

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: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#60) of three residents reviewed for abuse were kept free from abuse out of 34 sample residents. Specifically, the facility failed to protect Resident #60 from sexual abuse by Resident #48. Findings include: I. Facility policy and procedure The Abuse Prevention policy and procedure, revised 7/18/23, was received from the nursing home administrator (NHA) on 7/27/26 at 11:34 a.m. It revealed in pertinent part, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. Establish a safe environment that supports, to the extent possible, a residents consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which may lead to conflict or neglect, such as: verbally aggressive behavior; physically aggressive behavior; sexually aggressive behavior; taking touching, or rummaging through other's property; and wandering into others room/space. II. Incident of sexual abuse by Resident #48 towards Resident #60 on 9/5/25A. Facility investigation On 9/5/26 at approximately 3:15 p.m. Resident #60 reported to the nurse on the 200 hall that Resident #48 came up from behind and hugged her. Resident #60 said Resident #48 told her You have a nice breast and then proceeded to reach down and touch one of her breasts. Resident #60 told Resident #48 that his actions were not okay with her and Resident #48 left. The facility placed the Resident #48 on one-to-one monitoring with a staff member to ensure the safety of other residents. Resident #60 was assessed by a registered nurse (RN) and no injuries were noted. Facility staff conducted interviews with both residents. Resident #48 verbalized to facility staff that he did speak to Resident #60 and touched her breast. The facility conducted interviews with five other residents and family members. No issues were identified from the interviews. The facility substantiated the allegation based on both parties being alert and oriented. Resident #48 (assailant) did have a history of making inappropriate comments towards female staff along with wandering into other residents' rooms or staff only areas within the building. Along with resident interviews, it was determined Resident #48 did put his arms around Resident #60 and touched her breast. B. Resident #48 (assailant) 1. Resident status Resident #48, age greater than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes, malignant neoplasm of the kidney (cancer of the kidney) and hypertension. The 7/9/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview of mental status (BIMS) score of 11 out of 15. He was able to ambulate independently with a walker. The MDS assessment indicated Resident #48 had behavioral symptoms not directed towards others (pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste) which occurred on one to three days during the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 065239	Facility ID: 065239 If continuation sheet Page 1 of 7

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: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	assessment look-back period. 2. Record reviewThe sexual inappropriateness care plan, initiated on 5/20/25 and revised on 9/10/25, documented Resident #48 had the potential to exhibit sexual inappropriateness. Interventions included redirection and reporting to the nurse if any inappropriate contact was attempted, behavioral health services were offered to the resident, education to not enter any female rooms even if invited and education he was not to touch any female resident or staff member inappropriately. An event progress note, dated 9/5/25 at 5:00 p.m., documented an assessment of Resident #48 was completed with no pertinent findingsAn alert charting note, dated 9/7/25 at 12:44 p.m., documented Resident #48 was on alert charting related to inappropriate behaviors with one-to-one supervision. The resident had spent most of his time in his room with no inappropriate behaviors reported by the one-to-one staff member. A progress note, dated 9/10/25 at 10:00 a.m., documented a huddle was performed with all nursing staff on the floor. The incident (with Resident #60) was reviewed with staff. Resident #48 would require one-to-one monitoring until further notice. The staff discussed the need to monitor residents in common areas when Resident #48 was among other residents. Staff was educated on redirecting residents if seen attempting to enter other residents' rooms.A psychosocial progress note, dated 9/11/25 at 12:08 p.m., revealed a behavioral health group met with Resident #48 related to counseling services. During the intake, Resident #48 refused services. A physician progress note, dated 9/12/25 at 1:00 p.m., revealed Resident #48 was observed to be groping a female resident's breast and making sexually suggestive comments. Both residents were separated immediately and Resident #48 was placed on one-to-one monitoring. Resident #48 was confronted about his behavior and he immediately apologized, admitted it was improper and promised not to do it again. The resident admitted to his age and that he was not sexually active with women anymore. He had, in the past, requested medication for erectile dysfunction (ED), stating he had ED and wanted to see if it still worked. Resident #48 also conveyed he masturbated privately. The physician documented this behavior did not seem to be compulsive and the resident had never been observed masturbating in a public setting. The physician documented Resident #48 was agreeable and got along well with others but at times refused care (such as showers), but for the most part he was cooperative. A plan of care note, dated 9/16/26 at 3:45 p.m., documented the interdisciplinary team (IDT) met to discuss the removal of one-to-one supervision for Resident #48. The physician, behavioral health services and all parties that were consulted felt one-to-one supervision for Resident #48 could be removed at that time. C. Resident #60 (victim) 1. Resident StatusResident #60, age greater than 65, was admitted on [DATE] and discharged from the facility on 5/29/26. According to the May 2026 CPO, diagnoses included type 2 diabetes, hypertension and bipolar disorder (mood swings).The 5/29/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment did not indicate the resident had behaviors. 2. Record reviewThe 5/29/25 impaired through process related to bipolar disorder care plan, initiated 5/29/25, revealed Resident #60 was at risk of sexual inappropriateness (initiated on 9/11/25). Interventions included behavioral health services were to follow the resident (initiated 9/9/25). An event note, dated 9/5/25 at 3:10 p.m., documented Resident #60 reported to the nurse she was sitting in the dining room when a tall, skinny man who lived in the facility and wore a red jacket and hat, approached her from behind, hugged her, groped her and told her she had nice breasts. Resident #60 reported to the nurse that she told him to stop and that it was not okay for him to touch her. Resident #60 reported the incident scared her and made her very uncomfortable. Resident #60's hands were tremulous (shaking). The nurse and Resident #60 then ambulated to the center court to identify the other resident. Resident #60 was not able to locate the alleged assailant (Resident #48) at that time and returned to her room. Resident # 60's responsible party was notified (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and questioned if the incident was observed by anyone. The nurse notified the responsible party that no one had come forward but the facility would be conducting an investigation. The responsible party questioned if it could have been the resident's psychosis. The responsible party was advised the alleged perpetrator (Resident #48) was placed on one-to-one supervision for safety. An event note, dated 9/5/25 at 5:10 p.m., revealed that during a skin assessment, Resident #60 stated He was so close to me that I could feel his whiskers on my face a couple times. It really scared me and made me feel uncomfortable. A late entry event note, dated 9/6/25 at 11:51 a.m., documented the social services director (SSD) met with Resident #60 to discuss how she was feeling regarding the incident with Resident #48 on 9/5/25. Resident #60 stated she was okay and did not feel fearful in the facility nor was she fearful of the alleged perpetrator (Resident #48). Resident #60 was informed that the SSD would meet with her over the next four days to ensure the resident continued to feel safe in the facility and address any concerns she may have. Resident #60 was also encouraged to let any staff members know if she needed anything. An alert note, dated 9/6/25 at 11:25 p.m., documented Resident #60 was on charting after being the receiver of inappropriate behaviors on 9/5/25. Resident #60 was anxious in the evening as she talked about the situation. Resident #60 was administered an as needed medication, hydroxyzine, to alleviate her anxiety. A psychosocial note, dated 9/7/25 at 10:05 a.m., documented the SSD met with Resident #60 to follow up with the encounter with the alleged perpetrator (Resident #48) on 9/5/25. Resident #60 reported she was doing just fine and was not fearful in the facility. Resident #60 reported she had trouble sleeping last night (9/6/25). However, the resident did not know if it was from the incident or her upcoming surgery. Resident #60 said she was not fearful of the male resident (Resident #48). However, she did not want to be near him because it made her feel creepy. III. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 7/29/26 at 3:28 p.m. CNA #2 said Resident #48 kept to himself and liked to eat in his room for meals. She was unaware of any sexually inappropriate behaviors Resident #48 had towards female residents or staff members. CNA #2 said if she observed or suspected abuse she would ensure resident safety and notify the nurse of any concerns. She said the nurse would then make notifications as needed for an investigation. CNA #1 was interviewed on 7/29/26 at 3:50 p.m. CNA #1 said Resident #48 was stubborn. She said if he did not want to do something he would refuse. She said the resident did interact with other residents at times but mostly liked to be by himself. CNA #1 said she was unaware Resident #48 had sexually inappropriate behaviors towards female residents or staff members. RN #3 was interviewed on 7/29/26 at 4:42 p.m. RN #3 said Resident #48 did have behaviors. She said he liked to spit in public spaces, he had sexual behaviors privately in his room. RN #3 said Resident #48 had an incident a while ago where he touched a female resident's breast (Resident #60), who no longer resided at the facility. RN #3 said both residents were able to make their needs known. RN #3 said Resident #60 came to her and reported what happened in the dining room with Resident #48. RN #3 said she ensured Resident #60 was safe and then reported the allegation to her charge nurse, the director of nursing (DON) and the NHA. RN #3 said Resident #60 was educated to not have her back to where people could come from behind her and she could not see them. RN #3 said a resident who spent a lot of time in the dining room/activity room changed where she sat to be able to see who was coming towards her. RN #3 said Resident #60 became more aware of her surroundings after the incident with Resident #48. RN #3 said the facility had a list of residents at the nurses' station to help identify residents at risk for sexual inappropriateness. RN #3 said both Resident #60 and Resident #48 were on the list, despite Resident #60 no longer residing in the facility. -RN #3 reviewed the list of residents at risk for sexual inappropriateness and said the last time the list was updated was 12/1/25. The SSD was interviewed on 7/30/26 at approximately 3:00 p.m. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	SSD said she was new to the facility as of July 2026 and was still getting to know the residents. The SSD said Resident #48 tended to keep to himself. She said she was aware he had sexually inappropriate behaviors towards female staff and residents. The SSD said staff would advise her of him asking for a kiss in behavior notes. The SSD said the facility had trained staff on how to redirect Resident #48 when he was being inappropriate. The SSD said Resident #48 was able to advocate for his needs independently and was redirectable. The NHA and the DON were interviewed together on 7/30/26 at 4:48 p.m. The NHA said if abuse was observed or suspected, staff were to ensure resident safety first, separating residents to ensure safety. The NHA said notifications needed to be made to the NHA, the DON, the physician, the police and the responsible party after an abuse incident. She said an investigation was started to determine what occurred. She said the investigation included interviewing the residents involved and anyone who may have witnessed the incident. The NHA said the facility completed other resident interviews and family interviews to ensure safety in the facility. The NHA said the facility would then implement interventions to prevent recurrence of the incident. The DON said Resident #48 liked to wander the facility. She said the incident on 9/5/25 between Resident #48 and Resident #60 was first incident of Resident #48 being sexually inappropriate with another resident. The DON said Resident #48 sometimes refused care from staff stating he was old enough and would do what he wanted. The DON said even though he refused care, Resident #48 was redirectable. The DON said during the investigation of the 9/5/25 incident, Resident #48 said he thought he and Resident #60 were good friends and it was a welcome interaction, so he made a comment about her breasts and then proceeded to touch them. The NHA said Resident #48 would tell female staff members that they were beautiful and request a kiss from them. She said staff had been educated to tell the resident that it was not appropriate behavior and report it to the nurse. The DON said Resident #60 enjoyed sitting in the dining room reading and doing puzzles. The DON said Resident #60 was alert and oriented. The DON said she felt Resident #48 and Resident #60 were establishing a friendship, as they had started to sit together at times. The DON said Resident #48 reported during the investigation that Resident #60 would hug him at times and he felt touching her would be okay with her. The NHA said based on resident interviews, Resident #48 admitted to touching Resident #60 breasts so the facility substantiated the allegation. The DON said all staff members were able to review the residents' care plans for behaviors and interventions to use. She said new issues arose that were added to care plans and discussed in huddles on the floor to ensure staff awareness of the concerns.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases on two out of two units. Specifically, the facility failed to: -Ensure housekeepers cleaned and disinfected the residents' rooms in a hygienic manner; -Ensure housekeepers performed hand hygiene while cleaning resident rooms; -Ensure housekeepers cleaned high touch surface areas; and, -Ensure dwell times (time needed to kill bacteria) were followed during resident room cleaning. Findings include: I. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 8/4/26 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 8/4/26 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. According to the United States Environmental Protection Agency (EPA), dated 5/3/21, retrieved on 8/4/26 from https://www3.epa.gov/pesticides/chem_search/ppls/070627-00074-20210503.pdf, Oxivir is a one-minute bactericidal, virucidal, and fungicidal A disinfectant and cleaner (that cleans, disinfects and deodorizes in one labor saving step) when used according to disinfection directions for use. According to Diversey Crew NA SC Non-Acid Bowl & Bathroom Disinfectant Cleaner, dated 2022, retrieved on 8/4/26 from (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	https://products.solenis.com/product/crewr-na-sc-non-acid-bowl-bathroom-disinfectant-cleaner-1ea-12ct-D039 Non-acid toilet bowl and urinal disinfectant/cleaner directions: Empty toilet bowl or urinal and apply a 1 oz. per gallon use-solution to exposed surfaces and under the rim with a cloth, mop, sponge or sprayer. Brush or swab thoroughly, allow to stand for 10 minutes and flush.B. Facility policy and procedureThe Daily Room Cleaning policy, revised October 2025, was received from the nursing home administrator (NHA) on 7/30/26 at 8:48 p.m. It revealed 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 and disinfect using a hospital grade EPA registered cleaner/disinfectant solution. The facility should refer to the Diversey - Approved Housekeeping Chemicals guide for a listing of appropriate cleaning and disinfectants. Daily cleaning of resident rooms includes:-Using a damp cloth, dust the room starting with the resident's area (overbed table, bedside table, and phone) and move to the rest of the items in the room. This includes windowsills, door frames, shelves, walls, and doors;-Clean high-touch surfaces at least daily including hand washing sinks;-Daily cleaning of resident bathrooms; and,Clean and disinfect high touch/frequently contaminated surfaces (sinks, faucets, handles, door handles, and clean toilet seat last) at least daily.II. ObservationsOn 7/27/26 at 8:30 a.m. housekeeper (HK) #1 was cleaning resident room [ROOM NUMBER], a double occupancy room currently occupied with one resident. HK #1 said the solution in the top container of the cleaning cart was from the premixed Oxivir 1 (disinfectant) solution dispensed in the janitor's closet.HK #1 applied gloves and entered the resident's room carrying a spray bottle labeled Oxivir 1 and a rag wet with the Oxivir 1 solution from the cleaning cart bin. She sprayed the sink and counter and began wiping down the counter, the top of the sink, the bowl of the sink, then back to the counter and sink handles, and moved to cleaning underneath the sink.-HK #1 failed to complete hand hygiene and change gloves after moving from cleaning dirtier areas to cleaner areas.HK #1 then exited the room and placed the dirty rag in the dirty rag bin on the cart.With the same dirty gloves, she picked out a clean rag from the disinfectant solution on the cart and entered the resident's room carrying the clean rag and the Diversey Crew (a toilet bowl and urinal disinfectant/cleaner) spray bottle. HK #1 sprayed the toilet bowl rim, the toilet bowl, and the surrounding floor. HK #1 unwrapped the toilet brush stored in plastic wrap on the floor, and scrubbed inside the bottom of the toilet bowl and then scrubbed the rim of the toilet with the brush. She then scrubbed the legs and bottom of the elevated toilet seat. She proceeded to flush the toilet without waiting the recommended dwell time of 10 minutes (see professional reference above).-HK #1 failed to follow the product dwell time when cleaning the toilet bowl.At 8:50 a.m. HK #1 said she was finished cleaning the room.-HK#1 failed to clean all high touch areas in the resident's room, such as the light switches, door handles, resident call light, and closet handles. On 7/29/26 at 9:50 a.m. HK #2 was cleaning resident room [ROOM NUMBER], a double occupancy room currently occupied with one resident.HK #2 said the solution in the top container of the cleaning cart was from the premixed Oxivir 1 solution dispensed in the janitor closet.HK #2 entered the resident's room with a spray bottle of Oxivir 1 solution and a clean rag, and sprayed the counter and sink area. HK #2 cleaned the top of the sink, the bottom of the sink bowl, underneath the sink area. Using the same rag used to clean the sink area and bowl, she proceeded to wipe down the resident's closet door and handles.-HK #2 failed to complete hand hygiene, change gloves and use a clean rag when moving from a dirtier area to a cleaner area. HK #2 retrieved a clean rag from the clean rag solution on the cleaning cart and re-entered the resident's room. She wiped down the headboard of the unoccupied bed next to the window in the room, and then wiped the bottom of the bed and surrounding floor. HK #2 moved to the occupied side of the room near the door and used the same gloves and rag to wipe the resident's (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Craft Dr Alamosa, CO 81101	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside table and personal items on the bedside table, such as the water container, flowers in a vase and lotion. -HK #2 failed to complete hand hygiene and change gloves when moving from cleaning the floor to the resident's bedside table and touching the resident's personal items on the bedside table. III. Staff interviewsHK #1 was interviewed on 7/27/26 at 8:55 a.m. HK #1 said she was trained by HK #2 and spent several days cleaning with HK #2 when she first started as a housekeeper in the facility. HK #1 said residents' rooms were cleaned daily. HK #1 said she changed the clean rag water in the cart after cleaning about every six resident rooms.HK #2 was interviewed on 7/29/26 at 10:30 a.m. HK #2 said every resident room was cleaned daily. HK #2 said she always completed hand hygiene and changed gloves when she left a resident's room. HK #2 said she changed the clean rag water and mop water on the cart every three resident rooms.The housekeeping supervisor was interviewed on 7/30/26 at 9:40 a.m. The housekeeping supervisor said she could train new housekeeping staff, or other experienced housekeeping staff could train new housekeeping staff. The housekeeping supervisor said she provided ongoing education to housekeeping staff with a daily huddle, and completed additional training of housekeeping staff as needed.The housekeeping supervisor said housekeeping staff were trained on the cleaning process, which was to clean from cleaner areas to dirtier areas. She said hand hygiene should be performed and gloves should be changed every time after cleaning a dirtier area, not just when exiting the resident's room. She said the appropriate cleaning process should be followed to prevent the spread of germs.The housekeeping supervisor said high touch contact areas, such as light switches and door handles, should be cleaned with every room cleaning to prevent the spread of germs.The infection preventionist (IP) was interviewed on 7/30/26 at 1:00 p.m. The IP said she provided oversight and training to the housekeeping staff, including the use of personal protective equipment (PPE) and hand hygiene.The IP said housekeeping staff should clean from cleaner areas to dirtier areas and from top to bottom. She said housekeeping staff should practice hand hygiene and glove changes when moving from dirtier areas to cleaner areas to prevent the spread of infections.The IP said she did not recall the dwell time for the Diversey Crew toilet cleaning product.The IP said housekeeping staff should not use dirty gloves to clean a bedside table and should not touch residents' personal care items with soiled gloves because this could spread germs.		