STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065226	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McIntosh Care and Rehabilitation Center	1800 Stroh Pl Longmont, CO 80501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#88) of three residents reviewed for accidents received adequate supervision out of 38 sample residents. Resident #88 was admitted on [DATE] with diagnoses cerebral infarction (stroke), acute respiratory failure, atrial fibrillation, pacemaker, osteoarthritis, obesity, hypertension and acute kidney failureOn 12/16/26, Resident #88 was being transported to an appointment in the facility's transportation van. Resident #88's wheelchair was not properly secured in the transportation van. During the transportation, Resident #88's wheelchair slipped and the resident hit her head on the van. The resident was transported to the emergency department (ED) and was admitted to the intensive care unit (ICU) for monitoring related to the sustained traumatic subdural hematoma (brain bleed) and Eliquis (blood thinner) use. Specifically, the facility failed to ensure Resident #88 was provided safe transportation. Findings include:Observations, record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 3/16/26 to 3/19/26, resulting in the deficiency being cited as past noncompliance with a correction date of 12/24/25. I. Incident on 12/16/25On 12/16/25 Resident #88 was being transported to a swallow study via the facility's transportation van. During the drive, Resident #88's wheelchair shifted, which caused her head to make contact with the interior of the van. The resident was transferred to the ED and was diagnosed with a subdural hematoma. II. Facility plan of correctionThe facility's plan of correction was provided by the director of nursing (DON) on 3/19/26 at 6:45 p.m. The plan revealed on 12/16/25 Resident #88 was not tied down, which caused the resident to hit her head during transportation. The plan revealed immediate actions that were implemented included: -Resident #88 was transferred to the hospital, observed overnight and returned to the facility on [DATE].-The resident was interviewed and mental health services were offered. -The hospital records were reviewed, the new recommendations and physician's orders were implemented. -Van driver #1 was suspended on 12/16/25 pending the investigation.-Additional residents were interviewed on 12/17/25 regarding safety concerns while being transported in the van. The plan revealed performance expectations included:-Total compliance with wheelchair and securement procedures.-Adherance to all transportation safety policies.-Safe driving practices. -Proper documentation/reporting of incidents. -Review of the facility's performance and adherence to the plan in the monthly quality assurance improvement plant (QAPI) meetings.The plan revealed the audit and monitoring plan included:-The DON would complete weekly audits for 12 consecutive weeks. The plan documented the plan of action included:-The driver was terminated.-The van was taken out of commission. -The van was taken to a third party vendor to be checked for safety concerns. -All transportation was outsourced to outside sources.-A new van driver would be hired. The new van driver would have complete training and safety competencies prior to starting.The transportation safety education was completed with staff from 12/17/25 to 12/24/25.On 12/24/25, staff members were provided additional education and required to demonstrate competency in properly and safely securing a resident in a wheelchair when using the facility's transportation van.The plan stated the compliance date was 12/17/25. -However, review of the plan revealed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
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F 0689 Level of Harm - Actual harm Residents Affected - Few	education and return demonstrations by staff for properly and safely securing a resident in a wheelchair for van transportation were not completed until 12/24/25.III. Resident #88A. Resident statusResident #88, age [AGE], was admitted on [DATE], discharged to the hospital on [DATE], readmitted on [DATE] and discharged home on 1/2/26. According to the January 2026 computerized physician's orders (CPO), diagnoses included cerebral infarction (stroke), acute respiratory failure, atrial fibrillation, pacemaker, osteoarthritis, obesity, hypertension and acute kidney failure.The 1/5/26 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident need set-up assistance with transfers.B. Record review1. Care planThe anticoagulant care plan, initiated on 11/14/25, revealed the resident was on anticoagulant therapy related to atrial fibrillation. Pertinent interventions included, administering medications per physician's orders, monitoring for signs and symptoms of bleeding and monitoring for signs of complications.The ADL care plan, initiated on 11/13/26, revealed the resident had an ADL self care performance deficit related to weakness, stroke, malnutrition and medication side effects. Pertinent interventions included providing therapy as ordered, encouraging the resident to participate to the fullest extent possible with each interaction, encouraging the resident to use her call bell for assistance and monitoring and reporting any changes to the physician. The brain injury care plan, initiated 12/18/26, revealed the resident had an alteration in neurological status related to a head injury and subdural hematoma. Pertinent interventions included giving medications as ordered, monitoring the resident and obtaining laboratory and diagnostics as ordered. 2. Progress notesThe 12/17/25 nursing progress note documented at 1:51 p.m. revealed Resident #88 returned to the facility at approximately 1:00 p.m. and was assisted to her room. The resident was chatting with the nurse regarding eating solid food and eating ice cream. The resident said she was glad to be back at the facility. The resident requested to have ice cream. The note documented the resident's husband arrived at the facility. The resident had a bruise to the right shoulder. The 12/19/25 physician's progress note documented the medical director reviewed the recent hospital records. The note documented it appeared that she may have sustained a very small 3 millimeter (mm) hemorrhage brain bleed as a result of the incident in the transport vehicle. The note documented because there was a lack of neurological signs/symptoms it was impossible to definitely say the two events were linked. 3. Hospital reportThe 12/16/25 hospital documentation revealed in pertinent part, the resident was admitted with a traumatic subdural hematoma. The resident arrived at the facility after she experienced a head injury during transportation to a swallow test when her wheelchair was not properly secured. When the transportation vehicle came to a sudden stop she hit her head on the window. The resident was brought to the emergency department for workup because she was on Eliquis related to atrial fibrillation and a recent stroke. A computed tomography (CT) scan was completed and revealed a 3 mm subdural hematoma in the midline area of the brain. The resident was admitted to the intensive care unit (ICU) for monitoring related to the resident's use of Eliquis. The resident was started on Keppra 750 milligrams (mg) twice a day for one week for seizure prophylaxis in relation to the subdural hematoma. 4. Facility investigation the 12/16/26 incidentThe 12/16/25 facility investigation was provided by the DON on 3/18/26 at 2:45 p.m. The investigation revealed the following timeline:On 12/16/26 Resident #88 was being transported to a swallow study appointment on 12/16/26. At 11:16 a.m. Resident #88 was assisted into the transportation bus. At 11:50 a.m. Resident #88's wheelchair shifted, causing her head to make contact with the interior of the van. The transport staff assessed the resident and advised that the resident received a medical evaluation at the ED. At 12:20 p.m. the assistant director of nursing (ADON), the DON and the nursing home administrator (NHA) directed van driver #1 to take Resident #88 to the hospital for evaluation. At 1:20 p.m. Resident #88 arrived at the hospital. At 2:00 p.m. a CT scan was completed and revealed a 3 mm subdural hematoma.At 2:51 p.m. Resident #88 was admitted to the ICU for observation.At 6:00 p.m. a second CT scan was completed and showed no changes in the subdural hematoma. On 12/17/25 the van was taken out of commission. On 12/17/25 the resident returned to the facility.On 12/17/25 van (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	driver #1 was terminated.On 12/17/25 the facility began to implement a process improvement plan (PIP). On 12/19/25 Resident #88 was seen by her primary care physician and remained at baseline. The investigation included an interview with van driver #1, dated 12/17/25. The interview was conducted by the clinical resource and the life safety resource. The interview documented van driver #1 said he parked the van in front of the facility, so the lift was on the sidewalk and as flat as possible. He said the resident was anxious while he was assisting her onto the lift, so he was explaining the safety measures he was taking. He said he used the lift to assist the resident into the van. He said while he was using the lift, he tied the resident down correctly. He said once as the resident was in the van, he locked the wheelchair brakes, secured the back of the wheelchair and placed the seatbelt and shoulder strap across the resident to secure the resident. Van driver #1 said he did not place the straps on the front of the wheelchair. Van driver #1 said he knew it was part of the procedure to secure the front straps. The interview documented van driver #1 said he made several turns and there were no concerns. He said he then heard a noise and Resident #88 screamed out. Van driver #1 said the resident was still sitting in her wheelchair with the foot pedals in place. The resident's wheelchair was in the same position and her head was approximately 12 inches from the lift gate. Van driver #1 said the resident reported she hit the back of her head on the window. Van driver #1 said he checked the resident's head and there were no signs of injury. The resident reported she was not dizzy, nauseated, or experiencing pain. Van driver #1 told the resident she needed to go to the ER. The interview documented the resident said she wanted to go to her appointment, so van driver #1 took her to the appointment. Van driver #1 said he then tied the front wheels down and then transported the resident to the appointment. Van driver #1 said after the appointment that was at the hospital, he assisted the resident to the ER. IV. Staff interviewsThe DON and the NHA were interviewed together on 3/29/26. The DON said van driver #1 called the facility when Resident #88 slipped from her wheelchair on 12/16/25. The DON said she told van driver #1 that Resident #88 needed to go to the ER. The DON said Resident #88 and her spouse declined to go to the ER and insisted on her going to her swallow study appointment. The DON said after the swallow study, the resident was transferred to the ER.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to honor resident choices for four (#17, #29, #41, #77) of 12 residents reviewed out of 38 sample residents. Specifically, the facility failed to ensure Resident #17, Resident #29, Resident #41 and Resident #77 received showers consistently according to the resident's choices and plan of care. Findings include:I. Facility policy and procedureThe Resident Showers policy, revised April 2025, was provided by the nursing home administrator (NHA) on 3/19/26 at 11:23 a.m. The policy read in pertinent part: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current stands of practice. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. Partial baths may be given between regular shower schedules as per facility policy.II. Resident #17A. Resident statusResident #17, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included unspecified dementia without behavioral disturbance.The 4/20/26 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. She required set-up assistance with activities of daily living (ADL) and supervision to touching assistance with showers. The MDS assessment did not document the resident was resistant to care. B. Record reviewThe ADL care plan, initiated 5/25/25 and revised 5/27/25, revealed the resident had an ADL self care performance deficit. Pertinent interventions included, set-up to supervised assistance with bathing/showering and as necessary. The resident preferred to shower in her room.-Review of the resident's comprehensive care plan did not reveal documentation indicating the resident was resistant to care.Resident #17's point of care (POC) response history for the bathing task revealed Resident #17 preferred showers on Monday and Thursday during the evening shift.Review of Resident #17's POC bathing task documentation from 2/19/26 through 3/16/26 revealed the resident refused all showers.The CNA shower/bath documentation revealed the following:The 2/19/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was Resident #17 said it was too cold. The 2/23/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was Resident #17 said she did not want to. The 2/26/26 CNA shower/bath documentation form documented Resident #17 refused. There was no reason documented for the refusal. The 3/2/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was Resident #17 said her schedule was full. The 3/5/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was the hot water was out before dinner and Resident #17 refused after dinner. The 3/9/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was Resident #17 said not today, maybe next time. The 3/12/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was Resident #17 said it was too cold. The 3/16/26 CNA shower/bath documentation form documented Resident #17 refused. The reason for refusal was Resident #17 said it was too late. A progress note, dated 3/2/26 at 4:40 p.m., documented Resident #17 was offered a shower through the day but she refused stating she did not create time for it. -There was no documentation that the resident had been provided showers or bed baths on other days.-There was no documentation that the resident was approached at different times or other interventions were attempted.III. Resident #29A. Resident statusResident #29, age less than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses include multiple sclerosis (MS) and weakness.The 12/10/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was set-up assistance for ADLs including showers. The MDS assessment did not document the resident was resistant to care. B. Resident interviewResident #29 was interviewed on 3/17/26 at 3:10 p.m. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29 said she was not receiving showers as often as she should. She said she was not asked regularly and this was very upsetting to her because she gets scabs on her scalp if she did not use her shampoo on a regular basis. She said she got angry because the scabs could be prevented if she used the shampoo regularly. She said she would not refuse showers. C. Record reviewThe March 2026 CPO documented ketoconazole external shampoo 1 percent (%) applied to scalp topically every 24 hours as needed for psoriasis (skin rashes). The ADL care plan, initiated 9/27/24 and revised 9/30/24, revealed the resident had an ADL self care performance deficit related to MS. Pertinent interventions included resident required one to two staff members to assist with bathing and she required one to two staff members' participation with personal hygiene and oral care, Resident #29's POC response history for the bathing task revealed Resident #29 preferred showers on Monday, Wednesday and Friday during the evening shift.Review of Resident #29's POC bathing task documentation from 2/27/26 to 3/16/26 documented the resident did not consistently receive showers on the preferred days.Review of Resident #29's POC documentation from 2/27/26 to 3/16/26 documented the resident received showers on 2/27/26, 3/4/26, 3/13/26 and 3/16/26. The resident received four showers out of nine opportunities. -However the POC response history for the bathing task documented a shower was provided on 3/4/26. There was a CNA shower/bath documentation, dated 3/4/26, signed by the CNA and nurse documenting the resident refused a shower that day. -CNA shower/bath documentation forms were requested for Resident 29 for this time period and were not provided.IV. Resident #41A. Resident statusResident #41, age less than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnosis included morbid obesity.The 2/20/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent on staff for showers and lower body dressing. She was substantial to maximal assistance for upper body dressing and setup assistance for oral hygiene and eating. The MDS assessment did not document the resident was resistant to care. B. Resident interviewResident #17 was interviewed on 3/19/26 at 8:53 a.m. Resident #17 said she did not receive her showers. She said she was not offered bed baths if she was not feeling up to getting out of bed. Resident #17 said she would accept a bed bath when she did not feel well enough to get out of bed. She said not getting showers made her feel forgotten and disgusting. She said she was not a dirty person and not showering regularly makes her feel dirty. C. Record reviewThe ADL care plan, initiated 9/1/24 and revised 1/20/25, revealed the resident had a self care performance deficit related to limited mobility. Pertinent interventions included, providing a sponge bath when a full bath or shower cannot be tolerated, and Resident #41 preferred to shower two times per week. Resident #41's POC bathing task revealed Resident #41 preferred showers on Wednesday and Sunday during the evening shift. Review of Resident #41's POC bathing task documentation from 2/25/26 to 3/18/26 revealed the resident did not consistently receive showers on her preferred days.Review of Resident #41's POC documentation from 2/25/26 to 3/18/26 revealed the resident received a shower on 2/25/26. The resident received one shower out of seven opportunities. The 3/11/26 CNA shower/bath documentation form documented Resident #41 refused. The reason for the refusal was the resident was not feeling good. A progress note, dated 3/4/26 at 10:07 p.m. documented Resident #41 switched her shower to the next day.-However there was no documentation the resident was offered or provided a shower or bed bath on 3/5/26. V. Resident #77A. Resident statusResident #77, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included vascular dementia without behavioral disturbance, and need for assistance with personal care.The 1/6/26 MDS assessment revealed the resident was cognitively impaired with a BIMS score of four out of 15. She required setup assistance for ADLs and partial to moderate assistance for showers.The MDS assessment did not indicate the resident was resistant to care.B. Record reviewThe ADL care plan, initiated 10/21/24 and revised 10/29/24, documented the resident had an ADL self care performance deficit. Interventions included, the resident preferred showers on Tuesdays and Thursdays and a bed bath on Saturday during the evening shift, and she required staff participation with bathing.Resident #77's POC for the bathing (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	task revealed Resident #77's preferred showers on Tuesdays and Fridays during the day shift.Review of Resident #77's POC bathing task documentation from 2/17/26 to 3/17/26 documented the resident did not consistently receive showers on the preferred days.Review of Resident #77's POC documentation from 2/17/26 to 3/17/26 revealed the resident received a shower on 3/17/26. The resident received one shower out of nine opportunities. -However, her care plan documented the resident preferred two showers a week and a bed bath once a week. There were four bed bath opportunities missed and a total of 13 missed bathing opportunities.The 2/17/26 CNA shower/bath documentation form documented the resident refused. No reason was provided. There was no nurse signature.The 3/6/26 CNA shower/bath documentation form documented the resident refused. The reason was the resident did not want one. The documentation was not signed by the nurse and signed by the CNA on 3/18/26 (during survey).The 3/13/26 CNA shower/bath documentation form documented the resident refused. No reason was documented. VI. Staff interviewsCNA #1 was interviewed on 3/17/26 at 11:00 a.m. CNA #1 said CNAs provided the showers for their residents. CNA #1 said there was a shower aide but the shower aide did not work everyday. CNA #1 said there was a shower schedule kept at the nurses' station. She said if a resident refused their shower they were asked to sign a form stating they refused. CNA #8 was interviewed on 3/19/26 at 12:49 p.m CNA #8 said if a resident refused their shower the CNA should be going back and offering at least three times. CNA #8 said if the resident continued to refuse the CNA would notify the nurse and the nurse would approach the resident and have the resident sign the refusal shower/bath documentation form. CNA #8 said if the resident refused a shower then a bed bath should be offered. CNA #7 was interviewed on 3/19/26 at 1:25 p.m. CNA #7 said the CNAs were responsible for providing showers to their residents. CNA #7 said if a resident refused the CNA would tell the nurse and the nurse would check with the resident and have the resident sign a refusal form. CNA #7 said if a resident asked to have a shower at a different time, the information was passed on to the next shift. CNA #7 said the staff tried to accommodate the residents' preferences. She said if the not applicable was marked on the POC under the shower/documentation it may be the shower was triggered for a day which was not a preferred day. The director of nursing (DON) was interviewed 3/19/27 at approximately 1:00 p.m. The DON said residents were typically scheduled for two showers a week. The DON said if a resident requested more than the facility attempted to accommodate the request. The DON said the CNAs were responsible for the showers on their shifts. The DON said if a resident refused the CNA was expected to make accommodations for the resident for example, a different time or offer a bed bath. The DON said the CNA was to check with the resident at least three times about bathing. The DON said if the resident continued to refuse the CNA notified the nurse and the nurse would also talk to the resident and have the resident sign the shower/bath documentation form. The DON said the shower/bath documentation form stated the reason for the refusal and both the CNA and nurse were to sign along with the resident. The DON said the not applicable on the task screen should not be marked. She said it may have been marked because a shower triggered on a nonscheduled shower day and the CNA marked not applicable. She said if not applicable was marked a shower was not provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to provide a clean, comfortable and homelike environment for resident rooms on two of four units. Specifically, the facility failed to provide clean linen hand towels and washcloths on a daily basis. Findings include:I. Facility policy and procedureThe Safe and Homelike Environment policy and procedure, reviewed January 2026, was provided by the nursing home administrator (NHA) on 3/19/26 at 1:13 p.m. It read in pertinent part, The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting. The facility will provide and maintain bed and bath linens that are clean and in good condition.II. ObservationsAn initial tour was conducted on 3/16/26 from 8:30 a.m. to 9:30 a.m. The following was observed:Resident rooms #306, #318, #406, #407, #410, #412 did not have linen towels or washcloths in the rooms.A tour was conducted on 3/17/26 from 8:00 to 8:15 a.m. and the following was observed:Resident rooms #306, #318, #406, #407, #410 and #412, did not have linen towels or washcloths in the rooms. There was one linen closet used for all the units. The linen closet was observed by two surveyors on 3/17/26 at 11:00 a.m. The linen closet contained two hand towels and 20 washcloths, 30 white bath towels.The linen closet was observed on 3/19/26 at 12:30 p.m. There were numerous linen towels and washcloths, bath towels and blue bath towels.III. Resident interviewsThe resident who resided in room [ROOM NUMBER] was interviewed on 3/17/26 at 8:35 a.m. She said she rarely had linen towels or washcloths. She said if she had the towels and washcloths she would be more likely to wash herself up. She said there were paper towels in her room, but she said the paper towels were not really for cleaning up. She said it would be nice to have the linen towels.The resident who resided in room [ROOM NUMBER] was interviewed on 3/17/26 at 3:30 p.m. She said she had to ask for clean towels and washcloths and most times she did not receive them. She said this was very frustrating for her to have to ask and still not receive them on a daily basis. The resident said she was independent and did not want to use paper towels to dry her hands or face. The resident who resided room [ROOM NUMBER] was interviewed on 3/18/26 at 11:00 a.m. during the resident council group meeting. She said she used paper towels because her dirty towels were not picked up and changed for clean towels so she had to use the same dirty towel to wash up. She would like to have clean towels. The resident who resided in room [ROOM NUMBER] was interviewed on 3/18/26 at 11:00 a.m. during the resident council group meeting. She said she had to ask for linen towels and washcloths and still did not receive them. She said she should not have to ask for clean linens. She said it was very frustrating to have to ask and not receive clean towels. The resident who resided in room [ROOM NUMBER] was interviewed 3/19/26 at 9:00 a.m. She said she was not offered linen washcloths or towels in the evening to wash her face or hands. The resident said she did not use her bathroom because she does not get out of bed. She said it would be nice to have the towels available in order to clean herself up. She said she liked to feel clean and washing her face and hands at night would help with that. IV. Staff interviewsCertified nurse aide (CNA) #1 was interviewed 3/17/26 at 11:00 a.m. CNA #1 said the clean linen closet was stocked by the laundry department daily. She said hand towels and washcloths were passed out daily. She said this was usually done by the night shift but it was everybody's responsibility to make sure the residents had towels. CNA #2 was interviewed on 3/18/26 at 12:00 p.m. She said hand towels and washcloths should be passed out to each room daily. She said the night shift usually stocks the rooms but all shifts were responsible for providing clean towels to the rooms. CNA #2 said the resident assistants used to stock the rooms but that position had been cut. She said the CNAs were now responsible for the resident assistants responsibilities, which included stocking the linens in the rooms. CNA #9 was interviewed on 3/18/26 at 2:40 p.m. CNA #9 said the CNAs should be providing the linen towels. She said during her shift she will take the towels into the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rooms so residents can wash their hands and face and remove them the same evening. She said she did not stock them overnight and she was not aware of who passed them out during the day.The housekeeping supervisor was interviewed on 3/19/26 at 12:30 p.m. The housekeeping supervisor said the laundry department was responsible for stocking the clean linen closet. The housekeeping supervisor said there were no linens stored in the laundry room. She said she recently, during the survey, put several hand towels and washcloths in circulation from their supply inventory. She said she was told the linens were running low. The director of nursing (DON) was interviewed on 3/19/26 at approximately 1:00 p.m. The DON said towels were passed out by the CNAs. She said the night shift should be auditing if the residents' rooms have clean linens. The DON said every resident should have their own hand towel and washcloth and should not have to ask for towels and washcloths. She said dirty linen should be removed and replaced by clean linens daily and as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure that all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards for one of the two medication carts. Specifically, the facility failed to ensure there were no loose pills in the medication cart. Findings include:I. Facility policy and procedureThe Medication Storage policy, dated 3/18/26, was received from the director of nursing (DON) on 3/18/26 at 8:42 p.m. It revealed in pertinent part, Medication carts should be kept clean and organized. Dropped, loose, refused, or unused medications should not be placed in the red biohazard/sharps containers, in the trash, or put down the drain per (State) regulations or taped back into prescription cards. These medications should be placed in the drug buster. Medications and biologicals are stored properly, following the manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe, effective drug administration.II. ObservationsOn 3/17/26 at 11:15 a.m., the three hundred north medication cart was observed with licensed practical nurse (LPN) #2. The following was observed:There were 40 loose medications at the bottom of the medication cart drawer. LPN #2 was able to identify some of the medications, which included: fluoxetine (antidepressant), losartan (used to treat high blood pressure), methocarbamol (muscle relaxant), potassium chloride, and a multivitamin. III. Staff interviewsLPN #2 was interviewed on 3/17/26 at 11:40 a.m. LPN #2 said the risk of having a loose medication would be that the nurse could pick it up, and it could be the wrong medication. LPN #2 said giving the wrong medication would result in a medication error. LPN #2 said the nurses were responsible for cleaning the medication cart on their assigned shift. The DON was interviewed on 3/17/26 at 12:10 p.m. The DON said the charge nurse was responsible for cleaning the medication cart once a month. The DON said the nurse assigned to the medication cart was responsible for cleaning the cart on their shift. The DON said that the expectation was that the nurse should clean during the medication pass, and if a pill pops out into the drawer, they should retrieve it.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review and interviews, the facility failed to ensure meals were served according to the resident's preferences on three of four units.Specifically, the facility failed to provide menus to residents in order for the residents to choose their meals and honor food preferences. Findings include:I. Facility policy and procedureThe Dietary Services for Food Preferences policy and procedure, reviewed January 2026, was provided by the nursing home administrator (NHA) on 3/19/26 at 1:13 p.m. It read in pertinent part: Food preferences, allergies and intolerances should be noted on the dietary ticket, also note cultural, ethnic, and religious preferences resident requests. Record of these preferences, allergies and intolerances on the resident's tray card and note in care plan/Kardex (staff directive tool) or electronic medical record (EMR). Preferences to be updated as notified. It is important that these preferences, allergies, and intolerances be honored on the service line and that appropriate substitutions are made when there is a dislike. Nursing staff/designee is responsible for obtaining meal orders and noting meal orders on tray tickets. Nursing staff/designee should take care to follow food preferences, allergies and intolerances when assisting residents with filling out meal tickets.II. ObservationDuring a continuous observation of the service line on 3/16/26, beginning at 12:15 p.m. and ending at 1:15 p.m. the following was observed:-A resident's meal ticket indicated the resident disliked pasta, the resident was served the main meal which was a pasta dish.-A resident's meal ticket indicated the resident disliked salad,the resident was served a green salad.-A resident's meal ticket indicated the resident disliked lasagna, marinara and rose sauce, she was served the main meal of pasta in red sauce. III. Resident interviews and observationsResident #45 was interviewed on 3/16/26 at 9:30 a.m. Resident #45 said she did not see the menu and said you get what she get.you get. She said she was frustrated the system changed and nobody came around to take her order. She said and she was supposed to eat what was given to her. She said she would preferred to make her own choices. Resident #41 was interviewed on 3/16/26 at 10:00 a.m. Resident #41 said she never knew what she was going to receive for her meals. She said there used to be a resident assistant who took meal orders. She said now that the position was eliminated the certified nurse aides (CNA) were supposed to take orders. She said it did not happen consistently. She said she had dislikes and allergies such as pork, fish and thyme that continued to be served to her because she was given the regular menu. Resident #41 said she told the CNAs she did not like pork but it continued to be served consistently on her breakfast tray. She said if she was given the choice she would choose food that she liked and would eat. Resident #29 was interviewed on 3/16/26 at 10:40 a.m. Resident #29 said since the resident assistantRA position was gone, the CNAs did not come around daily to take orders. She said she will received the main menu item and a lot of the time it had items she would not chose so she did not eat it.Resident #29 was interviewed again on 3/17/26 at 3:30 p.m. Resident #29 said she did not eat her lunch from the previous day (the pasta with what looked like red sauce) because it looked too much like lasagna which she told the staff she did not like to eat. She said she would not have ordered the meal if she was given the option. Resident #41 was interviewed again on 3/19/26 at 9:00 a.m. Her breakfast meal was served during this time with pieces of pork sausage. She said she has told the CNAs, who pass the trays, she did not like pork items. She said however, she continued to receive pork items frequently. She said it has been frustrating not choosing her meals and she became upset especially if she was served a meal she would not have ordered. She said she would often send the tray back because it was not what she would have ordered. III. Resident group interviewSix residents (#6, #17, #24, #25, #48, #68) were identified as alert and oriented by facility and assessment were interviewed 3/18/26 at 11:00 a.m. Four of the six residents frequently attended the resident council meetings. The residents were in agreement since the resident assistant's position had been eliminated, the process of taking meal orders had not been consistent. Residents #6, #24, and #48 said they did not always know what they (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were going to be served for meals because they did not always choose. Resident #68 said he went to the nurses' station and got the menu himself to fill out in order to receive what he liked. He said the staff did not take his order. Resident #48 said she was allergic to many things and she was always served sandwiches. She said she was tired of the sandwiches and felt stuck with them because that was what was chosen for her. She would like to see the menu so she can choose for herself. Resident #24 said since there was no longer a resident assistant she did not know when she would choose her meals. The resident assistant came every day and now she could choose a couple of times a week. Resident #24 said the meal just came and she would not know what has been ordered for her. She said this was frustrating not to choose her meals. Resident #6 said he often received items on his tray that he did not like. He said he did not drink milk, but got it every morning. He said he told the CNAs when they delivered the tray but he continued to receive the milk. He said he did not fill out menus consistently since the resident assistant position was eliminated and CNAs did not consistently come and take meal orders. He said if he had the choice he would not choose milk every morning. IV. Record reviewThe resident council meeting minutes, dated 1/28/26, revealed the residents in attendance voiced concerns with the meal tickets. -The minutes did not specify what specific concerns the residents had with the meal tickets. The resident council meeting minutes, dated 2/25/26, revealed the residents were advised by the dietary manager (DM) the kitchen was looking into a better meal ticket system since the resident aides were no longer in the building. -However, there was no documentation indicating the facility provided follow up regarding the potential new system. The food council meeting minutes, dated 3/4/26, revealed the residents in attendance complained they were not always getting a choice of their meal. A dietary performance improvement plan (PIP), dated 3/1/26, was provided by the NHA on 3/19/26 at 1:38 p.m. The PIP read in pertinent part, The PIP identified residents' meal orders were not taken by the staff on a regular basis. The items to address were identified as educating residents who were capable of taking their own orders and turning in their tickets, identifying residents who regularly dined in the dining room and educating staff on residents who will need their meal orders taken. The correction action plan identified residents into four categories; residents who needed their meal orders taken, residents who were capable of taking their own orders and turning them in, residents who regularly received the main meal, and residents who dined in the dining room and were able to request an alternate.-The PIP did not address how residents were categorized.-The PIP did not address how residents who were categorized as regularly receiving the main meal would be able to choose their own meals. Resident #41 and Resident #45, who were categorized as regularly receiving the main meal, were two residents who said they did not get options for meals. The plan was to educate residents of the new change and ensure they were comfortable with the new process. For residents who were identified as capable of taking their own orders and turning the tickets in; the DM would provide the residents their meal tickets a week in advance. The residents were then responsible to turn in their tickets to a staff member the day before the meal was served. -The PIP did not address what meal was provided for the residents who were identified as responsible for their own order if their ticket was not turned in timely. For residents that were identified as dining in the dining room; they will be educated that their orders will no longer be taken and the resident would need to notify staff, when they arrive in the dining room, if they choose an alternate meal. The residents also need to notify staff if they will not be dining in the dining room and request either the main meal or an alternate. The dietary manager will also post a week at a glance menu at the nurses' station. -The PIP did not address how residents who dine in the dining room and have a cognitive impairment were given choices during meals because the resident was now responsible for notifying staff if they want the alternate meal when they arrive at the dining room. -The PIP did not address how the residents who were identified on the always regular menu and who did not dine in the dining room were provided with meal options. The dietary aide would ask specific residents for their meal preference the day before and determine whether they would like a room tray or will be eating in the dining room.The goal date for the action plan was (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/20/26. -However, observations and resident interviews during the survey revealed there were ongoing issues with the residents not being able to make their own choices regarding the foods they received at meals (see observations and interviews above).V. Staff interviewsCNA #2 was interviewed on 3/18/26 at 12:00 p.m. CNA #2 said the night shift should be taking the residents' orders for the next day. She said she was not sure how it worked on the night shift. She said since there were no longer resident aides the CNAs had to take over those duties and taking meal orders was one of the duties. The regional dietary resource was interviewed on 3/19/26 at 11:32 a.m. The regional dietary resource said the facility was going through a transition with taking orders. The regional dietary resource said a resident aide used to take the resident orders the day before. The regional dietary resource said there was no longer a resident aide and now the CNAs were supposed to be taking the menu orders the day before. The regional dietary resource said the staff member taking the order should provide a description of the meal, ask about alternative items and turn in the meal ticket. The regional dietary resource said if a resident told a CNA or another staff member of their dislikes this information should be communicated to the dietary staff in order to make changes to their meal ticket. The regional dietary resource said the dietitian met with the residents on admission then quarterly and as needed to review likes and dislikes. She said a PIP was initiated that identified and addressed meal order issues.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.Specifically, the facility failed to ensure the laundry area and three soiled utility rooms were free from multiple environmental concerns. Findings include:I. ObservationsOn 3/17/26 at 11:15 a.m., the soiled utility room (in the laundry area) and the laundry were observed with the laundry aid. The solid utility room had a deep, large area of multiple layers of floor linoleum tile, cut out with eight tiles missing. There was a pile of dirt and debris along the base tiles behind the entrance door. The sheetrock was torn along the walls. There were areas of torn sheet rock without texture or paint.The laundry aide said that the lint traps were cleaned every two hours. There was dust built up behind the dryer near the vent pipe. There was peeling sheetrock outside the dirty utility room along the wall. There were missing cover-base tiles, approximately three feet.There was torn linoleum on the floor near the stand-alone washer. There was a hole in the wall, approx three by three inches, on the wall with a stand-alone washer. There was chipped paint outside the dirty utility room. There was a missing transition strip with five chipped floor tiles.On 3/19/26 at 12:28 p.m. The above concerns remained. The three-by-three-inch hole had been repaired).On 3/19/26 at 12:37 p.m. the north soiled utility room was observed with the housekeeping supervisor.There was sheet rock damage above the hopper (basin used to collect waste). The room had three cracked floor tiles under the hopper and four cracked floor tiles under the bins.On 3/19/26 at 12:45 p.m., the south soiled utility room had a loose metal heater cover and nine missing wall tiles at the door. II. Staff interviewsThe housekeeping supervisor was interviewed on 3/19/26 at 3:45 p.m. She said she had not placed any work orders to have anything corrected before the survey. She said it was the responsibility of the staff to place a work order to get items fixed and/or replaced. The maintenance supervisor was interviewed on 3/19/26 at 4:10 p.m. he said that the flooring was ordered to be replaced, but would start in the more visible areas. He said he filled the hole in the laundry room, which was damaged. The maintenance supervisor said the above issues were a problem. He said it was a safety concern if a staff member tripped and fell.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain accurate medical records for advance directives on each resident for one (#29) of six residents reviewed out of 38 sample residents. Specially, the facility failed to ensure Resident #29's medical orders for scope of treatment (MOST) form corresponded with the computerized physician orders (CPO) for no cardiopulmonary resuscitation (CPR). Findings include:I. Facility policy and procedureThe Advanced Directive and Associated Documentation policy and procedure, reviewed [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 1:13 p.m. It read in pertinent part, It is the policy of this facility that a resident's choice about advance directives will be recognized and respected. Advance care planning will occur periodically (at least quarterly, annually and on the change of condition) to review the advance directive and/or preferences regarding treatment options with the resident or their representative to ensure that they are still the wishes of the resident. Such reviews will be made during the assessment process and recorded in the medical record. The resident may modify or cancel the advance directive decision at any time; changes or revocation of a directive must be submitted to the facility, in writing and immediate action must be taken to implement desired changes.II. Resident #29A. Resident statusResident #29, age less than 65, was admitted [DATE]. According to the [DATE] CPO, the diagnoses included multiple sclerosis (MS), gastro-esophageal reflux disease (GERD), bipolar disorder, muscle weakness and chronic pain. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. B. Record review and observationObservation on [DATE] during the initial tour 8:30 a.m. revealed a green dot next to Resident #29's door name tag.Observation on [DATE] at 3:15 p.m. revealed a green dot next to Resident #29's door name tag.Resident #29's MOST form located in the advance directive binder at the nurses' station and uploaded into the electronic medical record (EMR) revealed it was signed and dated [DATE] by the resident. It was signed and dated by the nurse practitioner (NP) on [DATE]. The MOST form indicated, no CPR with selective treatment which included intravenous (IV) antibiotics and fluids, do not intubate and to avoid intensive care. The [DATE] CPO revealed a physician's order that Resident #29's code status was to receive CPR, ordered [DATE].-The CPO did not correspond with the directive on the MOST form, after the resident made a change in [DATE], six months prior. The care plan review document, dated [DATE], revealed the care conference was attended by Resident #29, her emergency contact, social services, a licensed practical nurse (LPN) and the medical provider. The care plan review document indicated Resident #29's advance directive was CPR.-However, Resident #29's MOST form was updated in [DATE], three months prior, to indicate she did not want CPR. C. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on [DATE] at approximately 1:30 p.m. She said in case of an emergency she looked at a resident's EMR for the resident's code status. LPN #2 said the hard copy of the advanced directive was kept in a binder located at the nurses' station labeled advanced directive binder. She said if the resident was transferred to the hospital she would make a copy of the advance directive located in the binder. LPN #2 said there was also a green dot on the resident's door name tag, located outside the room, to indicate if the resident was a full code. The director of nursing (DON) and regional nurse consultant were interviewed on [DATE] at 3:02 p.m. The DON said there was an advanced directive binder at the nurses' station where the MOST forms were kept. The DON said the advance directive forms should match the resident's CPO. The DON said a change in a resident's advanced directive was discussed during the interdisciplinary team's (IDT) morning meeting or during change of shift report. The DON said the expectation was that the nurse who received the new order would discontinue the old order and initiate the new order in the CPO. The DON said the new form was scanned into the resident's EMR and added to the advanced directive (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	binder. The DON said the advance directives were reviewed at least quarterly during the care conferences. The DON said monthly audits were completed to compare the advanced directive binder to the CPO. The DON confirmed the green dots on the door name tags indicated that resident was a full code. The DON was interviewed again on [DATE] at 8:15 a.m. She said she spoke with Resident #29 on [DATE] during the survey who confirmed her wish for no CPR. The DON said the order was changed in the EMR.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review and interviews, the facility failed to properly store, prepare, distribute and serve food in accordance with professional standards for food service safety.Specifically, the facility failed to ensure the facility's one dishwashing room was maintained and repaired in a timely manner. Findings include:I. Professional referenceAccording to the Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 3/26/26. The regulations revealed in pertinent part, physical facilities should be maintained in good repair. Physical facilities should be cleaned as often as necessary to keep them clean. Intake and exhaust air ducts should be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. (Chapter 6)II. Facility policy and procedureThe Safe and Homelike Environment policy, revised 10/1/24, was provided by the nursing home administrator (NHA) on 3/19/26 at 4:45 p.m. The policy revealed the facility would provide housekeeping and maintenance services as necessary to maintain a sanitary, orderly and comfortable environment. The staff were to report any unresolved environmental concerns to the NHA. III. Environmental tourAn environmental tour of the facility's dish washing room was conducted on 3/17/26 at 7:30 a.m. There was chipped paint on the wall at the entrance to the room. The air vent exterior metal cover contained black debris and lint. One wall was not completely painted. The exhaust vent over the dish washing machine had areas of black debris. The ceiling pipes were dusty. There was torn floor laminate (composite material) approximately four feet in length at the juncture of the floor and wall, under the sink near the dish washing machine. The baseboard was separated (pulled away from the wall) almost the entire length of the wall under the sink. The left corner of the room at the entrance door was dirty (uncleaned surface) and had various amounts of debris scattered on the floor. IV. Staff observations and interviewsThe NHA conducted an environmental review of the dish washing room with the surveyor on 3/19/26 at 7:21 a.m. The NHA observed the above listed concerns. The NHA said he was not aware of these issues. The registered dietitian (RD) conducted an environmental review of the dish washing room with the surveyor on 3/19/26 at 7:35 a.m. The RD observed the above listed concerns. The RD said she had not put in any work orders for these concerns.