STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065264	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walbridge Memorial Convalescent Wing	100 Pioneers Medical Center Dr Meeker, CO 81641

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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 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 record review and interviews, the facility failed to provide a menu that offered a variety of food options. Specifically, the facility failed to ensure residents were not served a repetitive menu that offered a high quantity of chicken and pork. Findings include:I. Facility policy and procedureThe Menu Planning policy, revised September 2023, provided by the dietary manager (DM) on 12/11/25 at 5:35 p.m. According to the policy, a seven day restaurant style menu shall be used to accommodate general therapeutic diets that would include a variety of selections. II. Resident interviewResident #28 was interviewed on 12/8/25 at 4:23 p.m. Resident #28 said there was too much chicken served on the menu. She said she did not complain because she understood that the large amount of chicken was probably due to a need for cost effective protein. III. Resident group interview Four residents (#7, #26, #27 and #28) who were identified as alert and oriented through facility and assessment the were interviewed in a group setting on 12/9/25 at 12:52 p.m. The residents said they were served chicken almost everyday and were frequently served pork. The residents in the group said they were tired of all the chicken and pork on the menu. IV. Record reviewResident council minutes were provided by the nursing home administrator (NHA) on 12/8/25 at 1:59 p.m. The September 2025 through December 2025 resident council minutes were reviewed pertaining to food. The council minutes did not identify the expressed concerns of too much chicken as identified in the above and below interviews. The October 2025 resident council minutes identified the DM informed the residents that the facility had a new five week menu cycle and to let him know if they did not like something or something was not working, the dietary department could change it. The weekly menus starting on 10/26/25 and ending on 11/29/25 were provided by NHA on 12/11/25 at 9:33 a.m. The menu for the week of 10/26/25 identified chicken was on the menu five days that week. The only days chicken was not served to the residents was on Monday 10/27/25 and Wednesday 10/29/25. Review of the weekly menu identified pork was served three times that week. The menu for the week of 11/2/25 identified chicken was on the menu three days that week. The chicken was served three days in a row on 11/2/25, 11/3/25 and 11/4/25. Review of the weekly menu identified a meal consisting of or included pork was served five times that week. The menu identified pork was served twice on 11/6/25. The menu for the week of 11/9/25 identified chicken was on the menu three days that week and a meal consisting of pork was served five times. The menu for the week of 11/16/25 identified chicken was on the menu three days that week and a meal that consisted of or included pork was served seven times that week and twice on 11/19/25. The menu for the week of 11/23/25 identified chicken was on the menu three days that week and a meal that consisted of or included pork was served six times that week and twice on 11/27/25. The menu did not identify what the residents were served for lunch on 11/27/25. The weekly menus starting on 11/30/25 and ending on 12/27/25 were provided by dietary manager (DM) on 12/11/25 at 5:23 p.m. The menu for the week of 11/30/25 identified chicken was on the menu five days that week and a meal that consisted of or included pork was served five times and twice on 12/4/25. The menu for the week of 12/7/25 identified chicken was on the menu three days that week and a meal that consisted of or included pork was served four times that week and twice on 12/11/25. The menu for the week of 12/14/25 identified chicken was on the menu twice that week. (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Pork was on the menu five times and was scheduled for two of the three meals on both 12/14/25 and 12/18/25.The menu for the week of 12/21/25 identified chicken was on the menu for three meals and scheduled to be served twice in a row on 12/21/25 and again on 12/22/25. Review of the weekly menu identified a meal consisting of or included pork would be served seven times that week and for breakfast and dinner on 12/24/25 and 12/25/25. V. Staff interviewsThe DM was interviewed on 12/11/25 at 4:57 p.m. He said Resident #28 recently said they were served too much chicken during a recent resident council. -However, review of the resident council minutes did not reveal this concern was documented or addressed in the meeting (see record review above). The DM said Resident #28 did not like chicken. The DM said it was important to have a balanced menu for residents to ensure the dietary department was meeting the residents' nutritional needs in addition to their preferences. He said he would look at the menu and replace the chicken with another protein if needed. The DM was interviewed again on 12/11/25 at 5:40 p.m. The DM said that he had an opportunity to review the menus and agreed with residents that chicken served five days a week would be too much chicken. He said he would work on changing the menu to provide more variety in the meals. The NHA was interviewed on 12/11/25 at 6:33 p.m. She said the DM and the registered dietitian collaborated together to create menus for the residents. The NHA said too much chicken was brought by the resident council. The NHA said she reviewed the menus and saw there was repeating protein in a week, like chicken and pork.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure food was served under sanitary conditions in the main kitchen. Specifically, the facility failed to ensure dishes were properly sanitized. Findings include:I. Professional reference According to the Food and Drug Administration Food Code (2022), retrieved on 12/17/25, Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required 160 degrees F (Fahrenheit). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 160 degrees). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 160 degrees F. (4-302.13)II. Facility policy and procedureThe High Temperature Sanitation policy, dated July 2025, was provided by the dietary manager (DM) on 12/11/25 at 3:35 p.m. The policy read in pertinent part, High temperature sanitation is the process of using hot water to sanitize the wares. This occurs when the surface temperature of the wares reaches 160 degrees Fahrenheit (F). The 160 degrees F surface temperature is achieved by utilizing all aspects of the ware washing process. It is accumulated on dishes over a period of time on hot water sanitizing dish machines, not just a single high temperature final rinse. Therefore, each step of the warewashing process must be operating at its proper temperature. The hot water is crucial in achieving the proper surface temperature as it is much longer than the rinse cycle. The water cycle will bring the surface temperature up to a certain point so that it goes into the final rinse, minimum temperature of 180 degrees F rinse water will bring the service temperature of the wares to 160 degrees F to properly sanitize.II. Observations and interviews The dishwashing machine and dish cycle was observed on 12/10/25 at approximately 11:50 a.m.Dietary aide (DA) #1 said the dishwashing machine was a high temperature machine. DA #1 said the temperature gauges on the digital screen were frozen so they used a temperature disk to get the temperature. He laid the disk flat on a plastic tray, placed the tray in the dishwasher and ran the disk through the wash and final rinse dish cycles. DA #1 opened the dishwasher and the temperature disk read 146 degrees F. He said they have had problems with their dishwashing machine and parts of it were broken. Observations of the dishwashing cycle were conducted on 12/11/25 between 10:00 a.m. and 10:10 a.m. The DM placed the temperature disk flat on a plastic tray, placed the tray in the dishwasher and ran the disk through the wash and sanitize dish cycles. The DM ran the machine four different times, checking the temperature disk after the final rinse cycle. Three out four times the temperature on the disk did not read over 160, with temperatures indicating disk surfaces level of 146 degrees F, 158 degrees F, 165 degrees F and 155 degrees F.The dishwashing machine was observed again with the DM on 12/11/25 at approximately 3:35 p.m. after he learned how to place the temperature disk in the dishwashing machine and after the finial rinse digital sensor was reset. The DM placed the disk on the rack set up like a plate and ran the dishwasher machine. The digital final rinse sensor read 184.82 degree F and the disk temperature read 170 F. The DM said that frozen digital temperature gauges might have affected the actual water temperature and he would contact the vendor to check if that could be a reason for the lower temperature observations.IV. Staff interviewThe DM was interviewed on 12/11/25 at 10:13 a.m. The DM said it was important for the water in the dishwashing machine to be hot enough to kill germs and bacteria on the dishes for proper sanitation. He said the dishwashing machine usually ran (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperatures of over 180 degrees F. The DM said he was surprised that the disk showed lower temperatures during the observations. He said the digital sensor gauge on the dishwashing machine had not been working for a while and their service vendor provided the kitchen with the temperature disk to check temperatures. He said the dishwasher was recently served by the vendor but the temperature sensor was not fixed. The DM said the dishwashing machine was old and he was working with the vendor to try to get a new one for the facility. The DM was interviewed a second time on 12/11/25 at 3:30 p.m. The DM said the wash cycle digital sensor on the washing machine was still broken but he was able to reset one of the sensors. The DM said he spoke to the dishwashing machine vendor and learned that he was setting up the temperature disk wrong. He said the disk should have been set in a rack like a plate and not flat to accurately read the surface level of the disk and ensure the temperature was high enough for sanitation. The DM said it was important for the kitchen staff to accurately take the temperature of the dishwashing machine to make sure there was no bacteria left on the plates after the final rinse cycle and ensure proper surface sanitation. He said the vendor would come back to the facility and fix all the gauges.The DM was interviewed again on 12/11/25 at approximately 4:45 p.m. The DM said he spoke to his dishwashing machine vendor who said a faulty sensor possibly could have affected the temperature levels of the water but that was not determined. The DM said new temperature gauges have been ordered so staff does not have to rely on the disk to check the sanitation surface levels of the dishes The nursing home administrator (NHA) was interviewed on 12/11/25 at 6:35 p.m. The NHA said the DM had brought up concerns about the dishwashing machine and wanted it replaced. The NHA said the facility was in the process of replacing the machine and a new machine was approved. She said she does not have an arrival date for the new dishwashing machine. V. Facility follow upThe dishwashing machine arrival date was provided by the NHA on 12/12/25 at 4:43 p.m. via email. According to the email, requests from the dishwashing machine vendor have been delayed but a new dishwashing machine was scheduled for delivery on 12/31/25 and the temperature gauges would be replaced as soon as possible and prior to the receipt of the new machine.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, record review and interviews, the facility failed to ensure the residents' right to a safe, clean, comfortable and homelike environment for four (#13, #26, #27 and # 28) of seven residents out of 19 sample residents.Specifically, the facility failed to provide washcloths and hand towels in Resident #13, Resident #26, Resident #27 and Resident #28's rooms. Findings include:I. Resident #13A. Resident statusResident #13, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included atrial fibrillation, depression, anxiety, osteoporosis, heart failure and dementia without psychotic disturbance and anemia.The 11/18/25 minimum data set (MDS) assessment revealed Resident #13 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. Resident #13 required substantial assistance with bathing, footwear and lower body dressing. Resident #13 required moderate assistance with toileting and upper body dressing and required only set up and clean up assistance with personal hygiene.B. ObservationsOn 12/8/25 at 4:58 p.m. Resident #13's room had no hand towels or washcloths in her bathroom. Resident #13 had a paper towel dispenser but no linens in the room.On 12/10/25 at 3:47 p.m. Resident #13's room had one hand towel and no washcloths.C. Resident interviewResident #13 was interviewed on 12/8/25 at 4:58 p.m. Resident #13 said she frequently did not have any wash cloths or hand towels in her bathroom. Resident #13 said she thought the linens were available but the staff frequently forgot to stock the rooms. Resident #13 said staff provided hand towels and washcloths whenever she asked, but she felt like she was being a bother by having to ask for something so simple all of the time. II. Resident #26A. Resident statusResident #26, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), depression, hypertension and edema.The 10/22/25 MDS assessment revealed Resident #26 was cognitively intact with a BIMS score of 15 out of 15. Resident #26 was independent with eating, personal hygiene, upper and lower body dressing and toileting. Resident #26 required moderate assistance with bathing.B. Resident interviewResident #26 was interviewed on 12/9/25 at 12:52 p.m. Resident #26 said the facility was inconsistent when stocking her room with washcloths. Resident #26 said when she requested washcloths from staff, sometimes staff would look and tell her none were available. Resident #26 said the issue was brought up in resident council and the facility ordered more, but keeping washcloths in her room remained inconsistent. III. Resident #27A. Resident statusResident #27, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included chronic kidney disease, heart failure, polyneuropathy and depression.The 9/23/25 MDS assessment revealed Resident #27 was cognitively intact with a BIMS score of 14 out of 15. Resident #27 was independent with eating, personal hygiene, bathing and toileting. Resident #27 required moderate assistance with upper body dressing and substantial assistance with lower body dressing and footwear.B. Resident interviewResident #27 was interviewed on 12/9/25 at 12:52 p.m. Resident #27 said the facility did not consistently have washcloths and hand towels stocked in her room. Resident #27 said sometimes staff told her no more washcloths were available until the next laundry delivery. Resident #27 said sometimes she had to use the corner of a previously used washcloth or towel to wash her face. IV. Resident #28A. Resident statusResident #28, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included hypertension, spinal stenosis of the lumbar region, chronic pain syndrome, osteoporosis and frequent migraines.The 10/21/25 MDS assessment revealed Resident #28 was cognitively intact with a BIMS score of 15 out of 15. Resident #28 was independent with eating, personal hygiene, dressing and toileting. Resident #28 required minimal assistance with bathing. Resident #28 ambulated independently with a walkerB. Resident interviewResident #28 was interviewed on 12/9/25 at 12:52 p.m. Resident #28 said the facility did not (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	always have wash cloths or hand towels available. Resident #28 said sometimes she had to use a large amount of paper towels to wash and dry her face and hands. V. Resident council meeting minutesThe resident council meeting minutes, dated 7/1/25, revealed a complaint from a resident that the unit was short on towels, washcloths and sheets. The minutes revealed the nursing home administrator (NHA) said she would follow up with laundry to ensure the facility was receiving adequate linen supplies. -However, the August 2025, September 2025, October 2025 and November 2025 resident council meeting minutes did not mention anything regarding follow-up for the lack of washcloths or hand towels.VI. Additional observationsOn 12/8/25 at 4:09 p.m. Resident #6's room had no washcloths or hand towels.On 12/9/25 at 8:48 a.m. Resident #16's room had no washcloths or hand towels.VII. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 12/9/25 at 9:08 a.m. CNA #3 said each residents' room should have washcloths and hand towels hanging on the towel rack in the bathroom. CNA #3 said the CNAs on each shift should be checking residents' rooms and restocking linens. CNA #3 said the reason no towels were in Resident #13's bathroom was probably because the night shift CNA used them and forgot to restock them. Licensed practical nurse (LPN) #2 was interviewed on 12/11/25 at 10:44 a.m. LPN #2 said she was aware the unit had frequent shortages of washcloths. LPN #2 said the facility's linen supply, including wash cloths and hand towels, was managed by the hospital laundry service attached to the unit. LPN #2 said each day, the unit CNAs went to each room and restocked the linens in the bathrooms and sometimes the CNAs let her know they ran out of linens. LPN #2 said the CNAs told her what room they were able to get to before running out of linens to restock. LPN #2 said when that happened, she would have to tell the night shift staff where to start restocking again when the next supply came back from the laundry. LPN #2 said she did not have a way to ensure the next shift followed through on restocking all of the remaining residents' rooms with washcloths and hand towels. LPN #2 said the facility did order more washcloths for the unit recently, but the availability or the linens could depend on the time the dirty linens were provided to laundry and the time the clean laundry arrived from the hospital. LPN #2 said the facility completed supply audits of certain items, but they currently did not audit washcloths or hand towels. LPN #2 said she planned to ask for these items to be added to the audit list to try to identify when linens were in short supply. The director of nursing (DON) was interviewed on 12/11/25 at 5:26 p.m. The DON said she remembered a lack of washcloths and towels was brought up in a resident council meeting a few months ago. The DON said she ordered more towels and washcloths for the units and had not heard any complaints since. The DON said she was not aware the CNAs were reporting they were running out of towels while trying to restock residents' rooms. The DON said paper towels were not adequate for a home-like environment because people would expect to be able to wash their face with linen washcloths or towels if they were in someone's home. The DON said staff were able to supply residents with washcloths upon request, but residents should not have to ask for them as they should be available in the bathroom. The DON said she planned to talk with her floor staff to find ways to track washcloths and ensure residents' rooms were adequately stocked with hand towels and washcloths.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to timely investigate an allegation of abuse involving one (#26) of three residents reviewed for abuse out of 19 sample residents.Specifically, the facility failed to timely investigate and report an allegation of misappropriation of property for Resident #26.Findings include:I. Facility policy and procedureThe Abuse Prevention Program policy, revised September 2023, was provided by the nursing home administrator (NHA) on 12/8/25 at 1:20 p.m. It read in pertinent part, To maintain an abuse free environment and establish guidelines to address suspected occurrences involving resident abuse (mistreatment, exploitation, neglect or verbal, physical or sexual abuse, including injuries of unknown source and misappropriation of resident property). Reports of abuse are promptly and thoroughly investigated. An occurrence report will be filled out within 24 hours by the charge nurse.The abuse policy outlined how to complete an investigation regarding misappropriation of property. According to the policy, the facility would review the complaint report; interview the person or persons reporting the incident; interview any witnesses to the incident; review the resident's medical record if indicated; search the resident's room with the resident's permission; interview staff members that had contact with the resident during the relevant periods or shifts of the alleged incident; conduct interviews with the resident's roommate, family members and visitors; and, create a root cause analysis with the circumstances surrounding the incident.The Reporting Suspicion of a Crime policy, revised December 2025, was provided by the NHA on 12/11/25 at 9:58 a.m. The policy documented reports of a suspected crime, to include allegations of misappropriation of resident property, would be reported to the appropriate parties no later than 24 hours after the issue was reported. II. Resident statusA. Resident statusResident #26, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and depression, unspecified.The 10/22/25 minimum data set (MDS) assessment identified Resident #26 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out 15. The MDS assessment indicated Resident #26 used a walker for mobility and was independent with most of her activities of daily living (ADLs). The MDS assessment did not indicate she had inattention, disoriented thinking or behaviors directed towards herself or others. B. Resident interviewResident #26 was interviewed on 12/8/25 at 5:16 p.m. Resident #26 said she was missing a $50.00 bill. She said the money had been missing for a couple of months. She said she had placed the bill under her pillow but it was no longer there when she attempted to retrieve it later that afternoon in October 2025. Resident #26 said she had reported it when she realized it was gone. She said she had a volunteer help her look for the money in her room but they could not find it. She said had not heard anything back from the facility after she reported the money missing from her room. Resident #26 was interviewed a second time on 12/10/25 at 10:20 a.m. Resident #26 said the missing $50.00 bill was given to her in a card from a friend of hers. She said she was so happy to have received the money because she was going to use it to buy her grandson a gift. She said she looked all over her room but still could not find it. She said she did not know if the money was somewhere in her room or if someone took it. Resident #26 said she still hoped the money would turn up. She said if she did not get the money back, she hoped that if someone took it from her, they were able to put it to good use.C. Record reviewA request made on 12/10/25 with the director of nursing (DON) for an October 2025 facility investigation for an allegation of Resident #26's missing money was not provided (refer to staff interviews below). A summary of a 12/10/25 grievance investigation for Resident #26's missing money and related documents were provided by the NHA on 12/11/25 at 9:58 a.m. The grievance summary identified the investigation was not complete and was ongoing. The summary outlined some of the steps taken during implementation of the 12/10/25 investigation, to include an internal misappropriation investigation, staff education of misappropriation and reporting and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmation that the allegation was reported to the State agency for possible misappropriation. According to the summary, all staff meetings agendas had been updated for misappropriation and reporting for additional review at all monthly staff meetings. The staff would be required to complete online training for protecting older adults on hire and annually. The volunteers would be re-educated on protecting older adults, reporting, and their role in any investigations, if applicable. The summary identified the topic of misappropriation, reporting and staff responsibility would be addressed during resident council. The summary indicated the video footage from the day of the event (10/30/25), on all persons entering/exiting the room, and those times had been reviewed and the facility administration planned to provide and implement personal lockboxes for residents' rooms if the residents agreed. The 12/10/25 grievance form identified Resident #26's grievance of missing money was documented as a grievance on 12/10/25 at 10:50 a.m. and submitted to the social services director (SSD). The grievance form documented the resident's account of the missing money. According to the grievance form, Resident #26 was provided $50.00 from the facility on 12/10/25 and she and her family were satisfied with the facility's response to her grievance. The grievance form indicated Resident #26 was offered a lock box to keep her money in, which she declined. The 12/10/25 misappropriation investigation documented the timeline of the allegation and the facility's response to the allegation regarding Resident #26's missing money. The investigation documented the money was last seen on 10/30/25 at 1:50 p.m. The money was reported missing on 10/30/25 at 4:06 p.m. to the DON. The allegation of the missing money was reported to the NHA and the risk manager on 12/10/25. The allegation of misappropriation was reported to the State agency and the ombudsman on 12/11/25. The investigation documented Resident #26 felt someone stole the money. III. Staff interviewsThe DON was interviewed on 12/10/2025 at 10:31 a.m. The DON said if a resident reported to her or staff that they were missing money, a grievance form and an incident report would be filled out, the NHA would be informed and an investigation would be conducted. The DON said Resident #26 reported to her that she was missing money from her room in October 2025. The DON said she was on the way out the door to an appointment and then was on leave for a week when it was initially reported to her. She said Resident #26 and a volunteer with the resident, had concerns about a newer staff member possibly taking the money. The DON said she informed licensed practical nurse (LPN) #2 of the missing money. The DON said the volunteer helped Resident #26 look for the money in her room. She said she did not know if an investigation on the missing money was completed or if the incident was reported. She said she did not inform the NHA of the resident's missing money in October 2025 or the days following the allegation. The DON said she should have checked on the status of the missing money when she came back from her leave. She said she had forgotten about it. She said she would report the missing money to the NHA, complete an incident report and grievance form and initiate an investigation (during the survey). The DON said the steps to follow up on the allegation of the missing money should have been started sooner. LPN #2 was interviewed on 12/10/25 at 10:54 a.m. LPN #2 said she was informed by the DON that Resident #26 had reported missing money from her room. She said the DON did not delegate any follow up responsibilities to her related to Resident #26's allegation of missing money. LPN #2 said she checked in with Resident #26 regarding the money on 12/8/25 and the resident said she might have lost the money herself. LPN #2 said she was not aware of any other residents reporting missing money in the facility. The DON was interviewed a second time on 12/10/25 at 4:59 p.m. The DON said she completed a grievance form for Resident #26 and the NHA started an investigation into the missing money. She said the incident was reported to the State agency. She said Resident #26 did not want the police to be called. The DON said Resident #26 was provided $50.00 from the facility to replace the missing money from October 2025. The NHA was interviewed on 12/10/2025 at 6:02 p.m. The NHA said an investigation into the missing money was now under way and the facility was in the process of interviewing staff and reviewed the video footage from 10/30/25, the day the money was reported missing. She said the video footage did not show any staff member alone in the resident's (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room on 10/30/25. The NHA said Resident #26 said she opened the card with the money in it and placed the money under the pillow because she was on her way to bingo. The NHA said when a resident reported missing money, the staff would conduct a search for it. She said the staff would notify the family when there was an accusation of missing money or suspicion of theft. She said it was not a usual practice to have a volunteer search the resident's room instead of staff. The NHA said the investigation into the missing money included reviewing the staff schedule to determine who was working at the time of the reported missing money and see if anyone witnessed suspicious activity. She said the facility would report the allegation to the State agency and the police if there was anything missing of monetary value. The NHA said Resident #26's allegation of missing $50.00 from her room on 10/30/25 should have been reported and investigated right after she reported it to staff. The NHA said staff should have then conducted a search for the money in her room after obtaining the resident's permission. The NHA said the staff searched for the money in Resident #26's room on the weekend following the 10/30/25 allegation. The NHA said she had not reported the missing money to the State agency but she was going to report it soon. She said would continue to educate staff to report any allegations of missing money and property to her as soon as they became aware of the allegation so it could be followed up with right away. The NHA said if an investigation was not conducted shortly after the allegation, then the facility was less likely to be able to correct the concern. The NHA was interviewed a second time on 12/11/25 at 6:33 p.m. The NHA said allegations of missing money in the facility were not a common event. She said another search in Resident #26's room was conducted, but the money was not found. She said the money was replaced and the incident had now been reported to the State agency.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to to ensure received treatment and care in accordance with professional standards of practice for one (#19) of six residents out of 19 sample residents.Specifically, the facility failed to: -Ensure residents' medications were not pre-poured; and,-Administer Resident #19's eye drops in accordance with professional standards.Findings include:I. Professional referencesAccording to the American Academy of Allergy, Asthma and Immunology, retrieved on 12/11/25 from https://www.aaaai.org/tools-for-the-public/conditions-library/allergies/eye-drops, When administering multiple eye medications, wait five to 15 minutes before delivering the second medication to the same eye in order to prevent dilution.According to Fundamentals of Nursing 10th edition by [NAME] and [NAME] et. al, 2021 pp. 672, Responsibilities of medication administration include knowing medication therapeutics, assessing a patient before administration, calculating doses, administering medications using the seven rights, monitoring and evaluating medication effects, and assessing a patient's ability to self-administer medications. The seven rights of medication administration include the right medication, right dose, right patient, right route, right time, right documentation, and right indication.II. Resident #19A. Resident statusResident #19, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included dementia, anxiety, macular degeneration and legal blindness. The 11/6/25 minimum data set (MDS) assessment revealed Resident #19 had severe cognitive impairment with impaired short-term and long-term memory. Resident #19 required moderate assistance with eating, repositioning and oral hygiene. Resident #19 required substantial assistance with toileting, bathing, dressing, footwear and personal hygiene. Resident #19 required moderate assistance with use of a wheelchair for mobility. B. ObservationsOn 12/10/25 at 9:09 a.m. licensed practical nurse (LPN) #3 administered the following medications to Resident #19:Refresh Ophthalmic Solution 1.4-0.6 % (polyvinyl alcohol-Povidone). Instill one drop in both eyes.Prednisolone acetate ophthalmic suspension 1 % (prednisolone acetate). Instill one drop in the right eye.-However, LPN #3 waited only one minute and eight seconds between each ophthalmic medication administration, which was below the recommended minimum wait time of five minutes.III. Pre-pouring medication failureOn 12/9/25 at 2:18 p.m., during observation of the medication storage area, three pill cups were observed in the top drawer of the medication cart. Each cup had one pill in it. Each cup was labeled with an unidentified resident's initials and the time the medication was ordered to be given, but the cups were not labeled with which medication was in the cup. LPN #1 said at the time that he went to administer the scheduled medications to three residents but they were not on the unit during lunch time, so LPN #1 said he labeled each cup and put them in the medication cart to give them when the residents returned. IV. Staff interviewsLPN #3 was interviewed on 12/10/25 at 11:43 a.m. LPN #3 said she was aware she did not wait the appropriate time between administering Resident #19's ophthalmic medications. LPN #3 said normally she would administer Resident #19's first ophthalmic medication, then his oral medication and then his second ophthalmic medication. LPN #3 said Resident #19 was sleepy this morning and the observation of his medication administration was not his typical morning routine. LPN #3 said she planned to administer the resident's other medications between eye drops to ensure there was an appropriate wait time between ophthalmic medications.LPN #1 was interviewed on 12/9/25 at 3:20 p.m. LPN #1 said he normally did not keep residents' medications in cups in the cart. LPN #1 said he did not check to see if the three residents were on the unit prior to preparing the scheduled medications. LPN #1 said normally he was told which residents were leaving the facility for appointments in the morning, but he was not told these three residents were leaving the unit. The director of nursing (DON) was interviewed on 12/11/25 at 5:26 p.m. The DON said it was considered standard practice to wait after administering the first ophthalmic medication before giving the second (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ophthalmic medication. The DON said the reason to wait was to ensure the first medication was not washed out by the second medication. The DON said LPN #3 should have planned the medication administration to give Resident #19's oral medication between ophthalmic medication administrations to ensure each medication had time to absorb. The nursing home administrator (NHA) was interviewed on 12/11/25 at 6:52 p.m. The NHA said LPN #1 spoke with her about the medications kept in cups in the medication cart. The NHA said LPN #1 told her the residents who were off of the unit were at the group interview. The NHA said LPN #1 still should have checked to see if the residents were available before preparing the medication. The NHA said LPN #1 should have also disposed of the medications when he found out the residents were not available and prepared new medications when the residents returned instead of storing the medications in cups in the medication cart. The NHA said medications should not be stored in a cup in the cart because the medications could be forgotten or administered incorrectly.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for two (#20 and #16) of four residents out of 19 sample residents. Specifically, the facility failed to:-Implement a recommended brace for Resident #20 to prevent a contracture; and,-Complete an occupational therapy assessment for Resident #16 to evaluate if an assistive device was necessary to prevent contracture, despite a documented decline in the resident's ability to feed herself.Findings include:I. Facility policy and procedureThe Rehabilitative Services policy and procedure, revised 11/1/23, was provided by the nursing home administrator (NHA) on 12/11/25 at 6:12 p.m. It read in pertinent part, We will provide restorative services while maintaining the highest possible level of activities of daily living (ADL). Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.II. Resident #20A. Resident statusResident #20, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included senile degeneration of the brain, thrombosis of the arteries of the upper extremities and age related physical disability. The 10/1/25 minimum data set (MDS) assessment revealed Resident #20 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. Resident #20 was dependent on staff for putting on footwear, required substantial assistance with toileting and bathing, required moderate assistance with dressing and supervision or cues with eating, personal and oral hygiene.B. Resident and resident's representative interviewOn 12/9/25 at 10:30 a.m., Resident #20 was sitting in her wheelchair with her representative son in the room. Both of Resident #20's hands rested in her lap in a closed position, making a fist. Resident #20 said her hands were always in this position because she had arthritis. Resident #20 said it was painful to open her hands, but denied having pain in them while they were at rest. Resident #20's representative said Resident #20 had a prescribed brace for her left hand. He said he had seen her wearing it before, but he said he could not find it in her room. C. ObservationsOn 12/10/25 at 7:44 a.m. Resident #20 was lying in bed. Resident #20 did not have the prescribed brace on her left hand or a washcloth in her hands to protect her skin. Resident #20 had a scant amount of blood around her right middle finger. On 12/10/25 at 9:17 p.m. Resident #20 was lying in bed with her hands closed without a brace on her left hand. Resident #20 said her hands felt numb, but not painful. D. Record reviewReview of Resident #20's December 2025 CPO revealed the following physician's order:Place a red foam device in the palm of left hand at bedtime for prevention of contractor, per physical therapy (PT), ordered 6/10/25.The physical therapy assessment, dated 5/15/25, revealed a physical therapy recommendation for orthosis (an external device like a brace or splint used to support, immobilize, correct, or improve the function of weak, injured, or deformed body parts) wear, including instructions to wear a thermoplastic splint (a custom medical device, molded from heat-softened plastic sheets, used for supporting, immobilizing, or mobilizing joints and limbs after injuries, surgeries, or for conditions like arthritis) in the left hand every night and as needed during the day.III. Resident #16A. Resident statusResident #16, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included dementia without behavioral disturbance, depression, heart failure and malignant neoplasm of the left breast. The 10/8/25 MDS assessment revealed that the resident had significant cognitive impairment with short term and long term memory deficits with a BIMS score of zero out of 15. Resident #16 required substantial assistance with eating and oral hygiene and was dependent on staff for repositioning, toileting, bathing and dressing.B. ObservationsOn 12/9/25 at 9:11 a.m. Resident #16 was sitting in a recliner in her room being assisted with eating by certified nurse aide (CNA) #3. Resident #16's hands were resting on her lap in a closed position, with the pads (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of her fingers resting on her palms. Resident #16 had dried blood on her left hand and nails. Resident #16 was able to open her hands with assistance from CNA #3 to allow CNA #3 to clean the dried blood and Resident #16 did not appear to have any open wounds to her hands. C. Record reviewThe 7/14/25 MDS assessment revealed that during the review period, Resident #16 required only supervision and cues with eatingThe 4/29/25 MDS assessment revealed that during the review period, Resident #16 required only set up and clean up assistance.-Despite the quarterly MDS assessments showing a decline in Resident #16's ability to feed herself, no physical therapy or occupational therapy evaluation was completed to assess if Resident #16 could have fed herself with adaptive feeding utensils, or to assess if Resident #16 required a device to prevent contracture. IV. Staff interviewsCNA #3 was interviewed on 12/9/25 at 9:28 a.m. CNA #3 said the dried blood on Resident #16's hands was likely from Resident #16 picking at her skin, which she tended to do frequently. CNA #3 said Resident #16 used to be able to feed herself but had required assistance more often over the last few months. CNA #3 said she thought she saw Resident #16 using a large handled adaptive utensil a long time ago, but she could not remember for certain. CNA #3 said Resident #16 was able to open her hands, but unless Resident #16 was prompted to open her hands, she typically saw them resting in a closed position.CNA #4 was interviewed on 12/11/25 at 8:54 a.m. CNA #4 said Resident #16 only ate about 25% of her breakfast that morning and had needed complete assistance with eating. CNA #4 said when serving Resident #16 meals, she set up the food for the resident and she would attempt to let Resident #16 feed herself. CNA #4 said she would check back in with her after approximately ten minutes and if Resident #16 had not eaten, she would offer to assist her with eating. CNA #4 said she had heard of Resident #16 previously using an adaptive utensil, but she had never seen Resident #16 have any adaptive utensils on her meal tray or use them. CNA #4 said Resident #20 did not have a brace in her left hand this morning (12/11/25). CNA #4 said the night shift CNA told her she was not able to find it when assisting Resident #20 to bed the previous night. CNA #4 said if staff was not able to find the brace for Resident #20, they could at least place a washcloth in Resident #20's hand to protect the resident's skin. Licensed practical nurse (LPN) #3 was interviewed on 12/11/25 at 9:03 a.m. LPN #3 said Resident #16 usually required assistance with eating. LPN #3 said she had not seen Resident #16 use a brace or adaptive utensil before. LPN #3 said she had seen Resident #20 wearing a red foam brace before. LPN #3 said since she heard CNA #4 could not locate the brace this morning (12/11/25), she planned to search Resident #20's room and if she could not find it, she planned to contact the PT for a new brace. The director of nursing (DON) was interviewed on 12/11/25 at 5:26 p.m. The DON said she was not aware of the MDS assessments reflecting a decline in Resident #16's ability to feed herself. The DON said to her knowledge, Resident #16 has always required assistance with eating. The DON said the facility only recently hired their first MDS nurse, and the MDS assessments completed earlier in the year may not be accurate. The DON said she planned to refer Resident #16 for a physical therapy or occupational therapy assessment. The DON said she planned to follow up with LPN #3 to see if she was able to find the brace for Resident #20's left hand. She said if the brace was unable to be located, the facility would order a new brace. The DON said the reason a CNA might not have known to place a wash cloth in Resident #20's hand to protect her skin if they could not find the correct brace could be because many of the CNA staff were still new. The DON said she planned to complete in-service education on using a brace or wash cloth to protect the skin for residents who had contractures in their hands.

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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 residents were free from accidents or hazards for one (#4) of two residents reviewed for accident hazards out of 19 sample residents. Specifically, the facility failed to implement effective fall interventions to prevent falls for Resident #4. Findings include:I. Facility policy and procedureThe Fall Management Program policy, revised February 2021, was provided by the nursing home administrator (NHA) on 12/11/25 at 6:12 p.m. It read in pertinent part, The facility operates in a culture of safety. Staff, residents and family members are encouraged to report any problems or potential problems. A falls management team is responsible for information gathering and developing a plan of action to deal with falls, near misses, and other safety concerns. Within seven days of a fall, the director of long term care or assistant director of long term care will do the following: Review TRIPS (tracking record for improving patient safety) and incident reports, ensuring concerns adequately addressed and that forms are properly filled out; incident reports will be forwarded to the risk manager. Gather data and bring it to the weekly interdisciplinary team (IDT) meeting for review, further problem solving, and monitoring of interventions. Findings and order requests will be forwarded to the attending physician as necessary via a physician communication form. Findings will be reviewed at the quarterly quality assurance and performance improvement (QAPI) meeting. The assistant director of long term care is responsible for initiating or updating care plans as needed for fall-related issues. The director of long term care and the assistant director of long term care are responsible for monitoring staff compliance and resident response to interventions.II. Resident #4Resident #4, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease (a disease causing shaking and affecting motor skills), depression, type 2 diabetes with polyneuropathy (tingling pain and numbness) and left rotator cuff tear.The 10/23/25 minimum data set (MDS) assessment revealed Resident #4 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #4 required supervision or cues when ambulating with a walker over 50 feet, required moderate assistance with bathing and toileting and required supervision or cues with dressing and footwear. The MDS assessment documented Resident #4 had zero falls during the review period.B. Resident interviewResident #4 was interviewed on 12/8/25 at 2:05 p.m. Resident #4 said she fell multiple times in the last few months including a fall overnight, early in the morning on 12/8/25. Resident #4 said her feet slid around in the non-slip socks and the side of the socks with the gripping material was not always touching the floor. Resident #4 said another thing contributing to her falls was that her incontinence brief frequently leaked when she walked and did not fit her well. Resident #4 said she changed her briefs herself. Resident #4 said in October 2025, she had a big fall and had to go to the emergency room and the fall left her with bruising for months. C. Record reviewResident #4's fall risk care plan, initiated 1/31/25 and revised 11/26/25, revealed Resident #4 was a high risk for falls related to Parkinson's disease, loss of balance, impaired decision making and impulsive behavior. Interventions included anticipating Resident #4's needs, ensuring the call light was within reach and encouraging Resident #4 to use the call light, non-slip floor grips at the bedside to assist Resident #4 when transferring out of bed, physical therapy evaluations and treatments as needed, ensuring Resident #4 wore proper footwear and for staff to review information on past falls and attempt to determine the cause of the falls, then alter or remove potential causes if possible.The occupational therapy (OT) evaluation, dated 7/21/25, documented Resident #4 was referred to OT due to a history of falls and safety concerns. The document revealed resident #4 had impaired cognition and limited safety awareness during transitional movements and activities of daily living (ADL) tasks. The document revealed Resident #4 was unable to demonstrate safe brake use with her four-wheeled walker during transitions. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document revealed an eight week therapy plan to increase resident stability, safety with four-wheeled walker use and reduce fall risk. The OT Discharge summary, dated [DATE], documented Resident #4 had inconsistent attendance to scheduled therapy appointments, but demonstrated improved endurance and activity tolerance. The document revealed the OT recommended Resident #4 had staff assistance with all out of bed transfers due to high fall risk and poor management of her walker. The document also revealed the OT recommended staff round as able to assess Resident #4's safety due to her lack of call light use and poor recall. The fall incident report, dated 10/26/25, documented Resident #4 had an unwitnessed fall. The document revealed Resident #4 got up from her bed using her walker to retrieve a card from a box sitting on the floor. Resident #4 leaned forward and lost her balance, falling forward and striking her face on the floor. The document revealed Resident #4 sustained a large hematoma (localized bleeding outside of blood vessels) to her forehead and bleeding from her nose. The progress note, dated 10/26/25, documented Resident #4 was transferred to the local emergency room for assessment after the unwitnessed fall. The progress note documented the resident had a hematoma to the forehead, facial bruising and bruising to the right knee. The fall care plan review form, dated 10/26/25 documented no changes to Resident #4's care plan.-There was no documentation in Resident #4's electronic medical record (EMR) to indicate the facility reviewed the resident's fall care plan and interventions to determine if the current fall interventions were effective or if new fall interventions were needed.The fall incident report, dated 11/25/25, documented Resident #4 had another unwitnessed fall. The document revealed Resident #4 was found sitting on the floor. The document revealed Resident #4 was ambulating back from the bathroom without her walker and without staff assistance. The document revealed Resident #4 said she got tired while walking back from the bathroom and tried to sit on her four-wheeled walker. The walker rolled away from her, causing her to fall. The document revealed staff education and reminders were provided to have Resident #4 call for assistance.-However, there was no documentation in Resident #4's EMR or the fall care plan review form to indicate the facility reviewed the resident's fall care plan and interventions to determine if the current fall interventions were effective or if new fall interventions were needed.The progress note, dated 12/8/25, documented Resident #4 refused to use the call light or ask for help. The progress note revealed Resident #4 removed her non-slip socks because they were wet due to an incontinence episode. The progress note revealed Resident #4 was checked on at 1:30 a.m. and fell at 2:00 a.m. The progress note revealed Resident #4 sustained a small red mark to her back.III. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 12/10/25 at 1:57 p.m. CNA #6 said Resident #4 ambulated in her room without calling for assistance frequently because Resident #4 preferred to change her own brief. CNA #6 said Resident #4 frequently refused to allow staff to put on a gait belt when ambulating. CNA #6 said she was not aware of any additional fall prevention measures for Resident #4 beyond standard fall precautions. CNA #6 said she tried to check on all residents every two hours, but to her knowledge there was no plan to check on Resident #4 more frequently for safety. Licensed practical nurse (LPN) #2 was interviewed on 12/10/25 at 3:14 p.m. LPN #2 said Resident #4 frequently refused staff assistance with care and ambulation. LPN #2 said Resident #4 had the right to refuse assistance from staff and when she did, staff should try to reapproach her and remind Resident #4 that the interventions were for her safety. The director of nursing (DON) was interviewed on 12/11/25 at 5:26 p.m. The DON said the facility frequently reinforced education about allowing staff to use a gait belt and to call for assistance, but the majority of the fall prevention interventions for Resident #4 were implemented in the spring of 2025 and had not changed since she started falling frequently again the past few months. The DON said the facility had identified that most of the time, Resident #4 was falling while ambulating to or from the bathroom. The DON said she planned to complete another OT evaluation request to see if they could provide any recommendations, similar to the recommendation from the OT to place grip tape on the floor in front of Resident #4's bed, implemented in January 2025 in order to prevent Resident #4 from slipping out of bed.The NHA was interviewed on 12/11/25 at 6:52 p.m. The NHA said the facility frequently (continued on next page)

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	065264	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walbridge Memorial Convalescent Wing	100 Pioneers Medical Center Dr Meeker, CO 81641

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed how Resident #4 continued to fall and did not know what other interventions they could offer Resident #4. The NHA said some of the interventions the facility offered beyond the standard fall precautions were refused by Resident #4. The NHA said the facility planned to reach out to the medical director of another facility to see if the other facility had any fall intervention recommendations they had not previously offered to Resident #4. The NHA said each of Resident #4's falls were reviewed in an IDT meeting as well as the QAPI meetings.-However, the facility was unable to provide documentation of an IDT review or suggested interventions after the fall that occurred on 10/26/25.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being one (#16) of five residents reviewed for unnecessary medications out of 19 sample residents. Specifically, the facility failed to discontinue or reevaluate a physician's order for Resident #16's as needed (PRN) Lorazepam (an antianxiety medication) after 14 days.Findings include:I. Resident #16A. Resident statusResident #16, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included dementia without behavioral disturbance, depression, heart failure and malignant neoplasm of the left breast. The 10/8/25 minimum data set (MDS) assessment revealed that the resident had significant cognitive impairment with short term and long term memory deficits. The assessment revealed Resident #16 had no behavioral symptoms of yelling, kicking, hitting or refusal of care during the review period. Resident #16 required substantial assistance with eating and oral hygiene and was dependent on staff for repositioning, toileting, bathing and dressing. B. Record reviewReview of Resident #16's December 2025 CPO revealed the following physician's order:Lorazepam 2 milligrams (mg)/milliliter (ml) oral liquid. Give 0.25 ml by mouth every six hours as needed for terminal agitation, ordered 11/20/25 with no end dateReview of Resident #16's November 2025 and December 2025 medication administration record (MAR) revealed no PRN doses were administered during that timeframe.The November 2025 pharmacist's monthly medication review, dated 11/28/25, revealed the consulting pharmacist for the facility documented requests for a related diagnosis and end date for Resident #16's PRN Lorazepam order.-However, the medication had not been discontinued or re-evaluated at the time of the survey. -Review of Resident #16's electronic medical record (EMR) revealed there was no documentation from the physician indicating a justification for continuing the resident's PRN Lorazepam beyond the 14 days.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 12/9/25 at 3:05 p.m. LPN #1 confirmed Resident #16's PRN Lorazepam order did not have an end date. LPN #1 said he was not aware the regulation required all PRN anxiolytic (antianxiety medication) to have a 14-day end date or additional documentation from the physician to continue the order beyond 14 days. LPN #1 said now that he was aware of the regulation, he planned to contact the prescribing physician to discontinue the medication since Resident #16 had not required any doses of the medication. The director of nursing (DON) was interviewed on 12/11/25 at 5:26 p.m. The DON said she was aware PRN anxiolytic (antianxiety medication) medications required a 14-day end date or additional documentation from a physician to continue the order beyond 14 days. The DON said she was not sure why the nurse who entered the physician's order forgot to add an end date when entering the order. The DON said she planned to change the order form used to request PRN Lorazepam so it required an end date to complete the order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.Specifically, the facility failed to implement enhanced barrier precautions for Resident #2 and Resident #8.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 12/19/25 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 employs 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.II. ObservationsOn 12/11/25 at 9:51 a.m. Resident #2's room was observed. Resident #2 required a feeding tube (a soft flexible tube inserted directly into the stomach to deliver nutrition, fluids and medications when a person is unable to eat or swallow safely) and had an indwelling urinary catheter.-However, there was no personal protective equipment (PPE), including gowns, observed in or near Resident #2's room. On 12/11/25 at 9:58 a.m. Resident #8's room was observed. Resident #8 had an indwelling urinary catheter.-However, there was no PPE, including gowns, observed in or near Resident #8's room.III. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 12/11/25 at 10:00 a.m. CNA #5 said she had been working at the facility for approximately 18 months. CNA #5 said the nurses cleaned the residents' catheters and it was the CNAs responsibility to empty each catheter every shift, then report the output to the treatment nurse to document. CNA #5 said she completed hand hygiene and wore gloves to empty the residents' catheters, but she did not wear a gown when draining a catheter. CNA #5 said she had not heard of or had any training on EBP. CNA #4 was interviewed on12/11/25 at 10:05 a.m. CNA #4 said she normally performed hand hygiene to empty the residents' catheters and used an alcohol swab to clean the catheter after emptying it. CNA #4 said she had not heard of or had any training on EBP. CNA #4 said she did not wear a gown when cleaning or emptying a resident's catheter. Licensed practical nurse (LPN) #2 was interviewed on 12/11/25 at 10:46 a.m. LPN #2 said she knew the facility had two residents with indwelling catheters and one resident with a tube feeding. LPN #2 said she wore sterile gloves when cleaning a catheter, but she did not wear a gown. LPN #2 said she had heard of EBP, but thought it was only for residents with compromised skin integrity. LPN #2 said she was not aware that all residents with a catheter should have EBP or that staff should wear a gown when providing care to residents on EBP. The infection preventionist (IP) was interviewed on 12/11/25 at 2:24 p.m. The IP said he started in his role as IP with the facility earlier this year (2025). The IP said he was new to EBP and was currently learning about the topic. The IP said he was not aware if any residents in the facility required EBP yet. The IP said he was aware of EBP for residents with wounds at risk for infection but he was not aware that residents with indwelling medical devices, including catheters and feeding tubes, also required EBP with direct care. The IP said he planned to review EBP guidance and audit residents in the facility to implement EBP for residents. The IP said currently, no residents in the facility had adequate EBP in place. The director of nursing (DON) was interviewed on 12/11/25 at 5:26 p.m. The DON said she had heard of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP precautions a few years ago, but she was not aware that EBP had become a regulatory requirement. The DON said the facility did not have an EBP program in place yet. The DON said she planned to work with the IP to implement a program, including staff education regarding EBP. The nursing home administrator (NHA) and the risk manager were interviewed together on 12/11/25 at 6:52 p.m. The risk manager said EBP precautions were reviewed for residents with wounds at high risk for infection during the quarterly quality assurance and performance improvement (QAPI) meetings. The NHA and the risk manager said they had not previously discussed implementing EBP for residents with indwelling medical devices. The NHA said she planned to review the policy and work with the IP to implement EBP precautions for all identified residents who needed EBP.