

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Hallmark Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3701 W Radcliff Ave Denver, CO 80236	
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 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 all drugs and biologicals were properly stored and labeled in accordance with accepted professional standards in two of six medication carts. Specifically, the facility failed:-Ensure insulin Lantus (insulin) and NovoLog (insulin) pens were labeled with open dates;-Ensure expired medications were removed from the medication cart;-Ensure injectable medications were not stored with a needle attached; and-Ensure medications were stored by administration route. Findings include:I. Professional referencesAccording to the Lantus (insulin glargine) 100 Units/ml manufacturer guidelines retrieved on 6/3/26 from https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf Always check the expiration date of the pen. After 28 days, throw your opened Lantus pen away - even if it still has insulin in it.According to the NovoLog FlexPen (insulin aspart) manufacturer guidelines retrieved on 6/3/26 from https://www.novolog.com/taking-novolog.html Dispose after 28 days, even if there is insulin left in the pen.According to the Ozempic semaglutide (a semaglutide primarily used to treat adults with type 2 diabetes by lowering blood sugar and reducing the risk of cardiovascular events) manufacturer guidelines retrieved on 6/3/26 from https://www.ozempic.com/ozempic-pen/dosing.html The Ozempic pen you are using should be disposed of after 56 days, even if it still has Ozempic left in it. Always remove and safely discard the needle after each injection and store the Ozempic pen without an injection needle attached. Always use a new needle for each injection. Keep the pen cap on when not in use.II. Facility policy and procedureThe Delivery and Storage of Medications and Supplies policy, dated 1/15/04, was provided by the nursing home administrator (NHA) on 6/3/26 at 4:08 p.m. It read in pertinent part, Staff receiving the delivery of medications, solutions, and supplies from the pharmacy must ensure that all products are promptly and properly checked for appropriate storage at the facility per pharmacy instructions. Staff receiving the delivery of medications, solutions, and supplies from the pharmacy must ensure that all products are promptly and properly checked for appropriate storage at the facility per pharmacy instructions.The Insulin Pen Administration policy, revised 5/27/25, was provided by the NHA on 6/3/26 at 4:08 p.m. It read in pertinent part, The facility will ensure residents with orders for insulin administration through the use of a pen delivery device is performed in accordance with current standards or practice and manufacturer's guidance. III. Observations and interviewsOn 5/28/26 at 2:25 p.m. the North medication cart on the East side of the facility was observed with registered nurse (RN) #1. The following items were found:A Lantus (insulin glargine) pen was found with no open date labeled on it. There was insulin medication present in the pen. RN #1 said she was going to do an investigation and call her colleague who worked the shift before her. RN #1 said she (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would call him and ask if he opened the insulin pen. RN #1 said she would keep the pen in the cart until the investigation was completed. RN #1 said if she needed to discard the pen, she would put it in the sharps container located on the cart. An Ozempic medication pen was found in the drawer of the medication cart (med cart). There was no open date on the pen and the Ozempic medication cap was not on the pen. Instead, there was a needle attached to the tip of the Ozempic pen and there was a loose white cap covering the needle. RN #1 said the resident received Ozempic once a week. RN #1 said she gave the resident a dose around 12:00 lunch time. RN #1 said she gave the dose and was going to put the pen back in the refrigerator, but did not know where the medication cap was. RN #1 said she believed the Ozempic pen had the open date written on the cap. RN #1 said if she found the Ozempic cap with the open date on it, she would put the pen back in the refrigerator. RN #1 said the needle that was attached to the pen was not used. RN #1 said she knew it was not used because she put it on the pen so that she could store the pen in the medication cart until she found the cap. -The needle was connected to the Ozempic pen during storage in the medication cart (see professional reference above). A second Lantus (insulin glargine) pen was found with no open date labeled on it. RN #1 said it was important to have open dates on insulin medications because insulin was only good for 28 days after opening the medication. RN #1 said if the insulin pen was expired, the facility would replace it and order another insulin pen from the pharmacy. RN #1 said going forward, she would make it a habit to check her insulin pens on a daily basis. On 5/28/26 at 3:10 p.m. the South medication cart on the East side of the building was checked with RN #2. The following items were found: A Lantus (insulin glargine) SoloStar pen was found in the med cart with no open date labeled on it. RN #2 was interviewed on 5/28/26 at 3:15 p.m. RN #2 said she could not find an open date on the Lantus pen. A NovoLog flex pen containing insulin aspart was found in the medication cart with 4/6/26 written on it in black. - The insulin pen was 24 days over the pharmacy recommendation date to dispose of it (see professional reference above) RN #2 was interviewed on 5/28/26 at 3:15 p.m. RN #2 said she was not sure what the date written in black meant. RN #2 said she was not sure if the written date identified the open or expiration date of the medication. RN #2 said the resident received the medication once daily. RN #2 said if the written date was the open date, the medication was expired because it had been more than 30 days since it was opened. RN #2 said it was important to have an open date on the pen, because some medications were only active for a certain amount of time. RN #2 said this was based on the manufacturer guidelines. RN #2 said she would re-order and waste the medication. RN #2 said she would waste the medication by bringing it to the medication room and placing it with other discontinued medications. RN #2 said the unit manager would then take the medications to be disposed of properly. In one drawer of the cart, not separated by dividers, there was an opened bottle of Pro T Gold (a medical-grade, ready-to-drink liquid collagen protein supplement) with residue on it next to Salonpas patches (an over-the-counter topical medication used to temporarily relieve aches and pains in muscles and joints) and a box of opened lancets (tiny, sterile medical needles used to prick the skin and draw small drops of blood often used to take blood sugars). RN #2 was interviewed on 5/28/26 at 3:15 p.m. RN #2 said she was not sure how the medications were supposed to be stored or if they were supposed to be stored by route. IV. Additional staff interviews The director of nursing (DON) was interviewed on 5/28/26 at 4:50 p.m. The DON said the nurse who opened the insulin or Ozempic pen was responsible for labeling the pen with the open date. The DON said it was important to have open dates on insulin pens, because insulin pens expired after 28 days. The DON said the proper way to give Ozempic was to put a needle on the pen, properly administer the medication, put the needle in the sharps container, and then put the lid back on the pen and properly store it. The DON said if an Ozempic pen was in the medication cart drawer with a needle attached to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development of transmission of disease and infection on two of two units. Specifically, the facility failed to: -Ensure housekeeping staff followed proper cleaning procedures for cleaning and disinfecting resident rooms and high-frequently touched areas (door handles, call lights, bed remote); -Ensure mop pads were changed after mopping the bathroom; and, -Ensure areas were cleaned from cleanest to dirtiest. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 6/4/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. II. Facility policy and procedure The Daily Room Cleaning policy, revised 4/1/26, was provided by the nursing home administrator (NHA) on 6/3/26 at 4:08 p.m. The policy read in pertinent part, The cleanliness of each resident's room is maintained on a daily basis by the housekeeping staff to provide a fresh, clean and sanitary environment and reduce the potential for nosocomial infections. Clean high-touch surfaces at least daily including handwashing sinks. Clean and disinfect high touch/frequently contaminated surfaces (sinks, faucets, handles, door handles, and clean toilet seat last) at least daily. III. Observations On 6/1/26 at 9:43 a.m. housekeeper (HK) #1 was cleaning room [ROOM NUMBER], a private room. The following was observed: HK #1 donned (put on) gloves and used a blue fluid labeled Oxivir (a disinfectant spray) and sprayed the bathroom sink, counter top, and toilet. She used the toilet brush to clean the inside of the toilet and tapped the toilet brush on the outer rim of the toilet. Wearing the same gloves, HK #1 went to the far side of the room and used the Oxivir spray and sprayed the window sill and a table. -HK #1 did not change her soiled gloves after cleaning the toilet and went to the far side of the room to spray the window sill and table. HK #1 doffed her gloves, performed hand hygiene and donned on another pair of gloves. She then returned to the bathroom and wiped the sink starting at the bowl of the sink working her way up to the handles and faucet. She then wiped the counter using the same rag. HK #1 then wiped the bathroom hand rails which were visibly dry with a dry rag. -HK #1 failed to clean the bathroom sink from the top to bottom or cleanest area to the dirtiest areas. She failed to use a separate rag to clean the counter top. HK #1 also failed to apply a disinfectant spray to the hand rails or her rag before wiping them down. HK #1 used a dry broom to sweep the room from the far side of the room to the entry way. She went back to the room and used a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dry rag to wipe the call light and bed remote. The call light and bed remote were visibly dry prior to HK #1 wiping them down with a dry rag. -HK #1 failed to apply any disinfectant spray on the rag or on the call light or bed remote prior to wiping them down with a dry rag. HK #1 applied a wet mop pad on the mop stick and proceeded to the far end of the room. HK#1 worked her way towards the bathroom mopping the room, she entered the bathroom to mop and came out of the bathroom continued mopping to the entry way and finished in the closet. She used the same mop pad for all areas. -HK #1 failed to change the mop pad for different areas of the room/bathroom. HK #1 said she was done cleaning the residents room at 10:17 a.m. -HK #1 failed to clean the light switches, television remote, room and bathroom door knobs during the observation. On 6/2/26 at 10:29 a.m. HK #2 was cleaning room [ROOM NUMBER], a double occupancy room. The following was observed:HK #2 was observed to clean the bathroom sink starting from the bowl, to the faucet, then the handles and lastly the counter top with the same rag. -HK #2 failed to clean the bathroom sink from the cleanest areas to the dirtiest area. She did not use a separate rag to clean the counter top.HK #2 used a dry broom to sweep the entire room starting from the far end of the room to the bathroom then to the entry. She then used a wet mop pad to mop the far side of the room, side B, continued to side A, then to the bathroom and finished at the entry way without changing the mop pad.-HK #2 failed to change the mop pad when she finished mopping side B, she did not change the mop pad when she finished mopping side A, and did not use a separate mop pad when she mopped the bathroom and then continued to mop the entry way. IV. Staff interviewsHK #2 was interviewed on 6/1/26 at 2:00 p.m. HK #2 said she cleaned the rooms everyday. HK #2 said cleaning of the rooms included spraying down and cleaning the bathroom, sink area and personal spaces such as the over-the-bed table, if the resident was agreeable. She said she cleaned the sink from the bowl up to the faucet. HK #2 said she used one mop pad to mop the entire room. She said it was important to clean areas like the light switches, call light, remotes because they were touched a lot. HK #2 said she was supposed to use one mop pad for the whole room. HK #1 was interviewed on 6/1/26 at 2:25 p.m. HK #2 said she cleaned the rooms everyday. She said she cleaned the bathrooms and the common space in the rooms with a cleaner. She said she was supposed to use the cleaning solution when cleaning the areas that were touched a lot such as the light switches, door knobs, call light and bed remote. HK #1 said she was supposed to use one mop pad for the whole room. The housekeeper director was interviewed on 6/1/26 at 4:27 p.m. The housekeeping director said she expected the housekeeping staff to spray down the room such as the bathroom, high-touch areas and personal areas such as the tables with their cleaning solution. She said they use Oxivir and it has a one minute dwell time. She said the housekeepers should start on the B side of the room and work their way out of the room. The housekeeping director said if the cleaning solution dried before the housekeeper was able to wipe the area the housekeeper should either respray the area or their rag before cleaning the area. The housekeeping director said an area should not be wiped down with a dry rag because the area would not get the maximum cleaning and disinfectant. The housekeeping director said sinks should be washed from the top down to the bowl and the counter top should be wiped down with a separate rag. The housekeeping director said this was done so there was no cross-contamination. The housekeeping director said high-touch areas should be cleaned daily, which included light switches, call lights, bed remotes, television remotes, bedside tables and doorknobs. She said these were important to clean properly for infection control. The housekeeping director said the housekeepers should sweep the whole room with a dry broom, including the bathroom prior to mopping the floor. She said the housekeepers then would place the wet mop pad on and mop the whole room starting from the side B side and working their way to the bathroom, the bathroom should be the last floor mopped. The housekeeping director said it would be (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the discretion of the housekeeper if the mop pad was changed before each section depending if the floor was soiled. The housekeeping director said this included the bathroom. She said it would be more sanitary to use one mop pad to mop the bathroom and change the mop pad to continue with the room. The infection preventionist and the director of nursing (DON) were interviewed together on 6/2/26 at 9:00 a.m. The infection preventionist said high-touch areas included hand rails, door handles, faucets and the DON added call lights, television remote and the bed control. Both agreed these items should be cleaned daily with a chemical disinfectant cleaner in order to prevent the spread of an infection. The infection preventionist and the DON said the most effective way to clean a room was from cleanest to the dirtiest part of the room and a sink should be cleaned from the top down. The infection preventionist said at least three mop pads should be used to clean a double occupancy room and at least two mop pads for a private room. They said the bathroom should have a separate mop pad. They said using the same mop pad increases the chances of potential infections.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide reasonable accommodation necessary to accommodate mobility and accessibility in the residents' environment for two (#21 and #50) of three residents reviewed out of 39 sample residents. Specifically, the facility failed to ensure Resident #21 and Resident #50's call lights were within reach when the residents were in their room. Findings include: I. Facility policy and procedure The Resident Call System policy and procedure, reviewed on 12/23/25, was received from the nursing home administrator (NHA) on 6/3/26 at 4:08 p.m. It read in pertinent part, The nurses's stations in the facility will be equipped to receive resident calls with the communication system through audible or visual signals, from resident rooms, toilets, and bathing facilities. All portions of the system will be maintained and function accordingly. The facility will maintain procedures and an alternate communication system in the event the system becomes inoperable. The call lights should be positioned within reach of the resident. Return demonstration may be used when educating the resident about call light use. If the resident is unable to demonstrate appropriate call light use, the nurse must be notified to determine an adequate alternative. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room. The call system must be accessible to the resident at each toilet and bath or shower facility, and would be accessible to a resident lying on the floor in this area. II. Resident #21 A. Resident status Resident #21, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included dementia, complete transverse atypical femoral fracture of the left leg (a stress fracture to the thigh bone). The 5/12/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. The resident was dependent on staff for most activities of daily living (ADL). B. Resident interview and observations Resident #21 was interviewed on 5/27/26 at 2:30 p.m. Resident #21 said she was not sure where her call light was. She said she could not find it. She said she needed assistance to go to the bathroom. She said she was not sure how to call for the nurse without the call light. Resident #21 was interviewed a second time on 6/1/26 at 8:39 a.m. She said she needed to use the toilet. She said she did not know how to call for assistance. She said she did not know where her call light was. During the interview the resident was feeling around the bed when asked about the location of the call light. The resident was unable to find the call light within her reach. She said it happened to her all the time that she could not find her call light. She said she could yell for assistance but her voice was loud enough for the staff to hear. On 5/27/26 at 2:30 p.m. Resident #21 was sitting in her wheelchair by her bed. Both call lights were on the bed approximately three to four feet away from her. The call light was out of reach for Resident #21. Resident #21 was alone in her room. On 6/1/26 at 8:30 a.m. Resident #21 was sitting in her wheelchair by her bed. One of the call lights was on the headboard and the other call light was on the bed. Both call lights were out of reach. Resident #21 was alone in her room. At 12:32 p.m. Resident #21 was sitting in her wheelchair eating. One of the call lights was on the head of the bed and the other call light was on the bed. Both call lights were out of reach for Resident #21. On 6/2/26 approximately at 3:00 p.m. Resident #21 was lying in her bed. Both call lights were clipped on the headboard. The headboard was not in reach of Resident #21. C. Record review The ADL care plan, revised on 5/8/26, revealed Resident #21 had self-care performance deficit due to being legally blind, a recent hip fracture, and impaired mobility. The care plan documented Resident #21 had two pancake call lights. Pertinent interventions included placing one of the call lights at the (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's hip and the one clipped to the resident's sheet. The care plan revealed that she was at risk for falls. D. Staff interviewsCertified nurse aid (CNA) #2 was interviewed on 6/2/26 at 4:22 p.m. CNA #2 said Resident #21 needed assistance from staff to get to the bathroom. She said Resident #21 used her call light if she needed assistance. CNA #2 said she clipped one call light onto Resident #21's clothes if she was in her wheelchair. She said the other call light should be clipped to the sheet. She said the call light should always be available for Resident #21. She said if the call light was not clipped on Resident #21's clothes, Resident #21 could not find it because she was blind. She said the Kardex (document the staff used for identifying resident care needs) indicated if a resident was not able to use the call light for any reason. Registered Nurse #4 (RN) was interviewed on 6/2/26 at 4:36 p.m. RN #4 said Resident #21 rarely used her call light due to her cognitive impairment. RN #4 said Resident #21 was blind. RN #4 said Resident #21 was aware of her needs. She said the staff checked on Resident #21 a couple times an hour.RN #4 said the care plan called for one pancake light to be placed at the resident's hip and one pancake light to be clipped to the resident's sheet when Resident #21 was in her room. She said the call lights should be within reach for Resident #21. The director of nursing (DON) was interviewed on 6/2/25 at 5.45 p.m. The DON said the call light was there for Resident #21 to use for assistance even though Resident #21 might not understand how to use the call light. The DON said Resident #21 had two pancake lights in her room. The DON said she expected frequent rounding from her staff. III. Resident #50A. Resident statusResident #50, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO diagnoses included nontraumatic acute subdural hemorrhage (a rare, life-threatening condition where blood rapidly accumulates between the brain and the skull without a head injury), parkinsonism (an umbrella term for a group of neurological disorders that cause motor symptoms similar to those of Parkinson's disease), Alzheimer's disease, muscle weakness, and repeated falls. The 3/16/26 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 12 out of 15. The resident required substantial to maximal assistance for most ADL.B. Resident interview and observationsResident #50 was interviewed on 5/27/26 at 2:38 p.m. Resident #50 said the staff hung the call light on the wall with a hook, which was too far for him to reach if he was in bed or in his wheelchair. He said he repeatedly asked staff not to hang it on the wall but the staff kept hanging it there. Resident #50 was interviewed again on 5/28/26 at 9:20 a.m. He said the staff either put the call light on a plastic hook on the wall, which was farther away from his hands or on its wire as the wire comes out of the wall. He said he could not reach either location. Resident #50 said that the staff clipped the call button on the wire the night before. He said the call lights should be laying on his bed if he was in his wheelchair. He said he mentioned it to the CNA's several times, but the staff kept ignoring him. He said he was not able to call for help if the call light was on the wall. He said he was not able to yell for help because his voice was too weak for the staff to hear. On 5/28/26 at 8:30 a.m. Resident #50's call light was clipped on the wall. The call light was clipped back on its wire near to the power outlet. The bed was alongside the wall and it was blocking Resident #50 to get to the call light. Resident #50 was sitting in his wheelchair near the bed. On 6/2/26 at 3:28 p.m. Resident #50's call light was hanging from a plastic hook on the wall. The bed was alongside the wall and it was blocking Resident #50 to get to the call light. Resident #50 was sitting in his wheelchair near the bed. C. Record reviewThe ADL care plan, revised 10/8/25, revealed Resident #50 had self-care performance deficit due to Alzheimer's, Parkinson's disease's, and subdural hemorrhage. Pertinent interventions included encouraging him to use the call light for assistance and having call light in reach. Resident #50 was identified to be at risk for falls. D. Staff interviewsCNA #1 was interviewed on 6/2/26 at 3:33 p.m. She said she came into Resident #50's room to change the bed a few minutes (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Hallmark Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3701 W Radcliff Ave Denver, CO 80236	
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ago and found the call lights hanging on the wall. RN #3 was interviewed on 6/2/26 at 3:30 p.m. She said that the staff should put the call light on the bed so Resident #50 would be able to reach it. She said Resident #50 had a tendency to lean over while in his wheelchair and that put him at risk for a fall. She said it was easier for Resident #50 to reach the call light if it was on his bed. She said it was important to leave the call lights on the bed to prevent future falls. The DON was interviewed on 6/2/26 approximately at 4:30 p.m. She said the call light should be available for Resident #50. She said Resident #50 was mobile in his wheelchair in his room and the call light should be on the bed for him to reach whenever he needed. She said Resident #50 would not be able to reach the call light if it was on the wall.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide the appropriate services to maintain ability to carry out ADLs for one (#6) of two residents out of 39 sample residents. Specifically, the facility failed to provide Resident #6 with nursing restorative therapy as recommended by physical therapy. Findings include: I. Facility policy and procedure The Restorative Nursing policy, reviewed 9/18/25, was provided by the nursing home administrator (NHA) on 6/3/26 at 4:08 p.m. It read in pertinent part, to promote the resident's optimum function, a restorative program may be developed by proactively identifying, care planning and monitoring of a resident's assessments and indicators. Restorative programs may be initiated by nursing and/or therapy. Refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial function. Measurable objectives and interventions must be documented in the care plan and in the medical record. Evidence of periodic evaluation by the licensed nurse must be present in the patient's medical record. II. Resident #6A. Resident status Resident #6, age [AGE], was admitted [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included restless legs syndrome, muscle weakness, abnormalities of gait and mobility, and history of falling. The 3/11/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of 10 out of 15. He was dependent on staff for toileting, lower body dressing and transfers. B. Resident and resident representative interview Resident #6 and Resident #6's representative were interviewed together on 5/27/26 at 2:20 p.m. Resident #6 said he was admitted to the facility for therapy, but had not received any recently. Resident #6's representative said he had therapy when he was first admitted to the facility and was discharged from physical therapy. The representative said he was supposed to continue with a nursing restorative therapy program. She said Resident #6 had not been receiving nursing restorative therapy consistently. She said she was told the restorative aide had been out of the building, which was causing the resident to not get the nursing restorative therapy. She said she had not been told when Resident #6 would resume consistent restorative therapy. Resident #6 and Resident #6's representative were interviewed together again on 6/2/26 at 1:30 p.m. Resident #6's representative said the resident had become weaker since the end of physical therapy. She said she had seen an overall decline and felt not having the nursing restorative therapy had contributed to his decline. Resident #6 said he felt his legs were weaker and has had an overall decline in strength. C. Record review A review of Resident #6's physical therapy Discharge summary, dated [DATE], revealed the physical therapist recommended Resident #6 be placed on a nursing restorative therapy program for pedaling of upper extremity and lower extremity recumbent bike with both feet strapped in for 10 minutes with monitoring of oxygen saturations. The functional goal care plan, dated 4/1/26, documented Resident #6 had limited physical mobility related to weakness. Pertinent interventions included nursing rehabilitation/restorative recumbent cross-trainer with set-up assist for 10 minutes on Mondays, Wednesdays and Saturdays. A review of the April 2026 documentation for nursing rehabilitation/restorative program revealed the recumbent cross-trainer with set-up assist for 10 minutes Monday, Tuesday and Wednesday was completed seven times out of 13 opportunities. A review of the nursing restorative therapy program evaluation, dated 4/30/26, revealed Resident #6 had been riding the recumbent cross-trainer and had been participating without difficulty. The (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation documented Resident #6's strength was improving. -Review of Resident #6's electronic medical record (EMR) did not reveal documentation of a May 2026 nursing restorative therapy program evaluation for May 2026. A review of the May 2026 documentation for nursing rehabilitation/restorative revealed the recumbent cross-trainer with set-up assist 10 minutes Monday, Tuesday and Wednesday was completed two times out of 13 opportunities. D. Staff interviews The unit care coordinator, who oversaw the nursing restorative therapy program, was interviewed 6/1/26 at 3:30 p.m. The unit care coordinator said she had two restorative therapy certified nurse aides (CNA). She said the two CNAs were able to follow through with the nursing restorative therapy program set up by the physical or occupational therapists. She said the full-time CNA had been out of the building for an extended period of time and the part-time CNA was often pulled to the floor to work as a unit CNA. The unit care coordinator said both of the CNAs could be pulled to work the unit. She said there was not a back up if the restorative CNAs were not available to provide the nursing restorative therapy. The physical therapist (PT) was interviewed on 6/1/26 at 3:48 p.m. The PT said the therapists set up a nursing restorative therapy program for the restorative CNA to follow in order to prevent decline or function the resident may have gained during therapy. The PT said a physical or occupational therapist would write up a nursing restorative therapy program and the therapist would train the restorative CNA on the nursing restorative therapy program. The PT said a resident can decline quicker if there was a nursing restorative therapy program set up and it was not being followed consistently. The director of nursing (DON) was interviewed on 6/2/26 at approximately 1:30 p.m. The DON said when a resident was no longer on skilled therapy the therapist would make a nursing restorative therapy recommendation for the resident and write out an appropriate program. She said the nursing restorative therapy program was to maintain and/or increase a resident's physical abilities. She said it was important to follow through with the therapist's recommendation to maintain the quality measures the resident achieved in therapy so the resident was functioning at their best capacity. The DON said there were three CNAs trained for the nursing restorative therapy program. She said one CNA was on an extended leave, one CNA was on vacation and one CNA was part-time. She said the part-time CNA also covers the floor. She said there was not a back up plan if the restorative CNAs were not available to provide the nursing restorative therapy.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, record review and interviews, the facility failed to maintain effective pest control program for one (#50) of five residents reviewed out of 39 sample residents. Specifically, the facility failed to maintain pest free environment in Resident #50's room. Findings include: I. Facility policy and procedure The Pest Control policy and procedure, reviewed on 7/9/25, was received from the nursing home administrator (NHA) on 6/3/26 at 4:08 p.m. It read in pertinent part, The facility will maintain an effective pest control program that provides frequent treatment of the environment for pests so that the facility is free of pests and rodents. Effective pest control program- is defined as measures to eradicate and contain common household pests (bed bugs, lice, roaches, ants, mosquitoes, flies, mice, and rats). The facility's staff will do monitoring of the environment. Pest control problems will be reported to the Director of Maintenance promptly. II. Observations and interviews Resident #50 was interviewed on /27/26 at 1:51 p.m. He said he had seen ants in his room several times. He said the ants crawled on him at night when he was in his bed. He said he had complained about the ants to the staff several times, but nothing had happened since. He said he continued seeing the ants in this room. On 5/27/26 at 2:00 p.m. three ants were observed crawling alongside the baseboard in Resident #50's room at the foot of the bed on the floor. On 5/28/26 at 8:40 a.m. five ants were observed crawling in Resident #50's room. One ant was crawling alongside the baseboard behind the bed. Two ants were observed crawling underneath the bedside table. Two ants were observed crawling on the other side of the room, under Resident #50's desk. Food crumbs were observed on the floor around the bed, around Resident #50 who was sitting in his wheelchair, and under his desk. There were no ant traps observed in his room. On 6/1/26 at 8:46 a.m. three ants were observed crawling along the baseboard behind Resident #50's bed. There were approximately 10 to 15 ants by the trashcan eating on a crumb. Resident #50 was attempting to crush them with his reacher (adaptive device). He was leaning over in his wheelchair and raised his voice. III. Record review The nursing home administrator (NHA) provided an email on 6/2/26 at 10:29 a.m. The email read in pertinent part, the pest control company came out today (6/2/26 - during the survey) and sprayed 211 (pest control spray) The email said the facility would always immediately address the concern as it was found and the facility got the pest control company to come to the facility as soon as possible. The email said the facility had noticed several food particles in the resident's room, so they were going to complete a deep clean of the resident's room. The email said the facility had had no concerns regarding pests through grievance forms or resident council. The email contained a receipt from the pest control company that revealed Resident #50's room was treated with Alpine WSG insecticide and Sumari Ant gel, which both target ants. The review of the March 2026, April 2026, and May 2026 pest control company service receipts revealed the pest control company applied Alpine WSG and Boracin for cockroaches. The documentation revealed both insecticides were effective on ants as well. The documentation indicated the pest control company applied the insecticides to the exterior and interior of the facility such as kitchen, dining room, locker room, breakroom, and laundry, but has not treated residents's rooms. V. Staff interviews Housekeeper #1 (HK) was interviewed on 6/1/26 at 12:41p.m. She said Resident #50 complained about the ants in his room approximately two weeks ago. She said she had not seen ants in his room until last week. She said she reported the aunts to the maintenance department last Monday (5/25/26). She said the room was treated for ants today for the first time (during survey). The director of housekeeping was interviewed on 6/2/26 at 9:05 a.m. She said she was not sure who cleaned up the ants by the trashcan on 6/1/25. She said she saw ants on that day when she started moving things around the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. She said she moved a chair from the corner of the room and found more food crumbs and ants. HK #1 was interviewed again on 6/2/26 at 1:39 p.m. She said she deep cleaned Resident #50's room and found more breadcrumbs on the floor and sugar packets in different drawers in his room. The maintenance director was interviewed on 6/1/26 12:49 p.m. He said they spot-treated for ants if a report came in and also used the pest control company for pest control. He said if staff reported pests, he would decide whether an in-house treatment was adequate treatment. He said if the in-house spray treatment was not enough to treat the pests problem, he would call the pest control company right away. He said he had never been alerted about ants in Resident #50's room until during the survey. He said he was told that the ants were seen around the trashcan. He said he treated the area, but did not see ants. The nursing home administrator was interviewed on NHA 6/1/26 at 1:26 p.m. He said today was the first time he was alerted about ants in Resident #50's room. He said there were no previous ant issues reported for that room.		