STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Care & Rehabilitation LLC	3131 S Federal Blvd Denver, CO 80236

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen.Specifically, the facility failed to ensure appropriate use of gloves when handling ready-to-eat foods. Findings include:I. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/7/26. It revealed in pertinent part, Food employees may not contact exposed ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301-11) Food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped to provide water at a temperature of at least 29.4oC (85oF) through a mixing valve or combination faucet.(2-301-12)II. ObservationsDuring a continuous observation of the dinner meal service on 4/1/26, beginning at 4:25 p.m. and ending at 5:55 p.m. the following was observed:At 4:30 p.m. dietary aide (DA) #2 placed three plates on the serving line. She picked up three hot dog buns with her bare hands and placed one bun each on a plate. At 4:38 p.m. DA #2 picked up a hot dog bun bare hands and placed it on a plate and assembled a meatball sandwich.At 4:40 p.m. DA #2 picked up a meal ticket. Without performing hand hygiene DA #2 picked up a hot dog bun with her bare hands and placed it on a plate. She assembled a meatball sandwich and passed the plate to cook (CK) #1.At 4:41 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich.At 4:42 p.m. DA #2 touched the counter top and picked a plate and put it on the counter top. Without washing her hands, she picked up a hot dog bun and placed it on the plate. She assembled a meatball sandwich and passed the plate to CK #1.At 4:45 p.m. DA #2 touched a wet towel on the table to her left with her right hand. CK #1 adjusted her shirt and apron around her waist with her bare hands.At 4:45 p.m. CK #1 picked up a meal ticket order]. She picked up a hot dog bun bare hands and placed it on the plate.At 4:46 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich.At 4:47 p.m. DA #2 picked up a meal ticket with bare hands. Without performing hand hygiene DA #2 picked up a hot dog bun with her bare hands and placed it on a plate. She assembled a meatball sandwich and passed the plate to CK #1. At 4:52 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich.At 4:54 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich. DA #2 swiped a plate with food bare hands with the chef.At 4:55 p.m. DA #2 brought trays bare hands from the dishwasher room. She grabbed meal tickets and placed them on the trays, picked up plates and placed them on the trays bare hands. She picked up hot dog buns bare hands and placed them on the plates.At 4:57 p.m. DA #2 picked up a hot dog bun bare hands and placed it on a plate and assembled a meatball sandwich.At 4:59 p.m. CK #1 touched her wrist watch with bare hands. Without washing her hands she picked a bowl, grabbed an utensil and scooped a spoonful of macaroni onto the bowl.At 4:59 p.m. without wearing gloves, DA #2 picked up a bun with her right hand, and assembled a meatball sandwich. CK #1 did not wash her hands after adjusting her shirt and apron and touching the plate. DA (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#2 picked up meal tickets on the table with both hands. She then picked up a plate with her right hand and placed a hot dog bun on the plate with her bare left hand. CK #1 finished assembling the plate and placed the plate on a tray in the window to be served to a resident.At 5:00 p.m. DA #2 touched her clothes. Without washing her hands, she resumed serving meals. At 5:16 pm DA #1 started assembling the meal plates and placed them in the meal cart bare hands.At 5:18 p.m. the staff continued to assemble meal plates bare hands and placed them in the meal cart.At 5:21 p.m. DA #2 washed her hands and picked a hot dog bun without wearing gloves and assembled a meatball sandwich.At 5:23 p.m. CK #1 washed her hands and scooped pasta salad onto a plate with a utensil.At 5:25 p.m. DA #1 started to assemble two meal plates. She used her bare hand to place a hot dog bun on two plates. The meal plates were assembled and placed in the meal cart for service.At 5:25 p.m. DA #2 touched her clothes with her hands. Without washing her hands she picked a meal ticket, read it and put it back on the tray. She picked a hot dog bun bare hand and placed on the plate, grabbed an utensil and scooped meatball onto the plate, passed the plate to CK #1 .At 5:27 p.m. DA #1 started to assemble three meal plates. She used her bare hand to place a hot dog bun on two plates. The meal plates were assembled and placed in the meal cart for service.At 5:45 p.m. DA #2 wore gloves and went to get more trays from the dishwashing room. She removed gloves and resumed serving meals bare hands.III. Staff interviewsDA #3 was interviewed on 4/2/26 at 3:20 p.m. DA #3 said she washed her hands, went to the serving line, served food, and washed her hands again before serving the next meal. DA #3 said she took a handwashing break between serving the next meal. DA #3 said she could not touch bread or buns with bare hands and avoided direct contact with ready-to-eat food. She said gloves should be worn and changed as needed after use. DA #3 said they did not wear gloves when serving food because they washed their hands consistently. She said DA #2 and CK #1 were not supposed to handle hot dog buns with bare hands.The kitchen manager was interviewed on 4/2/26 at 3:38 p.m. The kitchen manager said kitchen staff should wash their hands consistently between tasks. He said they should use tongs or wear gloves for a single task while handling ready-to-eat food. The dietary cook said DA #2 and CK #1 should not touch hot dog buns with bare hands. The kitchen manager said the dietary staff should have worn gloves when handling the hot dog buns.The nursing home administrator (NHA) was interviewed on 4/6/26 at 2:34 p.m. The NHA said the kitchen staff were educated on proper hand hygiene during meal preparation and service on 4/1/26.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, record review and interviews, the facility failed to ensure residents received food and fluids prepared in a form designed to meet his or her needs per speech therapy recommendation, physician orders and the residents care plan.Specifically, the facility failed to ensure soft and bite size chicken was produced and serviced according to the International Dysphagia Diet Standardisation Initiative (IDDSI) standards. Findings include:I. Professional referenceAccording to the IDDSI reference (July 2019), retrieved on 4/14/26, https://www.iddsi.org/images/Publications-Resources/DetailedDefnTestMethods/English/V2DetailedDefnEngli: Can be eaten with a fork, spoon or chopsticks. Can be mashed/broken down with pressure from fork, spoon or chopsticks. A knife is not required to cut this food, but may be used to help load a fork or spoon. Soft, tender and moist throughout but with no separate thin liquid. Chewing is required before swallowing. Bite-sized pieces as appropriate for size and oral processing skills. Adults no larger than 1.5 centimeters (cm). Fork pressure test: pressure from a fork held on its side can be used to cut or break apart or flake this texture into smaller pieces. When a sample the size of a thumb nail (1.5 by 1.5 cm) is pressed with the tines of a fork to a pressure where the thumb nail blanches to white, the sample squashes, breaks apart, changes shape, and does not return to its original shape when the fork is removed.II. Facility policy and procedureThe Therapeutic Diet Orders policy and procedure, revised 4/2/26, was provided by the nursing home administrator (NHA) on 4/2/24 at 3:47 p.m. The policy read in pertinent part, The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.III. Record reviewThe texture modified diet menu was provided by the NHA on 4/1/26 at 9:47 a.m. The menu documented the residents prescribed a soft and bite sized diet were to receive the following items for dinner on 4/1/26:-Bite-size meatballs with thick sauce with a minced or pureed bun;-Bite-sized pasta salad with vinaigrette; and,-Bite-sized chilled peaches.-However, the facility failed to serve the menu as posted. IV. Observations During a continuous observation of the meal service on 4/1/26, beginning at 4:25 p.m. and ending at 5:55 p.m. The following was observed: At 4:29 p.m. the soft and bite sized menu items were in the hot steam table. The mechanically altered menu items held in the hot food holding table were reviewed with cook (CK) #1. CK #1 said foods in the hot food holding table were for the soft and bite sized meals. The chicken for the soft and bite sized meals was approximately 1/4 inch to 1/2 inch in size.-However, soft and bite sized foods should be less than 1.5 cm by 1.5 cm (see professional reference above). At 4:35 p.m. CK #1 assembled a soft and bite-sized texture plate. CK #1 scooped the diced chicken, green beans and rice. He covered it all with au-jus. The plate was delivered to a resident seated in the dining room.At 4:48 p.m the kitchen manager was notified the chicken was diced incorrectly. The kitchen manager was asked to do a fork test and he said he was not sure how to do the fork test. After demonstrating the fork test with the dietary cook, the chicken did not break apart or flake. At that time the kitchen manager corrected the issue and made the chicken pieces smaller.V. Staff interviewsCK #1 was interviewed on 4/1/26 at 4:36 p.m. during meal service. CK #1 said the chicken was for the soft and bite sized Level 6 texture and minced and moist Level 5 texture. She said the chicken was prepared at the facility by the kitchen manager, who cooked and diced the chicken.The kitchen manager was interviewed on 4/1/26 at 4:49 p.m. The kitchen manager said the chicken on the hot line was the chicken for the soft and bite sized Level 6. He said he did not do the fork test prior to service. He said he cut the size of the chicken according to (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the size of the thumb nail in the picture posted on the wall in the kitchen and the au-jus was to put on top of the chicken for moisture. The kitchen manager said he had done a fork test to ensure the correct texture of the food in the past but did not do it at that time. He said he was not sure how to do the fork test.The regional clinical resource was interviewed on 4/1/26 at 5:45 p.m. The regional clinical resource said she had printed the IDDSI education materials for the staff to do additional education and assigned the electronic IDDSI learning to them in the system. She said the training would take about an hour and a half to complete and they would start working on it possibly the following day.The kitchen manager was interviewed again on 4/2/26 at 3:38 p.m. The kitchen manager said he received training on textures one month later, shortly after the facility changed the ownership. He said he relied on his previous facility texture training for reference. The kitchen manager said there was a choking risk associated with an incorrect texture.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of four units. Specifically, the facility failed to:-Ensure housekeeping staff followed appropriate infection control procedures when cleaning and disinfecting residents' rooms and high frequency touched areas (call lights, door handles, light switches and bed controls);-Ensure housekeeping staff followed disinfectant dwell times (amount of time required to ensure germs are eliminated) when cleaning residents' rooms;-Ensure housekeeping staff performed appropriate hand hygiene between glove changes; and,-Ensure Resident #6's catheter tubing was not touching the floor.Findings include: I. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 4/7/26 from https.//pubmed.ncbi.nlm.nih.gov. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease). Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stays, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 4/7/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/pre ent/resource-limited/cleaning-procedures.html#cdc_generic_section_2-4-1-general-environmental-cleaning-te It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. B. Facility policy and procedures The Routine Cleaning and Disinfecting Resident Rooms policy and procedure, revised 4/2/26, was provided by the nursing home administrator (NHA) on 4/2/26 at 4:21 p.m. It read in pertinent part, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Cleaning considerations include, but are not limited to, the following: dry cleaning procedures will be conducted before wet procedures, clean from areas that are visibly clean and least likely to be contaminated to areas usually visibly dirty, clean from top to bottom (bring dirt from high levels down to floor levels), clean from back to front areas. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to: toilet flush handles, bed rails, tray tables, call buttons, television remote, telephones, toilet seats, monitor control panels, touch screens and cables, resident chairs, IV poles, blood pressure cuffs, sinks and faucets, light switches and door knobs. Disinfectant solutions will be prepared fresh daily and changed frequently in order to ensure effectiveness. Follow manufacturer recommendations for dilution and frequency of changing of disinfectant solution. Follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection. Change solution after cleaning a room under transmission-based precautions. Clean and disinfect any equipment that enters the room before use in another location. Verify products used to clean and disinfect surfaces in rooms under transmission-based precautions are effective against the pathogen of concern. The Handwashing/Hand Hygiene policy and procedure, revised 2026, was provided by the NHA on 4/6/26 at 8:43 a.m. It read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Applying and removing gloves: perform hand hygiene before applying non-sterile gloves. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. When (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. Then perform hand hygiene. C. Observations During a continuous observation on 4/2/26, beginning at 10:47 a.m. and ending at 11:05 a.m. Housekeeper (HK) #1 was observed exiting room [ROOM NUMBER] and using alcohol-based hand rub (ABHR). She pushed the housekeeping cart to room [ROOM NUMBER], a double-occupancy room, and donned gloves. She knocked on the door and asked permission to clean the room. HK #1 removed a spray bottle of disinfectant and a clean blue rag. The disinfectant spray bottle had a label on it that indicated the disinfectant had a dwell time of three to five minutes. At 10:48 a.m. HK #1 sprayed the residents' sink and faucet with the disinfectant. She removed the toilet brush from the cart and placed it in the bathroom. She removed her gloves and donned clean gloves without performing hand hygiene. At 10:50 a.m. (two minutes after spraying the disinfectant), HK #1 wiped out the sink and faucet with the blue rag. She splashed water onto the mirror and wiped it clean. She placed the disinfectant spray bottle and rag back into the cart and removed her gloves. HK #1 donned clean gloves, without performing hand hygiene, and removed the disinfectant spray bottle and a rag from the cart. She sprayed the rag with the disinfectant and wiped the top of the over bed table for bed B. She sprayed the rag again and wiped down the legs and base of the overbed table. She placed the disinfectant spray bottle and rag back into the cart and removed her gloves. Without performing hand hygiene, HK #1 donned clean gloves and removed the disinfectant spray bottle and a rag from the cart. She sprayed the rag with the disinfectant and wiped the top of the over bed table for bed A. She folded the rag in half, sprayed it with disinfectant and wiped down the legs and base of the overbed table. She placed the disinfectant spray bottle and rag back into the cart and removed her gloves. Without performing hand hygiene, HK #1 donned clean gloves and removed the disinfectant spray bottle and a clean rag from the cart. She sprayed the rag with the disinfectant and wiped off the top and front of bed A's nightstand. She placed the disinfectant spray bottle and rag back into the cart and removed her gloves. -HK #1 failed to allow the disinfectant to remain on surfaces for the appropriate disinfectant dwell time while cleaning the residents' room. -HK #1 failed to disinfect high touch areas, such as the door knobs, light switches, call light and bed controller. -HK #1 failed to perform hand hygiene during her multiple glove changes. HK #1 donned clean gloves without performing hand hygiene and removed a clean rag from the cart. She entered the bathroom of room [ROOM NUMBER] and used the toilet brush to scrub the toilet seat, underneath the toilet seat, the rim of the toilet and then the toilet bowl. She used the dry blue rag (without any disinfectant spray) to wipe the toilet rim, underneath the toilet seat, the toilet seat, the toilet tank, the top of the toilet tank and the base of the toilet. She placed the rag and the toilet brush back into the cart and removed her gloves and then donned clean gloves without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HK #1 failed to use disinfectant to clean any parts of the toilet. -HK #1 failed to disinfect the light switch and door knobs in the bathroom. -HK #1 failed to clean from top to bottom or clean to dirty when cleaning the toilet. -HK #1 failed to perform hand hygiene between glove changes and after cleaning the bathroom. HK #1 donned clean gloves and proceeded to sweep the room and empty the trash. She placed the broom and trash onto the cart and removed her gloves. She donned clean gloves, without performing hand hygiene and removed a mop pad from the mop bucket and mopped bed B's side of the room. She removed her gloves and donned clean gloves without performing hand hygiene. She removed the soiled mop pad from the mop handle and placed it in a bag. HK #1 removed her gloves and donned clean gloves without performing hand hygiene. She removed a clean mop pad from the mop bucket and mopped bed A's side of the room. She removed the soiled mop pad and placed it on the cart. She removed her gloves and donned clean ones, again without performing hand hygiene. HK #1 removed a clean mop pad from the mop bucket and started to mop the bathroom. She removed her gloves, used ABHR and removed a roll of toilet paper from the cart. She returned to the bathroom and finished mopping. She removed her gloves and donned clean gloves without performing hand hygiene. She removed a fourth mop pad from the mop bucket and mopped behind the door and the entry to the room. She removed her gloves and washed her hands, she shut the door, donned clean gloves and removed the soiled mop pad. She placed the soiled mop pad onto the cart and removed her gloves. She placed a wet floor sign at the entrance of the room and pushed the cart to the next room. -HK #1 failed to consistently perform hand hygiene between glove changes while cleaning the bathroom of room [ROOM NUMBER]. D. Staff interviews HK #1 was interviewed on 4/2/26 at 3:08 p.m. HK #1 said she had cleaned residents' rooms the same way for 28 years. She said if she left a room or removed a mop pad, she would change her gloves. She said she should perform hand hygiene between glove changes to prevent bacterial microbes. She said the disinfectant needed to remain wet on surfaces for three to five minutes to kill microbes. She said the toilet brush could be used on the seat and the toilet bowl and that was how she always cleaned the toilet. She said the toilet should be cleaned from top to bottom to prevent taking dirt to cleaner areas to prevent contamination. She said she always sprayed the rag instead of the surfaces because some residents did not like the disinfectant to be sprayed. She said high touch areas should be cleaned daily, but she was unable to identify what the high touch surfaces were. She said she did receive training on cleaning residents' rooms and it was important to disinfect and clean the rooms properly to prevent the spread of infections. The housekeeping supervisor (HKS) was interviewed on 4/6/26 at 1:35 p.m. The HKS said residents' rooms were cleaned daily. She said the disinfect spray should be left wet on the surface for three to five minutes and was used for surfaces and a different disinfectant was used for the bathroom, which also had a dwell time of three to five minutes. The HKS said the toilet brush should only be used inside the toilet bowl and nowhere else. She said the toilet should be disinfected and cleaned from top to bottom. She said high touch areas included (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the over bed table, the television remote, the call light, the bed controller, the door knobs and lights switches and they should be disinfected daily. She said the disinfectant should be sprayed directly on a surface and not sprayed just on the rag. She said she would immediately provide education to the housekeeping staff on hand hygiene, the correct use of the disinfectants and the proper room cleaning procedure. The infection preventionist (IP) was interviewed on 4/6/26 at 2:421 p.m. The IP said hand hygiene should be performed in between glove changes, when entering a resident's room, when exiting a resident's room and when hands were visibly soiled. She said when disinfecting a surface, the surface should remain visibly wet for the correct dwell time before being wiped. She said high touch areas should be cleaned daily. She said the toilet brush should only be used in the toilet bowl. She said she would immediately provide education to the housekeepers for the areas of concern. E. Facility follow-up The facility provided all housekeepers education on 4/6/26 that included hand hygiene and best practices when cleaning/disinfecting resident rooms. -However, the education was not provided to the housekeeping staff until the concern was brought to the facility's attention during the survey. II. Failed to ensure Resident #6's catheter tubing was not touching the floor A. Facility policy and procedure The Catheter Care policy, undated, was received from the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. The policy read in pertinent part, Ensure the drainage bag is located below the level of the bladder to discourage backflow of urine. B. Observations On 3/30/26 at 10:19 a.m. Resident #6's tubing for his urinary catheter was observed hanging and dragging on the floor while the resident was self-propelling himself in his wheelchair. 04/1/26 at 12:39 p.m. the tubing for Resident #6's urinary catheter was observed to be hanging and dragging on the floor while the resident was self-propelling himself to the dining room in his wheelchair. An unidentified staff member was following behind Resident #6. -However, the unidentified staff member made no attempts to ensure the urinary catheter tubing was adjusted to prevent it from dragging on the floor. C. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 4/2/26 at 2:37 p.m. CNA #3 said he was assigned to monitor Resident #6 one-on-one and he was required to accompany the resident anywhere he chose to go in the facility and assist him with care as needed. CNA #3 said a resident's urinary catheter bag should not touch the ground because the ground was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dirty. Licensed practical nurse (LPN) #3 was interviewed on 4/2/26 at 2:57 p.m. LPN #3 said the CNAs were responsible for making sure that the Resident #6's urinary catheter bag was transferred when the resident transferred from his bed to his wheelchair and that the catheter tubing was free from dragging on the floor. LPN #3 said the importance of making sure the urinary catheter tubing was not dragging on the floor was to prevent urinary tract infections (UTI). LPN #3 said she had not observed Resident #6's urinary catheter tubing dragging on the floor, but she said Resident #6 did throw the urinary drainage bag on the floor. She said the resident's urinary catheter tubing could have been dragging on the floor, but she said she would pick it up if she observed it.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were provided prompt efforts by the facility to resolve grievances for one (#1) of three residents reviewed for grievances out of 53 sample residents.Specifically, the facility failed to report, document and follow-up on grievances reported by Resident #1 concerning her care preferences.Findings include:I. Facility policy and procedureThe Grievances policy, revised April 2017, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. It read in pertinent part, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, or any other concerns regarding his or her stay at the facility. Grievance also may be filed regarding care that has not been furnished.II. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included amyotrophic lateral sclerosis (a nervous system disease that affects nerve cells in the brain and spinal cord), anxiety disorder, depression, tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck), and acute respiratory failure with hypoxia (a condition where tissues and organs do not receive adequate oxygen).The 2/10/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent with toileting, personal hygiene and eating.B. Resident interviewResident #1 was interviewed on 3/30/26 at 10:29 a.m. Resident #1 said she informed a certified nurse aide (CNA) #1 approximately one week ago that she was frustrated that several CNAs assigned to provide her with care could not understand her during care. The resident said she told CNA #1 that she was frustrated and it made her angry when they could not understand what she asked for during her care. The resident said several CNAs would just nod their heads and keep going with her care. Resident #1 said she informed CNA #1 one week before the survey that she was tired of not being understood, but nothing had changed.Resident #1 was interviewed a second time on 4/1/26 at 1:50 p.m. Resident #1 said no staff members had had a discussion with her about her concern since she informed CNA #1 of the concern. Resident #1 said she told CNA #1 that her preference was to be assigned a CNA who could understand English, but she continued to have CNAs who could not understand her during care.C. Record reviewA review of the facility's Grievance Log, from 1/21/26 through 4/1/26, revealed that no entries had been made regarding Resident #1's concerns about her care provider preferences. During this time frame, the facility failed to document any formal or informal grievances regarding the resident's care-related preferences not being met.III. Staff interviewsCNA #1 was interviewed on 4/1/26 at 2:46 p.m. CNA #1 said she was in charge of scheduling. CNA #1 said Resident #1 had informed her one week prior to the survey about her specific preference for her care providers. CNA #1 said the resident had requested to be assigned a CNA who could communicate proficiently in English to support her care and enhance interaction during clinical tasks. CNA #1 said Resident #1 had mentioned she often became frustrated because several CNAs had difficulty understanding her due to their limited English proficiency. CNA #1 acknowledged that she had not completed a formal grievance report and had not documented the concern in the resident's electronic medical record (EMR). CNA #1 said she did not inform the grievance official about Resident #1's concern.The social services director (SSD) and the regional clinical resource were interviewed together on 4/1/26 at 4:00 p.m. The SSD said she was involved with the grievance process, along with the NHA. The SSD said grievance forms were readily available at the front desk and at each nurses' station. She said to facilitate the grievance process, facility (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were trained to assist residents who needed help completing grievance forms when a grievance was reported to them. She said staff could also report a resident grievance directly to her or the NHA. The SSD said she had not received any grievances from Resident #1.The regional clinical resource said all grievances should be reported immediately to the SSD or the NHA. She said grievances should be resolved within three days of receiving them. The regional clinical resource said CNA #1 should have reported Resident #1's concern regarding her care preferences immediately to the SSD or the NHA. The regional clinical resource said the facility would immediately offer education about the grievance policy to all staff.IV. Facility follow-upOn 4/6/16 at 9:54 a.m. the NHA provided an undated grievance educational in-service sheet.-The provided grievance education in-service sheet was not signed by CNA #1, who was the CNA who failed to report Resident #1's grievance concern. -Additionally, the education was not provided to staff until after the grievance concern was brought to the attention of the facility during the survey.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for activities of daily living (ADL) received the necessary care and services out of 53 sample residents.Specifically, the facility failed to utilize language communication tools to support effective interaction for Resident #1 during care. Findings include:I. Facility policy and procedureThe Non-Discrimination-Effective Communication and Modification for Disabilities policy and procedure, dated 1/1/26, was received from the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. It revealed in pertinent part, It is the policy of this facility to take reasonable steps to ensure that individuals with disabilities are not discriminated against and provided with the appropriate services to enhance communication.The facility must ensure that its health programs and activities provided through information and communication technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. If an action required to comply with this section would result in such an alteration or such burdens, the facility shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the benefits and services of the health program or activity provided by the facility.All staff will be provided notice of this policy, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of an interpreter and how to access appropriate auxiliary aids and services.The facility will conduct a regular review of the language access needs of our resident population, as well as update and monitor the implementation of the policy, as needed. Considerations for policy review include, but are not limited to: a. Changes in demographics of the resident population. b. Mechanisms for securing interpreter services. c. Equipment used for the delivery of language assistance. d. Complaints filed by individuals with limited English proficiency (LEP). e. Feedback from residents.II. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included amyotrophic lateral sclerosis, anxiety disorder, depression, tracheostomy, and acute respiratory failure with hypoxia (a condition where tissues and organs do not receive adequate oxygen).The 2/10/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She was dependent on staff for toileting, personal hygiene, and eating.B. Resident interviewResident #1 was interviewed on 4/1/26 at 1:50 p.m. Resident #1 said that several certified nurse aides (CNAs) assigned to her care could not understand her due to their limited ability to speak English.Resident #1 said that due to her medical condition, she was not able to use her hands to demonstrate or assist the staff in understanding her needs. She said that the CNAs did not utilize any tools or devices to translate or facilitate communication. Resident #1 said she had often become frustrated and angry because her needs were not being met in a timely manner. She said she had informed the facility's scheduler of her concern a week prior, but had not heard back. Resident #1 said she continued to have CNA's who were not able to understand her. Resident #1 said she told CNA #1 that she was frustrated and it made her angry when they could not understand what she asked for during her care. The resident said several CNAs would just nod their heads and keep going with her care. Resident #1 said she informed CNA #1 last week that she was tired of not being understood, but nothing had changed.C. ObservationOn 3/31/26 at approximately 12:20 p.m., Resident #1 was in bed when her lunch arrived. CNA #4 set the lunch tray on the bedside table, and while she was exiting the room, Resident #1 asked the CNA #4 if she had forgotten to bring her beverage with her meal. CNA #4 did not answer, walked out of the room and continued with the meal pass. The staff members passing room trays (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were observed speaking to one another in a language other than English and did not pause their conversation and tasks to acknowledge the resident's concern. Resident #1's body remained immobile due to her medical condition, and she was not able to use her voice and hand gestures to point toward her needs. CNA #4 did not attempt to utilize any alternative communication aids, such as a translation device, picture board, or simplified verbal cues. D. Record reviewResident #1's communication care plan, last revised on 4/2/26, revealed Resident #1 had expressed frustration with communication due to difficulty understanding some accents. Interventions included supporting Resident #1's understanding and comfort, monitoring and documenting the resident's satisfaction with communication, and adjusting caregiver assignments as appropriate to support effective interactions. -The care plan failed to address Resident #1's specific communication barriers with non-English speaking staff. Review of Resident #1's electronic medical record (EMR) did not reveal documentation indicating that staff members utilized alternative communication methods when they were unable to understand the resident's verbal requests. TIII. Staff interviewsThe regional clinical resource was interviewed on 4/1/26 at 2:45 p.m. The regional clinical resource said that all facility staff had been trained to utilize alternative means of communication to ensure resident needs were understood.The regional clinical resource said her professional expectation was that staff use the facility's language line devices, which were currently stored in the speech therapy department. The regional clinical resource said she would ensure that the language line devices were moved to and maintained at the nursing station for immediate staff access. The regional clinical resource said she would immediately initiate staff education regarding communication protocols and would update Resident #1's care plan to include specific interventions and the use of assistive devices to bridge the language gap.The director of nursing (DON) was interviewed on 4/6/26 at 5:50 p.m. The DON said the facility had recently hired several bilingual staff members to assist with the diverse needs of the resident population. She said it was her expectation that any staff member encountering difficulty communicating with a resident should seek assistance from colleagues capable of interpreting. The DON said that staff should have utilized alternative forms of communication, including the facility's language line and communication boards, to facilitate understanding during care. She said when communication barriers were not immediately identified and resolved, it could result in a delay in care and potentially impact the resident's safety and well-being. The DON said she did not know why the staff failed to use other means of communication; however would ensure staff were retrained to be aware of the tools available for them to use. License practical nurse (LPN) #1 was interviewed on 4/6/26 at 6:15 p.m. LPN #1 said she had not observed staff using any communication devices or assistive tools when providing care to residents. LPN #1 said that several CNAs had difficulty understanding English, which created barriers during resident interactions. LPN #1 said while she had occasionally intervened to assist with communication, she was not able to do so consistently because she was often busy with other resident care responsibilities when the CNAs required assistance.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#24 and #80) of seven residents received treatment and care in accordance with professional standards of practice out of 53 sample residents.Specifically, the facility failed to:-Ensure physician's orders for wound care were followed for Resident #24; and,-Ensure Resident #80 was consistently administered pain medication per physician's orders.Findings include:I. Failed to ensure physician's orders for wound care were followed for Resident #24 A. Facility policy and procedureThe Wound Treatment Management policy, revised 4/7/26, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. The policy read in pertinent part, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.B. Resident #241. Resident statusResident #24, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included an unspecified open wound on the right lower leg, lymphedema (swelling due to the fluid building up in the body's tissues) and unsteadiness on feet.The 3/27/26 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 MDS assessment indicated the resident was independent with completing most of his activities of daily living (ADL).The assessment indicated the resident had one venous and/or arterial ulcer (open wound that developed on the lower legs due to problems with blood circulation).2. Wound care observationsDuring a continuous observation of Resident #24's wound care on 4/2/26, beginning at 9:20 a.m. and ending at 9:49 a.m., the following was observed:The assistant director of nursing (ADON) and registered nurse (RN) #1 were observed providing wound care to Resident #24. The ADON collected wipes and began wiping down the treatment cart in the hallway. After wiping down the treatment cart, she placed a clean chuck (a disposable absorbent pad placed on a bed or chair to protect it from moisture) pad over the treatment cart where she laid out 4 by 4 gauze pads and rolled gauze.The ADON performed hand hygiene with alcohol-based hand rub (ABHR), applied a gown and gloves and entered Resident #24's room. The ADON began wiping down the resident's bedside table with disinfectant wipes and asked the resident if he had any pain. The ADON removed her gloves, performed hand hygiene with ABHR and put on new gloves. RN #1 handed the ADON two chucks pads. The ADON placed one chuck pad on the bedside table with the edges hanging over the table. The second chuck pad was placed under Resident #24's right lower leg. The ADON advised the resident if he had pain to let her know throughout the process.The ADON began by taking off an Ace bandage from around Resident #24's right lower leg, then removed the rolled gauze which was noted to have dry serosanguineous (a thin and light pink watery fluid coming from a wound) drainage to it. She removed three abdominal (ABD - a large thick padded dressing) pads from around Resident #24's leg. The ABD pads were noted to have copious amounts of serosanguineous drainage.The ADON removed her gloves, performed hand hygiene with ABHR and put on new gloves.RN #1 entered Resident #24's room with no gown or gloves and placed supplies on the bedside table consisting of 4 by 4 gauze pads, skin prep, rolled gauze, a medicine cup labeled silver sulfadiazine (a cream applied to the skin to prevent or treat infection in wounds) and a cup labeled with Dakin's solution (specialized wound solution). The ADON opened one package of non-woven 4 by 4 gauze pads and placed it into the cup with the Dakin's solution in it to soak the gauze. She then took one gauze pad out of the cup and used the gauze pad to wipe the resident's wound. She discarded the gauze pad and collected another gauze pad. She performed this action three times, each time using a new gauze pad. She then opened a new package of 4 by 4 gauze pads and took a dry gauze pad out and dried the wound. She removed her gloves, performed hand hygiene with ABHR and put on a new pair of gloves. RN #1 left Resident #24's room (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and returned a few minutes later with adaptic (a non-stick gauze dressing placed directly on a wound). The ADON added the silver sulfadiazine to the adaptic and placed it on the Resident #24's right leg.RN #1 pulled out a roll of tape from her scrubs pocket with her bare hands, cut a piece of the tape and placed it on the curtain. The ADON asked RN #1 about ABD pads. RN #1 said the ABD pads had not been ordered. The ADON continued to place the adaptic on Resident #24's right leg, wrapped it with the rolled gauze and taped it with the pieces of tape that RN #1 had placed on the curtain. -The ADON failed to follow the physician's order for Resident #24's right leg wound treatment. She failed to use skin prep around the peri wound (skin around a wound) and failed to apply ABD pads prior to wrapping the resident's leg with the rolled gauze (see physician's orders below).3. Record reviewReview of Resident #24's April 2026 CPO revealed the following physician's orders: Wound care right lower extremity: quarter strength Dakin's, plus skin prep, plus 1% silver sulfadiazene (silvadene), plus adaptic, plus ABD and Kerlix (a soft and absorbent gauze roll used to cover and hold dressings in place). Every shift for wound care and as needed for soiled/dislodged, ordered 4/2/26.-However, the ADON failed to use skin prep and apply the ABD pads to the resident's wound (see observations above). C. Staff interviewsThe ADON was interviewed on 4/2/26 at 10:42 a.m. The ADON said she rounded weekly with the wound physician. After reviewing Resident #24's order for wound care to the right lower extremity, the ADON acknowledged she did not use an ABD pad at the time of the dressing change for Resident #24's wound. She said the ABD pad was important to use for the resident as he had a lot of drainage coming from his leg wound. She said the ABD pad was also to help prevent the pulling of new tissue growth from the wound when removing old dressings. She said she would go back and apply the ABD pads to the resident's wound.The director of nursing (DON) was interviewed on 4/6/26 at 5:57 p.m. The DON said the importance of following the physician's order for wound care was to prevent an infection. She said the ADON should have reviewed the treatment order for Resident #24's leg wound prior to providing wound care. She said the facility provided in-service training for wound care on 4/2/26 (during the survey). She said the wound care nurse had gone back and redone Resident #24's wound dressing (on 4/2/26).II. Failed to ensure Resident #80 was consistently administered pain medication per physician's ordersA. Facility policy and procedureThe Pain Management policy, revised 4/7/26, was provided by the NHA on 4/7/26 at 4:24 p.m. The policy read in pertinent part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will:-Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated; and,-Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to:-Facial expressions (grimacing, frowning, fright, or clenching of the jaw); and, -Behaviors such as: resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal.The Unavailable Medications/Emergency kit (Ekit) policy, revised 4/7/26, was provided by the NHA on 4/7/26 at 4:24 p.m. The policy read in pertinent part, This facility shall use uniform guidelines for unavailable medications. The facility maintains a contract with a pharmacy provider to supply the facility with routine, as needed (PRN), and emergency medications. A STAT (medical term meaning right away or immediately) supply of commonly used medications is maintained in-house for timely initiation of medications. As a first intervention, the nurse shall check the Ekit for availability of the medication before proceeding with other steps. The facility shall follow established procedures for ensuring residents have a sufficient (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supply of medications.B. Resident #801. Resident statusResident #80, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included chronic pain syndrome, spinal stenosis (narrowing in the spine that could press on nerves and cause pain or numbness) at cervical region (related to the neck area of the body) and alcoholic polyneuropathy (damage or disease affecting many nerves in the body at the same time).The 1/21/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident was independent with completing his ADLs.The MDS assessment indicated the resident had pain or hurting during the assessment look-back period. 2. Resident interviewResident #80 was interviewed on 3/30/26 at 2:03 p.m. Resident #80 said he had not received his morphine (pain medication) for 24 hours because the facility ran out of medication and they did not order it. Resident #80 said he was in pain, specifically down on his left leg. Resident #80 said he had not received his pain medication several times in the past because the facility ran out of pain medication and did not order it on time.3. Record reviewResident #80's pain management care plan, revised on 3/6/26, revealed the resident was at risk for pain related to a medical diagnosis of chronic pain. Interventions included administering medications as ordered, monitoring for possible adverse effects of pain management interventions, assessing pain every shift and as indicated and positioning for comfort.Review of Resident #80's April 2026 CPO revealed the following physician's order: Morphine Sulfate ER (extended release) oral tablet extended release 30 milligrams (mg). Give one tablet by mouth three times a day related to chronic pain syndrome, ordered 9/4/25. Review of Resident #80's January 2026 medication administration record (MAR) revealed Resident #80 did not receive his scheduled morphine on 1/1/26 and 1/2/26.Review of Resident #80's March 2026 MAR revealed Resident #80 did not receive his afternoon scheduled morphine on 3/30/26. The nursing progress note, dated 3/30/26 at 11:58 a.m., documented morphine sulfate oral tablet extended release 30 mg was waiting on reorder.-However there was no documentation indicating the reason the morphine medication was not administered to the resident on 1/1/26 and 1/2/26.C. Staff interviewsLicensed practical nurse (LPN) #4 was interviewed on 4/2/26 at 1:04 p.m. LPN #4 said the facility should not run out of medication. He said if a medication was not available, he would check the facility's Ekit and contact the pharmacy to get the access code to obtain the medication from the Ekit. LPN #4 said the physician's order should already be in place but sometimes the pharmacy delivery ran late. He said he would call the physician to follow up and ensure the pain medication prescription was sent to the pharmacy for an existing physician's order. LPN #4 said Resident #80's morphine order was already in the system but there was a delay in delivery of the medication. He said medications could sometimes take more than five hours to be delivered. LPN #4 said Resident #80 needed pain medication on 3/30/26 but the morphine ER 30 mg was not available at that time. He said there was only morphine ER 15 mg available in the Ekit. LPN #4 said he could not administer it to Resident #80 because it was not consistent with the physician's order. He said he should have gotten a new physician's order to administer the morphine 15 mg that was in the Ekit.LPN #2 was interviewed on 4/6/26 at 10:19 a.m. LPN #2 said Resident #80 did not get his morphine on 3/30/26 due to the medication being unavailable. LPN #2 said when he noticed it, he notified the physician who was present in the facility at that time. He said the physician did not place a new order because an order was already pending. LPN #2 said the Ekit had only morphine ER 15 mg but he could not administer it to Resident #80 because there was no order for that dose.The pharmacist was interviewed on 4/6/26 at 3:16 p.m. The pharmacist said the pharmacy made two deliveries per day and followed specific order cut-off times for each delivery. She said orders received before 11:00 a.m. were included in the 1:00 p.m. delivery run, if they had no issues. She said it could take three to four hours for medications to be delivered to the facility. The pharmacist said even though morphine ER 15 mg was available in the Ekit, she did not expect the nurses to administer it to Resident #80 to make it 30 mg. She said a one-time physician's order would be required to administer the morphine ER 15 mg dose.The DON was interviewed on 4/6/26 at 5:57 p.m. The DON said if nurses noticed a resident had run out of pain (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication at the time of administration, they should check the Ekit and medication storage. The DON said if the medication was available, they would have administered it to Resident #80. The DON said because the Ekit had morphine ER 15 mg, the nurse could have administered two tablets to Resident #80 to make the 30 mg dose.IV. Facility follow up The NHA provided the following information on 4/7/26 at 4:24 p.m., after the survey exit. The documentation provided revealed Resident #80 did not receive his afternoon dose of morphine on 3/30/26 because the facility ran out medication. The nurse documented that the medication was reordered. Resident #80 had no increase in pain related to the missed dose as evidenced by his pain being reported as 0 out of 10 on the following dose and the next day. The documentation indicated the nurse was provided re-education with the expectation that the physician be notified of missed medications and the expectation that the Ekit be utilized if medication was not available. -However, the morphine was a scheduled medication and the facility failed to order it on time to prevent missed doses of the medication.-Additionally, the re-education was not provided to staff until after the concern was brought to the attention of the facility during the survey.-The facility failed to include documentation of the in-service education provided to staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent (%).Specifically, the facility had a medication error rate of 7.41%, which was two errors out of 27 opportunities.Findings include:I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed., E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environmentˆ.ˆ ˆˆProfessional Standards such as nursing scope ˆand standards of practice apply to the activity of medication administrationˆ. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. ˆMany medication errors ˆcan be linked ˆin some way to an inconsistency ˆin adhering to these seven rightsˆ: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Medication Administration policy, revised 4/7/26, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. It read in pertinent part, Review the medication administration record (MAR) to identify the medication to be administered.Compare the medication source (bubble pack, vial) with the MAR to verify the resident's name, medication name, form, dose, route, and time. Refer to the drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. Administer the medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Observe the resident consumption of the medication.III. Observations On 4/1/26 at 8:57 a.m. LPN #6 was preparing to administer medications for Resident #1. LPN #6 said she did not have the diclofenac external gel 1% (a topical nonsteroidal anti-inflammatory drug (NSAID) used to treat arthritis pain in joints such as the hands, knees and ankles) available in the medication cart. LPN #6 said she would re-order the medication and hopefully the medication would be delivered that day. -LPN #6 administered the remaining medications to Resident #1 and was unable to give the diclofenac.On 4/2/26 at 8:43 a.m. licensed practical nurse (LPN) #5 went into Resident #43's room. Resident #43 said she had eaten breakfast already. LPN #5 checked Resident #43's blood sugar. The blood sugar was 205 mg/dl (milligrams per deciliter). LPN #5 went back to the medication cart and retrieved Resident #43's medications. On 4/2/26 at 9:11 a.m. LPN #5 pulled an insulin lispro vial out of its packaging in an attempt to prepare it for Resident #43. The insulin vial was empty. LPN #5 said she would call the pharmacy to get another vial of insulin. -However, LPN #5 did not call the pharmacy, inform a supervisor or check other areas of the facility for insulin at that time. -LPN #5 administered the remaining medications to Resident #43 but did not administer the insulin lispro.Cross-reference F760 for failure to ensure residents were free from significant medication errors.IV. Record reviewReview of Resident #1's April 2026 CPO revealed the following physician's order:Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical). Apply to bilateral upper extremities topically three times a day for chronic pain. Apply 2 grams (gm) each administration, ordered 2/5/26.Review of Resident #1's April 2026 MAR revealed diclofenac sodium external gel was not documented as given, but instead was documented as 9 (other) for both the morning and afternoon due times.The 4/1/26 at 9:16 a.m. progress note revealed the diclofenac sodium external gel was ordered. The 4/1/26 at 1:25 p.m. progress notes revealed the physician was notified.Review of Resident #43's April 2026 CPO revealed the following physician's order:Insulin Lispro Injection Solution 100 units/ml (Insulin Lispro). Inject 20 units subcutaneously before meals for type 1 diabetes. Check blood glucose prior to administration and record glucose level, ordered 3/1/26.Review of Resident #43's April 2026 medication administration record (MAR) revealed LPN #5 documented Resident #43's blood sugar as 125 mg/dl and that she gave the insulin lispro on 4/2/26.-However, Resident #43's blood sugar was 205 mg/dl and the resident did not receive the insulin lispro on 4/2/26 (see observations above).V. Staff (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	InterviewsLPN #6 was interviewed on 4/1/26 at 9:26 a.m. LPN #6 said diclofenac sodium gel treated chronic pain and was placed topically on the pain site. LPN #6 said she would call the pharmacist and notify the nurse practitioner (NP) that Resident #1 did not receive the medication.On 4/2/26 at 11:54 a.m. LPN #5 was interviewed to follow-up on Resident #43's omitted insulin administration (see observation above). LPN #5 said she had not had time to give the insulin to the resident yet.Cross-reference F760 for failure to ensure residents were free from significant medication errors.On 4/2/26 at 12:10 p.m. the director of nursing (DON) and the regional clinical resource were alerted that Resident #43 had not received her morning dose of lispro insulin. The DON said LPN #5 should have retrieved insulin lispro from the facility's emergency kit (E-kit) which had multiple insulin vials available. The DON said LPN #5 should have reached out to other staff members for help to retrieve the insulin. The DON said LPN #5 could have then administered the insulin. The DON said staff should not document that a medication was given on the MAR if the medication was not given. The regional clinical resource said the facility would let the physician know that Resident #43 did not receive her morning dose of insulin. She said Resident #43 would have her blood sugar checked and receive her afternoon dose of insulin.The DON and the regional clinical resource were interviewed together a second time on 4/2/26. The regional clinical resource said residents' blood glucose levels were recorded just before nurses administered insulin to residents. The DON said LPN #5 was an agency staff member and it was her first shift at the facility. The DON said agency staff received verbal education on policies and procedures before working at the facility. The DON said education was also uploaded to the care system for agency staff to view. The DON said she would review the agency nurse education and orientation that was in place for agency staff. The pharmacist was interviewed on 4/6/26 at 3:16 p.m. The pharmacist said insulin was a hormone naturally created in the body. She said type 1 diabetes was a disease where the pancreas did not produce enough insulin to control the blood sugar in the body. The pharmacist said insulin medication was used to get residents' blood sugar levels to a normal level. The pharmacist said it was important for residents to receive insulin before eating because every time people ate there were carbs and sugars in the food consumed. The pharmacist said it was important to give the insulin before eating to help counteract the escalation of blood sugar right after a resident ate. The pharmacist said if a resident missed a dose of insulin, generally it would cause an increase in the resident's blood sugar and if blood sugar levels got high enough, a resident could go into a coma.The pharmacist said diclofenac was a topical NSAID used for inflammation and arthritis. The pharmacist said that in a resident who had chronic pain syndrome, a missed dose would cause a lack of anti-inflammatory effects. The pharmacist said this could lead to an increase in pain and swelling.The DON and the regional clinical resource were interviewed together again on 4/6/26 at 5:26 p.m. The DON said nurses should follow the five rights of medication administration. The DON said the five rights of medication administration were right person, right time, right route, right dose and right reason.The DON said if residents ran out of pain medication, the nurses could go to the facility's emergency kit and look for the medication there. The DON said it was important to receive pain medication timely so residents did not have pain. The DON said nurses should contact the physician if the pain medication was unavailable.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#43) of four residents out of 53 sample residents. Specifically, the facility failed to ensure Resident #43 was administered an insulin medication per physician's orders.Findings include:I. Facility policy and procedureThe Medication Administration policy, revised 4/7/26, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. It read in pertinent part, Review the medication administration record (MAR) to identify the medication to be administered.Compare the medication source (bubble pack, vial) with the MAR to verify the resident's name, medication name, form, dose, route, and time. Refer to the drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. Administer the medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Observe the resident consumption of the medication.II. Resident #43A. Resident statusResident #43, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included type 1 diabetes mellitus (a condition where the pancreas makes little to no insulin, which was required to allow glucose into cells to produce energy), hypothyroidism (low thyroid levels) and asthma (chronic long-term respiratory disease).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 14 out of 15. The MDS assessment revealed Resident #43 was receiving insulin.B. ObservationsOn 4/2/26 at 8:43 a.m. licensed practical nurse (LPN) #5 went into Resident #43's room. Resident #43 said she had eaten breakfast already. LPN #5 checked Resident #43's blood sugar. The blood sugar was 205 mg/dl (milligrams per deciliter). LPN #5 went back to the medication cart and retrieved Resident #43's medications. On 4/2/26 at 9:11 a.m. LPN #5 pulled an insulin lispro vial out of its packaging in an attempt to prepare it for Resident #43. The insulin vial was empty. LPN #5 said she would call the pharmacy to get another vial of insulin. -However, LPN #5 did not call the pharmacy, inform a supervisor or check other areas of the facility for insulin at that time. -LPN #5 administered the remaining medications to Resident #43 but did not administer the insulin lispro.Cross-reference F759 for failure to ensure the facility was free from a medication error rate of five percent (5%) or greater. On 4/2/26 at 12:43 p.m. registered nurse (RN) #1 was observed checking Resident #43's lunch time blood sugar level. RN #1 cleaned Resident #43's finger with alcohol, drew a drop of blood from the finger, and used the glucometer to test the blood sugar. The glucometer read 191 mg/dlC. Record reviewReview of Resident #43's April 2026 CPO revealed the following physician's order:Insulin Lispro Injection Solution 100 units/ml (Insulin Lispro). Inject 20 units subcutaneously before meals for type 1 diabetes. Check blood glucose prior to administration and record glucose level, ordered 3/1/26.Review of Resident #43's April 2026 medication administration record (MAR) revealed LPN #5 documented Resident #43's blood sugar as 125 mg/dl and that she gave the insulin lispro on 4/2/26.-However, Resident #43's blood sugar was 205 mg/dl and the resident did not receive the insulin lispro on 4/2/26 (see observations above).Review of Resident #43's progress notes on 4/2/26 at 2:21 p.m. revealed the physician was notified that Resident #43 missed a dose of insulin in the morning. The note revealed no adverse reactions were noted. -However, the progress note was not documented until after the concern of the morning insulin dose not being administered to Resident #43 was brought to the facility's attention on 4/2/26 (see interviews below).III. Staff interviewsOn 4/2/26 at 11:54 a.m. LPN #5 was interviewed to follow-up on Resident #43's omitted insulin administration (see observation above). LPN #5 said she had not had time to give the insulin to the resident yet.On 4/2/26 at 12:10 p.m. the director of nursing (DON) and the regional clinical resource were alerted that Resident #43 had not received her morning dose of lispro insulin. The DON said LPN #5 should have retrieved insulin lispro from the facility's emergency kit (E-kit) which had multiple insulin vials available. The DON said LPN #5 should have (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reached out to other staff members for help to retrieve the insulin. The DON said LPN #5 could have then administered the insulin. The DON said staff should not document that a medication was given on the MAR if the medication was not given. The regional clinical resource said the facility would let the physician know that Resident #43 did not receive her morning dose of insulin. She said Resident #43 would have her blood sugar checked and receive her afternoon dose of insulin.The DON and the regional clinical resource were interviewed together a second time on 4/2/26. The regional clinical resource said residents' blood glucose levels were recorded just before nurses administered insulin to residents. The DON said LPN #5 was an agency staff member and it was her first shift at the facility. The DON said agency staff received verbal education on policies and procedures before working at the facility. The DON said education was also uploaded to the care system for agency staff to view. The DON said she would review the agency nurse education and orientation that was in place for agency staff. The pharmacist was interviewed on 4/6/26 at 3:16 p.m. The pharmacist said insulin was a hormone naturally created in the body. She said type 1 diabetes was a disease where the pancreas did not produce enough insulin to control the blood sugar in the body. The pharmacist said insulin medication was used to get residents' blood sugar levels to a normal level. The pharmacist said it was important for residents to receive insulin before eating because every time people ate there were carbs and sugars in the food consumed. The pharmacist said it was important to give the insulin before eating to help counteract the escalation of blood sugar right after a resident ate. The pharmacist said if a resident missed a dose of insulin, generally it would cause an increase in the resident's blood sugar and if blood sugar levels got high enough, a resident could go into a coma.The DON and the regional clinical resource were interviewed together again on 4/6/26 at 5:26 p.m. The DON said nurses should follow the five rights of medication administration. The DON said the five rights of medication administration were right person, right time, right route, right dose and right reason.