STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065244	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Springs Healthcare	2305 Blake Ave Glenwood Springs, CO 81601

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide reasonable accommodations for six (#9, #7, #8, #15, #2 and #13) of 10 residents out of 15 sample residents.Specifically, the facility failed to ensure call lights were within reach for Resident #9, Resident #7, Resident #8, Resident #15, Resident #2 and Resident #13.Findings include: I. Facility policy and procedure The Answering the Call Light policy, revised September 2022, was provided by the nursing home administrator (NHA) on 4/21/26 at 6:48 p.m. The policy read in pertinent part, Ensure that the call light system is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. II. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, chronic kidney disease and dysphagia. The minimum data set (MDS) assessment was not completed at the time of the survey. The 4/21/26 at 2:04 p.m. progress note revealed Resident #9 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out 15. B. Resident observations and interview On 4/20/26 at 4:22 p.m. Resident #9 was in her room, requesting assistance. Resident #9 lifted up her right hand. Her lifted hand had feces covering her palm and fingers. She requested wipes to clean up with and said she already used her napkin. A soiled napkin was on top of her lunch plate on the bedside table next to her. Her call light was not turned on and it was not accessible. The resident identified that she was lying partially on top of it and could not reach it. The staff were not observed in the hallway or near the resident's room. At 4:23 p.m. a resident in a room near Resident #9's room turned their call light on to notify staff that Resident #9 needed assistance. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
NAME OF PROVIDER OR SUPPLIER Glenwood Springs Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 Blake Ave Glenwood Springs, CO 81601	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:26 p.m. an unidentified certified nurse aide (CNA) entered Resident #9's room and closed the door. C. Record review The activities of daily living (ADL) care plan, revised 4/21/26, documented Resident #9 had an ADL self-care performance deficit related to chronic kidney disease. The fall care plan, revised 4/21/26, identified Resident #9 needed a safe environment and prompt response to all requests for assistance. Interventions, initiated 4/21/26, included ensuring the resident had a workable, reachable call light and encouraging her to use the call light for assistance as needed. III. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2026 CPO, diagnoses included unspecified sequelae of unspecified cerebrovascular disease, dysarthria (speech disorder) following other cerebrovascular disease, cognitive communication deficit, need for assistance with personal care, muscle weakness, unspecified lack of coordination, other abnormalities of gait and mobility and repeated falls. The 3/25/26 MDS assessment documented Resident #7 had moderate cognitive impaired with a BIMS score of nine out 15. The MDS assessment revealed the resident did not have inattention or disoriented thinking and understood what was said to her. Resident #7 was dependent on staff assistance for bed mobility, toileting, dressing, personal hygiene and surface-to-surface transferring. Resident #7 used a wheelchair for a mobility device. According to the MDS assessment, Resident #7 had unclear speech and difficulty communicating some words. B. Resident observations and interview On 4/20/26 at 3:59 p.m. Resident #7 was in her bed. Resident #7 had a distressed look on her face. The resident's mouth was open, brow furrowed and her eyes were squinting. Her call light cord was hanging on the far corner of a dresser drawer. Resident #7 was not able to reach the cord and indicated that she needed staff assistance. On 4/21/26 at 10:58 a.m. Resident #7 was in bed asleep. Her call light was under a blanket on top of her wheelchair, approximately four feet from her and on the opposite of her bedside dresser. At 1:29 p.m. Resident #7 was awake in her bed. Her call light was on the right side of her, next to her pillow. She reached for the call light and pushed the button to signal for assistance. She shook her head no when asked if her call light was always within her reach. An unidentified CNA entered Resident #7's room and asked the resident if she needed her brief to be changed and she nodded yes. C. Record review (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADL care plan, revised 9/16/25, documented Resident #7 had an ADL self-care performance deficit related to impaired mobility and a traumatic brain injury (TBI). The care plan directed staff to encourage Resident #7 to use the call light/bell to call for assistance (initiated 1/10/2020). D. Staff interview CNA #1 was interviewed on 4/21/26 at 2:41p.m. CNA #1 said Resident #7 was able to make her needs known but had difficulty speaking. She said the resident was able to say yes, no, nod and make verbalization sounds. CNA #1 said the resident was able to use her call light and would often push it. She said Resident #7 would sometimes sleep with the call light in her hand. -However, observations revealed Resident #7's call light was not always consistently within reach of the resident (see observations above). IV. Resident #8 A. Observation and interview On 4/20/26 at 4:05 p.m Resident #8 was in his wheelchair, next to his bed. Resident #8 said he did not know where his call light was. The resident looked around his bed and found the call light under his bed. He attempted to grab the call light with a reaching device but could not retrieve the call light from the floor independently. He said he tried to keep the call light on his bed but sometimes it would fall on the floor. V. Resident #15 A. Resident status Resident #15, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included chronic kidney disease and chronic obstructive pulmonary disease. The 4/17/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She required moderate assistance with ADLs. B. Observations and interview On 4/21/26 at 11:10 a.m. Resident #15 was sitting in her wheelchair in her room. The resident's call light was lying on the bedside table behind the resident and she was unable to reach the call light. On 4/21/26 at 2:05 p.m. Resident #15 was sitting in her wheelchair in her room. Her call light was lying on the bed, out of her reach. Resident #15 said she wanted to lie down in her bed. She said she could not reach her call light. C. Record review Resident #15's fall risk care plan, revised 4/21/26 (during the survey), revealed the resident was at low risk for falls. The resident required a safe environment with a reachable call light. Interventions included ensuring the resident's call light was within reach and encouraging the resident to use the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light for assistance as needed. D. Staff interview CNA #4 was interviewed on 4/21/26 at 2:10 p.m. CNA #4 said residents had to have their call lights next to them to call for staff assistance. She said the residents were checked on every 15 minutes to make sure call lights were next to them. She said Resident #15 was a vulnerable resident and required more assistance with transfers and cares. CNA #4 said Resident #15's call light should be within reach for her. -However, observations revealed Resident #15's call light was not always consistently within reach of the resident (see observations above). VI. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included cerebral infarction affecting his right dominant side, epilepsy and blindness. The 4/16/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required moderate assistance with ADLs. B. Observation On 4/21/26 at 11:06 a.m. Resident #2's call light was observed lying on the floor underneath the bed, out of reach of the resident. C. Record review Resident #2's fall risk care plan, revised 10/17/23, revealed the resident was at high risk for falls due to impaired mobility related to epilepsy, cerebral infarction affecting the right dominant side and blindness. Intervention included ensuring the resident's call light was within reach and encouraging the resident to use the call light for assistance as needed. VII. Resident #13 A. Resident status Resident #13, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included cervical fracture and Huntington's disease (neurological disease of the brain). The 3/21/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He required moderate assistance with ADLs. B. Observation and interview On 4/21/26 at 3:00 p.m. Resident #13's call light was on the floor underneath his bed and out of reach of the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 said he was able to use his call light but he did not know where the call light was. C. Record review Resident #13's fall risk care plan, revised 3/13/26, revealed the resident was at risk for falls related to impaired mobility. Interventions included ensuring the resident's call light was within reach and encouraging the resident to use the call light for assistance as needed. VIII. Additional staff interviews The director of nursing (DON) was interviewed on 4/21/26 at 5:10 p.m. The DON said call lights needed to be within reach of the residents and answered timely to ensure residents' needs were met, such as timely bathroom assistance and to help prevent falls. She said the facility conducted a call light training on 4/21/26 (during the survey) after it was identified that not all residents' call lights were within reach. The NHA was interviewed on 4/21/26 at 5:27 p.m. The NHA said the facility had created a performance improvement plan (during the survey) to address residents' call lights out of reach. IX. Facility follow up A call light education, dated 4/21/26 (during the survey) , was provided by the NHA on 4/21/26 at 6:46 p.m. The education documented all residents should have their call lights within each at all times. According to the education, staff should place call lights on mobile residents' beds and dependent residents should have their call lights clipped to them in a place the resident could easily reach the device. The education documented the staff were informed that they should always tell the resident where the call light was prior to leaving the room and ensure the resident was able to reach the call light.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to timely report an allegation of abuse involving two (#1 and #2) of six residents reviewed for abuse out of 15 sample residents.Specifically, the facility failed to:-Timely report an allegation of physical abuse by Resident #2 towards Resident #1; and,-Timely report an allegation of verbal abuse by Resident #1 towards Resident #2.Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, was provided by the nursing home administrator (NHA) on 4/21/26 at 6:48 p.m. It read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If abuse, neglect, exploitation, or misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and two other officials according to state law. The administrator or other individuals making the allegation immediately reports his or her suspicion to the following person or agencies: The state licensing/certification agencies responsible for surveying/licensings of facility; the local/state ombudsman; the residents' representative; adult protective services; law enforcement officials; and, facility medical director. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents.According to the policy, the facility should report within two hours if the allegation involved abuse or resulted in serious bodily injury or within 24 hours of an allegation that did not involve abuse or resulted in serious bodily injury.II. Allegation of physical abuse by Resident #2 towards Resident #1 Record review and interviews during the survey (see below) identified a 1/30/26 allegation of verbal abuse involving Resident #1 and Resident #2. The allegation was not reported to the State Agency until 2/2/26, three days after the incident occurred.A. Facility investigationA 1/30/26 physical abuse investigation involving Resident #1 and Resident #2 was provided by the NHA on 4/21/26 at approximately 9:30 a.m. The investigation included the incident report to the State Agency, related progress notes (see below) and a witness statement. The incident report identified the incident occurred on 1/30/26 at 9:37 p.m. and the incident report was submitted to the State Agency on 2/2/26 at 6:42 p.m. According to the incident report, the initial report was due on 1/31/26 at 9:37 p.m. The initial report was marked late. The initial report documented that on 2/2/26 at 5:00 p.m the nurse management team was made aware of an incident between Resident #1 and Resident #2 that occurred on 1/30/26 at approximately 9:00 p.m. The investigation identified a certified nurse aide (CNA) heard arguing in the room of Resident #1 and Resident #2. The CNA entered the residents' room and discovered one of the residents (Resident #2) hitting another resident (Resident #1). The CNA intervened and separated the residents. The CNA alleged that she reported it to the nurse but the nurse did not report it to the facility management. The facility notified police, conducted a head-to-toe assessment, attempted to change resident rooms, and began conducting resident abuse surveys on 2/2/26. A 2/2/26 witness statement, included in the 2/2/26 investigation of the incident and documented by licensed practical nurse (LPN) #1, identified that on 1/30/26 she heard yelling in the hallway. CNA #5 told LPN #1 that Resident #2 was yelling at Resident #1. CNA #5 separated the residents and the yelling stopped. According to the witness statement, CNA #5 did not inform LPN #1 that there was physical hitting between the residents during the argument. The statement documented CNAs were instructed to report any additional yelling so proper protocols could be initiated.The facility investigation documented the alleged victim (Resident #1) did not feel threatened or unsafe and was refusing to change rooms. The facility substantiated the allegation. A. Resident #1 (alleged victim)1. Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statusResident #1, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included anoxic brain damage, personal history of traumatic brain injury, insomnia due to other mental disorders, restlessness and agitation, chronic systolic congestive heart failure and major depressive disorder, recurrent. The 2/19/26 minimum data set (MDS) assessment identified Resident #1 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out 15. The MDS assessment indicated Resident #1 had lower extremity impairment on both sides with no upper extremity impairment. According to the MDS assessment, Resident #1 had verbal behavioral symptoms directed toward others.2. Record reviewA 2/2/26 nursing note documented LPN #2 received a statement on 2/2/26 from an overnight CNA indicting another resident (Resident #2) punched Resident #1 and CNA #2 had intervened by removing the other resident away from Resident #1. According to the note, LPN #2 interviewed Resident #1. Resident #1 said he was yelling and cursing at Resident #2 and Resident #2 punched him three times in the arm before the CNA entered the room and intervened. Resident #1 said he was not scared of the other resident and did not want to move rooms. The note indicated Resident #1 would inform staff immediately if he felt uncomfortable or wanted to move rooms. -Review of progress notes did not reveal documentation of the resident-to-resident altercation on 1/30/26. B. Resident #2 (alleged assailant)1. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included legal blindness, hemiplegia with hemiparesis (motor impairment on one side) following cerebral infarction (stroke) affecting right dominant side, muscle weakness and personal history of malignant neoplasm (cancerous tumor) of the brain.The 2/7/26 MDS assessment identified Resident #2 was cognitively intact with a BIMS score of 15 out 15. The MDS assessment indicated the resident's vision was severely impaired. He had upper and lower extremity impairment on one side. He used a walker and a wheelchair for mobility. According to the MDS assessment, Resident #2 did not have physical or verbal behavioral symptoms directed toward others. 2. Resident interview Resident #2 was interviewed on 4/21/26 at 10:50 a.m. Resident #2 said he did not get along with Resident #1. He said they had gotten into a physical fight. He said they were not offered to change rooms after the fight. He said Resident #1 would tell him that he would kick his (expletive) and was very rude to him. He said he just tried to ignore Resident #1 until he was moved to another room.3. Record reviewA 2/2/26 at 5:38 p.m. nursing note, documented by the former director of nursing identified Resident #2 was involved in a resident-to-resident altercation. According to the note, a resident (Resident #1) made a statement that Resident #2 did not like so Resident #2 hit Resident #1 in the upper right arm three times.-The note did not identify when the altercation occurred.A 2/2/26 at 6:17 p.m. nursing note, documented by LPN #2, identified she received a statement from the overnight shift CNA that on 1/30/26 at approximately 9:00 p.m. Resident #2 became aggressive with another resident and punched the resident (Resident #1) three times. Resident #2 said Resident #1 kept cursing at him and threatening to hit him so Resident #2 approached Resident #1 and hit him three times before the CNA entered the room and removed him from Resident #1. According to the note, there were no injuries to either resident. The note documented LPN #2 educated Resident #2 that the behavior was inappropriate and he could not put his hands on other residents. III. Allegation of verbal abuse between Resident #1 and Resident #2Record review and interviews during the survey (see below) identified a 2/13/26 allegation of verbal abuse involving Resident #1 and Resident #2 which was not reported timely to the State Agency.An email, provided by the NHA on 4/22/26 at 2:49 p.m., documented the facility reported the 2/13/26 allegation of potential verbal abuse to the State Agency on 4/21/26 at 7:39 p.m. (after the survey exit). A. Resident #1 (alleged assailant) 1. Record reviewThe 2/13/26 behavior note documented LPN #2 was walking past Resident #1's room when she heard him yelling aggressively and inappropriately at his roommate (Resident #2). The note documented Resident #1 told Resident #2 I hate you, shut your stupid mouth and I will (expletive) you up. According to the note, LPN #2 entered the room and told Resident #1 that he was being inappropriate. Resident #1 told LPN #2 that he hated (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been a heightened level of sensitivity and timely reporting of any incidents between Resident #1 and Resident #2 because the residents had just had a punching altercation a couple weeks prior to the verbal altercation. He said he was aware that Resident #1 moved to another room but he believed it was because there was a need to accommodate room changes for other residents and Resident #1 was asked again if he wanted to move and he agreed. The DON said she had heard there was a fight between Resident #1 and Resident #2 (on 1/30/26), but she was a floor nurse at the time and she was not the DON. She said she was not aware of all the circumstances of the incident. The NHA and the DON said staff received frequent abuse training with online modules. The NHA said the facility would implement an abuse performance improvement plan that included increased staff training. The DON and the NHA said the facility had scheduled an all staff in-service on 4/22/26 and they would review the protocol for reporting abuse and the performance improvement plan. V. Facility follow upA performance improvement plan was provided by the NHA on 4/21/26 at 6:46 p.m. The performance improvement plan identified the improvement plan was initiated on 4/21/26 (during the survey) to address the concern that not all staff were aware of the importance of reporting abuse/neglect immediately. The plan included resident interviews to identify if there were additional resident concerns on abuse, education to all staff and the interdisciplinary team (IDT) regarding the definitions of abuse, federal and state reporting requirements and expectations to immediately report potential abuse to the NHA. The performance improvement plan identified the facility would implement an abuse allegation checklist and leadership would review the 24-hour communication log five days a week to ensure all unreported incidents of abuse were identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
NAME OF PROVIDER OR SUPPLIER Glenwood Springs Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 Blake Ave Glenwood Springs, CO 81601	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#7) of three residents reviewed for accident hazards out of 15 sample residents. Specifically, the facility failed to ensure staff utilized a mechanical lift, as was care planned, when transferring Resident #7 from her wheelchair to her bed.Findings include: I. Facility policy and procedure The Lifting Machine, Using a Mechanical Lift policy, revised July 2017, was provided by the nursing home administrator (NHA) on 4/21/26 at 6:48 p.m. The policy read in pertinent part, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions.At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.Mechanical lifts may be used for tasks the require lifting a resident from the floor, transferring a resident from bed to chair, lateral transfers, lifting limbs and toileting or bathing or repositioning. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. Before using a lifting device, assess the resident's current condition, including physical. Determine if the resident's weight and medical condition are appropriate for the use of a lift.II. Observation and staff interview On 4/21/26 at 12:30 p.m. Resident #7 was observed being wheeled into the resident's room by certified nurse aide (CNA) #2. CNA #2 left the room and left the resident with CNA #1, who was already in the room, and CNA#1 shut the door. At 12:40 p.m. CNA #1 opened the resident's door and exited the room carrying a bag of soiled linens. Resident #7 was observed lying on her bed.-However, CNA #1 was the only staff member present in the resident's room at the time of the resident's transfer. Additionally, there was no mechanical lift observed in the resident's room or in the vicinity outside the resident's room.CNA #1 was immediately interviewed upon exiting Resident #7's room (at 12:40 p.m.) CNA #1 said she used a mechanical lift to transfer the resident into bed. She said CNA #2 had assisted her. When prompted, CNA #1 said Resident #1 used the mechanical lift as needed and sometimes she was just a two-person transfer. She said CNA #2 assisted her after lunch to get the resident into bed without the use of the mechanical lift. She said she did use the mechanical lift to transfer Resident #7 before lunch. -However, CNA #2 did not remain in the room to assist with the transfer after wheeling the resident's wheelchair to her room after lunch (see observation above).III. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included cerebrovascular disease, other symptoms and signs involving musculoskeletal system, repeated falls and traumatic brain injury. The 3/20/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. She required maximum assistance with activities of daily living (ADL). The MDS assessment indicated the resident was a high fall risk and required a mechanical lift for all transfers. B. Record Review The ADL care plan for mobility and transfers, revised 11/12/25 revealed Resident #7 used the wheelchair and was able to self propel at times. The resident did not ambulate and she required a hoyer lift (mechanical lift) for all transfers.Review of Resident #7's April 2026 CPO revealed the following physician's order: Mechanical lift for all transfers, ordered 1/20/26. The physical therapy note, dated 1/16/26, revealed Resident #7 was non-ambulatory and demonstrated severe mobility limitations. It was recommended the nursing staff utilize the hoyer lift (mechanical lift) to ensure safety. The resident exhibited impulsive and unsafe behaviors, including intentionally lowering herself from the wheelchair and the bed, resulting in a high risk for injury. Due to impaired safety awareness, dependence for mobility and inability to perform functional transfers, mechanical lift use was medically necessary to reduce risk of injury to both the resident and the nursing staff. IV. Staff interviews CNA #3 was interviewed on 4/21/26 at 1:15 p.m. CNA #3 said he assisted CNA #1 with using a mechanical lift to transfer Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#7 today (4/21/26) before lunch. He said his resident assignment list documented what residents needed, a mechanical lift or just a one- or two-person transfer. He said he misplaced the assignment sheet and was not sure if Resident #7 was a lift or not off the top of his head. He said he would check with other CNAs to find out. The director of rehabilitation was interviewed on 4/21/26 at 1:30 p.m. The director of rehabilitation said Resident #7 used the mechanical lift for all transfers. She said the resident was evaluated by the physical therapist back in May 2025 and it was recommended the resident use the mechanical lift for safety concerns. She said the care staff were educated on how to use the mechanical lift and the resident's care plan reflected the use of the mechanical lift. She said there was another physical therapy evaluation completed this year (2026) with the same recommendations. CNA #4 was interviewed on 4/21/26 at 2:10 p.m. CNA #4 said Resident #7 used a mechanical lift for all transfers. She said as of today (4/21/26), the facility would be implementing a white board in the residents' rooms to write down how to transfer the residents. She said the transfer information was on the residents' Kardex (a tool utilized to provide consistent care) but not all staff looked at the Kardex. She said if the mechanical lift was not used when transferring Resident #7, it would be dangerous for staff and the resident could be harmed. The director of nursing (DON) was interviewed on 4/21/26 at 5:10 p.m. The DON said she thought Resident #7 used a mechanical lift at times and was a two-person transfer at other times. She said she was not sure, but she said a mechanical lift was used for safety to transfer a resident from bed to chair or chair to bed. She said she had not educated staff on the use of a mechanical lift but implemented the training today (4/21/26) after she was made aware of the concerns regarding Resident #7's transfers from staff. She said a mechanical lift was safer for the resident versus a two-person transfer without the mechanical lift. She said there was a potential that staff could drop the resident or cause harm without the use of the mechanical lift during transfers. The NHA was interviewed on 4/21/26 at 5:27 p.m. The NHA said the facility started a performance improvement plan (PIP) as of today (4/21/26), which included staff training on mechanical lifts and a full-house audit of residents who used a mechanical lift. The NHA said the PIP would be implemented to start immediately for the safety of residents and staff. V. Facility follow-up On 4/22/26 at 11:58 a.m. (after the survey exit) the NHA provided additional information which included documentation of an in-service to care staff to reinforce safe transfer practices and proper use of resident care information on the Kardex. Education was completed on 4/21/26 with eight direct care staff members.