STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065259	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care Center	6005 S Holly St Littleton, CO 80121

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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 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 seven medication carts and two of three medication storage rooms. Specifically, the facility failed to: -Ensure ophthalmic solutions were labeled with the date when the medications were opened;-Ensure there were no loose pills in the bottom of the medication cart drawers; and,-Ensure that lorazepam and insulin vials were labeled with the dates the medications were opened.Findings include:I. Professional referenceHeath Direct Pharmacy Service's Did You Know? Ophthalmic Medication Beyond Use Date Guide, (revised April 2024) was retrieved on 5/20/26 fromhttps://www.hdrxservices.com/wp-content/uploads/2024/04/799-[NAME]-Ophthalmic-Medication-Beyond- It read in pertinent part, Once the ophthalmic drops are opened, current practice guidelines recommend discarding the medication after 28 days due to concerns of stability and sterility. Novartis, the manufacturer of Pataday, (revised June 2020) was retrieved on 5/19/26 from https://www.novartis.com/sg-en/sites/novartis_sg/files/Pataday-July_2020.SIN-App050221.pdf#:~:text=Results It read in pertinent part, Pataday Olopatadine Ophthalmic Solution 0.2%. Store at 2 degrees Celsius (C) to 25 degrees C (36 degrees Fahrenheit (F) to 77 degrees F). Discard four weeks after opening. Joint Commission: What are the Joint Commission's expectations for managing multi-dose vials of sterile, injectable medication? (revised 4/23/26) was retrieved on 5/20/26 from https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-fa If a multi-dose vial has been opened or accessed (needle-punctured), the vial should be dated with the last date that the product should be used (expiration date) and discarded within 28 days. The Food and Drug Administration's (FDA) Insulin Storage and Effectiveness (revised 9/19/17), was retrieved on 5/19/26 from fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-p It read in pertinent part, Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 degrees F and 86 degrees F for up to 28 days and continue to work.II. Facility policy and procedureThe Medication Storage policy dated 2008 was received from the director of nursing (DON) on 5/13/26 at 4:20 p.m. It read in pertinent part, Pharmacy Labels: Prescription medications must have a pharmacy label attached. If the item is very small, the label may be affixed to a plastic bag or vial. Medication carts should be checked monthly and as needed to verify that labels and dates are correct. Individual use items follow the manufacturer's guidelines listed on the packaging. III. ObservationsOn 5/11/26 at 5:39 p.m. the Evergreen medication cart was observed with licensed practical nurse (LPN) #1. The following items were found:-One opened bottle of Artificial Tears ophthalmic drops without a label to indicate the date it was opened;-One opened bottle of Pataday ophthalmic drops without a label to indicate the date it was opened;-One opened vial of Humalog insulin in the top drawer, without a label to indicate the date it was opened; and,-Seven loose medications were found at the bottom of the (continued on next page)

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

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	second drawer. The pills were not in a container and there was no label to identify what any of the pills were.On 5/12/26 at 2:15 p.m. the Aspen unit medication cart was observed with registered nurse (RN) #1. The following item was found:-One loose pill was found at the bottom of the second drawer. The pill was not in a container and there was no label to identify what the pill was. On 5/12/26 at 3:05 p.m. the Columbine unit medication cart was observed with LPN #2. The following items were found:-Eight loose pills were found at the bottom of the second drawer. The pills were not in a container and there was no label to identify what any of the pills were; and,On 5/12/26 at 3:15 p.m. the Columbine medication storage room was observed with LPN #2.The following item was found:-One opened vial of lorazepam in the refrigerator without a label to indicate the date it was opened. IV. Staff interviewsLPN #1 was interviewed on 5/11/26 at 5:55 p.m. LPN #1 said every nurse should clean the medication carts on their shift. She said the night nurses performed a more thorough cleaning, and the unit nurse managers checked the medication cart for labels, open dates, and expiration dates of medications. LPN #1 said medications should be labeled with the open dates to prevent giving expired medications to a resident.RN #1 was interviewed on 5/12/26 at 2:35 p.m. RN #1 said every nurse was responsible for cleaning the medication cart and labeling the medications with the date when they opened the medications. RN #1 said if a nurse dropped a medication in the medication drawer, the nurse should pick it up. LPN #2 was interviewed on 5/12/26 at 3:20 p.m. LPN #2 said that the nurses were responsible for keeping the medication carts clean. LPN #2 said the nurses who opened the medications should date the medications with the date they opened it so staff did not give an expired medication to a resident. She said the unit managers checked the medication carts for labels and expired medications. The DON was interviewed on 5/12/26 at 5:15 p.m. The DON said that the medication carts should be cleaned by the nurses on their shifts. She said if a medication was dropped in the drawer of a medication cart, the nurse should pick it up. The DON said the nurses should date the medications when they opened them, to prevent the administration of expired medications to residents.

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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, distribute and serve food in a sanitary manner in the main kitchen.Specifically, the facility failed to ensure food was held at the correct temperature. Findings include:I. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 5/18/26. It revealed in pertinent part, Except during preparation, cooking, or cooling, or when time is used as the public health control time/temperature control for safety food shall be maintained at 135 degrees Fahrenheit (F) or above and 41 degrees F or less. (3-501.16) II. Facility policy and procedureThe Dietary Guidelines Manual / Food Temperatures policy, dated 2015, was provided by the nursing home administrator (NHA) on 5/15/26 at 5:13 p.m. The policy read in pertinent part, The temperatures of the food items will be taken and properly recorded for each meal. Hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F. Hot food items may not fall below 135 degrees F after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees F and reheated to at least 165 degrees F prior to serving. Temperatures should be taken periodically to ensure hot foods stay above 135 degrees F and cold foods stay below 41 degrees F during the portioning, transporting and serving process until received by the resident. Normally hot foods will be 165 to 180 degrees F or higher when removed from the cooking heat source. If held at 160 to 180 degrees F this will ensure serving at 135 degrees F or above. III. ObservationsDuring a continuous observation of the dinner meal service on 5/12/26, beginning at 4:05 p.m. and ending at 6:09 p.m., the following was observed:At 4:05 p.m. cook (CK) #1 checked the temperatures of food lined up on the steam table ready for the meal service. CK #1 used a digital thermometer and the following temperatures were recorded:-The pureed beef was 127 degrees F.-The hamburger patties were 127 degrees F.At 4:22 p.m., without reheating the food, CK #1 and CK #2 began serving the hamburger patties, pureed beef and the banana pudding. -CK #1 assembled meal plates with the hamburger patties and the pureed beef at an inappropriate holding temperature.IV. Staff interviewsCK #1 was interviewed on 5/13/26 at 3:13 p.m. CK #1 said he checked the food temperatures after cooking, on the steam table less than 30 minutes prior to meal service and during the meal service. CK #1 said he documented the temperature checks in the food temperature log. He said the ideal holding temperature should be 170 degrees F for hot food. CK #1 said the steam table helped maintain proper holding temperatures as they put food on the line 30 minutes before the meal service. CK #1 said serving food at 127 degrees could get residents sick.CK #2 was interviewed on 5/14/26 at 3:26 p.m. CK #2 said they checked temperatures while cooking, after cooking and before meal service. She said she documented the temperature checks in the temperature binder. She said the holding temperature should be 165 degrees F for hot food and 35 to 40 degrees F for cold food. CK #2 said she would throw away food that was not held at an appropriate temperature. She said residents could become ill if food was served at an inappropriate holding temperature. The dietary manager (DM) was interviewed on 5/13/26 at 3:44 p.m. The DM said cooks checked food temperatures while cooking, before meal service and during the meal service. She said cooks documented temperature checks in the food temperature log and she personally followed up to ensure the logs were up to date. The DM said she educated the staff regarding temperature checks and how properly to follow recipe instructions. She said the holding temperature should be 140 degrees F for hot food on the line table. The DM said cooks should keep food covered and stir the food.to maintain proper holding temperatures on the steam table. She said CK #1 did not recall the hamburger patty was 127 degrees F, but she provided temperature checks in-service for the staff. She said if food was not at an appropriate temperature, she would tell cooks to throw it away and cook another one.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to maintain accurately documented medical records for one (#13) of four residents reviewed for ADLs out of 40 sample residents.Specifically, the facility failed to:-Ensure Resident #13's bathing record was accurately documented related to whether the resident received or refused her scheduled bed baths; and,-Ensure Resident #13's care plan included documentation to indicate the resident refused her offered bed baths at times.Findings include:I. Facility policy and procedureThe Clinical Manual/Activities of Daily Living (ADL) policy, dated 2008, was provided by the nursing home administrator (NHA) on 5/15/26 at 5:13 p.m. The policy read in pertinent part, ADL documentation to reflect resident performance and staff assistance provided. Documentation must be completed in accordance with system workflows and facility standards. Enter information to reflect the resident's true functional status. Documentation to be completed prior to the end of the shift. Notify the nurse of resident changes in status or refusals.II. Resident #13A. Resident statusResident #13, age less than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included paraplegia (paralysis in the lower part of the body affecting both legs), multiple sclerosis (abnormal hardening or thickening of body tissue) and colostomy (a surgical procedure creating an opening in the belly so stool could leave the body through that opening).The 3/4/26 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 revealed the resident was dependent on staff assistance with toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene.The MDS assessment did not indicate Resident #13 refused care.B. Observations and interviewOn 5/11/26 at 5:29 p.m. Resident #13 was in her room. The resident's hair was disheveled and looked uncombed and tangled. Resident #13 said she was not getting her regularly scheduled bed baths. She said she was scheduled for bed baths three times a week, but the certified nurse aides (CNA) only provided her with a bed bath once a week, sometimes two times a week. Resident #13 said she smelled bad and her hair was disgusting. She said she felt awful when she did not get her bed baths. Resident #13 said she voiced concerns to the unit manager and she filed grievance forms regarding not receiving her bed baths. Resident #13 said the facility tried to address it for a few weeks, then it went back to how it was before. She said she had not told the unit manager again. Resident #13 said she had refused bed baths twice, one time when she was in pain and the other time was when the staff member wanted to provide a bed bath at 12:00 a.m.On 5/12/26 at 1:30 p.m. Resident #13 was lying in bed on her back and looking at her computer screen. The resident's hair was disheveled and looked uncombed and tangled.C. Record review-Review of Resident #13's comprehensive care plan failed to reveal documentation related to the resident's bathing preferences or documentation to indicate the resident refused her bed baths at times.The 2026 shower book revealed Resident #13 was scheduled for bed baths on Tuesdays, Thursdays and Saturdays.Review of Resident #13's February 2026 shower sheets revealed the following:Bed baths were provided for Resident #13 on 2/3/26 and 2/12/26.Resident #13 refused bed baths on 2/5/26, 2/7/26, 2/14/26, 2/17/26, 2/24/26 and 2/28/26.-However there was no documentation to indicate if Resident #13 was offered and/or refused a bed bath on 2/10/26, 2/19/26, 2/21/26 and 2/26/26. Review of Resident #13's March 2026 shower sheets revealed the following:Bed baths were provided for Resident #13 on 3/3/26, 3/6/26, 3/12/26, 3/16/26, 3/23/26 and 3/26/26. Resident #13 refused a bed bath on 3/5/26, 3/7/26, 3/19/26, 3/21/26, and 3/31/26.-However there was no documentation to indicate if Resident #13 was offered and/or refused a bed bath on 3/10/26, 3/14/26, 3/17/26, 3/24/26 and 3/28/26. Review of Resident #13's April 2026 shower sheets revealed the following:Bed baths were provided for Resident #13 on 4/2/26, 4/9/26, 4/23/26 and 4/29/26.Resident #13 refused (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a bed bath on 4/16/26.-However there was no documentation to indicate if Resident #13 was offered and/or refused a bed bath on 4/4/26, 4/7/26, 4/11/26, 4/14/26, 4/18/26, 4/21/26, 4/25/26, 4/28/26 and 4/30/26. III. Staff interviewsCNA #1 was interviewed on 5/14/26 at 9:08 a.m. CNA #1 said he was aware of residents' shower schedules from the shower book at the unit manager's office. He said if a resident refused a shower, he would reapproach the resident a couple of times later. CNA #1 said he would document on the shower sheet if the resident still refused and let the nurse know. He said Resident #13 was scheduled for bed baths on Tuesdays and Thursday evenings. He said he was not aware of the reason Resident #13 missed her scheduled bed baths.-However, CNA #1 reviewed the shower book and acknowledged Resident #13 was scheduled for bed baths three times a week.The unit manager was interviewed on 5/14/26 at 9:38 a.m. The unit manager said she was the one who updated the shower book and let the CNAs know when it was updated. She said if residents refused showers, she would expect CNAs to try three times and then document the refusal. The unit manager said Resident #13 was scheduled for bed baths on Tuesdays, Thursdays and Saturdays. The unit manager was not able to provide an explanation regarding missing bed bath documentation for Resident #13. The director of nursing (DON) stopped in during the interview and said they would provide more documentation.-However the additional bed bath documentation provided by the DON did not include information for the dates when there was no documentation to indicate if Resident #13 received or refused her scheduled bed baths (see record review above).The DON and the unit manager were interviewed together on 5/14/26 at 5:45 p.m. The DON said she expected CNAs to re-approach Resident #13 if she refused her bed baths. The DON said the facility tried to accommodate Resident #13 when she expressed her preferences regarding which staff members she wanted to provide her care. The DON said she educated CNAs to make sure their documentation was accurate and said the facility was in transition to electronic charting for showers. The DON said Resident #13 had behavior issues leading to refusals of her bed baths sometimes. The DON said she encouraged CNAs to always offer bed baths to Resident #13.