STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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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 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. Based on observations and interviews, the facility failed to provide a safe, sanitary, functional and comfortable environment for residents, staff and the public in three of four shower rooms.Specifically, the facility failed to ensure shower rooms were maintained in safe, sanitary and working condition.Findings include:I. Facility policy and procedureThe Safe, Homelike Environment policy, reviewed December 2025, was provided by the nursing home administrator (NHA) on 1/14/26 at 3:08 p.m. It read in pertinent part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.The Housekeeping Services Infection Control policy, revised January 2009, was provided by the NHA on 1/14/26 at 3:30 p.m. It read in pertinent part, It is the policy of this facility to require effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites. Frequent cleaning of the facility's interior will aid in physically removing and reducing microorganisms' potential contribution to the incidence of health-associated infections (HAI). The housekeeping supervisor will implement effective systems of environmental sanitation, including a regular cleaning schedule for all areas. The housekeeping supervisor will work closely with the infection control team to establish and maintain consistent practices and high standards of cleanliness. Periodic inspection of the facility will be made by the housekeeping supervisor as a joint exercise with the infection control team. Common bathrooms and showers:-Bathrooms to be cleaned as needed or daily;-Common showers will be cleaned frequently; and,-Housekeeping will disinfect water fixtures and all touch surfaces.II. ObservationsDuring the initial walkthrough of the facility on 1/11/26 the following was observed:At 9:21 a.m. the 200 hallway shower room lights were on and the door was held open with a gait belt that was tied around the door handle and attached to the shower railing. The shower head tubing had a continuous drip of water which resulted in the shower floor remaining wet with a pool of water in the middle. There was a black substance observed in the silicon caulking of the shower.At 9:42 a.m. the shower head tubing was continuously dripping water in the secure unit shower room causing the shower floor to remain wet. There was a black substance observed in the silicon caulking of the shower. The floor was sticky.On 1/12/26 the following was observed:At 9:12 a.m. water continued to leak from the shower head tubing in the 200 hallway shower room. The floor was wet and the black substance in the silicon caulking of the shower was still present.At 9:19 a.m. the flooring in the 600 hallway shower room was cracked and peeling with an uneven surface. There was a black substance observed in what was left of the silicon caulking of the shower. All of the caulking was damaged; it had been ripped or torn out in some areas, and looked gummy and built up in other areas. The shower drain cover did not entirely cover the shower drain. A hard white substance was observed built up on the shower drain.At 11:35 a.m. water continued to leak from the showerhead tubing in the secure unit shower room. The floor was wet and the black substance in the silicon caulking of the shower was still present.III. Resident interviewResident #99 was interviewed on 1/11/26 at 12:45 p.m. Resident #99 said the flooring of the 600 hallway shower room needed to be updated because it was cracked and peeling. He said he thought he was the only (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident bothered by the floor because he was the only resident who stood and independently showered, while the other residents used a shower chair or shower bed. Resident #99 said the facility would not listen to him about his concerns with the shower room.IV. Staff interviewsThe maintenance director (MTD) and the maintenance resource were interviewed together on 1/13/26 at 2:05 p.m. during a tour of the facility's four shower rooms. The maintenance resource said the continuous dripping of water from the shower heads in the shower rooms was an expected result of the backflow valves to prevent contamination of the water, and the black substance in the silicon caulking of the showers was residue. He said he did not believe the facility had mold test kits readily available, and he would follow-up regarding ordering one.The MTD and the maintenance resource observed the 200 hallway shower room floor and confirmed that it was wet. The maintenance resource said the shower head dripping was related to an issue with the shower cartridge. He said he did not think harm could be caused by the shower floor remaining wet without being able to fully dry.The 600 hallway shower room was occupied during the shower room tour. The maintenance resource said he did not know if he could say the flooring in the 600 shower room was not a sanitizable surface, even though it was cracked and not intact. He said he would recommend replacing the coating on the shower floor.The NHA was interviewed on 1/13/26 at 2:30 p.m. during a tour of the facility's four shower rooms. The NHA said he requested from maintenance a timeline of the status of repairs to the damaged floor in the 600 hallway shower room, as well as what the unidentified black substance was in and under the silicon caulking in the shower rooms. He said he would have to speak to maintenance regarding how often the MTD or the housekeeping supervisor checked the shower rooms and why the MTD had not identified the black substance under the caulking.The shower head tubing leaks in the 200 hallway, 600 hallway and the secure unit were observed with the NHA. The NHA agreed the shower floor being wet with the shower room door held open with a gait belt could have been a risk for wandering residents to slip and fall.The NHA and the maintenance resource were interviewed together on 1/14/26 at 2:00 p.m. The maintenance resource said the housekeepers cleaned and inspected the shower rooms daily, and there was an expectation for the housekeeping staff to report any leaks or concerns to the MTD, either verbally or by submitting a work order. The maintenance resource said there had not been any work orders written for the shower head tubing leaks. He said the results of the mold test kit would not arrive until after the survey exit, but the maintenance team was correcting the issue and would follow-up once the repairs were completed (during the survey).V. Facility follow-upOn 1/14/26 at 2:39 p.m. the facility's shower rooms were observed again along with the NHA and the maintenance resource. The tour of the 600 hallway shower room revealed the following:The flooring had been refinished/re-painted with a vinyl coating. The maintenance team had scraped the old silicone caulking out, cleaned the area and would be replacing the caulking. There was no longer a black substance in the shower. There was no water dripping from the shower head tubing and the vinyl coating was still drying.The tour of the 200 hallway shower room and the secure unit shower rooms revealed the following:The silicon caulking had been scraped out, cleaned and replaced in both shower rooms. There was no longer a black substance found in either shower. There was no water dripping from the shower head tubing, and the floor was dry.-However, the maintenance repairs in the shower rooms were not conducted until the concerns were brought to the facility's attention during the survey.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observations and interviews, the facility failed to ensure adequate outside ventilation by means of windows or mechanical ventilation in three out of four shower rooms.Specifically, the facility failed to ensure the ventilation fans in the shower rooms were operational.Findings include:I. Professional referenceAccording to the U.S. Department of Energy's Office of Energy Efficiency and Renewable Energy, April 2021, retrieved on 1/20/26 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. II. Facility policy and procedureThe Safe, Homelike Environment policy, reviewed December 2025, was provided by the nursing home administrator (NHA) on 1/14/26 at 3:08 p.m. It read in pertinent part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. General considerations: -Minimize odors by reporting bathrooms needing cleaning to Housekeeping Department;-Report any unresolved environmental concerns to the Administrator; and,-Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.The Housekeeping Services Infection Control policy, revised January 2009, was provided by the NHA on 1/14/26 at 3:30 p.m. It read in pertinent part, It is the policy of this facility to require effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites. Frequent cleaning of the facility's interior will aid in physically removing and reducing microorganisms' potential contribution to the incidence of health-associated infections (HAI). Periodic inspection of the facility will be made by the housekeeping supervisor as a joint exercise with the infection control team.III. ObservationsDuring the initial walkthrough of the facility on 1/11/26 the following was observed:At 9:21 a.m. there was no air flow coming from the ventilation fan in the 200 hallway shower room. The ventilation fan was not moving, and it was muggy and hot in the shower room.At 9:42 a.m. there was no air flow coming from the ventilation fan in the secure unit shower room. The ventilation fan was not moving, and it was muggy and hot in the shower room.On 1/12/26 the following was observed:At 9:12 a.m. there was still no air flow coming from the ventilation fan in the 200 hallway shower room.At 9:19 a.m. the 600 hallway shower room was muggy and hot.At 11:35 a.m. there was still no air flow coming from the ventilation fan in the secure unit shower room. The ventilation fan was not moving, and it was muggy and hot in the shower room.On 1/13/26 at approximately 3:30 p.m. the maintenance team was working in the secure unit shower room. The maintenance team brought in parts to work on the ventilation fan.On 1/13/26 at 2:30 p.m. the ventilation fan in the 600 hallway shower room would not suck a tissue that was held up to it.IV. Staff interviewsThe maintenance director (MTD) and the maintenance resource were interviewed on 1/13/26 at 1:51 p.m. during a tour of the facility's shower rooms. After inspecting the secure unit shower room, the maintenance resource said there was not any air flow.The maintenance resource searched for and found the switch to the ventilation fan in the 200 hallway shower room. When he flipped the switch, the ventilation fan was operating with a loud whirring noise. The maintenance resource said the fan would be repaired by the maintenance team. The maintenance resource said the bathrooms and shower rooms must be ventilated by a fan or a window. He said the ventilation fan in the secure unit should be operational since there was no window. The maintenance resource said the harm of the ventilation fans not working was uncomfortability related to foul orders and un-steaming the showers.The NHA was interviewed on 1/13/26 at 2:30 p.m. while touring the facility's shower rooms. The NHA observed the unoperational (continued on next page)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ventilation fan in the secure unit, the operational but loud ventilation fan in the 200 hallway shower room and observed the tissue being held up to the ventilation fan in the 600 hallway shower room (see observations above) without air flow. He said he would have to speak to maintenance and follow up regarding how often the MTD or the housekeeping supervisor checked the shower rooms.The NHA and the maintenance resource were interviewed together on 1/14/26 at 2:00 p.m. The maintenance resource said the housekeepers cleaned and inspected the shower rooms daily, and there was an expectation for the housekeeping staff to report any leaks or concerns to the MTD, either verbally or by submitting a work order. He said there had not been any work orders written for the ventilation fans in the shower rooms.V. Facility follow-upThe shower rooms were observed again, along with the NHA and the maintenance resource on 1/14/26 at 2:39 p.m. The shower room tour revealed the following:The ventilation fan in the 600 hallway shower room was operational. The ventilation fan in the secure unit shower room was operational. The maintenance resource said the motor needed to be replaced.The ventilation fan in the 200 hallway shower room remained operational, and was much quieter.-However, the repairs to the ventilation fans in the shower rooms were not conducted until the concerns were brought to the facility's attention during the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and interviews, the facility failed to provide a safe, clean, sanitary and comfortable environment on the secured unit. Specifically, the facility failed to:-Ensure the blinds in the secured unit's common area and in residents' rooms were in good repair;-Ensure lights in the residents' bathrooms were working properly; -Ensure each resident had hand towels available for use in their bathrooms; and,-Ensure maintenance and patchwork was completed in a timely manner on the secured unit and in residents' rooms.Findings include:I. Facility policy and procedureThe Safe and Homelike Environment policy, reviewed December 2025, was provided by the nursing home administrator (NHA) on 1/14/26 at 3:08 p.m. It read in pertinent part, The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. The facility will provide and maintain bed and bath linens that are clean and in good condition. The facility will provide and maintain adequate and comfortable lighting levels in all areas. The maintenance director (MTD) will perform periodic rounds to ensure functioning lights.II. ObservationsDuring the initial tour of the facility's secured unit on 1/11/26 at 11:10 a.m. the following was observed:The last ceiling light at the end of the hall, outside of the common area which was the secured unit's dining room, was flickering. The hallway ceiling light fixtures had numerous dark particles in four of the eight light covers. The common area's blinds had many missing and broken slats.The entrance way to the common area and near the nurses' station had chipped paint and missing drywall at the lower end of the wall.In room [ROOM NUMBER] the blinds had missing and broken slats.Rooms #404, #405, #407, #408, #411, and #413 did not have hand towels available in the rooms.room [ROOM NUMBER] had a flashing bathroom light, one bathroom light bulb was not working and there were white paint splotches on the wall. On 1/12/26 at 9:15 a.m. the following was observed on the secured unit:Rooms #403, #404, #405 and #411 did not have hand towels available in the rooms. Rooms #403 and #411's blinds had broken and missing slats and white paint splotches on the bathroom wall. On 1/13/26 at 9:51 a.m. the following was observed on the secured unit:room [ROOM NUMBER] had blinds with broken slats hung on the windows. room [ROOM NUMBER] still had blinds with missing and broken slats. room [ROOM NUMBER] had holes in the wall above the television, paint was coming off the wall near the floor at the end of the bed, blinds with broken slats hung on the window and white paint splotches were on the bathroom wall.room [ROOM NUMBER] had white paint splotches on the bathroom wall. room [ROOM NUMBER] had blinds with broken and missing slats hung on the windows, the bathroom wall had white paint splotches, one light bulb in the bathroom was not working and the ceiling light in the room was missing the cover. room [ROOM NUMBER] had blinds with broken slats hung on the windows. There were many tiles missing from the bathroom wall and a tile missing next to the soap dispenser. room [ROOM NUMBER] had 16 tiles missing from the bathroom wall. The adjacent tiles from the missing tile pieces were sticking out from the wall with sharp edges. room [ROOM NUMBER] had dried, brown liquid marks on the bedroom wall, the blinds with broken slats hung on the windows and the bathroom wall had white paint splotches. room [ROOM NUMBER] the bathroom walls had white paint splotches.room [ROOM NUMBER] had a flashing bathroom light and one light bulb not working, the bathroom walls had white paint splotches and paint chipped off the bedroom walls near the door. Rooms #402, #403, #404, #405, #406, #407, #408, #411, #412 and #414 did not have any hand towels available in the rooms or bathrooms. III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 1/13/26 at 10:22 a.m. LPN #1 said each room should have hand towels for the residents to use. She said the hand towels were kept in the shower room on the secured unit, however when she went to look for them, the hand towels were not stocked. She said the night shift was to restock the linens and pass (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out towels to each room. Certified nurse aide (CNA) #1 was interviewed on 1/13/26 at 10:25 a.m. CNA #1 said the night shift was responsible for passing out clean hand towels to each room and stocking the cart in the shower room with linens. He said if the night shift did not replace the hand towels the day shift was responsible for providing the hand towels, but this may not happen until later in the day.-However, observations made on the secured unit on 1/11/26, 1/12/26 and 1/13/26 revealed there were no hand towels delivered to any rooms on those days. The MTD and the maintenance resource were interviewed together on 1/13/26 at 1:50 p.m. The MTD and the maintenance resource were shown the missing bathroom wall tiles in room [ROOM NUMBER]. The MTD said he was not aware of the missing tiles. He said all staff were trained to use the electronic communication system to report any needed repairs. He said the system generates a report and gets prioritized by the maintenance department. He and the MTD resource also said the maintenance department did monthly audit rounds on the nursing units to look for any areas that needed to be repaired or replaced. He said after these rounds the maintenance department generated an electronic communication system report for the areas of concern. The MTD said the white paint splotches in the bathrooms were probably from someone from his team who repaired holes in the wall and would be returning to repaint the wall. The MTD said he was not sure when the repairs in the wall were started. He said the walls should be repainted within a couple of hours of the patching. -However, the splotches on the wall were observed on 1/11/26, two days prior to the interview with the MTD. -The audit round logs for the secured unit were requested but were not provided by the survey exit on 1/14/26. The maintenance resource provided the October 2025, November 2025 and December 2025 electronic communication system maintenance reports, however, none of the above areas of concern were documented in the reports. CNA #1 was interviewed a second time on 1/13/26 at 2:03 p.m. CNA #1 said he was aware of the electronic communication system and had used it to report the missing bathroom tiles in room [ROOM NUMBER], however he was not sure how long it had been since he made the report. He said he did not report the broken blinds in the rooms because he thought someone would have seen they needed to be repaired. The NHA was interviewed on 1/14/26 at 10:10 a.m. The NHA was shown the broken and missing slats on the window blinds in room [ROOM NUMBER]. He said the facility had replaced a few blinds but the residents broke them when they wanted to look out the windows because the residents did not know how to operate the blinds. He said the facility was looking for alternatives for window coverings. The NHA was interviewed a second time on 1/14/26 at 10:40 a.m. The NHA said the maintenance department was measuring the windows in the residents' rooms on the secured unit to replace the broken blinds and in the common area (during the survey). He said the blinds needed to be ordered because of the window size.The NHA and the maintenance resource were interviewed together on 1/14/26 at 2:39 p.m. The NHA and MTD resource said the window blinds in rooms #402 and #403 were replaced, the ceiling light at the end of the hall was fixed and was no longer flickering and the ceiling fixtures on the secured unit were cleaned out. The NHA and the maintenance resource said metal corner guards were applied to the walls near the nurses' station on the secured unit and the entrance to the common area. They said rooms #407 and #408 had the bathroom light bulbs replaced and the walls with the missing tiles in room [ROOM NUMBER] had been repaired.-However, all of the maintenance repairs were started during the survey, after the facility became aware of the maintenance concerns.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#3) of two residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing out of 43 sample residents. Specifically, the facility failed to ensure Resident #3, who expressed suicidal ideations, was provided psychosocial support.Findings include:I. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included amputation of the right leg above the knee, ostomy (a surgical procedure that creates an opening (stoma) in the abdomen, rerouting urine or stool from the digestive or urinary tract to exit the body into a collection pouch), chronic obstructive pulmonary disease and chronic viral hepatitis C.The 10/8/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The mood assessment revealed the resident expressed felt down, depressed, and hopeless. B. Resident observation and interviewResident #3 was interviewed on 1/12/26 at 1:45 p.m. in his room. Resident #3 said he had been at the facility for almost a year. Resident #3 said he used to receive occupational and physical therapy to get stronger but he was no longer receiving therapy. He said the staff would sometimes assist him out of his bed and into his wheelchair but then the staff just sat him in front of his television. Resident #3 said that all of his personal items were in storage and he could not reach his prior roommate to obtain any of his belongings. He said he did not want to live in the facility but no one was helping him to leave. He said he had been very depressed about not being able to leave and he had lost weight because he had lost interest in eating due to his depression. Resident #3 said he wanted to discharge home or to another facility, such as an assisted living facility, and he did not understand why the facility had given up trying to find him alternative living options. Resident #3 said he often thought about killing himself but did not have the ability, however he said he would do it if he could find a way. He said sometimes he thought about overdosing or obtaining a gun he hoped was in his stored belongings. He said he had not received any visits from a psychologist for his depression or his struggle to adjust to facility placement. C. Record reviewThe discharge care plan, revised 4/30/24, revealed Resident #3 would be staying at the facility for long-term care. Interventions, initiated 3/2/24, included establishing a pre-discharge plan with the resident, family/caregivers and evaluating the resident's progress and revising the care plan as needed.The mood care plan, initiated 11/6/24, revealed the resident had the potential for mood problems related to his disease process. The resident would at times state he wished he was dead. Interventions, initiated 11/6/24, included providing behavioral health consultants as needed and monitoring mood patterns of depression, anxiety or sad mood.-The mood care plan failed to reveal any updates after Resident #3's 10/14/25 suicide lethality assessment (see assessment below). The trauma care plan, revised 12/3/25, revealed Resident #3 was at risk for re-traumatization related to a history of trauma, grief and loss. The resident was especially sad around the holidays and wished to be back in his home. The resident's sister recently passed away. Interventions, initiated 12/3/25, included providing extra emotional support during the holidays and documentation of behaviors, and the resident's response to interventions.The January 2026 CPO revealed the following physician's orders:Refer to behavioral health for psychiatric and psychological evaluation and treatment as indicated, ordered on 10/17/24.-The CPO failed to reveal any monitoring for signs of depression, anxiety, sad mood, or suicidal ideations (see mood care plan above). Review of Resident #3's electronic medical record (EMR) from 10/1/25 through 1/12/26 revealed the following:A social services note, dated 10/13/25, revealed the resident expressed to the social worker that he missed being at home. A suicide lethality (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, dated 10/14/25, revealed Resident #3 had expressed feeling bad about not being able to go home without a plan and was placed on 15-minute safety checks. A nursing condition note, dated 10/15/25, revealed the resident was noted to be depressed about his health.A social services note, dated 12/1/25, revealed Resident #3 expressed to the social worker that he was not feeling well after being informed that his sister had passed away.-There was no documentation in the resident's EMR to indicate the resident was offered behavioral health services to address the resident's feelings regarding his sister's passing. A social services quarterly note, dated 12/3/25, revealed the resident's older sister passed away, and he was very distraught. The resident had been seen by behavioral health in the past but currently was not being seen.-There was no documentation in the resident's EMR to indicate the resident was offered behavioral health services to address the resident's feelings regarding his sister's passing, despite the resident voicing that he was very distraught. A weight summary, dated 12/3/25, revealed the resident's weight was 161.4 pounds (lbs).A weight summary, dated 12/16/25, revealed the resident's weight was 159.9 lbs.A weight summary, dated 12/31/25, revealed the resident's weight was 153.4 lbs.-There was no documentation to indicate the resident's lack of appetite had been addressed to see if the resident was not eating due to depression (see staff interviews below). -Despite the physician's order to refer Resident #3 to behavioral health for psychiatric and psychological evaluation and treatment as indicated (see physician's orders above), the resident's EMR failed to reveal psychological services had been provided to the resident.II. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 1/13/26 at 11:06 a.m. CNA #5 said Resident #3 refused care and sometimes he would not eat very much of his food or any at all. CNA #5 said she was not instructed to monitor him for depression or suicidal ideations and she was not aware he had a history of thoughts of self harm. Registered nurse (RN) #1 was interviewed on 1/13/26 at 11:18 a.m. RN #1 said Resident #3 had multiple forms of cancer and had told her that he knew he would die. She said he did not want to eat anything, had no appetite and only wanted to smoke and drink soda. RN #1 said she was the one who had to tell the resident that his older sister died in a car accident last month (December 2025) and he was devastated. She said he told her he was now completely alone and had nothing to live for. RN #1 said sometimes he verbally expressed not wanting to live anymore and sometimes his depression was displayed as refusals or verbal aggression. She said when Resident #3 expressed suicidal ideations, the staff would put him on 15-minute checks. She said there was no current monitoring for his suicidal ideations. -However, per CNA #5, she was not aware the resident had a history of self harm or that he was supposed to be monitored for depression or suicidal ideation (see interview above).The social services director (SSD) and the social services assistant (SSA) were interviewed together on 1/13/26 at 3:32 p.m. The SSA said Resident #3 did not have a discharge plan back into the community because he was unable to care for himself and did not have anyone to assist him in his apartment. She said physical and occupational therapy were discontinued because he was unable to make progress. The SSA said she talked with Resident #3 every few months regarding his desire to discharge and his inability to do so, but she said he continued to want to leave the facility. The SSA said the suicide lethality assessment completed on 10/14/25 (see record review above) was completed after Resident #3 made statements about wanting to overdose on his medications, however there was no means for him to obtain enough medication from the nurse to overdose and the staff watched the residents take their medications.The SSD said the psychologist provider the facility used had been seeing Resident #3 previously when he expressed suicidal ideations in November 2024. However, the SSD said when she researched (during the survey) why he was no longer being seen, she was informed there had been an issue with the resident's insurance but the facility had not followed up on this loss of services in 2024. The SSD did not know why there had not been any follow up. III. Facility follow-upThe nursing home administrator (NHA) sent an email on 1/15/26 at 4:39 p.m. which included a timeline the facility had created documenting Resident #3's history. It revealed the following;Resident #3 had been admitted to the facility on [DATE] for short term rehabilitation with (continued on next page)

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Boulder Canyon Health and Rehabilitation	4685 Baseline Rd Boulder, CO 80303

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the goal to return home after being hospitalized and having his right leg amputated above the knee. The resident's therapy stopped on 5/14/24 and it was recommended he stay in the facility for long term care, however he wanted to return home. A discharge plan was established with home healthcare services, but when the ambulance arrived to transport Resident #3 home the ambulance staff refused to transport him for safety reasons and he had to remain in the facility. After this, the resident began displaying behaviors of using drugs, perseverating on his condition, and being sexually inappropriate towards staff. On 10/17/24, Resident #3 began seeing the behavioral health provider, but only saw the mental health provider a total of three times and therapy ended on 12/10/24. The timeline concluded by documenting Resident #3 was not seen by a mental health provider in 2025 due to insurance coverage.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide one (#94) resident of five sample residents with a nourishing, palatable and well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences out of 43 sample residents. Specifically, failed to provide Resident #94 a nourishing, well-balanced diet that met his daily nutritional dietary needs, taking into consideration the resident's vegan preferences.Findings include:I. Resident #94A. Resident statusResident #94, age [AGE], was admitted to the facility on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included displace fracture of shaft of humerus on left arm, obsessive-compulsive disorder (OCD), disease of digestive system and unspecified protein-calorie malnutrition.The 12/30/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. He required set up assistance with eating. B. Record reviewA review of the January 2026 physician`s order revealed the resident was prescribed a regular diet, regular texture, thin liquids consistency and preferred a vegan diet. The physician`s order indicated for staff to honor resident rights to make personal dietary choices and provide dietary education as needed.A review of the weekly menu revealed that there was no available vegan menu developed by a registered dietitian (RD). Review of the alternative food item menu revealed the facility had highlighted or hand written additions that were considered vegan.Resident #94's nutrition care plan, dated 12/24/25, revealed he consumed a regular diet, regular texture, thin liquids consistency and preferred a vegan diet. The nutrition assessment, dated 12/30/25, revealed that Resident #94`s estimated nutritional need was 1614 to 1935 calories per day, 65 to 77 grams protein per day, and 1614 to 1935 ml fluid per day. -However, there was no documentation that indicated the facility assessed his current menu to see if it was providing adequate nutrition. C. Resident interview and observationResident #94 was interviewed on 1/13/26 at 12:05 p.m. The resident said he had been a strict vegan for many years. He said he ate plain boiled or steamed vegetables, beans and grains. He said he did not use any animal products or vegetable oils. He said it was important to him that salt and other spices were not added to his food. Resident #94 said the facility tried to provide foods per his preference initially, however the food always came either with added salt or oil. He said the only meal he was able to eat at the facility was breakfast that consisted of apple sauce, almond milk and oatmeal. He said his sister brought him food every day for lunch and ate the leftovers for dinner.During the interview, the resident had six 12 ounce deli containers in front of him. The containers had the following foods: chopped avocado, steamed broccoli, boiled [NAME], steamed squash, boiled potatoes and cooked beans. The resident was eating from deli containers. He said he would eat some for lunch and kept the remaining in the ice box. He said he would finish the remaining food for dinner.D. Family interviewThe resident's sister was interviewed on 1/13/26 at 12:05 p.m. She said she was responsible for bringing food daily to the facility for the resident and that put a significant strain on her life. She said her brother previously stayed in other medical facilities that were able to accommodate his diet. She said she was bringing food daily out of fear that he would lose weight as he already was under weight and prolong his stay at the facility. II. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 1/14/26 at 10:34 a.m. She said Resident #94 was on a vegan diet. She said the resident did not like refined sugar, meat or processed food. CNA #6 said the resident only ate breakfast at the facility which was usually applesauce, almond milk and oatmeal. She said Resident #94`s sister brought lunch and dinner for Resident #94. She said the facility offered string cheese and yoghurt for a snack, but he refused. She said the facility had fruits to offer for snacks for vegans. She said Resident #94 would not eat fruit because it was high in sugar. She said Resident #94 would occasionally eat raw carrots. She said Resident #94`s sister usually (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brought five bowls of different food items daily for lunch and dinner. She said the staff just gauged his intake by percent and tracked that information. Licensed practical nurse (LPN) #2 was interviewed on 1/14/25 10:25 a.m. She said she was not sure if the resident ate meat or dairy. She said Resident #94`s sister brought food into the facility daily for him. She said Resident #94 had anxiety and OCD, so he was very particular about his meals. The dietary manager (DM) was interviewed on 1/14/26 at 10:49 a.m. She said the facility`s vegan menu was created by the dietary software. She said she would provide a copy of the vegan menu.-However, documentation indicating the facility ensure the resident was provided with a nourishing, well-balanced diet that took into consideration Resident #94's dietary preferences were not provided. The regional dietary consultant and the RD were interviewed together on 1/14/26 at 4:30 p.m. The regional dietary consultant said that the facility did not have daily menus for residents who were on vegan diets. She provided a document titled alternate food item menu with highlighted vegetarian items. She said Resident #94 could choose his meals from this list. She said this list was provided to him upon admission. She said this was the menu that CNAs were to follow when offering a resident his meal. -The vegetarian diet print out did not have extensions with serving size, ingredients or calculated nutritional value of meals.The RD said she did not have a vegan menu for the Resident #94 that included the calculations of nutritional value of his meals to ensure he met his estimated nutritional needs. She said she was in the facility on 1/13/26 during the lunch time, but she did not know what the resident ate for lunch or dinner. She said the family brought all the meals for the resident except for breakfast. III. Facility follow-upThe facility provided a letter on 1/14/26 at 4:29 p.m. that documented the facility indicated the resident chose to follow a vegan diet. The letter indicated a vegan diet was not a therapeutic diet to address a disease state and rather a preference. The letter documented the facility should honor this preference by offering appropriate alternative food substitutions within the standard menu framework. The letter documented all substitutions provided to accommodate a vegan preference should be reviewed by the director of food and nutrition services to ensure appropriateness, nutritional adequacy and alignment with facility standards. The letter documented the resident's preference should be documented and communicated to dietary and nursing staff, with ongoing monitoring to ensure satisfaction and nutritional status are maintained.-However, the facility failed to ensure the resident's nutritional needs were assessed based on his dietary preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease, including COVID-19 in one of four shower rooms and one resident room.Specifically, the facility failed to:-Ensure the sharps container in the 600 hallway shower room was not overfilled;-Ensure staff members wore the appropriate personal protective equipment (PPE) when entering Resident #68's room, who was COVID-19 positive; and,-Ensure visitors were encouraged to wear N-95 masks when entering a COVID-19 positive resident room.Findings include:I. Sharps container failureA. Facility policy and procedureThe Sharps Disposal Infection Control policy, revised April 2020, was provided by the nursing home administrator (NHA) on 1/14/26 at 1:55 p.m. It read in pertinent part, It is the policy of this facility to discard contaminated sharps into designated containers. During use, containers for contaminated sharps will be sealed and replaced when they are 75-80 percent (%) full to protect employees from punctures and/or needle sticks when attempting to push sharps into the container. Incorrect disposal or handling of contaminated sharps should be reported to the infection control designee.B. ObservationOn 1/12/26 at 9:19 a.m. the sharps container in the 600 hallway shower room was overflowing with used razors. Additional used razors were sitting on top of a cabinet which was beneath the sharps container as a result of the container being too full.C. Staff interviewsCertified nurse aide (CNA) #6 and licensed practical nurse (LPN) #2 were interviewed on 1/14/26 at 12:45 p.m. LPN #2 said the nurses were responsible for managing their own sharps containers, and not emptying the containers timely imposed the risk of needle sticks or punctures and the transmission of bloodborne pathogens.LPN #5 was interviewed on 1/14/26 at 12:54 p.m. LPN #5 said Resident #99 told her the sharps container was full one week ago, and she meant to change it sooner but she got busy. She said she switched the full sharps container for an empty one on 1/12/26 (during the survey). LPN #5 said the nurses were responsible for managing the sharps containers, and she did not know if housekeeping had access to the key to unlock the sharps containers. She said an overflowing sharps container would increase the risk of pokes or pricks and transmission of bloodborne infections.LPN #4 was interviewed on 1/14/26 at 12:56 p.m. LPN #4 said he had never come on shift to a full sharps container, but if it were full he would have emptied it right away. He said the nurses had the keys to the sharps containers and were responsible for emptying and managing the containers. LPN #4 said the risk of not emptying the container timely could lead to pokes and cause infections, such as Hepatitis A or Human immunodeficiency virus (HIV)/Acquired immunodeficiency syndrome (AIDS).The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 1/14/26 at 1:05 p.m. The IP said the nurses were responsible for managing the sharps containers and were expected to lock the container before placing them in the biohazard room and replacing the container with an empty one. She said it was important to empty the containers timely in order to prevent needle sticks.II. Personal protective equipment (PPE) failuresA. Facility policy and procedureThe Personal Protective Equipment (PPE) policy, revised August 2025, was provided by the NHA on 1/14/26 at 1:55 p.m. It read in pertinent part, This facility promotes appropriate use of PPE to prevent the transmission of pathogens to residents, visitors and other staff.All staff who have contact with residents and/or their environments must wear PPE as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely.Respiratory protection: wear a National Institute for Occupational Safety and Health (NIOSH)-approved N95 or higher-level respirator to prevent inhalation of pathogens transmitted by the airborne route.B. ObservationsDuring a continuous observation on 1/13/26, beginning at 11:15 a.m. and ending at 12:42 p.m., the following was observed:At 12:19 p.m. CNA #7 approached Resident #68's (who was COVID-19 positive) room. CNA #7 was wearing a surgical mask over her nose and mouth, and donned gloves, a gown and goggles prior to entering the resident's room.While CNA #7 donned her (continued on next page)

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