STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065208	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsprings Care Center	3636 S Pearl St Englewood, CO 80113

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure food was stored, prepared, and served under sanitary conditions in the main kitchen.Specifically, the facility failed to ensure:-Perishable foods were discarded after the date of expiration; and, -Perishable foods were labeled and dated.Findings include:I. Professional reference According to the Colorado Retail Food Establishment Rules and Regulations (effective 3/16/24) retrieved 9/16/25A date marking system that meets the criteria using a method approved by the Department for refrigerated, ready-to-eat, potentially hazardous food (time/temperature control for safety food) that is frequently re-wrapped, such as lunch meat or a roast. Marking the date or day of preparation with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. Marking the date or day the original container is opened in a food establishment with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. Using calendar dates, days of the week, color coded marks or other effective marking methods. (Chapter 3-29)II. ObservationsThe initial kitchen tour was conducted on 9/7/25 at 7:12 a.m. The following was observed in the walk-in refrigerator;-A bag of romaine romaine lettuce that was brown and was labeled with a discard date of 8/25/25;-A bag of parsley with a discard date of 8/1/25;-A pan labeled watermelon with a discard date of 8/26/25.-An uncovered, unlabeled pan with three patties resembling sausage;-An unlabeled pan, dated 9/6/25, with five hard boiled eggs;-An unlabeled pan, dated 8/2/25, with what resembled beans inside;-An unlabeled pan, with a black substance that resembled beans; and,-A pan with five wrapped, unlabeled blocks of sliced cheese.III. Staff interviewsDietary aide (DA) #1 was interviewed on 9/7/25 at 7:30 a.m. DA #1 said that all the items in the walk-in refrigerator should be dated as soon as opened and if in a manufacturer's bag. She said the kitchen staff utilized the discard dated that was printed on the package by the manufacturer. DA #1 said all food items in the walk-in refrigerator should be labeled. She said the romaine lettuce, parsley and watermelon should have been discarded. DA #1 said she was unable to identify the unlabeled pans with the food items resembling beans. The dietary supervisor (DS) was interviewed on 9/9/25 at 11:30 a.m. The DS said he had worked at the facility for almost a year. He said his expectation was for the kitchen staff to check the walk-in refrigerator every evening before leaving and then again when the opening staff came in the morning to ensure food was discarded timely. The DS said all food items needed to be labeled and all the food needed a discard date. He said if items were not labeled or dated, the residents could be at risk of being provided food items that are contaminated and spoiled.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure residents were not responsible to purchase items or services for which payment was made under Medicaid or Medicare. Specifically, the facility failed to ensure routine hygiene items such as hand soap in the resident rooms were provided at no cost to the residents.I. Facility admission agreementThe facility's admission agreement, dated 2018, was received from the nursing home administrator (NHA) on 9/8/25 at 10:41 a.m. It read in pertinent part,Services (items) covered under Medicaid/Medicare: Routine personal hygiene items and services, as needed, to meet your needs, including, but not limited to: hygiene supplies, comb, brush, soap, and disinfecting soaps or specialized cleansing agents when indicated to treat special skin.II. ObservationsOn 9/9/25 at 10:03 a.m. room [ROOM NUMBER] was observed. There was no bar soap or liquid hand soap in the resident bathroom. On 9/09/25 at 10:05 a.m. room [ROOM NUMBER] was observed. There was no bar soap or liquid hand soap in the resident bathroom.On 9/9/25 at 10:33 a.m. room [ROOM NUMBER] was observed. There was no bar soap or liquid hand soap in the resident bathroom. On 9/9/25 at 10:36 a.m. room [ROOM NUMBER] was observed. There was no bar soap or liquid hand soap in the resident bathroom.On 9/9/25 at 12:45 p.m. room [ROOM NUMBER] was observed. There was bar soap but no liquid hand soap in the resident bathroom.On 9/9/25 at 12:48 p.m. room [ROOM NUMBER] was observed. There was no bar soap or liquid hand soap in the resident bathroom.On 9/10/25 at 10:50 a.m. room [ROOM NUMBER] was observed. There was no bar soap or liquid hand soap in the resident bathroom.III. Resident group interviewA group interview was conducted on 9/9/25 at 2:42 p.m. with five residents (#20, #30, #39, #47 and #55) who were determined to be interviewable, per the facility and assessment. Resident #30 and Resident #47 said the residents were told they had to purchase their own toiletries, to include soap for their bathrooms, razors, mouthwash and deodorant. IV. Additional resident interviewsResident #4 was interviewed on 9/9/25 at 10:03 a.m. Resident #4 said the facility did not provide him with hand soap and he had to provide his own soap. Resident #16 was interviewed on 9/9/25 at 2:10 p.m. Resident #16 said he and his roommate had to purchase their own hand soap for the bathroom. Resident #12 was interviewed on 9/9/25 at 2:36 p.m. Resident #12 said the bar soap in his bathroom belonged to his roommate, who purchased it himself. Resident #12 said when he told the staff he was out of hand soap in his room, the nurses told him he could purchase soap from the store or the activities department. Resident #55 was interviewed on 9/10/25 at 10:50 a.m. Resident #55 said the nurses told the residents they had to provide their own personal hygiene items, to include hand soap in the bathrooms. Resident #55 said if residents attended activities, they could win points and use the points to purchase personal hygiene items from the activities department. V. Staff interviewsThe activities director (AD) was interviewed on 9/9/25 at 10:55 a.m. The AD said the facility's previous AD used a ticket system where residents could earn tickets for coming to activities and use the tickets to purchase items in the resident store. The AD said she used a punch card system for the residents, instead of tickets, but the concept was the same. During the interview, the resident store was observed with the AD. The store contained personal items, such as deodorant, body wash and bar soap that the residents could purchase with their points. Licensed practical nurse (LPN) #1 was interviewed on 9/9/25 at 11:40 a.m. LPN #1 said the housekeepers were responsible for filling the soap dispensers in the residents' rooms. Certified nursing aide (CNA) #2 was interviewed on 9/9/25 at 11:45 a.m. CNA #2 said the housekeepers and the maintenance department were responsible for filling the soap dispensers in the residents' rooms. Housekeeper (HK) #1 was interviewed on 9/10/25 at 9:20 a.m. HK #1 said she did not know who filled the soap dispensers in the residents' rooms, but she thought it might be the CNAs.-However, observations of seven residents' rooms revealed there was no liquid hand soap in the residents' bathrooms and multiple residents' interviewed said they had to purchase their own soap (see (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observations and interviews above).The NHA was interviewed on 9/10/25 at 1:00 p.m. She said the facility provided standard personal hygiene items and liquid soap in the hand soap dispensers in the residents' rooms free of charge to the residents. The NHA said the facility did not expect the residents to use their personal funds to pay for hand soap or personal hygiene items.-However, resident interviews revealed they were told they had to purchase their own soap and the AD said residents could use their punch card points to purchase personal hygiene items, such as soap (see resident interviews and the AD's interview above).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide a clean, comfortable and homelike environment for residents in two of four hallways and two of four shower rooms.Specifically, the facility failed to:-Ensure Resident #4's window blinds and walls were cleaned and maintained and the resident's bed was in good condition;-Ensure bath towels were available for resident use in shower rooms; and,-Ensure residents' rooms were free from debris and odors and appropriate personal hygiene items were available. Findings include: I. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy, revised August 2013, was provided by the nursing home administrator (NHA) on 9/11/25 at 1:20 p.m. It read in pertinent part, Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled. Manufacturer's instructions will be followed for proper use of disinfecting (or detergent) products. Walls, blinds and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Floor mopping solutions will be replaced every three residents' rooms, or changed no less often than at 60-minute intervals. Personnel should remain alert for evidence of rodent activity (droppings) and report such findings to the environmental services directly. Clean personal use items (lights, phones, call bells, and bedrails) with disinfectant solution at least twice weekly. Clean curtains, window blinds and walls when they are visibly soiled or dusty. II. Failed to ensure Resident #4's window blinds and walls were cleaned and maintained and the resident's bed was in good condition A. Resident observation and interview Resident #4's room was observed on 9/8/25 at 12:46 p.m. Resident #4's horizontal blinds in the window were covered with a layer of dust. The footboard of Resident #4's bed was secured to the bed on only one side and the other side of the footboard was loosened from the bed with an approximately six-inch long crack. Resident #4 had a bed cane (assistive device) on the left at the head of his bed. The bed cane had multiple brown and gray soiled spots. The wall next to the resident's window had multiple brown spots splattered on the wall and dried drip splatters that ran down the wall. Resident 4 said when housekeeping came to clean his room, they would change the trash bags and empty the trash but they did not clean under the bed or clean his window blinds. Resident #4 said the footboard of his bed was broken. Resident #4's room was observed a second time on 9/9/25 at 10:03 a.m. The resident's horizontal window blinds, footboard of the bed and the walls had not been cleaned or repaired and were in the same condition as on 9/8/25 (see observation above). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 said facility staff hid supplies and would not provide him with cleaning wipes to clean his bed cane. He said he had filed multiple grievances about his room being cleaned and he said only one housekeeper would clean the horizontal blinds. During a continuous observation on 9/9/25 from 11:34 a.m. to 11:47 a.m. an unidentified housekeeping staff member was observed cleaning Resident #4's room. The housekeeping staff member did not clean Resident #4's window blinds or the bed cane. B. Record review The Environmental Checklist for Monitoring Terminal Cleaning was provided by the NHA on 9/10/25 at approximately 12:00 p.m. The checklist documented staff were to evaluate the following priority sites in each residents' room: bed rails/controls, cubicle and/or window curtains, walls if soiled and floors. C. Staff interviews The regional clinical resource (RCR), the NHA and the regional director of operations were interviewed together on 9/11/25 at 3:00 p.m. The RCR said the facility reached out to the regional maintenance director for assistance (during the survey). The RCR said the regional maintenance director assisted the facility in updating their housekeeping cleaning checklists to Spanish (during the survey) as much of their housekeeping staff spoke Spanish. The NHA said residents' rooms should be deep cleaned periodically and when deep cleaned, the staff should clean under the resident's beds. The regional director of operations said the regional maintenance director helped (during the survey) realign the housekeeping tasks so the deep cleaning in residents' rooms was completed on a better rotating basis to include the horizontal window blinds and the walls. The regional director of operations said a room deep clean could not be done every day but should be rotated in a way that was efficient to ensure that the items in the room were cleaned on a rotating schedule instead of not at all. III. Failed to ensure bath towels were available for resident use in shower rooms A. Observations On 9/9/25 at 11:40 a.m. the second floor shower room nearest to resident room [ROOM NUMBER] was observed to have a linen rack containing sheets and fifteen wash cloths on it. There were no bath towels for residents on the linen rack or visible in the shower room. On 9/9/25 at 12:00 p.m. a male resident was observed being wheeled out of the shower room on a shower bed by an unidentified certified nurse aide (CNA). The unidentified CNA pushed the shower bed into the resident's room. The resident had a sheet covering his body and no visible bath towels for drying the resident. On 9/9/25 at 12:10 p.m. the first floor shower room nearest to resident room [ROOM NUMBER] was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed to have a linen rack containing sheets and five wash cloths on it. There were no bath towels for residents on the linen rack or visible in the shower room. B. Resident interviews Resident #4 was interviewed on 9/8/25 at 12:31 p.m. Resident #4 said there were rarely bath towels in the shower room and this affected his ability to take a shower. Resident #4 said sometimes he tries to take a shower and the facility did not have any bath towels available so he had to wait a day or two to take a shower. Resident #4 said the facility did not give him a reason as to why they were out of towels when this occurred. He said he thought the facility's laundry department was ineffective. Resident #4 said on the first weekend of September 2025, he was told by facility staff that the bath towels were wet in the dryer and no one had run the dryer so the residents did not have bath towels to use that weekend. C. Staff interviews CNA #2 was interviewed on 9/9/25 at 11:45 a.m. CNA #2 said that all the linens, including bedding and bath towels, were kept on a rack in the shower rooms. -However, observations revealed there were no bath towels in two of the shower rooms (see observations above). Licensed practical nurse (LPN) #2 was interviewed on 9/9/25 at 11:50 p.m. LPN #2 said that all the linens, including bedding and bath towels, were kept on a rack in the shower rooms. LPN #2 said she did not know what the residents used to dry off when the facility was out of bath towels. The maintenance director (MTD) was interviewed on 9/10/25 at 12:09 p.m. The MTD said he was the maintenance director and the supervisor of the housekeeping department. He said the housekeepers were to clean linens daily and keep the shower rooms stocked with bath towels every day. The MTD said he did not have a written schedule for when the housekeepers checked the shower rooms for linens and would expect the CNAs to let him know if they were out of bath towels. IV. Failed to ensure residents' rooms were free from debris and odors and appropriate personal hygiene items were available. A. Observations A tour of the facility's second floor was conducted on 9/8/25 at 7:30 a.m. and again at 3:00 p.m. The following was observed: Resident rooms #215, #218 and #219 were missing hand soap, towels and the paper towel dispensers were empty in each bathroom. The hand sanitizer dispensers additionally were empty in each room. Resident room [ROOM NUMBER] had a clogged toilet. Resident room [ROOM NUMBER] had a strong urine odor. There was brown liquid between the beds which had a strong urine smell and seeped between the floor tiles when pressure was applied to the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER] had four meal trays full of plates, food, drinks and utensils on the floor of the room, along with cigarette butts, food crumbs and soiled clothing. The bathroom sink had black spots. There was a strong smell of urine, body odor and smoked cigarettes in the room. On 9/9/25 at 9:30 a.m. and again at 2:30 p.m. the following was observed: Resident rooms #215, #218 and #219 were missing soap, towels and paper towels in their bathrooms. The hand sanitizer dispensers were additionally empty in each room. On 9/9/25 at 9:30 a.m. according to the residents in room [ROOM NUMBER], their toilet had been unclogged. -However, the toilet had been clogged since 9/6/25 (see resident interview below). On 9/9/25 at 11:45 a.m. the maintenance director (MTD) was observed in resident room [ROOM NUMBER] with a work cart and floor tiles. He removed seven tiles from the floor. On 9/9/25 at 11:52 a.m. housekeeper (HK) #2 was observed pouring blue liquid from an unlabeled bottle onto the floor in room [ROOM NUMBER] to try to cover the urine odor. HK #2 said the blue liquid was disinfectant. On 9/10/25 at 9:30 a.m. and again at 2:30 p.m. the following was observed: Resident rooms #215, #218, and #219 were missing soap, towels and paper towels in their bathrooms. The hand sanitizer dispensers were additionally empty in each room. On 9/10/25 at 2:30 p.m. the MTD had removed the remaining loose tiles from the floor in room [ROOM NUMBER], disinfected the floor and replaced the tiles. On 9/11/25 at 8:20 a.m. and at 2:15 p.m. the following was observed: Resident rooms #215, #218, and #219 were missing soap, towels and paper towels in their bathrooms. The hand sanitizer dispensers were additionally empty in each room. B. Resident interviews The two residents who resided in room [ROOM NUMBER] were interviewed together on 9/8/25 at 7:30 a.m. The residents said their bathroom rarely had soap or towels. They said they would tell the staff, but the soap and towels did not get replaced. They said they had notified nursing staff that the toilet had been clogged for the past two days (since 9/6/25) and nothing had been done about it. The residents said they did not know how the staff washed their hands if there was no soap in the bathrooms and the hand sanitizer dispenser in their room seemed to be always empty. The residents said their room was not cleaned everyday. The resident who resided in room [ROOM NUMBER] was interviewed on 9/9/25 at 1:30 p.m. She said she did not have soap or towels in her bathroom. She said she did not feel these items were replaced timely. C. Staff interviews (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MTD was interviewed on 9/8/25 at 12:28 p.m. The MTD said he was not aware of the floor issue in room [ROOM NUMBER] until it was brought to his attention during the survey. He said the loose tiles and brown liquid could be from mopping the floors and the water settled in between the tiles and became rusty. He said the brown fluid could have been there for quite awhile. The MTD said the floor was an easy fix and he would replace the tiles. The MTD said the residents' rooms were cleaned daily with the floors being mopped, bathrooms cleaned and wiping down of surface areas. He said the rooms were scheduled for monthly deep cleans, which had a more in-depth cleaning checklist. The floor technician was interviewed on 9/9/25 at 11:52 a.m. The floor technician said the smell coming from the floor in resident room [ROOM NUMBER] was urine seeping from under the tiles. The NHA was interviewed on 9/10/25 at 1:00 p.m. The NHA said the liquid under the tiles was not rusted water but urine. She said the residents should have been moved out of the room until all the affected areas in the room were cleaned and treated. She said she would have them moved to complete the maintenance on the floor properly. HK #2 was interviewed on 9/11/25 at 9:30 a.m. She requested for another staff member, the social services assistance (SSA), to interpret because she read and spoke very little English. HK #2 said she did not have a cleaning checklist on her cart. She said there was a checklist for rooms that received a deep clean. She said the checklist was filled out after the shift. She said the checklists were kept in a binder in the MTD's office. HK #2 said the checklist and the cleaning bottles on her cart were written in English.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the environment was free of accidents and hazards for three (#48, #68 and #5) of four residents reviewed for accidents/hazards out of 39 sample residents. Specifically, the facility failed to: -Ensure Resident #48 and Resident #68 were re-assessed to determine if they were safe to smoke independently; -Ensure staff were consistently implementing the care planned fall interventions for Resident #5; and, -Ensure Resident #5's fall care plan was updated with all fall interventions.Findings include:I. Resident #48A. Resident statusResident #48, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included schizophrenia and a traumatic brain injury (TBI). The 6/4/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to participate in the brief interview for mental status (BIMS) assessment. A staff assessment for mental status revealed the resident had short and long term memory impairments, disorganized thinking, difficulty with following what was said and he had moderate impairments to his daily decision-making skills.B. ObservationsOn 9/8/25 at 9:50 a.m. Resident #48 was propelling himself (in his wheelchair) in circles in the activity room. He was wearing a shirt with two cigarette burns on the lower part of his shirt closest to his waist. He continued to propel himself in and out of the activities room, while watching the designated smoking patio. At 10:04 a.m., he propelled himself outside to the smoking patio and picked up a still lit cigarette butt he found on the floor, and then used the lit butt to light other cigarette butts he found on the floor in the smoking patio. At 10:24 a.m., he found a partially smoked cigarette on the floor in the smoking patio, but could not find a lit butt so he started asking other residents for a lighter. On 9/8/25 at 1:31 p.m. Resident #48 was in the designated smoking patio picking up still lit cigarette butts he found on the floor, smoking the lit butt and using it to light other cigarette butts he found on the ground. The smoking patio was directly next to the activities room and could be observed from inside the activity room through the glass windows. Several staff members walked back and forth in the activities room and did not check on Resident #48. C. Record reviewResident #48's smoking care plan, revised 5/5/25, revealed the resident was an independent smoker and the staff held his cigarettes and lighter for him. Interventions included to monitor the resident for unsafe smoking practices and burn holes in his clothing and re-evaluate the resident on a quarterly and as needed basis (initiated 9/3/25). A review of Resident #48's electronic medical record (EMR) failed to reveal documentation to indicate the resident was being monitored for unsafe smoking behaviors for Resident #48.A smoking/vaping risk assessment, dated 8/19/25, revealed Resident #48 was identified as an independent smoker with supervision for impulsiveness.-Review of Resident #48's EMR revealed there was no updated smoking assessment to determine if the resident was safe to continue as an independent smoker after he was involved in a physical altercation with another resident while trying to smoke cigarette butts off the ground on 8/9/25.Cross reference F600 for failure to keep residents free from abuse.II. Resident #68A. Resident statusResident #68, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included diabetes. The 6/6/25 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 12 out of 15. B. Resident observationsOn 9/8/25 at 9:56 a.m. Resident #68 was observed outside in the designated smoking patio sitting in a patio chair. When Resident #68 finished his cigarette, he dropped the lit cigarette on the ground and went back inside. On 9/8/25 at 1:34 p.m. Resident #68 was observed outside in the designated smoking patio sitting in a patio chair. When Resident #68 finished his cigarette, he flicked the lit ash on to the ground and then put out his cigarette butt on the arm of the metal chair he was sitting in. C. Record reviewResident #68's smoking care plan, revised 6/17/25, revealed the resident was an independent smoker. Interventions included to monitor the resident for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsafe smoking practices and burn holes in his clothing and re-evaluate the resident on a quarterly and as needed basis (revised 6/17/25). A review of Resident #68's EMR failed to reveal documentation to indicate the resident was being monitored for unsafe smoking behaviors.A smoking/vaping risk assessment, dated 9/2/25, revealed Resident #68 was identified as an independent smoker.III. Resident #5A. Resident statusResident #5, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included metabolic encephalopathy, schizoaffective disorder, dementia, hallucinations and artificial right hip. The 7/26/25 MDS assessment revealed the resident had mild cognitive impairments with a BIMS score of 12 out of 15. The MDS assessment documented the resident had limited range of motion in his lower extremities, shortness of breath when lying down, used a walker and wheelchair for mobility, and required two person total assistance with toileting, bathing, putting on shoes, bed mobility and transfers. The MDS assessment indicated the resident had had two falls since the prior assessment. B. Resident observationsOn 9/8/25 at 10:02 a.m. Resident #5 was sleeping in his bed in his room without the bed in the lowest position. On 9/10/25 at 1:50 p.m. Resident #5 was lying in his bed in his room without the bed in the lowest position. C. Record reviewResident #5's fall care plan, revised 8/18/25, revealed the resident was at risk for falls related to a history of falls and impaired mobility. Interventions included ensuring his bed was in the low position while in bed (initiated 1/8/25), ensuring the resident was wearing appropriate footwear when mobilizing in his wheelchair (initiated 1/8/25), ensuring the call light was within reach (initiated 6/24/25), physical therapy evaluate and treat (initiated 6/24/25), reviewing information on past falls and attempting to determine the cause of falls (initiated 6/24/25), ensuring a floor mat was next to the left side of bed (initiated 7/4/25), keeping his bed in lowest position at all times when in bed (initiated 7/8/25) and ensuring the resident's personal items, including water, snacks and the call light were within reach (initiated 7/17/25). -The intervention of ensuring the resident's bed was in the lowest position was added to the care plan on 1/8/24 and was added again on 7/8/25.-There were no new interventions added to the care plan for the resident's falls on 8/11/25 or 8/22/25 (see falls below), and there was no documentation to indicate the care plan had been reviewed to determine if the interventions were effective or if new interventions were needed. A review of Resident #5's EMR from 7/4/25 to 9/9/25 revealed the following progress notes:A nursing note, dated 7/4/25, revealed Resident #5 was found on the floor in his room. He was lying on his left side with complaints of pain in his right shoulder. The resident told the staff he had been trying to reach an item from his bedside table and rolled out of his bed onto the floor. A fall mat was ordered. A risk management review note, dated 7/7/25, revealed the root cause analysis of the fall on 7/4/25 was confused, unsteady gait with an intervention of a fall mat on the left side of the resident's bed. A nursing note, dated 7/7/25, revealed Resident #5 reported he had rolled out of his bed when trying to reach for his bed control. He rolled onto the fall mat on his floor. A risk management review note, dated 7/8/25, revealed the root cause analysis of the fall on 7/7/25 was unsteady gait, weakness with an intervention of keeping the bed in the lowest position.A nursing note, dated 7/17/25, revealed a nurse and nursing student entered Resident #5's room to find the resident lying on his stomach on the fall mat. The resident's bed was in the lowest position. The resident reported he had rolled out of bed when he attempted to reach for his water pitcher. A nursing note, dated 8/9/25, revealed a certified nurse aide (CNA) reported that she found Resident #5 on the floor mat in his room. He told the CNA he had been reaching for a book and had slid out of his bed. The resident's bed had been in the lowest position.A risk management review note, dated 8/11/25, revealed the root cause analysis of the fall on 8/9/25 was balance impairments with an intervention of keeping the call light placed within reach, ensuring personal items were placed within reach and changing out the resident's air mattress with a pressure-reducing mattress.-However, the resident's care plan was not updated with the intervention of switching to a pressure-reducing mattress.A nursing note, dated 8/22/25, revealed the resident had activated the call light and was found lying on his floor. The fall mat was in place. -The note failed to indicate if the (continued on next page)

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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. Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on three of four hallways.Specifically, the facility failed to:-Ensure enhanced barrier precautions (EBP) were followed during a transfer for Resident #49, who had an indwelling medical device (Foley catheter); -Ensure enhanced barrier precautions (EBP) were followed during resident care for Resident #47, who had an indwelling medical device (enteral feeding tube); and,-Ensure staff performed hand hygiene consistently during medication administration for Resident #31, Resident #14 and Resident #24.Findings include: I. Facility policy and procedure The Infection Control and Surveillance policy, July 2023, was provided by the nursing home administrator (NHA) on 9/8/25 at 1:53 p.m. It read in pertinent part, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program is developed to address the facility-specific infection control needs, requirements identified in the facility assessment and the infection control risk assessment. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). The infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Important facets of infection prevention include: educating staff and ensuring that they adhere to proper techniques and procedures; instituting measures to avoid complications or dissemination; and educating staff and ensuring that they adhere to proper techniques and procedures. II. EBP failure during a transfer with Resident #49 A. Professional reference Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), April 2024, was retrieved on 9/15/25. It read in pertinent part, 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. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Standard precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	holding the cup from the sides. RN #2 grabbed a pair a gloves from a box located on top of the medication cart and donned them. -RN #2 did not perform hand hygiene prior to donning the gloves. A certified nurse aide (CNA) handed an electronic wrist blood pressure cuff to RN #2 from behind the nurses' station. RN #2 attached the blood pressure cuff to Resident #31's left wrist. After the resident's blood pressure reading was obtained, RN #2 removed the blood pressure cuff from Resident #31's wrist and placed it on top of the medication cart. RN #2 removed her gloves and threw them away. RN #2 grabbed the cup of water and the medication cup containing Resident #31's medications and handed them to the resident to take. RN #2 observed the resident take her medications and then performed hand hygiene at the medication cart. -RN #2 did not perform hand hygiene after she removed her gloves and before giving Resident #31 her medications and a cup of water. At 9:26 a.m., RN #2 said Resident #14 requested pain medication. The door to Resident #14's room was closed. RN #2 knocked on the door, opened it with her left hand, and stood in the doorway with her right hand resting on the inner doorframe. RN #2 assessed Resident #14's pain and said she would get his pain medication. RN #2 closed the door with her left hand and walked back to the medication cart. RN #2 unlocked the medication cart, grabbed a medication cup from the stack of cups located on the left of the medication cart and placed the medication cup on top of the cart. RN #2 unlocked and opened the narcotic medication drawer and removed the blister pack containing Resident #14's medication. RN #2 picked up the medication cup and popped one tablet from the blister pack into the medication cup. RN #2 placed the medication cup on top of the medication cart and returned the blister pack to the narcotic medication drawer. RN #2 picked up a pen, opened the narcotic medication log, and logged the medication. RN #2 grabbed a plastic cup from the left side of the medication cart and filled it with the water pitcher. RN #2 picked up the medication cup and the cup of water and walked to Resident #14's room. RN #2 held the medication cup and the cup of water by the bottom in her right hand and used her left hand to knock on and open Resident #14's room. RN #2 walked into Resident #14's room and handed him the medication cup and the cup of water. RN #2 observed Resident #14 take his medication and then exited the resident's room. -RN #2 did not perform hand hygiene after preparing medication and before walking into Resident #14's room and administering the medication to the resident. During a continuous observation on 9/10/25, beginning at 12:42 p.m. and ending at 12:50 p.m., licensed practical nurse (LPN) #3 was observed during medication administration. The following was observed: LPN #3 performed hand hygiene at the medication cart. She unlocked the medication cart and began preparing medications for Resident #24. LPN #3 obtained a medication cup from a stack of cups located on the left side of the medication cart. LPN #3 opened a bottle of medication and poured it into the medication cup. LPN #3 opened a medication drawer, obtained a resident labeled blister pack of medication, and popped one tablet into the medication cup. LPN #3 unlocked the narcotic medication drawer and obtained a resident labeled blister pack of medication. LPN #3 popped a half tablet of medication into the medication cup. LPN #3 closed the narcotic medication drawer and grabbed and opened the narcotic medication binder, on top of the medication cart and logged the medication. LPN #3 grabbed a water cup from a stack of cups located on the left side of the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsprings Care Center	3636 S Pearl St Englewood, CO 80113

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication cart. LPN #3 poured water into the cup from a water pitcher sitting on top of the medication cart. LPN #3 picked up the cup of water and the medication cup containing Resident #24's medications and walked toward the resident's room. Upon entering Resident #24's room, LPN #3 handed him the medication cup and the cup of water. LPN #3 verified Resident #24 took his medication. LPN #3 threw the cup of water and the medication cup away and exited Resident #24's room. -LPN #3 did not perform hand hygiene during the preparation of Resident #24's medication, upon entering the resident's room or upon exiting the resident's room. C. Staff interviews RN #2 was interviewed on 9/10/25 at 9:31 a.m. RN #2 said hand hygiene should be performed before, during and after medication preparation. She said hand hygiene should also be performed before and after medications were administered to a resident. RN #2 said hand hygiene should be performed to decrease the risk of transmitting organisms and help reduce the risk of infection. LPN #3 was interviewed on 9/10/25 at 1:17 p.m. LPN #3 said hand hygiene should be performed before and after all resident care. LPN #3 said hand hygiene was important because it helped decrease the risk of infection. The RCR was interviewed on 9/11/25 at 2:30 p.m. The RCR said facility staff were supposed to perform hand hygiene when going in and out of a resident room and also between glove use. The RCR said proper hand hygiene was important to help prevent the transmission of organisms.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to:-Ensure the first floor north shower gurney pad was smooth, cleanable, in good repair, and cleaned according to manufacturing instructions; and, -Ensure the residents' shower rooms were maintained in a safe, sanitary and working conditions. Findings include: I. Failure to ensure the shower gurney pad was maintained and cleaned per instructions A. Facility policy and procedure The Manual Cleaning Shower Bed policy and procedure, undated, was provided by the nursing home administrator (NHA) on 9/10/25 at 10:02 a.m. It read in pertinent part, Usage recommendation: Recommended for showering people who are unable to stand or sit in a chair. Cleaning instructions: Clean cushion, pipe and fittings with in-house disinfectant after each use. Wipe down casters after each use. Avoid using solvent based or abrasive cleaners. B. Observations and interviews A continuous observation on 9/9/25, beginning at 12:22 p.m. and ending at 12:51 p.m., revealed the following: At 12:22 p.m. certified nurse aide (CNA) #5 wheeled the shower gurney out of room [ROOM NUMBER] and into the shower room located on the first floor north unit. The gurney had a blue pad made of foam on top of it. The headrest of the pad had approximately eight to ten cracks in it, exposing the material's inner foam. The body of the pad had approximately 20 to 25 cracks in it, exposing the material's inner foam. CNA #5 wheeled the shower gurney into an open shower located straight forward upon entering the shower room. At approximately 12:27 p.m. CNA #5 was interviewed. CNA #5 said the shower bed was cleaned using a cleansing spray located in the shower room. CNA #5 went to the cabinet and retrieved an unlabeled spray bottle that contained a yellow liquid. CNA #5 said she did not know what chemical the liquid was. CNA #5 said the fluid was mixed by housekeeping. CNA #5 said the shower gurney and pad should be cleansed between residents. CNA #5 said the shower gurney and pad should be sprayed with the yellow liquid. CNA #5 said the mixture should be left for three minutes and then rinsed off with warm water. CNA #5 said the inner exposed foam was kept dry by using a towel on top of the foam and underneath the resident. CNA #5 said she was going to clean the shower gurney and pad. CNA #5 donned gloves, she grabbed a blanket and one washcloth from the linen cart and placed them on top of the shower gurney pad. CNA #5 turned on the shower. CNA #5 wet the washcloth then pumped three pumps of Total Bath Skin and Hair Cleanser onto the washcloth. CNA #5 wiped the top of the shower gurney pad with the washcloth, including over all of the exposed cracks in the foam. CNA #5 rinsed the washcloth under the water and reapplied more of the cleanser. She then used the washcloth to wipe down the frame of (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shower gurney. CNA #5 rinsed out the washcloth and placed it in the dirty linen. CNA #5 disconnected the shower head from the wall of the shower. At 12:32 p.m. CNA #5 grabbed the shower head from the wall. Used water from the shower head to rinse off the shower gurney and pad. CNA #5 sprayed water directly over spots in the pad where the exposed foam was located. Water was flowing into multiple open spots of the exposed inner foam padding. CNA #5 rinsed off the frame of the shower gurney and reconnected the shower head to the wall. At 12:34 p.m. CNA #5 turned the water off and used the blanket to wipe down the shower gurney pad and frame. At 12:36 p.m. CNA #5 retrieved the unlabeled spray bottle containing the unknown chemical and sprayed it onto the shower gurney pad and frame. At 12:39 p.m. CNA #5 said the chemical spray needed to sit for three minutes. CNA #5 left the shower room. At 12:42 p.m. CNA #5 returned to the shower room and donned a pair of gloves. Obtained a blanket from the linen cart. CNA #5 used the blanket to wipe down the shower gurney pad and frame. CNA #5 placed the blanket in a bag for dirty linen, removed her gloves and threw them away. At 12:45 p.m. CNA #5 said the shower gurney was ready for the next resident to use. CNA #5 said she should report any issues with resident care equipment to maintenance. CNA #5 said the potential risks associated with the wet, exposed inner foam of the shower pad included growth and spread of organisms. CNA #5 said she would report the shower issue to the maintenance director (MTD). At 12:51 p.m. CNA #5 spoke with the MTD. The MTD said he would look at the shower gurney pad. The MTD said the director of nursing (DON) was responsible for ordering the shower gurney pad. On 9/9/25 at 3:18 p.m. the shower gurney and pad were observed The shower gurney pad's inner foam was exposed. The exposed foam was wet to the touch and water trickled and pooled when pressure was applied to the pad. II. Failure to ensure the shower rooms were maintained in safe, sanitary, and working condition A. Observations On 9/7/25 at 7:28 a.m. during the initial walk through of the shower rooms, the following was observed: The second floor shower room, nearest to resident room [ROOM NUMBER], revealed the drain in the shower had an unsecure drain cover that did not stay in place over the hole in the shower floor, broken pieces of a body wash bottle were on the floor of the shower and an unlabeled spray bottle of yellow liquid in an unlocked cupboard. The second floor shower room, nearest to resident room [ROOM NUMBER], revealed four wet towels on the floor and one wet towel on the shower chair, an approximate 10 inches wide by 2 inches high section of wall with missing caulking on the baseboard and a black substance in the place of the (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing caulking. The first floor tub and shower shower room, nearest to the business office, revealed the tub had a bin and broken plastic inside of it with an approximate six inches wide by eight inches long yellow and brown stain in the tub around the drain. On two of the four sides of the shower area, an unidentified grayish black discoloration in circular shapes that had spread up the wall approximately four inches high from the baseboard was observed and the shower head was dripping. On 9/9/25 at 11:35 a.m. the following was observed: The second floor shower room, nearest to resident room [ROOM NUMBER], revealed the drain in the shower has an unsecure drain cover that did not stay in place over the hole in the shower floor and an unlabeled spray bottle of yellow liquid in an unlocked cupboard. The second floor shower room, nearest to resident room [ROOM NUMBER], revealed an approximate 10 inches wide by two inches high section of wall with missing caulking on the baseboard and a black substance in the place of the missing caulking. The first floor combined tub and shower shower room nearest to the business office, revealed the tub had an approximate six inches wide by eight inches long yellow and brown stain in the tub around the drain. On two of the four sides of the shower area, an unidentified grayish black discoloration in circular shapes that had spread up the wall approximately four inches high from the baseboard was observed. The shower head was dripping and had a trash can underneath it to catch the water. B. Staff interviews Licensed practical nurse (LPN #1) was interviewed on 9/9/25 at 11:40 a.m. She said the housekeepers were to clean the shower rooms everyday and the certified nurse aides (CNA) were to clean the shower rooms after every resident. CNA #2 and CNA #3 were interviewed together on 9/9/25 at 11:47 a.m. Both CNA #2 and #3 said the housekeepers were to clean the shower rooms everyday and the CNAs were to clean the shower rooms after every resident. The MTD was interviewed on 9/10/25 at 12:09 p.m. He said he oversaw the maintenance and housekeeping departments. He said the reason the 2nd floor shower room (nearest to resident room [ROOM NUMBER]) had an unsecure drain cover so the staff could pull hair out of the drain. The MTD said the housekeepers were to clean the shower rooms everyday and the CNAs were to clean the shower rooms after every resident. He said he did do random, spot checks of the housekeepers work, however, he did not document those checks. The MTD also said there wasn't a written daily cleaning schedule for the housekeepers or a sign off of work completed, because he knows what they do and do not do. He said he did not have a work order for the dripping shower head, and could not explain why the CNAs and housekeepers had not advised him. The NHA was interviewed on 9/10/25 at 1:15 p.m. She said the broken drain cover should be replaced and if there was an issue with hair, a new drain cover that would collect hair should be installed. Housekeeper (HK) #1 was interviewed on 9/11/25 at 9:20 a.m. She said the black substance on the wall in the first floor shower room (nearest to the business office) was very old and she had tried to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#27 and #43) of six residents reviewed for abuse out of 39 sample residents were kept free from abuse. Specially, the facility failed to protect Resident #27 and Resident #43 from physical abuse by Resident #48.Findings include: I. Facility policy and procedure The Abuse policy, dated 5/3/23, was received from the nursing home administrator (NHA) on 9/8/25 at 10:41 a.m. It read in pertinent part, If a resident experiences a behavior change resulting in aggression toward other residents, the community will implement interventions for protection of the alleged assailant and other residents. The facility conducts further assessment and arranges for appropriate psychiatric evaluation for further screening. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization, can then be implemented. II. Incident of physical abuse of Resident #27 by Resident #48 on 8/9/25 A. Facility investigation The 8/9/25 facility investigation documented an unwitnessed physical altercation between Resident #48 and Resident #27. Another resident had thrown a partially smoked cigarette on the ground on the designated smoking patio. Resident #27 went to reach for it, and Resident #48 then pushed her and scratched her arm in order to retrieve the cigarette for himself. Resident #27 reported the incident to the nurse and contacted the police herself. The two residents were separated by staff and assessed for injuries and no injuries were noted. When interviewed by facility staff, Resident #27 denied feeling fearful. Resident #48 denied the incident occurred. Resident #27 and Resident #48 were both placed on 15-minute checks for 24 hours and the resident's responsible parties and the physician were notified. The investigation documented that the facility unsubstantiated abuse. -However, abuse occurred due to Resident #48 making willful physical contact with Resident #27. B. Resident #48 (assailant) 1. Resident status Resident #48, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included schizophrenia and a traumatic brain injury (TBI). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/4/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to participate in the brief interview for mental status (BIMS) assessment. A staff assessment for mental status revealed the resident had short and long term memory impairments, disorganized thinking, difficulty with following what was said and he had moderate impairments to his daily decision-making skills. The MDS assessment indicated the resident had behaviors of physical and verbal aggression towards others, rejection of care and experienced delusions and hallucinations. 2. Record review Resident #48's trauma care plan, initiated 5/30/24, revealed the resident had a history of trauma, difficulty connecting and trusting others. His behaviors included being resistive to care and poor interpersonal skills. Interventions, initiated 5/30/24, included assessing his need for additional services and therapeutic support or specialists from the community, offering him referrals periodically and as needed, and providing consistent care providers whenever possible. Resident #48's behavior care plan, revised 2/24/25, revealed the resident had the potential to be physically aggressive related to a history of physical aggression towards others. Interventions, initiated 2/24/25, included administering medication as ordered, assessing the resident's needs, monitoring and documenting behaviors and interventions tried, intervening before agitation escalated, guiding the resident away from sources of distress, engaging the resident calmly in conversation and if the resident's responses were aggressive, staff was to walk calmly away and reapproach later. -The care plan failed to identify the episodes of physical aggression on 8/9/25 (with Resident #27 - see facility investigation above) and 8/19/25 (with Resident #43 - see facility investigation below) and the interventions implemented to prevent further abuse incidents. A review of Resident #48's electronic medical record (EMR), from 5/6/25 to 8/20/25, revealed the following; A behavior note, dated 5/6/25, revealed Resident #48 propelled himself (in his wheelchair) past another resident and attempted to strike the other resident. The two residents were separated without contact. A behavior note, dated 5/28/25, revealed Resident #48 had thrown his coffee in the face of the nurse, kicked, pulled hair, and punched the nurse. To resolve the incident, another staff member had to come and remove the resident. A behavior note, dated 7/2/25, revealed Resident #48 had attempted to swing at a staff member and the social worker was notified. A nurse progress note, dated 8/9/25, revealed Resident #48 was on 15-minute checks after an altercation with another resident (Resident #27). A behavior note dated, 8/10/25, revealed Resident #48 had a verbal altercation with another resident and was placed on 15-minute checks for observation. -A review of Resident #48's EMR failed to reveal the behavior interventions that were attempted for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's behaviors and what precipitating factors were analyzed to prevent recurrence. -A review of the resident's behavior progress notes from 8/9/25 failed to reveal specific documentation of the physical altercation Resident #48 was involved in with Resident #27. C. Resident #27 (victim) 1. Resident status Resident #27, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included chronic obstructive pulmonary disease. The 8/29/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident did not have any behaviors. 2. Record review Resident #27's behavior care plan, initiated 6/3/25, revealed the resident could be resistive or refuse personal care such as showers. Interventions, initiated 6/3/25, included praising the resident and allowing the resident to make decisions about her treatment. -Resident #27's care plan failed to address the incident with Resident #48 on 8/9/25. A review of Resident #27's EMR, from 8/1/25 to 8/9/25, revealed the following; A nursing progress note, dated 8/9/25, revealed Resident #27 had reported to the nurse that she was scratched on the arm by another resident (Resident #48). The two residents were on the designated smoking patio and Resident #48 pushed and scratched Resident #27 after trying to take a cigarette from her that she had picked up from the ground. III. Incident of physical abuse of Resident #43 by Resident #48 on 8/19/25 A. Facility investigation The 8/20/25 facility investigation documented that on 8/19/25, Resident #43 called Resident #48 names and was yelling at him. Resident #48 picked up a step stool and threw the stool at Resident #43 and caused a skin tear on Resident #43's eyebrow. Immediate interventions put in place by the facility included asking both residents to stay on their separate floors through the night, both residents were placed on 15-minute checks and the police were notified. Witness statements were taken and additional facility residents were interviewed. The investigation documented Resident #43 was an at-risk adult and had a history of behaviors with the potential to be verbally aggressive and use derogatory names and racial slurs related to poor impulse control. The resident was involved in a previous altercation. Resident #48 was documented as having a history of physical behaviors and refusals and the resident had a care plan for his behaviors. He had been involved in three other occurrences of physical aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident to express himself and feelings towards the situation and provide positive feedback for good behavior; emphasize the positive aspects of compliance and when the resident became agitated, intervene before the agitation escalated, initiated 1/12/24 and educate the resident on healthy and appropriate interactions with peers, initiated 8/21/25. An 8/20/25 nursing note, documented at 6:03 a.m., revealed that Resident #43 sustained a small laceration above his left eyebrow, and the area was severely bruised. All parties were notified. An 8/20/25 nursing note, documented at 6:12 a.m., revealed that Resident #43 refused neurological signs and symptoms checks and refused to speak to police. An 8/21/25 nursing note, documented at 5:15 p.m., revealed that Resident #43 was being monitored following an altercation with another resident Resident #48). The resident was not cooperative for a full neurological assessment. The resident denied having pain. Bruising with a small laceration was noted to the resident's left eye brow area and a bandage in place was clean, dry and intact. No signs of infection were noted. IV. Staff interviews The NHA was interviewed on 9/11/25 at 12:00 p.m. The NHA said the facility's procedure after an incident of resident-to-resident physical abuse was to separate the residents, assess the residents for any physical or psychosocial harm and contact the NHA for notification and further direction. The NHA went over a timeline of what the facility had done for Resident #48 after the 8/9/25 incident with Resident #27. The NHA said the facility provided Resident #48 with education to not hit other residents and he was placed on 15-minute checks on 8/9/25. She said the physician's assistant reviewed Resident #48's medications on 8/10/25 with no changes made. She said the social services consultant reviewed Resident #48's EMR on 8/14/25 and recommended contacting the physician for psychoactive medication changes and initiating a positive incentive program for Resident #48. The NHA said Resident #48 was placed on 15-minute checks again on 8/19/25 (following the incident with Resident #43). She said the resident's medications were reviewed by the physician's assistant again on 8/20/25. The NHA said the social services consultant's recommendations on 8/14/25 (see above) were not put into place because she (the NHA) believed the social worker had followed up, but the NHA had not verified whether or not she had followed up on the recommendations. The NHA said she did not know why the residents' care plans had not been updated after the incidents. The NHA acknowledged, due to Resident #48's complex medical conditions (schizophrenia and a TBI), the facility should have followed the recommendations of the social services consultant on 8/14/25, as well as including a psychiatrist to review the resident's EMR for medication and behavior modification recommendations. She said the facility would get a referral for a psychiatrist to review Resident #48.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the state mental health agency promptly after a significant change in the resident's mental condition for one (#7) of four residents out of 39 sample residents. Specifically, the facility failed to notify the state mental health agency authority of Resident #7's necessity for inpatient psychiatric hospitalization.Findings include:I. Facility Policy and ProcedureThe Pre-admission Screen and Resident Review (PASRR) policy, dated 9/26/23, was provided by the nursing home administrator (NHA) on 9/11/25 at 9:15 a.m. It revealed in pertinent part, If a resident's psychiatric status changes after admission. The social services staff are responsible for contacting Omnibus Budget Reconciliation Act (OBRA - state mental health agency) coordinator via completion and submission of a PASRR level I screen and indicate the reason for referral as a change in mental health status or psychiatric diagnosis. Notification of changes are to be made within 10 business days of identifying the change. Status change Level I screens should be submitted in the following circumstances:-If there is a change in psychiatric diagnosis,-Significant deterioration in mental health condition; significant increase in psychiatric symptoms, or-Psychiatric hospitalization, regardless of whether there is a change in diagnosis or medication.II. Resident #7A. Resident statusResident #7, age [AGE], was admitted to the facility on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder, demoralization and apathy, delusional disorder and unspecified mood.The 7/30/25 minimum date set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #7 was independent with all of his activities of daily living (ADL).B. Record reviewThe comprehensive care plan, initiated 3/18/22 and revised 8/15/22, revealed Resident #7 had a PASRR level II related to schizoaffective disorder, bipolar type and history of probable neurocognitive disorder due to traumatic brain injury (TBI) with past behavior disturbances. -On 9/10/25 (during survey) the resident's comprehensive care plan was updated to include a suicidal ideation care plan focus. The care plan documented the resident was at risk for feelings of hopelessness and suicidal ideation. Resident #7 had a history of making statements of wanting to die. Review of Resident #7's electronic medical record (EMR), from 6/9/25 through 9/7/25, revealed the following progress notes:A progress note, dated 6/10/25 at 6:46 a.m., documented Resident #7 walked to the nurses' station and started to smash computers to the floor. The nurse phoned 911 and the resident was handcuffed and escorted out. A progress note, dated 6/19/25 at 11:55 a.m., documented Resident #7 returned to the facility. A progress note, dated 6/23/25 at 3:59 p.m., documented Resident #7 had a follow up with his physician following a psychiatric hospital stay. A progress note, dated 6/26/25 at 6:25 p.m., documented Resident #7 was seen by the physician due to Resident #7 refusing to take his medications. A progress note, dated 6/27/25 at 5:50 p.m., documented the facility received a call from a hospital stating Resident #7 had been found intoxicated and taken to the emergency room by the police. Resident #7 was being admitted for psychosis. The note documented that the resident had signed himself out on an independent pass.A progress note, dated 7/28/25 at 8:23 p.m., documented Resident #7 was readmitted from a behavioral health transition of care hospital. A progress note, dated 7/29/25 at 9:30 a.m., documented Resident #7 was seen by his physician for readmission to the long-term care facility following a recent hospitalization with decompensation. Resident #7 was reported to have suicidal ideations with a plan. The resident returned with new medication orders for clozapine (an antipsychotic medication) and haloperidol (an antipsychotic medication).A progress note, dated 7/31/25 at 4:47 p.m., documented Resident #7 said he wanted to die. He denied having any plan to harm himself and frequent checks were initiated. -Review of Resident #7's EMR, from 6/9/25 through 9/7/25, revealed there was no social services documentation related to the resident's two (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatric hospitalizations, the new psychotropic medications or the suicidal ideations. -Review of Resident #7's EMR revealed there was no documentation to indicate that the OBRA coordinator was notified of the resident's decline in behavior, medication changes and psychiatric hospitalizations. Resident #7's level II PASRR evaluation was dated 6/18/2020. Resident #7's Colorado PASRR level II Notice of Determination for Mental Illness was dated 6/24/2020.C. Staff interviewsThe social services director (SSD) and the social services consultant (SSC) were interviewed together on 9/10/25 at 1:27 p.m. The SSD said a status change PASRR level I should be submitted when there was a change in a resident's diagnosis or a significant change in the resident's mood or behavior. She said when a resident was decompensating, the facility should notify the mental health agency, the physician and update the resident's care plan of the changes.

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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. Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%).Specifically, the facility had a medication error rate of 8%, or two errors out of 25 total opportunities for error.Findings include:I. Facility policy and procedureThe Medication Administration policy, dated 8/4/25, was provided by the nursing home administrator (NHA) on 9/10/25 at 10:02 a.m. It read in pertinent part, Resident medications are administered in an accurate, safe, timely, and sanitary manner. Verify the medication label against the medication administration record (MAR) for accuracy of drug frequency, duration, strength, and route. The nurse is responsible to read and follow precautionary or instructions on prescription labels. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. Report any discrepancies to the pharmacy. Do not administer the medication until the discrepancy is resolved. Never administer medications from an unmarked container.II. ObservationsOn 9/10/25 at 9:08 a.m., registered nurse (RN) #2 was dispensing medications to Resident #31. RN #2 dispensed one tablet of Aspirin (blood thinner) 81 milligrams (mg) enteric coated (EC - a polymer barrier applied to oral medication that prevents it from dissolving in the highly acidic stomach environment) into a medication cup. RN #2 poured a cup of water and handed the water and medication cup to Resident #31. Resident #31 took the medication.On 9/10/25 at 9:08 a.m. RN #2 was dispensing medication to Resident #59. RN #2 dispensed one tablet of Paliperidone (antipsychotic) EC 6 mg into a medication cup. RN #2 poured a cup of water, walked into Resident #59's room and handed him the cup of medication and water. Resident #59 took the medication.III. Record reviewReview of Resident #31's September 2025 computerized physician orders (CPO) revealed the resident had a physician's order for Aspirin 81 mg chewable tablets.-However, RN #2 administered an enteric coated Aspirin to Resident #31 instead of chewable aspirin (see observation above). Review of Resident #59's September 2025 CPO revealed the resident had a physician's order for Paliperidone EC 6 mg tablet. Take 2 tablets in the afternoon. -However, RN #2 dispensed one tablet of Paliperidone to Resident #59 during the morning administration pass (see observation above).IV. Staff interviewsThe regional clinical resource (RCR) was interviewed on 9/11/25 at 2:30 p.m. The RCR said a lower dose of an administered medication could lessen the effect of the medication. The RCR confirmed Resident #59's order for Paliperidone was for two tablets instead of one tablet. The RCR said Resident #31's physician's order for Aspirin read chewable tablets, however, she said the resident did not need a chewable table.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of four medication carts.Specifically, the facility failed to:-Ensure residents' medications were labeled and dated appropriately with the resident's name, the date the medication was opened and the expiration date, as applicable; and,-Ensure over-the-counter (OTC) medications stored in medication carts were not expired.Findings include:I. ObservationsOn [DATE] at 10:48 a.m. medication cart #1 on the first floor was observed with licensed practical nurse (LPN) #1. The following items were found:-There was an albuterol sulfate 90 microgram (mcg) inhaler stored in an appropriately labeled medication box; however, the inhaler inside the box was not labelled with the resident's name for Resident #2.-Resident #2's albuterol sulfate inhaler was labeled with a medication expiration date of [DATE].-There was a Breo ellipta 50/25 mcg inhaler stored in an appropriately labeled medication box; however, the inhaler inside the box was not labelled with the resident's name for Resident #31.-There was a [NAME] 160-4.5 mcg inhaler stored in an appropriately labeled medication box; however, the inhaler inside the box was not labelled with the resident's name, the date the medication was opened or the medication's date of expiration for Resident #52.On [DATE] at 11:15 a.m. the south medication cart on the second floor was observed with LPN #2. The following item was found:-There was a vitamin B-12 100 mcg tablet medication bottle with an expiration date of [DATE] in the OTC drawer of the medication cart.II. Staff interviewsLPN #1 was interviewed on [DATE] at 10:48 a.m. LPN #1 said the albuterol sulfate inhaler had expired after she noticed the expiration date when the medication was removed from the medication cart during the observation (see observations above). She said the medication should have been removed from medication cart #1 when it expired.LPN #2 was interviewed on [DATE] at 11:15 a.m. LPN #2 acknowledged the OTC medication on the south medication cart had expired. She said the expired medication did not belong in the medication cart.The regional clinical resource (RCR) was interviewed on [DATE] at 1:00 p.m. The RCR said the typical process for medication labelling was to label the individual medication bottles inside their respective medication boxes with the resident's name and the medication expiration date. She said she was not sure how to best label inhalers, as a Sharpie pen could rub off and the pharmacy would not want to open a medication box to apply a label to the medication bottle.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received the required therapy services which were ordered by the physician for one (#74) of three residents reviewed for therapy services out of 39 sample residents. Specifically, the facility failed to ensure Resident #74 received specialized rehabilitative services as ordered on admission to the facility, to maintain the resident's highest practicable level of physical, mental, functional and psycho-social well-being.Findings include:I. Professional referenceAccording to [NAME], D (2023) Tips for a Comprehensive Post-admission Medical Record Review, retrieved on on 9/18/25 from: https://www.aapacn.org/article/tips-for-a-comprehensive-post-admission-medical-record-review American Association of Post-Acute Care Nursing, Omissions and inaccuracies in the medical record can hinder resident quality of care. Omitting or incorrectly transcribing medications or treatments can lead to adverse outcomes due to incorrect dosage, missed medications or skipped treatments. II. Resident #74A. Resident statusResident, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included traumatic subarachnoid hemorrhage (brain bleed) with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter, nondisplaced fracture of navicular (bone in the foot) of left foot, subsequent encounter for fracture with routine healing, nondisplaced fracture of medial malleolus (bony bump on the inner side of the ankle) of left tibia (shinbone), subsequent encounter for closed fracture with routine healing, displaced fracture of neck and right talus (ankle bone), subsequent encounter for fracture with routine healing, other fracture of upper and lower end of right fibula (calf bone) , subsequent encourager for closed fracture with routine healing, nondisplaced fracture of cuboid bone (bone outer side of foot) of left foot, subsequent encounter for fracture with routine healing, nondisplaced fracture of anterior process of left calcaneus (heel bone), subsequent encounter for fracture with routine healing and unspecified multiple injuries, subsequent encounter. The 9/8/25 minimum data set (MDS) revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The functional ability portion of the MDS assessment was still in progress at the time of the survey. According to the resident's activities of daily living (ADL) care plan (see record review below), the resident required staff assistance for ADLs and had limited physical mobility.B. Resident interviewResident #74 was interviewed on 9/8/25 at 10:00 a.m. Resident #74 said she was admitted to the facility in order to continue therapy services, but she said she had not been seen by a physical therapist (PT), an occupational therapist (OT) or a speech therapist (ST) yet. She said when she was discharged from the rehabilitation hospital, she was told she would continue her therapy at the facility. Resident #74 said she had been working with a walker at the previous facility but had not yet received a walker at this facility and she had been limited to the wheelchair. Resident #74 said she had asked different staff members about the therapy services but she had not received an answer from anyone.C. Record reviewResident #74's admission physician's orders, dated 8/22/25, revealed the resident was to be discharged to a long-term care facility (LTC) for PT, OT and ST.-Review of Resident #74's September 2025 CPO revealed there were no referral physician's orders for PT, OT or ST to evaluate and treat the resident. Review of the activities of daily living (ADL) functional abilities care plan, initiated 9/8/25 and revised 9/9/25, revealed Resident #74 required assistance with bed mobility, dressing and transfers. Review of the mobility care plan, initiated 9/9/25 (during the survey), documented Resident #74 had limited physical mobility related to recent polytrauma (multiple injuries at once) resulting in multiple fractures. Pertinent interventions included providing supportive care, assistance with mobility as needed, PT, OT referrals as ordered and PRN (as needed).III. Staff interviewsThe regional clinical resource (RCR) was interviewed on 9/10/25 at 12:45 p.m. The RCR said the admitting nurse input and reconciled the physician's orders in the resident's electronic medical record (EMR). The RCR said she was not aware Resident #74 did not have physician's orders (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for therapy to evaluate and treat. She said the orders were missed being input into the resident's EMR by the admitting nurse on 9/3/25. IV. Facility follow upOn 9/10/25 Resident #74's September 2025 CPO revealed a physician's order for PT, OT, ST evaluation and treatment, ordered 9/10/25 (during the survey). -However, the physician's order was not entered into the resident's EMR until seven days after Resident #74's admission to the facility on 9/3/25.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure adequate outside ventilation by means of windows, or mechanical ventilation for two out of four shower rooms. Specifically, the facility failed to ensure ventilation fan covers were kept clean and operational in the resident shower rooms. Findings include:A. Professional referenceAccording to the U.S. Department of Energy's Office of Energy Efficiency and Renewable Energy, April 2021 retrieved on 9/19/25 from: https://docs.nrel.gov/docs/fy21osti/79150.pdf., Proper ventilation helps reduce the concentration of bioaerosols (bioaerosols consist of aerosols originated biologically such as metabolites, toxins, or fragments of microorganisms), which can be particularly important in nursing homes due to the presence of vulnerable adults. Good ventilation can improve the health and wellbeing of the residents by reducing infection risks and preventing respiratory issues. By ensuring proper ventilation, nursing homes can significantly enhance the safety and quality of life for their residents. B. Observations On 9/7/25 at 7:28 a.m. during the initial walk through of the shower rooms, the following was observed:The first floor tub and shower room, nearest to the business office, revealed there was no air flow coming from the ventilation fan in the shower room. The ventilation fan wall cover was covered with a thick layer of what resembled gray dust. The first floor shower room, nearest to resident room [ROOM NUMBER], revealed there was no air flow coming from the ventilation fan in the shower room.On 9/9/25 at 11:35 a.m. the following was observed:The first floor tub and shower room, nearest to the business office, revealed there was no air flow coming from the ventilation fan in the shower room. The ventilation fan wall cover was covered with a thick layer of what resembled gray dust. The first floor shower room, nearest to resident room [ROOM NUMBER], revealed there was no air flow coming from the ventilation fan in the shower room.C. Staff interviewsThe regional maintenance director was interviewed on 9/11/25 at 11:30 a.m. while touring the shower rooms. The regional maintenance director said the facility used a mechanical ventilation system. He said the ventilation system prevented condensation risks by pulling moisture laden air out of the room. The regional maintenance director said if a ventilation system was not operational in a humid environment, it could contribute to the growth of mold. He said to ensure the ventilation system was working properly in the rooms and shower rooms, a piece of paper could be put up to the vent and if there was proper air flow, the paper would be pulled to the vent. The regional maintenance director said the ventilation fan and cover should be cleaned every six months. After inspecting the first floor tub and shower room ventilation cover, the regional maintenance director acknowledged there was not any air flow and the ventilation cover had not been cleaned within the last six months. After inspecting the first floor shower room ventilation cover, the regional maintenance director acknowledged there was not any air flow.