being fitted for hand splints by the orthotics clinic. The director of rehabilitation was interviewed on 4/9/26 at 12:43 p.m. The director of rehabilitation said Resident #15 had been admitted to the facility with the Swan neck deformities in his hands. The director of rehabilitation said that on 11/30/25 Resident #15 was screened by therapy services and was found to have had a significant decline in function. The director of rehabilitation said Resident #15 was functional after he completed rehabilitation, but at the time of the screening on 11/30/25, his hand and ankle contractures had worsened. The director of rehabilitation said at the time of the screening, Resident #15 said his goal was to be able to use his hands again, which prompted the therapy department to place the referral for hand splints. The director of rehabilitation said the standard treatment for Swan neck deformities was stretching, diathermy and splinting. The director of rehabilitation said Resident #15's Swan neck deformities would not improve without splinting. The director of rehabilitation said Resident #15 did not receive hand splints when he was admitted to the facility, because the rehabilitation department was focused on his lower extremity mobility.The DON was interviewed on 4/9/26 at 2:16 p.m. The DON said if a resident declined in their ability to perform ADLs or had a change in clinical presentation, nursing staff should inform the interdisciplinary team (IDT). The DON said splint management was managed by the rehabilitation department. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individual providing services for one (#47) of two residents reviewed for hospice care services out of 39 sample residents. Specifically, the facility failed to: -Establish a communication process, including how the communication would be documented between the facility and the hospice provider for Resident #47; and, -Ensure hospice agency staff notes were easily accessible to the facility staff and included consistent documentation of hospice care visits for Resident #47.Findings include: I. Facility policy and procedure The Hospice Service Facility Agreement policy and procedure was provided by the nursing home administrator (NHA) on 4/9/26 at 4:42 p.m. It read in pertinent part, The written agreement(s) will set out at least the following: a communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. The facility will, under a written agreement, ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.II. Resident #47A. Resident status Resident #47, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included hypertensive heart disease, atherosclerotic heart disease, senile degeneration of the brain, restlessness and agitation. The 3/6/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. She used a wheelchair. She required partial assistance with eating and required substantial assistance with personal hygiene. She was dependent on oral hygiene, toileting, and showering, The assessment revealed the resident was receiving hospice care services. B. Resident's representative interview Resident #47's representative was interviewed on 4/6/26 at 4:03 p.m. The representative said Resident #47 was admitted to the facility because the resident's representative was no longer able to care for her at home because Resident #47 had dementia and required more supervision. The resident's representative said Resident #47 had fallen a couple of times since she was admitted to the facility and the hospice care services company had provided a Broda chair (a specialized wheelchair) to help prevent the resident from falling. C. Observations On 4/7/26, at 12:50 p.m. Resident #47 was escorted to the dining room by two hospice staff members. The hospice staff members immediately left the dining room. Resident #47 was in a Broda chair. -However, review of Resident #47's electronic medical record (EMR) did not reveal documentation of the hospice staff visit with Resident #47 (see record review below).On 4/8/26 at 12:01 p.m., Resident #47's room was observed. Resident #47's bed had an air mattress and a lipped mattress (a raised supportive perimeter mattress used to help prevent falls).-However, review of Resident #47's EMR did not reveal documentation that the durable medical equipment (DME) had been supplied by the hospice care services company (see record review and interviews below). D. Record review The hospice care plan, revised 3/11/26, revealed Resident #47 received hospice care services due to senile degeneration of the brain (a progressive, age-related decline in cognitive function caused by brain cell damage). Interventions included contacting the hospice agency for any change in condition, coordinating cares between the hospice agency and facility staff, educating staff to resident's needs and desires, encouraging socialization and activity as resident desired and was able; honoring advance directives, monitoring for complaints of pain or discomfort and providing interventions as orders, providing medication as ordered and providing ongoing emotional support to the resident and family members. The fall care plan, revised 3/11/26, revealed Resident #47 was at risk for falls due to terminal agitation, poor safety awareness, unable to retain new learning, noted to be restless at times and may (continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cause slip from bed or chair. Interventions included assessing the resident's wheelchair for an alternative option, hospice was notified for a volunteer to sit with the resident, hospice was to perform a medication review; medication review by hospice for restlessness, and adjusting air mattress firmness for comfort. Review of Resident #47's April 2026 CPO revealed the following physician's orders: Admit to hospice with a terminal diagnosis of senile degeneration of the brain, ordered 2/20/26. -A review of Resident #47's EMR revealed no documentation to indicate hospice volunteer services were requested (see care plan above). -A review of Resident #47's EMR revealed no hospice notes were documented from 3/25/26 to 4/9/26. -Additionally, a review of Resident #47's EMR revealed no documentation to indicate a Broda chair and a lipped mattress were provided by the hospice care services company. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/9/26 at 9:46 a.m. LPN #1 said she knew a resident received hospice care services based on a physician's order. She said she knew a hospice worker visited if they came during her shift. She said she thought the director of nursing (DON) and the social services director (SSD) were the hospice coordinators for the facility. She said hospice was responsible for providing residents with DME, such as wheelchairs and mattresses. She said Broda chairs were used when residents were extremely agitated or terminally agitated. She said sometimes residents would slide out of a regular or high back wheelchair and a Broda chair was recommended. She said a Broda chair was a way for a resident to get out of their bed and still be able to sleep comfortably in a chair. She said a Broda chair was harder for residents to get out of the Broda chair. She said if a resident was on hospice, hospice completed the evaluation and assessment. She said she did not document if a resident had a Broda chair. She said a lipped mattress was used for the same reason, when a resident was more at risk for rolling out of bed. She said she was familiar with Resident #47. She said the resident had a Broda chair to help prevent her from falling. She said she did not remember when the Broda chair was delivered but thought it was about two weeks ago and hospice provided the Broda chair. -However, there was no documentation in the resident's EMR of an evaluation and assessment completed by hospice for the Broda chair or lipped mattress (see record review above).The DON was interviewed on 4/9/26 at 12:49 p.m. The DON said she was the hospice coordinator for the facility. She said nursing knew a resident received hospice care services based on change of shift report and on the face sheet. She said the hospice care services company was responsible for any DME needs the resident might have. The DON said hospice staff checked in with the floor nurse and the floor nurse entered a progress note regarding the hospice visit. The DON said hospice staff checked in with her as well. The DON said she was familiar with Resident #47. She said the resident had a Broda chair and a lipped mattress for safety and the hospice care services company had provided it. She said she did not know the hospice notes were not available in Resident #47's EMR. |