

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Hilltop Park Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 290 S Monaco Pkwy Denver, CO 80224	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations and interviews, the facility failed to ensure facility menus met the needs of residents and were followed. Specifically, the facility failed to ensure correct and adequate portion sizes were served according to the menu extensions. Findings include: I. Menu extensions The posted menu included pineapple glazed ham, mashed potatoes, sliced parsley carrots. The dessert was orange dream cake. The menu extensions were provided by the nursing home administrator (NHA) on 6/25/26 at 7:55 a.m. The regular menu extensions documented serving sizes for the regular diet as three ounces of pineapple glazed ham, one half cup (four ounces by volume) of mashed potatoes, one half cup of parsley carrots, and one cupcake each for the orange dream cupcake. The soft and bite size level six menu extension documented serving sizes as a #8 (one half cup) scoop of ham, one half cup of mashed potatoes, and one half cup of parsley carrots. The mince and moist level five menu extension documented serving sizes as a #8 (one half cup) of ham, one half cup of mashed potatoes, and one half cup of minced and moist parsley carrots. The puree level four menu extension documented serving sizes as a #8 scoop (one half cup) of the puree ham, one half cup of pureed mashed potatoes and a #12 scoop (one third of a cup) of pureed carrots. II. Lunch meal observations and interviews During a continuous observation of the lunch meal on 6/24/26, beginning at 10:46 a.m. and ending at 12:20 p.m., the following was observed: At 10:55 a.m. cook #1 said the blue #16 scoops (two ounces by volume) in the pan were for the puree and minced and moist diets. [NAME] #1 said the green scoop (#12 scoop and two and three fourths ounces by volume) was for the soft and bite size ham and mashed potatoes. A three ounce ivory handled portion control ladle was in the pan of sliced carrots. [NAME] #1 placed the #16 blue scoops in the pans of puree ham and carrots, the minced moist ham and carrots, and the green scoops in the pans of mashed potatoes and soft and bite size ham. At approximately 11:00 a.m. meal service began in the kitchen. Observations during meal service revealed the following: The mashed potatoes were served using the #12 green scoop (one third of a cup) for regular diets, mince and moist level six diets, soft and bite size level five diets and puree diets. -However, according to the diet extensions the mashed potatoes were to be served as a one half cup portion. The parsley carrots were served using the three ounce ivory handled portion control ladle for the regular diets and soft and bite size level six diets. -However, according to the diet extensions the parsley carrots were to be served as a one half cup portion for the regular and soft and bite size level six diets. The ham was served using the #12 green scoop for the soft and bite size diets. -However, according to the diet extensions the ham was to be served as a one half cup portion. Ham and carrots were served using the #16 blue scoop for the mince and moist level six diets and puree diets. -However, according to the diet extensions the ham was to be served as a one half cup portions for the mince and moist level six and puree diets; and, carrots were to be served as a one half cup portion for the mince and moist level diet and a one third of cup portion for the puree (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 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 observations and interviews, the facility failed to provide a comfortable and homelike environment in three of four units. Specifically, the facility failed to: -Ensure the blinds, window sills, wall air conditioners and walls in resident rooms were clean and in good repair; and, -Ensure facility spas were in good working condition and the tile was in good repair. Findings include: I. Facility policy and procedure The Homelike Environment Policy, revised February 2021, was provided by the nursing home administrator (NHA) on 6/25/26 at 7:55 a.m. It read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment; inviting colors and décor personalized furniture and room arrangements. The Cleaning and Disinfecting Residents' Rooms policy, revised February 2026, was provided by the NHA on 6/25/26 at 7:55 a.m. It read in pertinent part, Resident rooms are cleaned regularly and as needed by housekeeping/environmental services. If the resident is in their room, request permission to enter and clean the room. If the resident is sleeping, showering, dressing, using the toilet, eating, or has visitors, reschedule the cleaning. Do not interrupt the resident during these activities to clean the room. Check the blinds, curtains, and windows. Clean if necessary. Terminal room cleaning: Check the blinds, curtains, and windows. Clean if necessary. II. Ensure the blinds, window sills, wall air conditioners and walls in resident rooms were clean and in good repair A. Observations On 6/21/26 at 3:15 p.m. the blinds in resident room [ROOM NUMBER] were coated with visible dust and cob webs. There were dead bugs in the window sill. On 6/21/26 at 4:48 p.m. Resident room [ROOM NUMBER] was observed to have a layer of dust on the window sill. There was dust and small pieces of debris in the wall air conditioner. On 6/22/26 at approximately 10:30 a.m. resident room [ROOM NUMBER] was observed to have multiple brown spots of various sizes, from approximately one quarter of an inch to one inch on the wall behind the bed from the privacy curtain in the middle of the room to the far wall. On 6/22/26 at 2:20 p.m. resident room [ROOM NUMBER] was observed to have approximately one (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inch of wallpaper missing around the perimeter of the walls of the bathroom between the baseboard and the wall. The edge of the wallpaper was peeling around the entire bathroom where the missing strip of wallpaper was. On 6/22/26 at 2:30 p.m. there was a hole observed the bathroom door of resident room [ROOM NUMBER]. On 6/24/26 at 10:05 a.m. Resident #121's wheelchair was observed to have small particles of white and gray dust and debris on one side of her wheelchair. On 6/24/26 at 10:10 a.m. room [ROOM NUMBER] was observed to have a missing door bolt, latch and face plate. Part of the door around the door handle was broken off and missing and exposed the interior of the door. On 6/24/26 at 3:10 p.m. room [ROOM NUMBER] was observed to have cob webs in the windowsill. The window jambs (sides and edge of the window opening) on the top and sides had multiple small pinpoint black spots. Wallpaper had peeled off the top and side window jambs and was hanging off the jamb approximately 2-3 inches for the three sides of the window. There was dust and debris inside the wall air conditioner and on the knobs. The wallpaper near the door to the room separated from the wall at the seams approximately six inches in length. The edge of the wallpaper was peeling around the entire bathroom where the missing strip of wallpaper was. B. Resident interviews The resident in room [ROOM NUMBER] was interviewed on 6/21/26 at 3:15 p.m. Resident #121 said the blinds in her room did not block the sun and she put the curtains up (over the blinds) a year ago. The resident in room [ROOM NUMBER] was interviewed on 6/24/26 at 10:05 a.m. Resident #109 said the dust from the wall air conditioner blew on her wheelchair leaving dust and debris on her wheelchair. The resident in room [ROOM NUMBER] was interviewed on 6/21/26 5:05 p.m. Resident #142 said her door was broken and had gotten stuck in the closed position and the maintenance director had to use tools to open the door. The resident in room [ROOM NUMBER] was interviewed on 6/22/26 at 2:30 p.m. Resident #105 said the hole was in the door prior to her moving into the room. She said she did not know what caused the hole. Resident #105 said no facility staff member had offered to fix it. The resident in room [ROOM NUMBER] was interviewed on 6/24/26 at approximately 3:10 p.m. Resident #10 said to look at the window in his room. Resident #10 said the wallpaper was peeling off his window. He said the facility sprayed the black spots in the window with bleach but the black spots did not disappear. Resident #10 said he did not have a window screen for his window. C. Staff interviews (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The housekeeping supervisor was interviewed on 6/25/26 at 2:13 p.m. The housekeeping supervisor said the staff had cleaned the bathroom walls in room [ROOM NUMBER], but the wallpaper was still brown and peeling from the bottom. She said the staff tried to clean the walls everyday but sometimes it was hard because the resident would be in the room and not let them clean. She said the resident in #305 would not let the staff clean the blinds because the resident had breathing problems. The housekeeping supervisor said that when staff did a deep clean, they cleaned the mattress, frame of the bed, privacy curtain, closet, walls, clean sheets, linens, pillow and cleaned the bathroom. She said the staff tried to clean the walls when a resident was discharged because it was very difficult to clean the walls while the resident was in the room. She said the air conditioning units were cleaned during the deep cleans and the staff dusted the unit and took the filters out and dust them. She said her staff deep cleaned everyday as best as they could if the resident let them. She said that her staff would tell her when they see something was broken or needs repaired and then she would let maintenance know. She said that window sills should be cleaned every day and privacy curtains should be cleaned on deep cleans. She said there was a list of rooms for each day that should be getting deep cleaned. She said she had permanent people scheduled for their permanent areas and those people have their certain duties. She said she would have her staff do their assigned duties first then she would walk their halls and point things out to them and have them clean those areas. She said that the shower rooms are cleaned everyday, sometimes more than once. She said that the certified nurse aides (CNAs) were responsible to clean after each resident. She said she was unsure of what the CNAs used to clean the showers. The NHA was interviewed on 6/25/26 at 4:06 p.m The NHA said they were remodeling the dry wall, FRP (fiberglass reinforced panels), blinds, lights, and were taking down wall paper in the facility. He said the door to room [ROOM NUMBER] was stuck and the maintenance director had to use something to open the door and it was going to be repaired and had been broken for approximately 10 days to two weeks. The NHA said room [ROOM NUMBER] had been sprayed in the window jamb. The NHA said when the facility turned rooms after a resident discharged they painted and cleaned the air conditioner, and there was no documentation of refusal to allow room cleaning. II. Failed to ensure facility spas were in good working condition A. Resident interview Resident #105 was interviewed on 6/22/26 at 2:30 p.m. Resident #105 said the shower head in the shower room was broken and wrapped with coban wrap (a lightweight, self-adhering wrap that is often used to secure dressings). She said she struggled to shower, because she used one hand to hold the shower head up and the other hand to support her nephrostomy site (a procedure to insert a thin catheter through the lower back directly into the kidney). B. Observations of shower rooms On 6/24/26 at 9:29 a.m. the following was observed: Outside of the Heritage [NAME] shower room, approximately one to two feet away from the door of (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shower room, the ceiling tile was stained a yellow color and was drooping down. The paint on the wall beneath the ceiling tiles was bubbling and felt damp to the touch. The bubbled paint started from the ceiling and went halfway down the wall. The wall below where the paint was bubbled, dipped into where the floor meets the wall was visible. The floor appeared to be warped and was also soft when stepped on. Inside the entrance of the shower room there was about two and a half to three feet of tile missing from the baseboard of the shower room. The wall behind the missing tile was also damaged. There were four to five gouges missing from the wall. There was four to five inches of wall completely missing. There were pieces of the wall sitting crumbled on the floor. Inside the shower room stall the floor was wet from a leak that was dripping from the ceiling from a small hole (approximately one inch by one inch), the tiled floor was visibly wet. There was about a foot to a foot and a half of cracked tile inside the shower stall. On 6/24/26 at 9:50 a.m. the following was observed: Inside the Grande Heritage shower room the first and third shower stalls had coban wrapped around the shower heads and the shower head holders. On 6/24/26 at 9:57 a.m. the following was observed: Inside the Medbridge shower room stall (located on the second floor directly above the Heritage [NAME] shower room) there was a visible space (approximately half an inch) in the caulking where the floor tile meets the wall tile. C. Staff interviews CNA #3 was interviewed on 6/24/26 at 1:00 p.m. CNA #3 said the hole along the bottom of the entrance in the Heritage [NAME] shower room happened, because of equipment running into it. She said maintenance was aware of the damaged wall and had tile coming. She said she was not aware of the dripping hole in the ceiling. CNA #4 was interviewed on 6/24/26 at 1:09 p.m. CNA #4 said that she was unsure of how long the coban had been wrapped on the shower heads in Grande Heritage's first and third shower stalls. She said she thought the coban was there to help stop the leaking of the shower heads when they were being used. CNA #5 was interviewed on 6/24/26 at 1:19 p.m. CNA #5 said that the reason they used that first stall in the Medbridge shower room was because the other ones did not have the heat lights installed and the residents would get really cold without the heat lights. The maintenance director was interviewed on 6/24/26 at 2:30 p.m. The maintenance director said he was aware of the wall and ceiling outside of the Heritage [NAME] shower room. He said it was coming from the Medbridge shower room. He said he had caulked the Medbridge shower but needed to (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	do it again. He said he was not aware that the moisture had gotten down into the lower part of the wall and the flooring outside of the Heritage [NAME] shower room. He said he was aware of the missing tiles inside of the Heritage [NAME] Shower room & the cracked tiles inside the shower stall. He said the tiles were on order and was waiting for them to come in. He said he was unaware of the leak inside the Heritage [NAME] shower stall. The maintenance director said that the shower heads and shower head holders in the first and third shower stalls in the Grande Heritage shower room, were on back order. He said he had ordered them and was notified they were on backorder. He said he wanted the same ones as before because he did not want to add more holes in the shower stalls by having to drill different holders into the showers.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in three of three medication carts. Specifically, the facility failed to ensure: -Residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened; and, -Medications were labelled appropriately with medication labels from the pharmacy. Findings include: I. Facility policy and procedure The Medication Labeling and Storage policy, revised February 2023, was provided by the regional clinical resource on [DATE] at 10:15 a.m. It read in pertinent part, Medication storage: If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is to be contacted for instructions regarding returning or destroying these items. Medication labeling: Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. Only the dispensing pharmacy may label or alter the label on a medication container or package. II. Observations On [DATE] at 7:54 a.m. Grand Heritage medication cart #1 was observed with licensed practical nurse (LPN) #4. The following items were found: There was one bottle of morphine sulfate 20 milligram per milliliter (mg/ml) oral solution stored in an appropriately labeled medication box. -However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #136. There was one vial of insulin lispro (Humalog). -However, the pharmacy label was destroyed, the box was labeled with a marker and the vial inside the box was not labelled with the resident's name or the date the medication was opened for Resident #57. On [DATE] at 8:52 a.m. the Heritage [NAME] medication cart was observed with LPN #5. The following items were found: There were three bottles of morphine sulfate 20 mg/ml oral solution stored in appropriately labeled medication boxes. -However, the individual medication bottles inside the boxes were not labeled with the resident's name or the dates the medications were opened, and the facility failed to remove discontinued medications from the medication cart in a timely manner for Resident #7 (see staff interview below). There was one fluticasone-salmeterol aerosol powder breath activated 250-50 microgram per actuation (mcg/act) inhaler stored in an appropriately labeled medication box. -However, the individual inhaler inside the box was not labelled with the resident's name or the date the medication was opened for Resident #96. On [DATE] at 9:07 a.m. the Medbridge medication cart was observed with the infection preventionist. The following item was found: There was one fluticasone-salmeterol (Wixela Inhub) aerosol powder breath activated 500-50 mcg/act inhaler stored in an appropriately labeled medication box. -However, the individual inhaler inside the box was not labelled with Resident #87's name. III. Staff interviews LPN #4 was interviewed on [DATE] at 7:54 a.m. LPN #4 said it was important for the individual medication bottles labelled inside their respective boxes so the staff could identify who the medication belonged to if the box was damaged or lost. LPN #5 was interviewed on [DATE] at 8:52 a.m. LPN #5 said Resident #7 expired on [DATE], but her narcotic medications were still in the medication cart. He said Resident #7's other medications had already been removed from the medication cart, but the narcotic medications were still there because they were considered (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to store, prepare and distribute food in a sanitary manner in the main kitchen. Specifically, the facility failed to ensure staff washed hands and changed single use gloves appropriately while preparing, plating and distributing ready to eat food in the main kitchen. Findings include: I. Professional reference The Colorado Retail Food Regulations (3/16/24), and retrieved on 7/2/26 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, unwrapped single-service and single-use articles, after handling soiled equipment or utensils; and, during food preparation: as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.14) Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301.11) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (3-304.15) II. Observations During a continuous observation of the lunch meal on 6/24/26, beginning at 10:46 a.m. and ending at 12:20 p.m., the following was observed: At 10:55 a.m. dietary aide #1 was at the sandwich station in the kitchen and wore black single use gloves on both hands. With gloved hands, dietary aide #1 cut a sandwich, holding the sandwich with her left hand, and the knife in her right hand. Dietary aide #1 picked up a paper meal ticket with her left gloved hand and set the ticket back down at the station in front of her. Wearing the same gloves, dietary aide #1 pulled two slices of bread from a plastic bread bag and placed them on the preparation table in front of her. Dietary aide #1 then used her gloved hands to separate slices of deli meat, which she placed on the sliced bread. Dietary aide #1 removed a lid from a pan on the cold station in front of her and with her right gloved hand removed a slice of cheese from the pan and placed it on the sandwich. She then walked away from the sandwich station to pick up six plates with her gloved hands in the plate rack. Dietary aide #1 did not wash her hands and change her gloves after changing tasks and soiling the gloves and before touching ready-to-eat food. At 11:05 a.m. while wearing the same gloves, dietary aide #1 placed a sandwich on a plate and cut the sandwich into quarters while holding the sandwich with her left hand. Dietary aide #1 then picked up meal tickets with her gloved hands, looked through them, and set them down at her station. Dietary aide #1 did not wash her hands and change her gloves after soiling the gloves and before touching ready-to-eat foods. At 11:09 a.m. while wearing the same gloves, dietary aide #1 picked up meal tickets with both hands, looked through them, set them back down at her station, and pulled bread out of a bread bag. Wearing the same gloves, dietary aide #1 placed the bread slices in the conveyor toaster and then picked up and read through the meal tickets again with her hands. Dietary aide #1 set the meal tickets back down at her station. Wearing the same gloves, dietary aide #1 picked up a bag of bread with both hands and secured the top of the bread bag and set it back down. Dietary aide #1 then walked away from the cold station to dry storage and came back with two bags of bread. Wearing the same gloves, dietary aide #1 placed two slices of bread in the conveyor toaster, removed her gloves to wash her hands, then donned new gloves. Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food. At 11:15 a.m. while wearing single use gloves, dietary aide #1 wrapped a plate with clear plastic (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wrap. Wearing the same gloves, dietary aide #1 picked up tickets with both her gloved hands, looked at the tickets, set the tickets down at her station and then touched the top of the sandwich with her right gloved hand. Dietary aide #1 picked up and moved the bread bag with her hands, then she sorted the meal tickets with her gloved hands.-Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food.At 11:19 a.m. dietary aide #1 moved a bag of bread with her gloved hands at her station. Wearing the same gloves, dietary aide #1 removed a lid from a pan at the station, touched the meal tickets, picked up and separated two plates with her gloved hands, and picked a piece of lettuce out of the pan to put on a plate. Dietary aide #1 placed the lid back on the pan and picked up and handled the meal tickets again with her gloved hands.At 11:20 a.m. while wearing the same gloves, dietary aide #1 picked up two tomato slices, placed them on a plate and then removed two toasted buns she had placed in the toaster. Wearing the same gloves, dietary aide #1 picked up two slices of cheese with her gloved hands and placed them on a plate.-Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food.At 11:25 a.m. wearing the same gloves, dietary aide #1 placed the sliced cheese onto a burger patty and bottom bun, and moved the lettuce and tomato to the top of the burger patty. Dietary aide #1 then added the top bun on top of the burger. Wearing the same gloves, dietary aide #1 picked up meal tickets, sorted them and set them back down at her station.At 11:28 a.m. while wearing the same gloves, dietary aide #1 picked up two pieces of bread. She picked up five meal tickets with her hands, looked through them, set them down and then picked up three plates. Dietary aide #1 opened a bread bag, removed bread and put bread in the toaster. Dietary aide #1 then picked up meal tickets and sorted them while wearing the same gloves.-Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food.At 11:33 a.m. wearing the same gloves, dietary aide #1 picked up a hamburger bun and placed a slice of cheese and sliced pickles on a bun and burger. Dietary aide #1 then picked up the meal tickets with her gloved hands, set the tickets down and then used both her gloves hands to put the bun on the top and cut the sandwich in half. -Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food.At 11:36 a.m. wearing the same gloves, dietary aide #1 picked up a plate with a sandwich and pulled the plastic wrap off the plate. Dietary aide #1 used her left gloved hand to hold the sandwich and her right gloved hand to cut the sandwich with the knife. Wearing the same gloves, dietary aide #1 used her left hand to grab a pan from the stove and used a spatula to slide an omelet onto a plate. Dietary aide #1 used her left gloved hand to sprinkle cheese over the top of the omelet.Wearing the same gloves, dietary aide #1 picked up the meal tickets with both hands, set them back down and placed a plate in front of her. dietary aide #1 opened a plastic bread bag with her gloved hands, removed a bun and wrapped the bread back up and tied the plastic at the top of the bag to seal it. -Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food.At 11:45 a.m. wearing the same gloves, dietary aide #1 cut a sandwich while holding the sandwich with her left hand and using her right hand to hold the knife. Dietary aide #1 then picked up a bun with her hands and placed it on the plate; with her right gloved hand she placed sliced cheese on the plate and then a piece of fresh lettuce she handled with both hands. Dietary aide #1 used her left gloved hand to add sliced pickles and then bacon slices to the sandwich with both gloved hands.-Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food.At 11:50 a.m. wearing the same gloves, dietary aide #1 picked up lettuce and placed it on a bun. dietary aide #1 then placed bread on top, cut the bread and served the cut sandwich. She tied the bread bag back up with her gloved hands.At 11:55 a.m. wearing the same gloves, dietary aide #1 picked up and touched the meal tickets and set them (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back down at her station. At 11:59 a.m. wearing the same gloves, dietary aide #1 cut a peanut butter and jelly sandwich on a plate, holding the sandwich with her left gloved hand and using a knife in her gloved right hand. -Dietary aide #1 did not wash her hands and change her gloves after changing tasks and before handling ready-to-eat food. III. Staff interviews The dietary manager (DM), regional clinical resource and registered dietitian the (RD) were interviewed together on 6/25/26 at 2:30 p.m. The DM said every time you changed tasks you should wash your hands and change your gloves. The DM said if you walked away from what you were doing during the task you needed to wash your hands and change your gloves before continuing the task. The RD said he did not notice dietary aide #1 had not changed her gloves as needed during meal service but he was more focused on the diets. The RD said the dietary staff had received glove use and handwashing training during the last couple weeks (prior to the survey) that included to change gloves as often as needed and including when the staff touched their clothes. The RD said that was part of their re-inservice and it was more detailed this time than a couple weeks ago. The DM said he had them all wash their hands for hand washing training. The regional clinical resource said the staff all did return demonstrations for handwashing training. IV. Facility follow up A hand hygiene dietary education was provided by the NHA at 11:13 a.m. The inservice was provided to the dietary staff on 6/25/26 (during the survey) by the RD and the DM. It documented that kitchen staff must wash hands immediately before putting on gloves and after removing them, as well as after these specific triggers: immediately after entering the kitchen or starting a shift, touching the face, hair, clothes or body, handing trash, dirty dishes or chemical cleaning supplies, and changing tasks. Correct glove use protocols included the following: Task switching-the moment you move from handling one type of food to another; and the moment your close hand touches anything other than the food or clean prep utensils-this included touching your apron, face, hair, phone, trash cans, or a refrigerator handle. The education documented that residents have weakened immune systems. A trace amount of bacteria from a cook's hand could cause a facility-wide outbreak. Cross contamination in long-term care kitchens could cause foodborne outbreaks that were fatal to elderly residents. For kitchen staff, hand hygiene and glove use are critical infection control barriers.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection on two of four units. Specifically, the facility failed to:-Ensure housekeepers cleaned high-touch areas, used proper dwell times, used proper cleaning and disinfecting techniques and performed hand hygiene when cleaning residents' rooms;-Ensure staff followed enhanced barrier precautions (EBP) when providing care); and, -Ensure residents did not enter the soiled linen room.Findings include:1. Failed to ensure housekeepers cleaned high-touch areas, used proper dwell times, used proper cleaning and disinfecting techniques and performed hand hygiene when cleaning residents' roomsA. Professional referenceAccording to the Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24), retrieved on 7/2/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html, it read in pertinent part, 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. General surface cleaning process: Thoroughly wet (soak) a fresh cleaning cloth in the environmental cleaning solution. Fold the cleaning cloth in half until it is about the size of your hand. This will ensure that you can use all of the surface area efficiently (generally, fold them in half, then in half again, and this will create 8 sides). Wipe surfaces using the general strategies as above (clean to dirty, high to low, systematic manner), making sure to use mechanical action (for cleaning steps) and making sure to that the surface is thoroughly wetted to allow required contact time (for disinfection steps). For higher-risk areas, change cleaning cloths between each patient zone (use a new cleaning cloth for each patient bed). Common high-touch surfaces include: bedrails, IV poles, sink handles, bedside tables, counters where medications and supplies are prepared, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), transport equipment (wheelchair handles), call bells, doorknobs, light switches High-touch and frequently contaminated surfaces in toilet areas (handwashing sinks, faucets, handles, toilet seat, door handles) and floors.The CDC/ Environment Cleaning Procedures (revised 3/19/24) was retrieved on 7/2/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/supplies-and-equipment.html#cdc_c read in pertinent part, Best practices for glove usage for cleaning: perform hand hygiene immediately before putting on gloves and directly after taking them off. When use of gloves is indicated, always change them between each cleaning session (routine cleaning of a patient zone under contact precautions, terminal cleaning of a general patient area).According to the Spartan Chemical Company, Inc. Retrieved from: https://www.spartanchemical.com/search?s=BNC-15 on 7/2/26. It read in pertinent part BNC-15 disinfectant had a Three-minute contact time for most bacteria and viruses, and a five-minute contact time for norovirus B. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy and procedure, revised February 2026 was received from 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing home administrator (NHA) on 6/25/26 at 7:51 a.m. It read in pertinent part, Apply gloves and other personal protective equipment (PPE) as indicated. Clean all high-touch areas with disinfectant solution: beside tables, overbed tables, chairs, phones, beds, lights, call bells, and bedrails. Mop the floors. Discard mop solution. Remove gloves and perform hand hygiene.C. ObservationsDuring a continuous observation on 6/23/26, from 12:07 p.m. to 12:30 p.m., housekeeper (HK) #1 was cleaning room [ROOM NUMBER], a double-occupancy room on the Grand Heritage unit. HK #1 used hand sanitizer and put on a pair of gloves. She pulled out her broom and dustpan from her cleaning cart and started sweeping side A (side closest to the door). She swept under his bed and picked up a box of Kleenex from the floor and put it on his bedside table. She then went directly to side B to sweep. She raised side B's bed and swept underneath. There was a fall mat leaning against a bedside table, she did not move the mat to sweep on the other side. She leaned her broom against pillows that were in a chair, then leaned down to remove a trash bag from side B's trash can. She then placed the trash bag into the dustpan. She then grabbed her broom and touched the pillows with her gloved hands, and emptied the dustpan into the trash compartment on her cart and replaced the broom and dustpan on her cart. HK #1 grabbed one clean rag from her cart and a red colored disinfectant, BNC-15. HK #1 did not change her gloves. She then sprayed the rag approximately five times, the rag was not saturated with the BNC-15 disinfectant. She then wiped down side A's television and then cleaned side B's television. She then wiped the windowsill and air conditioning unit. She then wiped above the lamps that were connected to the wall. She then moved to side A and wiped his bedside table. The areas that she wiped were visibly wet for five seconds or less. She then returned to her cart. She did not change her gloves.-HK #1 did not disinfect high-touch areas such as the residents' call light or bed remotes for the residents on either side of the room. -HK #1 did not use separate rags for each side of the room. The surfaces wiped with the rag with BNC-15 did not stay wet for the three-minute dwell time (see professional reference above). HK #1 grabbed the toilet brush and the receptacle that it was sitting in, out of the housekeeping cart. The toilet brush was sitting in the receptacle in a blue liquid. The toilet brush head was completely covered in the blue liquid. HK #1 opened the bathroom door and set the toilet brush receptacle and the toilet brush in the bathroom on the floor. She then returned to the cart and she grabbed a blue rag and a red rag and the BNC-15 disinfectant. She then went to the bathroom and sprayed the toilet with the BNC-15 disinfectant. She then sprayed the blue rag with the BNC-15 approximately five times, the rag was not saturated. She then wiped the mirror, towel rack, and then the sink. She then checked her phone and confirmed she had let the BNC-15 sit for three minutes on the toilet. She then flushed the toilet, put the blue cleanser that the toilet brush was sitting in inside the toilet, then cleaned the inside of the toilet bowl, she then tapped the toilet brush three times on the rim of the toilet to get the excess liquid off the brush then returned the toilet brush to its receptacle. She then wiped down the outside of the toilet with the red rag. She then took the bag of trash out of the trashcan, sprayed the trashcan with the BNC-15 and using the red rag she immediately wiped the trashcan and then put in a new trash bag. She then took the two rags, toilet brush receptacle and put them in her cart. She then took off her gloves and performed hand hygiene and put on new gloves. She then reached into the mop bucket and pulled two mop pads out. She put one on her mop handle and proceeded to push the mop from the door way on side A over to side B. She mopped the entirety of side B then proceeded to mop side A using the same mop pad. She then pulled the mop pad off and replaced it with the clean one she had pulled out earlier. She then mopped the bathroom. She pulled off the mop pad and then put the two mop pads in the dirty container on her cart. She then swept up the lint and debris with her broom and dustpan. She took off her gloves and performed hand hygiene. -HK #1 did not disinfect high-touch areas such as the residents' call light or (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	door handles for the shared bathroom. The surfaces wiped with the rag with BNC-15 did not stay wet for the three-minute dwell time (see professional reference above). During a continuous observation on 6/24/26, from 8:45 a.m. to 8:55 a.m., HK #2 was cleaning room [ROOM NUMBER], a single-occupancy room on the Heritage unit. HK #2 performed hand hygiene and put on a pair of gloves. She entered the room and opened the bathroom door and sprayed the toilet and sink with BNC-15 disinfectant. The sink had personal hygiene items (toothbrush and toothpaste) sitting on the counter. She did not move the items prior to spraying the disinfectant. She then closed the bathroom door and sprayed a rag about five times with the BNC-15 disinfectant. The rag was not saturated with the disinfectant. She then wiped the side table and then the window sill. She emptied the trash can and then disposed of the bag in her cart. She did not change her gloves. -HK #2 did not disinfect high-touch areas such as the residents' call light or bed remotes for the resident in the room. The surfaces wiped with the rag with BNC-15 did not stay wet for the three-minute dwell time (see professional reference above). -HK #2 did not move the resident's personal hygiene items before spraying the disinfectant. HK #2 then swept the room. She then emptied the dustpan and replaced the broom and dustpan on her cart. She then grabbed two rags one green and one blue and took the toilet brush receptacle and disinfectant into the bathroom. She then poured some of the blue cleaner into the toilet bowl and cleaned the inside of the toilet with the toilet brush. She then used the green cloth to wipe down the sink. She then used the blue cloth to wipe the outside of the toilet. She then used the green cloth to wipe the handrail. She then went to her cart and replaced the toilet brush receptacle and discarded the dirty rags. She did not change her gloves. HK #2 reached into the cart and pulled out a mop pad from the mop bucket using the same gloves. She then mopped the bathroom floor. She then took that mop pad off of the mop handle and put it in the dirty area of her cart. She then reached in and grabbed another mop pad, using the same gloves and mopped the room. When she finished mopping the room she discarded the mop pad into the dirty area on her cart and then took off her gloves and performed hand hygiene. -HK #2 failed to change her gloves and perform hand hygiene after cleaning the toilet. HK #2 did not disinfect high-touch areas such as the residents' call light or door handles in the bathroom. The surfaces wiped with the rag with BNC-15 did not stay wet for the three-minute dwell time (see professional reference above). D. Staff interviews HK #1 was interviewed on 6/23/26 at approximately 12:30 p.m. HK #1 said the BNC-15 had a three-minute dwell time. She said that she did not spray the room with the BNC-15, but she sprayed the toilet and let the disinfectant sit for three minutes. HK #2 was interviewed on 6/24/26 at 9:02 a.m. HK #2 said that high-touch areas were tables, lights, television controls, everything that the resident touches. She said she changed her gloves and performs hand hygiene when she left a room and when she cleaned the bathroom. The housekeeping supervisor was interviewed on 6/24/26 at 2:10 p.m. The housekeeping supervisor said the housekeepers should be spraying the rags, so that the rags were saturated with the disinfectant so that the areas that they were wiping will have a dwell time of three minutes. She said high-touch areas were door knobs, telephones, light switches, call lights and bed controls. She said the housekeepers should be cleaning all of those areas. She said the housekeepers should be using different rags for double-occupancy rooms. She said housekeepers should also use different mop pads for each side of the room. She said that housekeepers should not be tapping the toilet brush on the toilet, she said they should not do that because the contents and debris that is on the toilet brush could be sprayed on to other surfaces in the bathroom. She said housekeepers should always take their gloves off and perform hand hygiene after cleaning the toilet and bathroom and that they should not be spraying disinfectant near residents' personal hygiene items. II. Failed to ensure staff followed EBP A. Professional reference According to the CDC Implementation of Personal (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 7/2/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, it read in pertinent part, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high-contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy and procedure, undated, was received from the NHA on 6/25/26 at 7:51 a.m. It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. Implementation of Enhanced Barrier Precautions: make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities include: Dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters, wound care: any skin opening requiring a dressing. C. Observations On 6/22/26 at 10:02 a.m. Two unidentified certified nurse aides (CNA) were providing incontinence care for Resident #2. The two CNAs were not wearing gowns. After finishing Resident #2's incontinence care the two unidentified CNAs transferred Resident #2 into her wheelchair using the Hoyer lift (a mechanical lift). Resident #2 had an indwelling catheter. There was an EBP sign on the door along with the EBP supplies such as gowns and gloves. -The two unidentified CNAs failed to don the correct PPE when providing direct care to Resident #2, who was on EBP. On 6/23/26 at 10:46 a.m. Resident #150 was being assisted out of the shower room in the shower chair by an unidentified CNA. The unidentified CNA was not wearing a gown. Resident #150 had an enteral tube feed. The unidentified CNA did not put on a gown when entering Resident #150's room. CNA #3 entered Resident #150's room to assist with care and did not put on a gown. Resident #150's door had an EBP sign as well as gowns and gloves. D. Staff interviews CNA #3 was interviewed on 6/24/26 at 11:07 a.m. CNA #3 said she did not need to put on a gown when providing catheter care or showers to residents with tube feed or wounds. She said she did not need to wear a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown when providing incontinence care for residents with tube feeds, catheters, or wounds. CNA #6 was interviewed on 6/24/26 at 11:51 a.m. CNA #6 said she would ask the nurse if a resident was on EBP and why they needed EBP. She said if a resident was on EBP she would wear a gown, gloves, and a mask if needed. She said she would also make sure to wash her hands with soap and water. Licensed practical nurse (LPN) #6 was interviewed on 6/24/26 at 12:21 p.m. LPN #6 said there were different types of EBP. She said she would normally wear a gown, gloves and depending on the precautions, goggles or a mask. She said the PPE should be put on before entering the room and taken off before exiting the room. The infection preventionist (IP) was interviewed on 6/24/26 at 4:03 p.m. The IP said education was provided on EBP annually to all staff during the skills fair. She said any resident that had an open wound that needed to be covered, indwelling device, dialysis, PICC line, PEG tube, IV, and ostomy would have EBP. She said that there were signs on the doors of residents' that were on EBP. She said that she would do rounds on the floor to make sure that staff were using the EBP. She said that she would complete additional training and reeducation with staff who did not use the precautions. She said the staff who were observed not wearing the PPE should have been wearing PPE because they were performing high-contact activities. The director of nursing (DON) was interviewed on 6/25/26 at 11:45 a.m. The DON said that EBP should be followed for residents with wounds, catheters, and tube feeds. She said staff should be wearing a minimum gowns and gloves. She said it was important for staff to wear the correct PPE because they could potentially introduce bacteria into the open area. III. Failed to ensure residents did not enter the soiled linen roomA. Professional referenceAccording to the CDC Laundry and bedding guidelines from the Guidelines for Environmental Infection Control in Health-Care Facilities (2003), retrieved on 7/2/26 from, https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.htmlIt read in pertinent part, The laundry process starts with the removal of used or contaminated textiles, fabrics, and/or clothing from the areas where such contamination occurred, including but not limited to patients' rooms, surgical/operating areas, and laboratories. Contaminated textiles and fabrics are placed into bags or other appropriate containment in this location; these bags are then securely tied or otherwise closed to prevent leakage. Single bags of sufficient tensile strength are adequate for containing laundry, but leak-resistant containment is needed if the laundry is wet and capable of soaking through a cloth bag. Bags containing contaminated laundry must be clearly identified with labels, color-coding, or other methods so that health-care workers handle these items safely, regardless of whether the laundry is transported within the facility or destined for transport to an off-site laundry service.B. ObservationOn 6/22/26 at 10:04 a.m. Resident #53 was helping Resident #113 open the soiled linen door. The soiled linen door had a coded lock. Resident #113 was able to push the correct code and start to open the door. Resident #53 then helped Resident #113 push the door open even more. Resident #113 tried to look through the bags of the soiled linens but then Resident #53 let the door close and both residents left the area. On 6/22/26 at 10:10 a.m. an unidentified CNA came out of a resident's room carrying soiled linen in a bag. The unidentified CNA opened the soiled linen door and Resident #113, came up to the CNA and began speaking to her. The CNA held the door open to the soiled linen room and Resident #113 began looking through the bags of soiled linens. The CNA then asked Resident #113 if she wanted to go and ask the laundry staff if they had seen any of her clothing. Resident #113 agreed. The CNA did not help Resident #113 wash her hands after going through the soiled linen. C. Staff interviewsCNA #3 was interviewed on 6/24/26 at 11:07 a.m. CNA #3 said that the soiled linen door was locked and residents cannot get in. She said she had never seen residents in that room. Registered nurse (RN) #2 was interviewed on 6/24/26 at 3:39 p.m. RN #2 said that the door to the soiled linen closes and locks automatically and that nurses and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNAs have the code for the door. She said she had never seen residents go into the soiled linen room before. The DON was interviewed on 6/25/26 at 11:45 a.m. The DON said it was not alright for residents to be in the soiled linen room. She said it was not okay for residents to be looking through bagged soiled linens. She said the staff member should not have allowed Resident #113 to look through the bags.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure two (#150 and #2) of five residents were provided with personal privacy out of 62 sample residents. Specifically, the facility failed to ensure:-Resident #2's room door and privacy curtain were closed during incontinence care; and,-Resident #150 was fully covered per her preference while being transported from the shower room in the shower chair back to her room.Findings include:I. Resident #150A. Resident statusResident #150, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician's orders (CPO), diagnoses included active primary multiple sclerosis, gastrostomy status (having an artificial opening in the stomach for long-term enteral nutrition or gastric decompression), epilepsy, and cerebral infarction (stroke). The 3/25/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment further revealed the resident needed substantial to maximal assistance with showering, toileting and dressing. B. Resident interview and observationResident #150 was interviewed on 6/22/26 at 2:33 p.m. She said that there were things that residents had to deal with while living in a facility. She said things like having to be naked under a sheet while being pushed in the hallway to the shower room. She said there were times when she had to remind staff to close her door and pull the curtain and to make sure she was fully covered. She said staff were very goal-oriented and just wanted to move on to their next task. On 6/23/26 at 10:46 a.m. Resident #150 was being transported in the shower chair from the shower room back to her room. Resident #150 had her left arm resting on the left armrest of the shower chair. The sheet that was covering her was pulled up around her left elbow and her left breast and stomach were visible. C. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 6/24/26 at 11:07 a.m. She said that when she had to transport a resident to and from the shower room on the shower chair, she would make sure that the resident was completely covered. She said she used draw sheets to cover the resident's front and back. CNA #6 was interviewed on 6/24/26 at 11:51 a.m. She said sometimes the residents would bring clothes with them to change into in the shower room. She said when she had to use the shower chair to take them to and from the shower room, she would make sure the resident was completely covered. Licensed practical nurse (LPN) #6 was interviewed on 6/24/26 at 12:21 p.m. She said that she would expect the resident to have a blanket or sheet covering their front and back. She said all body parts should be covered. The director of nursing (DON) was interviewed on 6/25/26 at 11:45 a.m. She said that residents should be completely covered when being transported to and from the shower room. She said it is important to ensure the resident's dignity and privacy. II. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter, Alzheimer's disease, metabolic encephalopathy (brain dysfunction), and acute respiratory failure with hypoxia (lungs cannot adequately supply oxygen to the bloodstream). The 3/27/26 MDS assessment revealed the resident was rarely or never understood through staff assessment. The staff assessment revealed the resident had short-term and long-term memory problems, and her cognitive skills for daily decision-making were severely impaired. The assessment further revealed she was dependent on staff for all of her activities of daily living (ADL). B. ObservationsOn 6/22/26 at 10:02 a.m. Resident #2's roommate exited their room. She left the door open using the magnetized door prop to hold the door open. Resident #2 was lying in her bed, which was visible from the hallway. There were two unidentified CNAs performing incontinence care for (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2. The blinds to the window to the outside were open and the privacy curtains were not drawn. The door remained open for approximately 30 seconds to one minute while the staff were providing incontinence care to the resident. C. Staff interviewsCNA #3 was interviewed on 6/24/26 at 11:07 a.m. She said that they should have the door closed and if the door was opened they should close it again. She said the staff should also have the privacy curtains drawn and if the window blinds are open, they should close them. CNA #6 was interviewed on 6/24/26 at 11:51 a.m. She said always closed the door when she performed incontinence care. She said that if the door was opened she would close the door. She said she would also make sure that the privacy curtains were closed depending on the resident's preference. She said sometimes some residents did not like their curtains to be closed. LPN #6 was interviewed on 6/24/26 at 12:21 p.m. She said she would expect the CNA to close the door and the privacy curtain to be pulled during incontinence care. She said she would expect the CNA to close the door if it was opened during care. The DON was interviewed on 6/25/26 at 11:45 a.m. She said that the door should be closed and the privacy curtain should be pulled during incontinence care. She said it was important to ensure the resident had privacy and dignity.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to revise and implement an effective discharge plan for two (#163 and #155) of three residents reviewed for discharge planning out of 62 sample residents. Specifically, the facility failed to:-Ensure the discharge planning process was documented, including the reason for discharge in Resident #163's electronic medical record (EMR); -Ensure the reconciled medication list, physician's orders and care plan provided to the resident at discharge were documented in Resident #163 and 155's EMRs;-Ensure Resident #155's discharge care plan was updated to include the resident's preference to transfer to another facility; and,-Ensure Resident #155's EMR contained documentation of the preparation provided to the resident prior to transfer to another facility in a form and manner the resident could understand. Findings include: I. Resident #163 A. Resident status Resident #163, age less than 65, was admitted on [DATE] and discharged on 10/31/25. According to the October 2025 computerized physician orders (CPO), diagnoses included acute respiratory failure, myocardial infarction (heart attack), end stage renal disease (loss of kidney function), congestive heart failure, vascular dementia (disrupted thinking caused by lack of blood flow to the brain) and metabolic encephalopathy (altered brain function). The 10/31/25 minimum data set (MDS) assessment documented in the staff assessment for resident cognition that the resident did not have a memory problem and was independent in making decisions regarding daily life. The assessment also revealed the resident needed partial to moderate assistance with activities of daily living (ADL) and was independent at meal time. The 10/31/25 MDS assessment documented the resident's discharge was an unplanned discharge and that the resident was discharged to a short-term general hospital. The assessment did not indicate the provision of the reconciled medication list to the resident at the time of discharge. -However, a review of the resident's discharge summary and staff interviews (see below) documented the resident discharged home and the discharge summary documented the resident was provided with a medication list. B. Record review The discharge care plan, initiated 10/1/25 and revised 12/19/25, documented Resident #163 would remain at the facility for long-term care due to her needing 24-hour nursing care and her family being unable to care for her at home. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pertinent interventions, initiated 10/1/25 and revised 12/19/25, included to encourage the resident's family to provide personal items as needed to create a more homelike environment; provide an arena such as interdisciplinary team (IDT) care conference for the resident, family and/or interested party to address plans for discharge and participate in the discharge planning process; review the plan of care as needed; and social services to schedule IDT care plan meetings upon admission, quarterly, and as needed. The 10/31/25 discharge summary and post-care instructions, provided by the nursing home administrator (NHA) on 6/24/26 at 10:00 a.m., revealed the following: The introduction documented copies of applicable documents were reviewed and provided to you (Resident #163). Please contact your primary care provider for further instructions. The discharge location was documented as home/community. The reason for discharge was documented as other, with no additional information documented as the reason for discharge. The primary care physician and the list of resources provided was not documented. The resident was documented as medically/therapeutically cleared for discharge, however the provider note on 10/30/25 failed to document any discharge notes. The records documented as provided were a medication list and care plan sent by paper (fax, copy of orders) with the resident. -However, the medication list and the care plan were not included in the discharge summary. The resident's name was typed in the signature of the receipt box but did not include a date of receipt. A review of Resident #163's EMR revealed the following: An 11/1/25 alert note documented Resident #163 was not in the facility and texted the director of nursing (DON) and staff would continue to follow up. An 11/1/25 EMR administration note documented Resident #163 was in the hospital. An 11/2/25 EMR administration note documented the resident was hospitalized . -However, according to the discharge evaluation and staff interviews (see above and below) the resident had been discharged home. C. Staff interviews (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, the DON, regional clinical resource #1 and regional clinical resource #2 were interviewed together on 6/25/26 at 4:00 p.m. The NHA said Resident #163 was informed she had community medicaid at her dialysis appointment and when that was communicated to the resident's niece, the niece said she would take the resident home. The NHA said the resident was to go to her appointment at the hospital and then discharge home with her niece. The DON said the resident's name could be electronically input into the discharge evaluation but no date was added. Regional clinical resource #1 said when the facility discharged Resident #163, the resident was not taken out of the system. Regional clinical resource #1 said the facility would submit a corrected MDS assessment for Resident #163 that updated her discharge location from the hospital to home. Regional clinical resource #2 said Resident #163 was not supposed to be listed as an active resident after discharge so the nurses were documenting the resident was still in the hospital (see above). The DON said the SSD could update the discharge plan, or the nursing staff could. II. Resident #155 A. Resident status Resident #155, age less than 65, was admitted on [DATE] and discharged on 1/27/26. According to the January 2026 CPO, diagnoses included chronic respiratory failure with hypoxia (lungs cannot adequately transfer oxygen to the bloodstream), malignant neoplasm of connective and soft tissue of right lower limb, including the hip (cancer of the soft tissue), and hypothyroidism. The 1/27/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The assessment revealed the resident needed moderate to substantial assistance for most of her ADLs. The 1/27/26 MDS assessment documented the resident's discharge was a planned discharge. The 1/27/26 MDS assessment documented the resident discharged to a skilled nursing facility. The 1/27/26 MDS assessment did not document provision of the current reconciled medication list to subsequent providers at discharge or to the resident at discharge. B. Record review The discharge care plan, initiated 5/23/25 and revised 2/1/26 (after her discharge), documented Resident #155 would remain in the facility for long-term care due to her need for 24-hour nursing care. Pertinent interventions included encouraging the resident to put personal items, as needed, in her (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room to create a homelike environment, reviewing the plan of care quarterly or as needed, social services to plan IDT care plan meetings upon admission, quarterly, and as needed. -However, the care was not updated to reflect the resident's preference to discharge to another facility. The 1/27/26 discharge summary and post-care instructions, provided by the NHA on 6/24/26 at 10:00 a.m., revealed the following: Resident #155's discharge location was documented as another skilled nursing facility. The reason for discharge was documented as resident preference. The records documented as provided were a medication list and care plan sent by paper (fax, copy of orders) with the resident. -However, the medication list and the care plan were not included in the discharge summary. A review of the resident's EMR revealed the following: A social services note, dated 2/19/25 at 9:59 a.m., documented that the business office assistant and the social services assistant spoke with Resident #155 about Medicaid redetermination and the need for her most recent bank statements. The note further documented that the business office assistant also spoke to the resident about the facility not receiving full payments. The note documented that the resident did not want to make full payments due to her purchasing her own food and medical supplies. -However, there were no further follow-up notes or documentation found in the resident's EMR about nonpayments. A social services note, dated 7/21/25 at 5:22 p.m., documented that Resident #155 wanted to obtain her state identification card and a copy of her social security card. The note documented that the resident hoped to discharge from the facility once she was clinically stable and she would apply for social security once she was discharged from the facility. The note documented that discharge planning was not done at that time. -However, no other follow-up notes or documentation were found in the resident's EMR about discharge plans or planning. Provider notes dated, 7/27/25, 10/23/25, 11/20/25, 12/10/25, 12/30/25 and 1/9/26 all documented, Resident #155 was planning to transition to the community within the month. The resident handled her own right hip wound by herself at the facility. She was able to manage her own finances plus other issues with the help of a transitioning team. The resident was informed she would get a three month supply of basic medications at discharge and continued to work with the facility. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, discharge planning documentation was not found in the resident's EMR. A social services note, dated 1/22/26 at 3:40 p.m., documented that medical records and pertinent paperwork were sent per the resident's request. A social services note, dated 1/26/26 at 12:08 p.m., documented that medical records and pertinent paperwork were sent per the resident's request. -However, the note did not document the reason why records were being sent. A discharge summary note, dated 1/27/26 at 1:10 p.m., documented Resident #155 was being discharged to another facility. The note documented the resident left the facility around 12:00 p.m. with her belongings and that one of the facility's van drivers drove her to the new facility. The note documented the resident was in her wheelchair and was stable upon leaving. C. Staff interviews The NHA, the DON, regional clinical resource #1 and regional clinical resource #2 were interviewed together on 6/25/26 at 4:00 p.m. The NHA said that Resident #155 had not paid her share of cost and that the facility had gone to meet with her to discuss her payments. He said that Resident #155 told them that she was never going to pay her full payment. He said that they had discussed the different options and that Resident #155 was okay with being discharged to another facility. He said that Resident #155 was happy when they discussed where she would be going because they would accept her without payment. He said they had discussed the 30-day notice with the ombudsman, but because they were under the understanding that Resident #155 wanted to go, they did not notify the ombudsman when she was discharged. He said that there was no documentation of the conversations that were held with Resident #155. He said the facility should have updated Resident #155's care plan to reflect her preferences to discharge.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure proper treatment and assistive devices to maintain visual abilities for one (#105) of three residents reviewed for ancillary services of 62 sample residents. Specifically, the facility failed to ensure Resident #105 received her eye glasses timely after an optometrist wrote a prescription. Findings include: I. Resident #105A. Resident status Resident #105, age greater than 65, was admitted to the facility on [DATE]. According to the June 2026 computerized physician orders (CPO), her diagnosis included type 2 diabetes mellitus. The 5/25/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required partial/moderate assistance with toileting, showering and dressing. She required supervision or set-up assistance for other activities of daily living (ADL). The MDS assessment revealed the resident's vision was adequate and she did not use corrective lenses or glasses. -However, the resident was waiting to receive her prescription glasses (see interviews and record review below). B. Resident interview and observations Resident #105 was interviewed on 6/22/26 at 2:30 p.m. Resident #105 said she had been waiting on new glasses for three months now. On 6/23/26 at 11:45 a.m. Resident #105 was walking down the hallway toward her room. She was not wearing glasses. Resident #105 asked an unidentified staff member if she ever got a hold of the eye doctor, and the staff member replied that the eye doctor was at the facility and might be able to answer her questions. Resident #105 was interviewed again on 6/24/26 at 11:12 a.m. Resident #105 was not wearing glasses. She said the optometrist did not provide her glasses or an update about her glasses while at the facility yesterday. C. Record review Review of Resident #105's June 2026 CPO revealed the following physician's order: May have vision consult and follow up as needed, ordered 2/16/26. The 4/27/26 optometry note documented Resident #105 did not have glasses previously, and she had early cataracts (clouding of the eye's normally clear natural lens). Resident #105 was diagnosed with regular astigmatism (a refractive error where the eye lens is curved more like a football than a perfectly round basketball), hypermetropia (a refractive error where the eyeball is too short or the cornea is too flat), presbyopia (the natural, age-related loss of your eye's ability to focus on objects up close) and age-related nuclear cataracts bilaterally (in both eyes). Review of the 4/27/26 eyeglass prescription revealed the facility received a prescription for bifocal lens (the top portion of the lens corrects distance vision, while the lower portion handles close-up tasks like reading). -However, there was no further documentation regarding Resident #105 receiving her prescription bifocal lens. Review of Resident #105's comprehensive care plan, initiated 2/18/26, did not reveal a person centered care plan for the resident's prescriptive eye glasses. III. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 6/24/26 at 12:46 p.m. CNA #2 said the optometrist probably came to the facility once per month, and any outside provider had a list of residents with an appointment that day. She said she did not know who was responsible for scheduling appointments. CNA #2 said she did not know if Resident #105 wore glasses or had vision concerns. She said the resident had not complained about her vision to her. Licensed practical nurse (LPN) #3 was interviewed on 6/24/26 at 3:25 p.m. LPN #3 said if a new order, such as new eye glasses, was received following an ancillary appointment, she would look at the appointment note to view the recommendations and enter a progress note based on the recommendations. She said the facility had an appointment scheduler who received a copy of the appointment note to review for follow up needs. LPN #3 said she had never heard that Resident #105 was supposed to wear glasses. The business operations manager was interviewed on 6/25/26 at (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:45 a.m. The business operations manager said she was filling in for the social services director (SSD) while she was out of the facility. She said she had experience in social work. The business office manager said if a resident received new glasses, her understanding was that the nursing team should be notified and a task for applying eye glasses would be initiated. She said the optometrist came to the facility probably about once per month, and the SSD was in charge of creating the list of residents needing to be seen by any ancillary specialists. The business office manager said she did not know if Resident #105 should be wearing glasses and she would have to go back and look. She said she did not know why the resident had not received eye glasses for a vision prescription dated 4/27/26, and she said she would have to look into this. The director of nursing (DON) was interviewed on 6/25/26 at 12:41 p.m. The DON said when there was a change in ancillary services, such as new eye glasses, social services should communicate with the floor nurses and the task or order should be updated. She said the optometrist came to the facility every month or every other month - unless someone needed follow up sooner. The DON said Resident #105 did not wear glasses, and was not wearing glasses in her photo within the facility's documentation system. The DON said the BOM was ordering the prescription eyeglasses now. The DON said the potential negative outcome of a resident going without their prescriptive eye glasses included bumping into something, falling and deteriorating vision/prescription changes. IV. Facility follow-up The nursing home administrator (NHA) provided a receipt for Resident #105's prescription eyeglasses on 6/25/26 at 6:26 p.m. (after survey exit). The eyeglasses were ordered and paid for on 6/25/26 at 12:37 p.m. The NHA said delivery should be expected in one week. -However, Resident #105's prescription eyeglasses were not ordered for approximately two months.		

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NAME OF PROVIDER OR SUPPLIER Hilltop Park Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 290 S Monaco Pkwy Denver, CO 80224	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide catheter care in accordance with standards of professional practice for one (#118) of three residents out of 62 sample residents. Specifically, the facility failed to ensure:-The urinary catheter was changed timely for Resident #118; and, -Resident #118, who was incontinent of the bladder, received appropriate treatment and services to prevent urinary tract infections (UTI) and to restore continence to the extent possible. Findings include: I. Facility policy and procedure The Catheter Care policy, revised August 2022, was provided by the nursing home administrator (NHA) on 6/25/26 at 7:55 a.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections (UTI). Changing catheters: Residents who form encrustations that can quickly lead to an obstruction need more frequent catheter changes at intervals specific to the individual resident. The catheter should be changed before a blockage is likely to occur. When changing a long-term indwelling catheter, leave the catheter out for at least one hour, but no longer than two hours, to allow the urethral glands to drain. Complications: observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately: in the event of bleeding, or if the catheter is accidentally removed; if the resident complains of burning, tenderness or pain in the urethral area; or, if signs and symptoms of UTI or urinary retention occur. II. Resident #118A. Resident status Resident #118, age greater than 65, was admitted to the facility on [DATE]. According to the June 2026 computerized physician orders (CPO), the diagnoses included a history of UTI, a history of sepsis, benign prostatic hyperplasia with lower urinary tract symptoms, neuromuscular dysfunction of the bladder and a history of epididymitis (inflammation of the coiled tube behind the testicles responsible for storing and carrying sperm - commonly caused by bacterial infections, including UTI). The 5/22/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required substantial/maximal assistance with toileting and partial/moderate assistance with mobility. The 5/22/26 MDS assessment revealed the resident used an indwelling catheter. B. Resident interview Resident #118 was interviewed on 6/22/26 at 4:38 p.m. Resident #118 said it had been a long time since his urinary catheter was changed. He said it was last changed on 5/10/26 and it hurt so (explicit language) bad. Resident #118 said he screamed when the nurse inserted the catheter, and the nurse told him it would get better. He said the next morning he was covered in a pool of blood so deep it went up to his elbow while he was sitting up in bed. Resident #118 said the facility called the ambulance and sent him to the hospital where he was diagnosed with supraventricular tachycardia (SVT - an abnormal heart rhythm where the heart beats between 150 to 220 beats per minute) and traumatic Foley replacement. Resident #118 was interviewed again on 6/23/26 at 2:35 p.m. Resident #118 said urinary catheter changes were always uncomfortable, but the pain associated with the 5/10/26 catheter change was off the chart. He said he asked the nurse to stop and slow down during the catheter insertion, but the nurse told him the pain would improve. Resident #118 said after the nurse left his room he was able to fall asleep but woke up around 9:00 a.m. with a gross feeling. He said he lifted up the sheets and about stroked out because he was covered in blood. C. Record review Resident #118's catheter care plan, initiated 12/18/25, revealed the resident had an indwelling catheter. Pertinent interventions included changing the catheter per the facility's policy and the physician's order; providing catheter care and emptying (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the catheter every shift and as needed; keeping the catheter anchored for security and to prevent trauma; and, notifying the physician of signs and symptoms of UTI such as mental status changes, foul smelling urine, color change in urine, hematuria (bloody urine), sedimentation, burning with urination and increased temperature. Review of the 5/11/26 urologist documentation revealed the following standard written physician's order: 16 Fr Foley catheter with 5 ml of water in the balloon. Change once per month, ordered 5/11/26. -However, the facility failed to enter the physician's order from the urologist into the resident's electronic medical record (EMR). Review of Resident #118's June 2026 CPO revealed the following physician's orders: Indwelling catheter: 18 French (Fr) catheter with 10 milliliters (ml) of water in the balloon. Change as needed (PRN) for dislodging, leaking, obstruction, or clogging of the catheter, ordered 5/20/26 and discontinued 6/24/26. Indwelling catheter: 16 Fr catheter with 5 ml of water in the balloon. Change PRN for dislodging, leaking, obstruction, or clogging of the catheter, ordered 6/24/26 (during the survey). The 5/10/26 nursing progress note documented at 10:04 a.m. revealed report was given in the morning from night shift that indicated the catheter was changed at 3:00 a.m. and was bleeding but flushed. The resident called and said his catheter was hurting and bleeding. This nurse checked and noted the catheter came out with clotting bright blood. The note documented the nurse offered to change the resident's catheter. The resident responded No do not touch me, I want to go to the hospital. The hospital was called and the nurse spoke to the physician who said it was okay to send the resident for catheter replacement non-emergently. The ambulance was called for transport and the ambulance would arrive at the facility in the next 30 minutes. The resident was made aware. The nursing progress note documented on 5/11/26 at 12:52 a.m. revealed the Foley catheter changed per order on 5/10/26 around 3:30 a.m. The existing Foley catheter was removed and replaced with 20 Fr catheter with 10 ml balloon inflation. The note documented bleeding was noted after insertion. The Foley catheter flushed, patent and draining a small amount of urine mixed with blood. Pain medication administered before and after Foley catheter change per medication administration record (MAR). The resident tolerated the procedure with discomfort noted. -Review of the EMR did not indicate Resident #118's Foley catheter had been changed since 5/10/26, which indicated the resident's catheter had not been changed for greater than 30 days per the urologist's order. The 5/18/26 hospital discharge documentation revealed the resident was in his usual state of health when last night the resident felt like he was not having much urine output from his Foley. The facility nurse exchanged his catheter and it was a difficult insertion causing pain and trauma. The resident presented to the hospital initially due to hematuria following Foley catheter exchange. In the emergency department, the resident was noted to be in SVT to the 230s. The resident was admitted for hematuria and tachycardia. The resident met sepsis criteria with tachycardia, leukocytosis and infectious source on arrival. Urine cultures were positive for extended-spectrum beta-lactamase (ESBL) UTI in the setting of recent traumatic Foley insertion at outside facility. The note documented two of two blood cultures taken on 5/10/26 grew methicillin-resistant staphylococcus aureus (MRSA). The source of his MRSA bacteremia was unclear - transthoracic echocardiogram (TTE) was without evidence of infective endocarditis (IE), magnetic resonance imaging (MRI) spine without infectious source, no new hardware. The note documented the resident was discharged with a total of six weeks of Vancomycin (antibiotic) via a peripherally inserted central catheter (PICC) for high-grade MRSA bacteremia of unknown source. D. Observation and staff interview The assistant director of nursing (ADON) changed Resident #118's catheter on 6/24/26 at 12:05 p.m. The ADON said there was sediment buildup on the end of the catheter from sitting in the resident's bladder. III. Staff interviews Licensed practical nurse (LPN) #2 and the director of nursing (DON) were interviewed together on 6/24/26 at 11:03 a.m. LPN #2 said she would (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the nurse about a residents' catheter if there was a change in condition, such as bloody urine or urine color change, so the nurse could document it and notify the physician. She said the catheter should be changed depending on the physician's order, which sometimes was weekly, but typically monthly. LPN #2 said the urinary catheter should be changed timely in order to prevent infection. She said she was familiar with Resident #118, but she did not know when his catheter was last changed. She said she needed to call her supervisor. The DON said Resident #118's catheter order was a PRN order, but she did not know the 5/11/26 urology order. The DON searched the resident's EMR and said the urology order was to change the catheter monthly. She said if Resident #118's catheter was last changed on 5/10/26 and the urology order on 5/11/26 said the catheter should be changed monthly, that the catheter was late and due to be changed.-The facility failed to ensure the urinary catheter was changed timely.The ADON was interviewed on 6/24/26 at 12:39 p.m. The ADON said Resident #118 had a lot of bleeding and urethral trauma from his previous catheter insertion. He said he thought the bleeding was related to the catheter getting pulled after it was secured to his leg. The ADON said the potential negative impact of traumatic catheter insertion could include Resident #118 not allowing the staff to place a catheter and showing a preference for the specialist to do it. He said it was important the catheter was changed timely for infection control and residents that grow sediment/crystallizations on the end of the catheter.The DON was interviewed again on 6/25/26 at 12:41 p.m. The DON said urinary catheters should be changed when they are clogged, dislodged or soiled, unless urology said otherwise. She said Resident #118's urinary catheter was not changed timely.The DON said the nurse called and told her she had difficulty inserting Resident #118's catheter on 5/10/26 and he went to the emergency room. The DON said she did not realize hours had lapsed between the insertion of the catheter and Resident #118 being sent out to the hospital. She said damage to the urethra and penis and psychosocial damage were potential negative outcomes of traumatic catheter insertions.		