STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065209	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Hills Health Care Center	1625 Carr St Lakewood, CO 80214

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and interviews, the facility failed to ensure that essential food service equipment was maintained in a safe and functional condition in the main kitchen.Specifically, the facility failed to repair a broken, nonfunctional heated plate dispenser in the main kitchen.Findings include:I. ObservationDuring a continuous observation on 5/13/26, beginning at approximately 11:45 a.m. and ending at the kitchen's heated plate dispenser/lowerator was observed to be completely disconnected from electrical power, with its power cord left unplugged and coiled on the floor beside the unit.The staff were placing the plates on top of the broken dispenser without electrical power. The internal heating elements were inactive and the unit was cold to the touch. The lunch plates stacked inside the dispenser, which were being pulled by dietary staff to serve hot food to residents, were unheated and room temperature.II. Staff interviewsCook #1 was interviewed on 5/13/26 at 2:00 p.m. [NAME] #1 said the equipment had been broken and out of service for over six months. [NAME] #1 said the kitchen manager had been informed of the malfunction when the issue first arose. [NAME] #1 said the last time she attempted to plug the unit into an electrical outlet to use it, the equipment sparked fire, prompting staff to immediately disconnect it and leave it unplugged to prevent a safety hazard.The dietary manager (DM) was interviewed on 5/13/26 at 2:10 p.m. The DM said the equipment was broken and staff were placing the plates on top of the broken dispenser without electrical power just to hold the plates during the trayline services. The DS said he was aware the plates were not heated. The DM said it was important to ensure hot foods were served hot. The DM said he was informed by the NHA that a new dispenser had been purchased and that it would be delivered soon.The NHA was interviewed on 5/14/26 at 2:35 p.m.The NHA said she was aware the dispenser was broken. She said the unit was found to be damaged beyond repair. The NHA said she had already purchased a brand-new plate dispenser, which was currently scheduled for delivery to the facility on 5/24/26. The NHA said there was no interim protocol to address the current service gap.

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for three of five certified nurse aides (CNA) reviewed.Specifically, the facility did not complete a performance review for CNA #3, CNA #7, and CNA #8.Findings include:I. Facility policy and procedureThe Performance Evaluation policy, reviewed 12/4/25, was received from the nursing home administrator (NHA) on 5/15/26 at 12:23 p.m. It read in pertinent part, Performance evaluations are defined as a formal and productive procedure to measure an associate's work and results based on their job responsibilities. It is an integrated platform for both the associate and employer to attain common ground on what both think is befitting a quality performance. This helps in improving communication, which usually leads to improved performance results. Annual performance reviews are given to all associates. II. Record reviewAnnual performance reviews were requested on 5/12/26 at 5:52 p.m. for CNA #3 (hired 8/12/20), CNA #7 (hired 2/12/25), and CNA #8 (hired 3/7/24).The provided review for CNA #3 was completed on 4/30/25.The facility was unable to provide a review for CNA #7.The provided review for CNA #8 did not have a date when the review was completed.A review of the provided evaluation for CNA #8 revealed that the employee failed to meet expectations in two competency areas: communication and punctuality.-There was no documentation revealing CNA #8 was provided education regarding communication and punctuality. III. Staff interviewThe NHA and the regional vice president were interviewed on 5/13/26 at 1:15 p.m. The NHA said the corporate guidelines for all branches of their corporation were to complete reviews once for all employees in May each year.The regional vice president said he would bring it up with corporate for discussion regarding the regulatory requirements to complete reviews at least every 12 months.The staff development coordinator was interviewed on 5/14/26 at 11:38 a.m. The staff development coordinator said the unit managers were responsible for completing employee reviews. The staff development coordinator said based on the outcome of the reviews, if an employee required additional training, he would provide that training.

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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 for two of three units.Specifically, the facility failed to:-Clean resident rooms in a hygienic manner;-Clean high touch areas; and, -Ensure dwell times were followed.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures retrieved on 5/21/26 fromhttps://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_\ Common high touch surfaces include bedrails, sink handles, call bells, bedside tables, doorknobs, and light switches.According to the Centers for Disease Control and Prevention (CDC) When and How to Clean and Disinfect a Facility on 5/5/26 fromhttps://www.cdc.gov/hygiene/about/when-and-how-to-clean-and-disinfect-a-facility.html#:~:text=During%2 After you apply the disinfectant to the surface, leave the disinfectant on the surface long enough to kill the germs. This is called the contact/wet time. The surface should stay wet during the entire contact time to make sure germs are killedAccording to the Diversey Virex 256 Manufacturer guidelines, retrieved on 5/21/26 at 6:00 p.m., retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.lalema.com/bt/bt_jh306278400_en.pdf The directions for use indicated that for disinfection, all surfaces must remain wet for 10 minutes. II. Facility policy and procedureThe Daily Room Cleaning policy and procedure, reviewed April 2026, was provided by the nursing home administrator (NHA) on 5/1/26 at 3:41 p.m. The policy read in pertinent part, The cleanliness of each resident's room is maintained on a daily basis by the housekeeping staff to provide a fresh, clean, and sanitary environment and reduce the potential for nosocomial infections. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Clean and disinfect using a hospital grade EPA registered cleaner/disinfectant solution. The facility should refer to the Diversey Approved Housekeeping Chemicals guide for a listing of appropriate cleaning and disinfectants -Clean high-touch surfaces at least daily including handwashing sinks. -Clean and disinfect high touch/frequently contaminated surfaces (sinks, faucets, handles, door handles, and clean toilet seat last) at least daily. III. Observations On 5/23/26 at 10:44 a.m. housekeeper (HK) #1 was cleaning room [ROOM NUMBER], a single occupancy room. At 10:44 a.m. HK #1 spray the sink with Virex disinfectant spray. At 10:46 a.m. HK #1 wiped the inside of the sink bowl and then wiped the outside of the sink and counter. At 10:46 a.m. HK #1 wiped the outside of the paper towel dispenser and the outside of the hand soap dispenser. HK #1 then cleaned the inside of the sink bowl again. -HK #1 failed to clean from the cleanest to dirtiest areas on the sink.On 5/13/26 at 10:53 a.m. HK #1 sprayed Virex onto a rag and then wiped the bedside table. At 10:56 a.m. the bedside table surface was dry. -However, according to the manufacturer guidelines the Virex 256 dwell time should have been ten minutes (see professional reference above).On 5/13/26 at 12:50 p.m HK #2 was cleaning room [ROOM NUMBER], a double occupancy room. At 12:51 p.m. HK #2 sprayed the sink with the Virex disinfectant cleaner. At 12:59 p.m. HK #2 wiped the inside of the sink and then the outside of the sink and counter with the same cloth. -However, according to the manufacturer guidelines the Virex 256 dwell time should have been ten minutes (see professional reference above).At 1:01 p.m. HK #2 scrubbed the inside of the toilet bowl and then the top of the toilet bowl rim with a toilet bowl scrub brush. At 1:02 p.m. HK #2 wiped the top of the toilet bowl rim and then brought the toilet seat down and wiped the top of the toilet seat with the same cloth. -HK #1 used the toilet bowl brush on the top of the toilet bowl. On 5/13/26 at 1:10 p.m. HK #2 sprayed the hallway door knob with the Virex directly and immediately wiped off the doorknob. -However, according to the manufacturer guidelines (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Virex 256 dwell time should have been ten minutes (see professional reference above).IV. Staff interviewsHK #2 was interviewed on 5/13/26 at 1:20 p.m. HK #2 said she had been at the facility for two years and trained for about one week. HK #2 said it took five to ten minutes for the Virex to disinfect and kill bacteria. HK #2 said the surfaces did not need to remain wet for the entire five to ten minutes to be effective. HK #2 said the sink bowl was the dirtiest location of the sink. HK #2 said residents brush their teeth or blow their nose and everything falls into the sink. HK #2 said she only used one rag in the bathroom. HK #2 said she should have cleaned the toilet from top to bottom and/or from the cleanest to dirtiest areas. HK #2 said this was important to prevent contamination of one area to another.HK #2 said high touch areas included the bathroom sink and handles, bedside tables, drawer handles, and door knobs. HK #1 was interviewed on 5/13/26 at 11:15 a.m. HK #1 said she had been at the facility for a year and a half and was trained by her supervisor for a couple of days. HK #1 said she cleaned the inside of the sink to the outside of the sink. HK #1 said that because residents spit and brush their teeth inside of the sink, the inside of the sink would be dirtiest. HK #1 said, in the future, she would switch to a clean cloth after wiping the inside of the sink bowl.HK #1 said high touch areas included the bedside tables, phones, call lights, door knobs, counters, and rails. HK #1 said she sprayed a towel with the Virex enough to get it wet and used it to wipe surfaces. HK #1 said the facility did not have a bucket to dip rags into disinfectant, although she had seen that in her past work environments. HK #1 said she sprayed the Virex onto the rags so that she didn't accidentally spray the resident. HK #1 said she was taught to spray the Virex onto the rag during training. HK #1 said the Virex disinfectant should sit on surfaces for five minutes. -However, the bedside table did not remain wet with the disinfectant on it for ten minutes and therefore did not meet the dwell time (see observations above).The director of housekeeping was interviewed on 5/14/26 at 11:10 a.m. The director of housekeeping said the facility used Virex 256 disinfectant and the dwell time was five minutes. -However, the manufacturer guidelines indicated that the full Diversey Virex 256 dwell time was ten minutes The housekeeping supervisor said she understood the facility should base dwell times off of manufacturer guidelines and that the surface must stay wet for the dwell time. The housekeeping supervisor said that she would have a meeting with the housekeepers and ensure they understood surfaces had to stay wet for the entire dwell time. The housekeeper supervisor said the facility was planning on switching to a disinfectant with a shorter dwell in the near future. The housekeeping supervisor said high touch surfaces were bedside tables, call lights, controllers, door knobs, bathroom bars, and bathroom call lights. The housekeeping supervisor said that housekeepers should clean the sink from the outside of the sink to the inside of the sink. The housekeeping supervisor said it was not correct to clean the inside of the sink bowl and then clean the outside, because the inside of the sink was dirtier than the outside.The housekeeping supervisor said the proper way to clean the toilet was always from top to bottom. The housekeeping supervisor said that housekeepers should not have wiped the toilet bowl rim and then the toilet seat because that would spread germs. The housekeeping supervisor said housekeepers should be cleaning the toilets from top to bottom and then changing rags. The housekeeping supervisor said she would have a meeting with the housekeepers and review the adequate cleaning procedure.The infection preventionist (IP) was interviewed on 5/14/26 at 2:31 p.m. The IP said if a surface did not stay wet long enough, the surface was not being adequately disinfected and viruses and bacteria were not being killed. The IP said that could lead to MDRO (multidrug-resistant organism) or biofilms (a complex community of microorganisms that stick to the surface and encased themselves in a slimy protective matrix of extracellular polymeric substance).

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure the resident was treated with respect and dignity and care was provided in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life to one (#90) out of three residents of 46 total sample residents.Specifically, the facility failed to ensure Resident #90 was provided with clean clothing. Findings include:I. Facility policy and procedureThe Resident Rights policy, revised on 3/3/26, was received from the nursing home administrator (NHA) on 5/15/2026 at 12:23 p.m. It read in pertinent part, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. II. Resident #90A. Resident statusResident #90, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician's order (CPO), diagnoses included chronic obstructive pulmonary disease with exacerbation(a respiratory disease with suddening symptoms), chronic respiratory failure with hypoxia (a long-term condition of failure to exchange oxygen), and dependence on supplemental oxygen.The 4/27/26 minimum data set (MDS) assessment revealed Resident #90 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required setup assistance with eating and moderate assistance with toileting and dressing. B. ObservationOn 5/11/26 at 11:00 a.m Resident #90 was sitting in his room. He was wearing blue jeans and a black t-shirt. The t-shirt was soiled with food stains. His closet contained a clean blue pair of underwear and a clean dark blue set of shorts. There were four long sleeve button-up shirts hanging in the closet.There was a pile of soiled clothing in a blue bag at the bottom of the closet.On 5/12/26 approximately at 9:00 a.m Resident #90 was wearing the same clothes as he was the day before. On 5/13/26 approximately at 10: a.m Resident #90 was wearing the same clothes as he was on 5/11/26.On 5/14/26 at approximately 1:00 p.m. Resident #90 was wearing the same clothes.C. Resident interviewResident #90 was interviewed on 5/11/26 at 11:00 a.m. He said he did not have any clean clothes besides one set of underwear and shorts. He said he was saving his last clean outfit for his discharge date . Resident #90 said he had been wearing the same clothes since Saturday (5/9/26).Resident #90 said he had asked the staff several times to take his soiled clothes to the laundry. He said he had around five to six pairs of underwear and he did not think his soiled clothes were ever taken to the laundry since he had been at the facility. Resident #90 said the staff kept forgetting about his laundry or they said that they were too busy and the next shift would do it. Resident #90 said he was upset that he did not have clean underwear to wear. He said he wanted to change his underwear at least every other day if not more often.D. Record reviewA review of the dressing task sheet for Resident #90 (4/24/26 to 5/14/26) documented the following:On 5/11/26 at 10:00 a.m. and 10:54 a.m. It documented Resident #90 was independent with changing his own clothing:On 5/12/26 at 5:00 p.m. It documented Resident #90 was independent with changing his clothes;On 5/13/26 at 12:07 a.m. and 10:53 a.m. It documented Resident #90 was independent with changing his clothes; [NAME] 5/14/26 at 4:35 a.m. and 7:49 a.m. It documented Resident #90 was independent with changing his clothes.-However, the facility failed to clean the resident's clothes (see resident interview above).III. Staff interviewsCertified nurse aid (CNA) #2 was interviewed on 5/13/26 at 8:20 a.m. She said the residents would let the staff know if they needed the staff to take soiled clothes to the laundry. She said the CNAs, nurses, or housekeeping were responsible for picking up and delivering the laundry. She said the facility did not track the frequency of each resident`s request and there was no system in place to make sure residents always had clean clothes to wear. She said the staff checked the residents` closet for soiled clothes. CNA #2 said if a resident had no clean clothing to wear the facility would look at donated clothes on hand to see if (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was any clothing they could give to residents. CNA #2 said if residents were independent with changing their clothing, the staff would ask if they had changed or if they needed clean clothing. She said the staff collected soiled clothing during both shifts. CNA #2 said residents had complained to her about running out of clean clothes before because housekeeping could not keep up with the demand sometimes. She said she let housekeeping know if a resident ran out of clothes. CNA #1 was interviewed on 5/13/26 at 9:15 a.m. She said the staff collected soiled laundry daily. She said Resident #90 did not refuse to change clothes or get his soiled laundry collected. She said if a resident was independent with dressing, she would still ask if they had soiled laundry to wash. She said she collected and asked all residents if they needed laundry to be laundered.The housekeeping supervisor was interviewed on 5/13/26 at 9:35 a.m. She said the laundry was completed daily. She said she did not have a way of knowing if a resident's laundry was not being done for any period of time. The housekeeping supervisor said the CNAs would know more about this. Registered nurse (RN) #1 was interviewed on 5/13/26 at 10:00 a.m. She said Resident #90 was independent with most of his activities of daily living and he was able to change clothes independently. She said she did not know when Resident #90 changed his clothes last time, but she was going to ask Resident #90. She said it was the CNAs responsibility to notice if a resident had not or needed to change their clothing. The director of nursing (DON) was interviewed on 5/14/26 approximately at 6:00 p.m. She said that CNAs should be asking residents daily if they needed their clothing laundered. She said from the nursing point of view staff should be noticing if a resident had not been changed for days.

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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 two (#44 and #66) of three residents reviewed for grievances out of 46 sample residents. Specifically, the facility failed to:-Effectively report, document, resolve, and follow-up on Resident #44's grievance regarding missing hearing aides and charger; and, -Effectively report, document, resolve and follow-up on Resident #66's grievances about two boxes of Christmas ornaments that went missing. Findings include:I. Facility policy and procedureThe Grievance Program Concern and Comment policy, revised 1/7/25, was received from the nursing home administrator (NHA) on 5/15/26 at 12:23 p.m. It read in pertinent part, The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. Prompt efforts to resolve refers to the facility acknowledgment of a compliant/grievance and actively working toward the resolution of that complaint/grievance. Any associate can assist in the completion of a concern and comment form. The facility will maintain a recordkeeping system of all complaints reported via the Concern and Comment Program and it shall include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, and a statement as to whether the grievance was confirmed or not confirmed. Following up with the resident and family to communicate a resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction. The executive director and/or designee is responsible for overseeing the facility's overall grievance program. II. Resident #44A. Resident statusResident #44, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough causing high blood sugar), cognitive communication deficit, chronic fatigue, muscle weakness, restless legs syndrome (a neurological condition causing an irresistible urge to move the legs), and major depressive disorder.The 4/9/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) of three out of 15.B. Resident #44's representative interviewThe resident's representative was interviewed on 5/12/26, at 1:43 p.m. The representative said the social services director (SSD) originally notified her of the disappearance of Resident #44's item on 5/5/26. The representative said the SSD told her that the resident's hearing aids, their storage case, and the charging port could not be located. The representative said the SSD told her Resident #44 had thrown the items into her room's trash can. She said it was highly unlikely that the resident would dispose of multiple components without staff noticing.The resident's representative said she was concerned about the facility's failure to protect the devices, which were left unsecured at the bedside. The resident's representative said the SSD did not mention during their conversation whether the incident was being investigated. She said the SSD asked if she would be willing to contribute $600 toward replacing the hearing aids. The representative said e the SSD also proposed substituting the hearing aids with a pocket talker device. The representative said she disagreed with permanently replacing the hearing aids with a pocket talker. She said she did not believe Resident #44 would benefit from that type of equipment. The resident's representative said she believed the facility failed to protect the resident's property. She said the facility failed to investigate the missing hearing aids. She said she wanted the hearing aid replaced because the facility failed to properly investigate the circumstances surrounding its disappearance. She said as of the date of this interview, the facility had failed to resolve the issue to her satisfaction.C. Resident interview Resident #44 was interviewed on 5/13/26 at 2:05 p.m. The resident said she was informed by a staff member that her hearing aids were being repaired and would be returned to her when the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repairs were completed. Resident #44 said she did not remember the staff member's name.D. Record reviewA review of the facility's grievance forms for Resident #44 over the previous six months revealed a grievance form was completed by the SSD on 5/5/26 at 4:47 p.m. The grievance form revealed that the SSD had been notified that Resident #44's hearing aids were lost. The SSD documented that it would cost $300 out of pocket to replace each one.-However, there was no documentation regarding the facility resolved the concern.A psychosocial note, dated 5/5/26 at 4:57 p.m., revealed that the social services were alerted that Resident #44's hearing aids had been misplaced. A second grievance report summary was filed and provided by the NHA on 5/13/26. The report was completed and signed by the NHA. It revealed that the SSD left a voicemail with the resident's representative to inform her that the facility had resolved the incident of the missing hearing aids. It revealed the facility to order a pocket talker and the incident was considered resolved.-However, the grievance form was completed and considered resolved without Resident #44's representative's approval. The representative said she did not approve of the pocket talker as a replacement (see interview above). III. Resident #66A. Resident statusResident #66, age less than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic respiratory failure with hypoxia (a condition in which body tissues and cells don't receive enough oxygen to function properly), chronic diastolic congestive heart failure, type 2 diabetes mellitus, major depressive disorder, and anxiety disorder.The 5/7/26 MDS assessment revealed Resident #66 was cognitively intact with a BIMS of 15 out of 15. B. Resident interviewResident #66 was interviewed on 5/13/26 at 2:44 p.m. Resident #66 said two boxes of personal Christmas ornaments, which had sentimental value, went missing from her room right after the Christmas holidays. Resident #66 said she notified the NHA immediately upon becoming aware that they were missing from her bathroom. Resident #66 said the NHA did not provide her with a grievance form to complete. She said she did not hear back from the NHA and the items were not located. Resident #66 said there was no resolution to the issue and felt the facility did not care to resolve the issue.C. Record reviewA review of the facility's grievance log from 12/1/25 through 5/13/26 revealed that no entries were documented regarding Resident #66's reported missing Christmas ornaments. IV. Staff interviewsThe SSD was interviewed on 5/13/26 at 10:15 a.m. The SSD said it was the responsibility of every staff member to ensure that residents' grievances were documented and reported to the NHA, the grievance official. The SSD said the initial grievance form would be submitted to her and she would immediately initiate an investigation and if the incident was not resolved, she would turn it in to the NHA for further review and consideration. The SSD said she was not aware of any missing boxes of Christmas ornaments belonging to Resident #66. The SSD said she became aware that Resident #44's hearing aids were missing on 5/5/26, and immediately contacted the audiologist to inquire about obtaining replacements. She said that the audiologist indicated it would cost $600 to obtain the replacement devices. -However, the grievance form documented the cost was $300 (see record review above). The SSD said she contacted the resident's representative to inquire whether the resident would be willing to cover the out-of-pocket cost, and she also discussed the alternative of replacing the hearing aids with a pocket talker. The SSD said she said Resident #44 probably should have not had access to her hearing aides when they were not in use, since she had a history of leaving them on meal trays due to her impaired cognition. She said that it was highly unusual for all of the hearing aid accessories, including the charger, to have gone missing along with the devices.Licensed practical nurse (LPN) #2 was interviewed on 5/13/26 at 11:25 a.m. LPN #2 said that if a resident reported a missing item or if staff identified that a resident's personal property went missing, it was the responsibility of each staff member to assist the resident in locating the item. LPN #2 said that if the item could not be found, staff were expected to assist residents in completing a grievance form if the resident was unable to do so independently, and to submit it to the SSD. LPN #2 said Resident #66 had informed her about her missing Christmas ornament boxes a while back.LPN #2 said she did not complete a grievance form for the resident's concern, even though she should have. LPN #2 said she forgot to (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the missing items in the resident's electronic medical record (EMR). The NHA and the regional vice president were interviewed on 5/13/26 at 1:25 p.m. The NHA said she was the grievance official and was involved in most grievance resolutions. The NHA said staff members filled out a grievance form whenever a resident reported a personal item was missing. The NHA said she believed Resident #44 had thrown away her hearing aids because of a history of doing so. She said she did not know why the hearing aids were left by the resident's bedside to charge. The NHA said she did not investigate the missing hearing aids because she did not investigate every reported missing blue sock.Cross reference F602: free from misappropriation of property. The NHA said Resident #66 informed her that her Christmas ornaments were missing from her room and asked an activity staff member to assist in locating them. The NHA said the activity staff member no longer worked for the facility. She said she did not complete a grievance form when she became aware of the missing ornaments. The NHA said she did not follow up on it to ensure Resident #66's concern was resolved. The regional vice president said the facility would review its grievance process and educate staff to ensure grievances are documented, investigated, and resolved in a timely manner.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate an allegation of misappropriation of residents property for two (#44 and #66) of two residents out of 46 sample residents.Specifically, the facility failed to investigate allegations of misappropriation of property for Resident #44 and Resident #66. Findings include:I. Facility policy and procedureThe Resident Rights policy, reviewed September 2025, was provided by the nursing home administrator (NHA) on 5/15/26 at 12:23 p.m. It read in pertinent part, The resident has the right to be free from abuse, neglect, misappropriation of the resident's property, and exploitation. The Abuse Protection of Residents policy, reviewed April 2026, was provided by the NHA on 5/15/26 at 12:23 p.m. It read in pertinent part, The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.Establish policies and procedures to investigate any such allegations.II. Resident #44A. Resident statusResident #44, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough insulin, causing high blood sugar), cognitive communication deficit, chronic fatigue, muscle weakness, restless legs syndrome (a neurological condition causing an irresistible urge to move the legs) and major depressive disorder.The 4/9/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired, with a brief interview for mental status (BIMS) score of three out of 15.B. Resident #44's representative interviewResident #44's representative was interviewed on 5/12/26, at 1:43 p.m. The representative said the social services director (SSD) originally notified her of the disappearance of Resident #44's hearing aids on 5/5/26. The representative said the SSD told her the hearing aids, their storage case and the charging port could not be located. The representative said the SSD told her Resident #44 had thrown the items into her room's trash can. She said it was highly unlikely that the resident would dispose of multiple components without staff noticing.The resident's representative said she was concerned about the facility's failure to protect the devices, which were left unsecured at the bedside. The resident's representative said the SSD did not mention during their conversation whether the incident was being investigated. She said the SSD asked if she would be willing to contribute $600.00 toward replacing the hearing aids. The representative said the SSD also proposed substituting the hearing aids with a pocket talker device. The representative said she disagreed with permanently replacing the hearing aids with a pocket talker. She said she did not believe Resident #44 would benefit from that type of equipment. The resident's representative said she believed the facility failed to protect the resident's property. She said the facility failed to investigate the missing hearing aids. She said she wanted the hearing aids replaced because the facility failed to properly investigate the circumstances surrounding the disappearance. She said as of the date of the interview, the facility had failed to resolve the issue to her satisfaction.C. Resident interview Resident #44 was interviewed on 5/13/26 at 2:05 p.m. Resident #44 said she was informed by a staff member that her hearing aids were being repaired and would be returned to her upon completion. Resident #44 said she did not remember the staff member's name.D. Record reviewThe communication care plan, initiated 6/18/19 and revised 5/5/26, revealed Resident #44 had a communication problem related to hearing deficits and a history of throwing away hearing aids and equipment. Pertinent interventions included anticipating and meeting the resident's needs, ensuring the resident's hearing aids were charged at night, and observing for the residents' ability to express and comprehend language, memory and reasoning ability.-The care plan did not include interventions to ensure the resident did not throw away her hearing aides. A review of the facility's grievance forms for Resident #44 over the previous six months revealed a grievance form, completed by the social services director on 5/5/26 at 4:47 p.m. The grievance form indicated that Resident #44's hearing (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aids were reported lost to social services. The SSD documented that it would cost $300.00 out of pocket to replace each one.-However, there was no documentation indicating the facility completed an investigation to determine how the resident's hearing aids, charger and storage case went missingA psychosocial note, dated 5/5/26 at 4:57 p.m., revealed that social services was alerted that Resident #44's hearing aids had been misplaced. -However, there was no documentation indicating the facility investigated to determine if the hearing aids were stolen or misplaced.III. Resident #66A. Resident statusResident #66, age less than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic respiratory failure with hypoxia (a condition in which body tissues and cells do not receive enough oxygen to function properly), chronic diastolic congestive heart failure, type 2 diabetes mellitus, major depressive disorder and anxiety disorder.The 5/7/26 MDS assessment revealed Resident #66 was cognitively intact with a BIMS score of 15 out of 15. B. Resident interviewResident #66 was interviewed on 5/13/26 at 2:44 p.m. Resident #66 said two boxes of personal Christmas ornaments, which had sentimental value, went missing from her room right after the Christmas holidays. Resident #66 said she notified the NHA immediately upon becoming aware that they were missing from her bathroom. Resident #66 said the NHA did not provide her with a grievance form to complete. She said she did not hear back from the NHA and the items were not located. Resident #66 said there was no resolution to the issue and felt the facility did not care to resolve the issue.C. Record reviewA request for an investigation regarding Resident #66's allegation of her missing sentimental Christmas ornament on 5/13/26 at 8:10 a.m. The NHA said the facility had not investigated the resident's allegation of missing Christmas ornaments. IV. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 5/13/26 at 11:32 a.m. LPN #2 said Resident #44 had a history of throwing hearing aids in the trash and accidentally leaving the device on a meal tray. LPN #2 said she did not remember what interventions were introduced for staff to implement to help prevent the devices from being lost. LPN #2 said the device and its accessories were kept on top of the resident's bedside drawer. LPN #2 said there was a trash can positioned by Resident #44's bedside drawer. LPN #2 said that Resident #66 had informed her about her missing Christmas ornament boxes a while back. LPN #2 said she did not inform the director of nursing (DON) or the NHA about Resident #66's missing ornaments. LPN #3 was interviewed on 5/13/26 at 11:40 a.m. LPN #3 said that Resident #44 had hearing impairments. LPN #3 said the staff had to talk loudly when speaking to her. LPN #3 said that the resident's hearing aids were stored on top of the resident's bedside drawer at all times when not in active use. LPN #3 said he had not seen the hearing aids or their accessories for quite some time. He said he had been out on vacation, and upon his return to the facility, the devices were no longer available. LPN #3 said he did not know why the hearing aids had been left on top of the resident's bedroom drawer rather than being safely secured when not in use.The SSD was interviewed on 5/13/26 at 11:50 a.m. The SSD said Resident #44 had hearing impairments. She said the hearing aids were stored on top of the resident's bedside drawer at all times when not in active use. The SSD said the staff reported to her on 5/5/26 that the hearing aids, along with all associated accessories, were missing from the resident's room. The SSD said it was unlikely for a resident with severe cognitive impairments to have intentionally thrown away the hearing aids along with all of their accessories. The SSD said that she did not know why the hearing aids had been left on top of the resident's bedroom drawer rather than being safely secured when not in use.The NHA was interviewed on 5/14/26 at 10:12 a.m. The NHA said she was aware that Resident #44's hearing aids, storage equipment and charger were missing and had not been found. The NHA said it was the facility's policy to ensure all personal property, especially assistive devices necessary for a resident's quality of life, were logged, tracked, and securely stored. The NHA said facility staff were trained and were expected to assist residents who could not manage these devices independently. The NHA said staff relied on the care plan for interventions. The NHA said if specific interventions were not written, consistency across shifts became a significant challenge. The NHA said Resident #44 had a documented history of throwing away her hearing aids in the trash. The NHA (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she did not conduct a formal investigation of the missing hearing aids.The NHA said Resident #66 informed her that her Christmas ornaments were missing from her bathroom. She said she asked an activities staff member to help the resident find the missing ornaments. The NHA said she did not receive feedback from the activities staff member and she failed to follow up with the staff member and Resident #66. The NHA said she felt the Christmas ornaments were not a big deal to Resident #66. -However, Resident #66 said the Christmas ornaments were sentimental to her (see resident interview above).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to develop an acute/baseline care plan for one (#51) of two residents reviewed for care planning out of 46 sample residents. Specifically, the facility failed to include Resident #51's seatbelt use on the baseline care plan.Findings include:I. Facility policy and procedureThe Person Centered Care Planning policy and procedure, reviewed 8/29/25, was retrieved from the executive director on 5/15/26 at 12:23 p.m. It read in pertinent part, Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. The care plan will include measurable goals, timeframes to meet the patient's, cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs. The care plan will reflect interventions that are person-centered, measurable, and include time frames to achieve the desired outcomes. The care plan will include services that may be needed but are not provided due to the patient's exercise of the right to refuse treatment, when applicable. The care plan will be developed and implemented to ensure consistency with implementation across all shifts. II. Resident #51A. Resident statusResident #51, age less than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included nondisplaced spiral fracture of the shaft of the left tibia (a stable twisting break of the shinbone where the bone remains perfectly aligned), age related osteoporosis (a bone disease that causes bones to become weak and brittle), muscle weakness, spastic hemiplegic cerebral palsy (a neurological condition causing muscle stiffness and weakness on one side of the body), and unspecified lack of coordination. The 5/4/26 minimum data set (MDS) assessment revealed Resident #51 was cognitively intact and had a brief interview for mental status (BIMS) score of 15 out of 15. The MDS revealed Resident #51 used a wheelchair and required partial assistance from another person to complete self care. The MDS revealed Resident #51 had impaired movement on bilateral lower extremities. The MDS revealed Resident #51 required substantial/maximal assistance from staff to complete upper body dressing (the ability to dress and undress above the waist, including fasteners if applicable). B. Observations and resident interviewOn 5/12/26 at 3:49 p.m., Resident #51 was observed sitting in her room with a gait belt wrapped around her waist and her wheelchair. Resident #51 said she wanted to use the gait belt so she did not slide out of the wheelchair. Resident #51 said she could unclip the gait belt and demonstrated she could unclip the belt.C. Record reviewResident #51's Kardex (staff directive tool) was reviewed on 5/12/26 at 6:15 p.m. The Kardex did not reveal information or guidance regarding Resident #51's makeshift wheelchair safety belt.Review of Resident #51's baseline care plan on 5/12/16 at 4:02 p.m. did not reveal the use of a makeshift wheelchair safety belt. The care plan did not clarify whether or not Resident #51 had the ability to take off the makeshift wheelchair safety belt by herself. D. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 5/12/26 at 4:40 p.m. CNA #4 said it was their first time working with Resident #51. CNA #4 said they had not noticed the gait belt was around her waist and wheelchair. CNA #5 was interviewed on 5/12/26 at 4:48 p.m. CNA #5 said that she had just helped get Resident #51 back to bed. CNA #5 said Resident #51 was wearing a gait belt around the waist and wheelchair. She said Resident #51 was wearing it when they went into the resident's room. CNA #5 said Resident #51 wore the gait belt around her waist and wheelchair when she was up in her wheelchair for positioning. CNA #5 said that they took the gait belt off of Resident #51. CNA #5 said she had previously seen Resident #51 take the makeshift wheelchair safety belt off herself. CNA #5 said the Kardex contained information about the makeshift wheelchair safety belt. -However, review of the Kardex and baseline care plan did not reveal documentation regarding the makeshift wheelchair safety belt (see record review above). CNA #5 said they thought Resident #51 was using the belt for safety, to prevent Resident #51 from falling (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forward out of her wheelchair. CNA #5 said the gait belt had a clip which would release the gait belt. CNA #5 said she had previously seen Resident #51 take the belt off by herself. Licensed practical nurse (LPN) #4 was interviewed on 5/12/26 at 5:22 p.m. LPN #4 said she was not sure whether or not Resident #51's ability to remove the makeshift care plan should be included on the care plan. She said Resident #51 had the ability to take the belt off herself. LPN #4 navigated to the electronic medical record (EMR) on the computer. LPN #4 said she could not find any documentation in the physical therapy or occupational therapy notes regarding the gait belt. LPN #4 said she could not find information on the gait belt in Resident #51's care plan. LPN #4 said care plans were important because they directed nurses on how to provide care to residents. LPN #4 said it was important to have this information on the care plan, because the gait belt could potentially be a restriction to the resident. LPN #4 said Resident #51 asked for the belt to be around her waist and wheelchair. LPN #4 said the makeshift wheelchair safety belt could potentially be a restraint but the resident was requesting to wear it. LPN #4 said staff could not tell the resident that she could not wear the belt because it was her choice and her right to have whatever she wants.The director of rehabilitation was interviewed on 5/12/26 at 5:25 p.m. The director of rehabilitation said she was not aware that Resident #51 had been using the makeshift wheelchair safety belt. The director of rehabilitation said Resident #51 was in one of the facility's wheelchairs they provided her. The director of rehabilitation said Resident #51 transitioned to a different room less than a week ago. The director of rehabilitation said when Resident #51 moved, a friend or family member brought in her own personal wheelchair from home. The director of rehabilitation said they had not assessed Resident #51's usage of the gait belt yet. The director of rehabilitation said the facility would assess Resident #51 in her personal chair and see if the gait belt would be appropriate. The director of rehabilitation said Resident #51's ability to use the makeshift wheelchair safety belt was not currently care planned. The director of rehabilitation said Resident #51 and her usage of the makeshift wheelchair safety belt would be evaluated and then added to the care plan if appropriate to do so.Occupational therapist (OT) #1 was interviewed on 5/12/26 at 5:51 p.m. OT #1 said Resident #51 had just recently started using this new wheelchair and gaitbelt. OT #1 said Resident #51 had gotten this wheelchair from someone and that it was her own personal wheelchair. OT #1 said Resident #51 wanted to use the makeshift wheelchair safety belt and did not want to be transferred or sit in the wheelchair if she did not have the gait belt present. OT #1 said she used the makeshift wheelchair safety belt when going back to her room. OT #1 said Resident #51 had just recently started using this new personal wheelchair because Resident #51 felt more protected using it. OT #1 said that during Resident #51's initial evaluation, she had a facility provided wheelchair. OT #1 said there was not an assessment or evaluation done on the resident and her ability to take the gait belt off because Resident #51 recently started using it. OT #1 said Resident #51 was able to adjust the gait belt and take it off.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide ongoing programs to support choices of activities and engaging programming based on the comprehensive assessment and care plan, that were designed to meet the interests of and support the physical, mental, and psychosocial well-being of one (#89) of two residents reviewed for activities out of 46 sample residents.Specifically, the facility failed to offer and provide personalized, meaningful activity programs for Resident #89 as documented in her care plans.Findings include:I. Facility policy and procedure The Therapeutic Activities Program policy, revised 3/24/26, was received from the nursing home administrator (NHA) on 5/14/26. It documented in pertinent part, Based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Activities refers to any endeavor, other than routine activities of daily living (ADLs), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence.II. Resident #89A. Resident statusResident #89, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO) diagnoses included vascular dementia with agitation and depression (mood imbalance).The 5/5/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment, with short term and long term memory issues per staff assessment. The resident was dependent on staff assistance for all ADLs.The MDS assessment revealed it was very important to the resident to listen to music, watch movies, be read to, and participate in animal-related activities. It was somewhat important to her to watch television.B. ObservationsDuring a continuous observation on 5/12/26, beginning at 1:43 p.m. and ending at 5:36 p.m., the following was observed:At 1:43 p.m. Resident #89 was asleep in bed. There was no music playing in the resident's room or any other type of meaningful activity. At 3:39 p.m. the resident was transferred to a wheelchair and positioned outside her room holding a stuffed animal. At 5:17 a.m. an unidentified staff member walked past Resident #89 and did not engage with the resident or provide meaningful activity.At 5:36 p.m. Resident #89 remained in her wheelchair in the hallway.During a continuous observation on 5/13/26, beginning at 8:30 a.m. and ending at 9:27 a.m., the following was observed:At 8:45 a.m. Resident #89 was lying in bed in her room with the television (TV) on. -No staff offered to assist Resident #89 to the scheduled 9:15 a.m. radio activity. C. Resident #89's representatives interviewResident #89's representative was interviewed on 5/11/26 at 2:30 p.m. Resident #89's representative said any time she came to visit her mother she often found her alone without any of the stuffed animals or busy boxes she had provided forResident #89to use. She said she had a strong desire to see Resident #89 involved in social activities. She said She knew Resident #89 was unable to participate in some activities due to her cognition, but sitting alone was not okay.D. Record reviewResident #89's activity care plan, revised 3/19/26, revealed Resident #89 was not alert, nor able to make her activity needs known. The care plan documented Resident #89 enjoyed music, reading, TV, animal visits and coloring. Pertinent interventions included encouraging as much social participation as possible during care activities, having one-on-one interactions, respecting the residents right to refuse conversation, encouraging the resident to play with a toy, busy blanket, or baby doll to comfort her as needed. Review of Resident #89's activity participation record (2/29/26 to 5/14/26) revealed the resident actively participated in TV daily. -The record failed to reveal documentation indicating the resident had participated in her preferred activities. The participation record revealed Resident #89 participated in six out of 35 music-related activities. The (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record did not document the resident had refused to attend. The participation records revealed out of 17 pet visits, Resident #89 did not participate in any of them. There were no documented refusals for pet visits.The participation records revealed out of 10 opportunities to participate in watching movies Resident #89 participated in one. There were no documented refusals. The participation records revealed out of 16 nail care activities Resident #89 participated in none. There with no documented refusals.III. Staff interviewsThe activities director (AD) was interviewed on 5/14/26 at 11:50 a.m. The AD said he was newly hired to the facility. The AD said the Resident #89 attended music activities including a one-on-one music therapy session in her room, but Resident #89 needed assistance to get to the activities. The AD said the activity department had staff coverage seven days a week and that activities staff invite all residents to each activity. He said everyone was invited to all activities. He said they even invited the residents who did not want to participate in the activity. He said it was his personal goal to have something for everyone to do, even if it was in their own room. The AD said that if an event was canceled, the activities staff try to let the residents know in a timely manner, and try to replace the event with something else, and post the change to the events calendar near the dining room. The AD said he and his staff conduct activities assessment for each resident quarterly or make changes based on changes in each resident's care plan.

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	065209	A. Building B. Wing	05/14/2026

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Western Hills Health Care Center	1625 Carr St Lakewood, CO 80214

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain hearing abilities for one (#44) of two residents reviewed for hearing and vision problems out of 46 sample residents.Specifically, the facility failed to ensure Resident #44 was assisted with alternate devices while she waited for her missing hearing aids to be replaced. Findings include:I. Facility policy and procedureThe Vision and Hearing Assistive Devices policy, revised September 2025, was provided by the nursing home administrator (NHA) on 5/15/26 at 12:23 p.m. It read in pertinent part, To ensure residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident with assistive devices, which include but not limited to hearing aids and amplifiers.II. Resident #44A. Resident statusResident #44, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough causing high blood sugar), cognitive communication deficit, chronic fatigue, muscle weakness, restless legs syndrome (a neurological condition causing an irresistible urge to move the legs), and major depressive disorder.The 4/9/26 minimum data set (MDS) assessment revealed the resident was cognitively impaired, with a brief interview for mental status (BIMS) of three out of 15.The assessment indicated the resident required hearing aids.B. Resident #44's representative interviewThe resident representative was interviewed on 5/12/26 at 1:43 p.m. The representative said the social services director (SSD) notified her that Resident #44's hearing aids went missing on 5/5/26. The resident representative said the absence of hearing aids created a severe communication barrier with Resident #44. She said that without the device and any alternative devices or methods, it became difficult and frustrating to communicate with the resident over the phone and significantly more difficult to engage in meaningful interactions. The resident's representative said it affected the overall quality of their time spent together.C. Resident observationsOn 5/12/26 at 2:10 a.m. Resident #44 was sitting in her recliner in her room with two family members. Throughout the interaction, Resident #44 frequently leaned forward to decrease the distance between herself and her daughter in an attempt to understand what was being said. Additionally, the resident repeatedly leaned back into her recliner, pointed to her ears, said she could not hear her daughter, and asked her daughter what she said.On 5/13/26 at 4:14 p.m. Resident #44 was in her room sitting in her recliner without her hearing aids and no alternative communication device was available to her.On 5/14/26 at 9:55 a.m. Resident #44 was in her room without her hearing aids and no alternative communication device was available to the resident.D. Record reviewThe communication care plan initiated on 6/18/19 and revised on 5/5/26, revealed the resident had a communication problem related to a hearing deficit. The care plan documented it was reported hearing aids were missing on 5/5/26 and had not been replaced. The care plan documented Resident #44 had a history of throwing the hearing aids in the trash. Interventions included using alternative communication tools as needed and discussing with the resident and resident's family concerns or feelings regarding communication difficulties.III. Staff interviewsCertified nurse aide (CNA) #2 was interviewed on 5/13/26 at 12:55 p.m., CNA #2 said Resident #44 had a hearing impairment and it was difficult to communicate with her without her hearing aids. CNA #2 said the resident's hearing aids had been missing for about three weeks. She said there had been no alternative communication device available.Licensed practical nurse (LPN) #3 was interviewed on 5/13/26 at 1:14 p.m., LPN #3 said Resident #44's hearing aids had been missing for some time now. LPN #3 said it has been difficult communicating with the resident without her hearing aids. He said the staff had to speak very loudly into Resident #44's ears in order for her to hear. LPN #3 said Resident #44 became frustrated when she could not hear and communicate appropriately with the staff. LPN #3 said there was no alternative communication device available to the resident.The SSD was interviewed on 5/14/26 at (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:20 a.m. The SSD said Resident #44 had a hearing deficit and required hearing aids. The SSD said she was informed Resident #44's hearing aid was missing and could not be located. The SSD said the staff was supposed to maintain and safeguard the hearing aids. The SSD said the resident requires assistance to wear the hearing aids and agreed that it should not be left on the resident's bedside drawer. The SSD said she was in contact with the resident's representative to obtain a replacement hearing aid or an alternative communication device. The SSD said Resident #44 did not currently have an alternative communication device.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#16 and #90) of three residents who required respiratory care received care consistent with professional standards of practice out of 46 total sample residents. Specifically, the facility failed to set the oxygen concentrator according to the physician's order. Findings include:I. Facility policy and procedureThe Oxygen Administration policy, revised on 3/3/26, was received from the nursing home administrator (NHA) on 5/15/26 at 12:23 p.m. It read in pertinent part, Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. To ensure that oxygen is administered and stored safely within the facility or in an outside storage area. Oxygen orders should include the specific liter flow required by the resident. Residents receiving oxygen at 4 liters per minute (LPM) or greater, via concentrator, should be connected to a humidifier.II. Resident #16A. Resident statusResident #16, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included COVID-19, chronic obstructive pulmonary disease (COPD), pneumonia due to COVID-19, interstitial pulmonary disease, acute and chronic respiratory failure with hypoxia, and dependence on supplemental oxygen.The 4/16/26 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. The resident required moderate assistance with showering and supervision with dressing. The MDS assessment indicated Resident #16 was receiving oxygen therapy.B. ObservationsOn 5/11/26 at 1:00 p.m. Resident #16 was lying in his bed on his back. The resident had an oxygen concentrator next to his bed. He was receiving oxygen through a nasal cannula (NC). The oxygen concentrator was set to 3.5 LPM.At 4:30 p.m. Resident #16 was in his bed, lying on his back. The resident had an oxygen concentrator next to his bed. He was receiving oxygen through a nasal cannula. The oxygen concentrator was set to 3.5 LPM.On 5/12/26 at 2:00 p.m. Resident #16 was in his bed, lying on his back. The resident had an oxygen concentrator next to his bed. He was receiving oxygen through a nasal cannula. The oxygen concentrator was set to 3.5 LPM.At 3:30 p.m. Resident #16 was in his bed, lying on his back. His oxygen concentrator was set to 3.5 LPM and he was receiving oxygen through a nasal cannula.On 5/13/26 at 8:15 a.m. Resident #16 was in his bed, lying on his back. The resident had an oxygen concentrator next to his bed. He was receiving oxygen through a nasal cannula. The oxygen concentrator was set to 3.5 LPM.-However, according to the May 2026 CPO Resident #16 oxygen flow rate was supposed to be 4 LPM (see record review).C. Record reviewA review of Resident #16's May 2026 CPO revealed the following physician's orders:-Oxygen at 4 LPM continuously per nasal cannula. Ordered on 3/20/26.-Check oxygen saturation every shift. Ordered on 3/20/26.-However, observations revealed Resident #16's oxygen was not administered per physician orders (see observations above). The oxygen care plan, revised 3/20/26, revealed the resident had oxygen therapy due to COPD. The intervention was to follow oxygen ordersReview of the May 2026 medication administration record (MAR) revealed nursing staff were documenting and signing off that Resident #4 was receiving oxygen at 4 LPM. -However, observations revealed Resident #16's oxygen concentration was set to 3.5 LPM (see observations above). D. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 5/13/26 at 10:15 a.m. CNA #1 said Resident #16 received 4 ti 5 LPM oxygen continuously through a nasal cannula. She said Resident #16 did not refuse to wear his cannula. CNA #1 said Resident#16 complied with his oxygen. She said Resident #16 did not adjust his own oxygen flow. She said the CNAs were responsible to check oxygen setting daily during vitals.Licensed practical nurse (LPN) #1 was interviewed on 5/13/26 at 10:18 a.m. He said Resident #16`s physician order for oxygen was 4 LPM. He said Resident #16`s oxygen concentrator was set to 3.5 LPM. He said the physician's order had not changed since the initial order on 3/20/26. He said Resident #16 should be on 4 LPM oxygen as the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order dictated. He said there was no active titration for Resident #16. III. Resident #90A. Resident statusResident #90, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included COPD with exacerbation, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen.The 4/27/26 MDS assessment revealed Resident #90 had moderate cognitive impairments with a BIMS score of twelve out of 15. He required setup assistance with eating and moderate assistance with toileting and dressing. The MDS assessment revealed that the resident required continuous oxygen.B. ObservationsOn 5/11/26 at 9:00 a.m Resident #90 was sitting in his room on a chair. There was an oxygen concentrator next to him. He was receiving 2.5 LPM via a nasal cannula.At 4:07 p.m Resident #90`s oxygen concentration was set to 2.5 LPM.On 5/12/26 at 9:35 a.m. Resident`s #90`s oxygen concentration was set to 2.5 LPM.On 5/13/26 at 8:04 a.m. Resident`s #90`s oxygen concentration was set to 2.5 LPM.On 5/12/26 at 10:00 a.m. Resident`s #90`s oxygen concentration remained 2.5 LPM.-However, Resident #90`s oxygen flow rate was supposed to be 3 LPM, per physician's orders (see record review below).D. Record Reviews A review of Resident #90's May 2026 CPO revealed the following physician's orders:-Oxygen at 3 LPM continuously per nasal cannula. Ordered on 4/24/26.-However, observations revealed Resident #90's oxygen was not administered per physician orders (see observations above). Resident #90's oxygen care plan, revised 3/28/26, revealed Resident #90 had oxygen therapy. The intervention was to administer 3 LPM via nasal cannula continuously.E. Resident interviewResident #90 was interviewed on 5/12/26 at 10:50 a.m. He said he did not adjust his own oxygen concentrator because he did not want to be short of breath. He said the nurse adjusted it if it was needed. He said the CNA took his vitals once a day and checked the oxygen level. He said he did not remember if anybody adjusted it on that day. D. Staff interviewsCNA #2 was interviewed on 5/13/26 at 8:20 a.m. She said CNAs took the resident's vital signs in the morning and the oxygen level was checked during that time. She said either CNAs or the nurse entered the readings into the electronic medical record (EMR). She said she would let the nurse know if the readings were out of baseline. CNA #2 said the nurse would inform staff of a new resident`s LPM on admission. She said she had access to the EMRto check the oxygen orders. She said the oxygen levels were mandatory during the vitals. She said the staff had to be eye level with the oxygen concentrator meter ball to read the setting correctly. CNA #2 said the line on the meter should cross the ball in the middle. Registered nurse (RN) #1 was interviewed on 5/12/26 at 10:00 a.m. She said CNAs took vitals in the morning. She said the nurse entered the results into the electronic medical record system. RN #1 said Resident #90`s oxygen concentration was set to 2.5 at the time of the interview. She said the CNA took Resident #90`s vital signs that morning and the CNA marked it as 3 LPM. RN #1 said Resident #90 should receive 3 LPM as the order said. She said it was important to follow the physician's order for the safety and well-being of the residents. IV. Additional staff interviewsThe director of nursing (DON) was interviewed on 5/13/26 approximately at 6:00 p.m. She said she expected the staff to follow oxygen orders. She said following oxygen orders was important for oxygenation. She said if a resident was not compliant with his oxygen orders, she would expect staff to mention it in the progress notes and in the care plan.