STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065265	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berthoud Care and Rehabilitation	855 Franklin Ave Berthoud, CO 80513

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and staff interviews, the facility failed to electronically submit complete and accurate direct care staffing information.Specifically, the facility failed to submit to the Center for Medicare and Medicaid Services (CMS) the Payroll Based Journal (PBJ) for the quarter (10/1/25 to 12/31/25) due to an unrecognized coding error.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 5/27/26 to 6/2/26, resulting in the deficiency being cited as past noncompliance with a correction date of 5/13/26.I. Record reviewThe CMS submission report, fiscal year quarter one, 2026 (10/1/25 to 12/31/25), revealed the facility failed to submit the required data for the quarter. A document titled PBJ final validation report was provided by the nursing home administrator (NHA) on 5/27/26 at 10:00 am. The report revealed PBJ information for fiscal year quarter two was submitted on 5/13/26 and was accepted.II. Facility's plan of correctionA document titled Process Improvement Plan, Payroll-Based journal Staffing Data Submission was provided by the NHA on 5/13/26 at 10:00 a.m. The plan documented the following:A root cause analysis was conducted after the rejected submission of quarter one PBJ information. It was determined the information was rejected due to a coding error attached to employee positions contained within the file. It documented the facility payroll vendor system was upgraded, resulting in an unanticipated increased length of time for the facility to review and validate data to be submitted and the facility was not notified of the increased time requirement. It documented the coding issue was not identified prior to the contracted service submission of the PBJ information and the investigation did not identify the coding error until several days past the submission deadline. The plan documented improvement goals with target dates, including the following:Ensure 100% of direct care staffing data is submitted accurately and on time each quarter, begin quarter two for 5/15/26 submission.Achieve zero discrepancies between PBJ records and payroll/agency source documents, by quarter three and quarter four, 2026.The facility will receive PBJ receipt of successful submission prior to the deadline, begin quarter two for 5/15/26 submission.The plan documented interventions which standardized the submission workflow including, Contracted service provider will provide preliminary PBJ report to facility to review and validate within 14 days prior to CMS submission deadline. Facility will review and validate preliminary report. Contracted service provider will submit PBJ report 10 days prior to submission deadline to allow for unforeseen errors and provide opportunity for facility to correct and resubmit. Contracted service will provide the validation of successful submission receipt to the facility.The plan documented the responsibility assignments for the PBJ information were to be submitted, including tasks of collecting staffing data, verification of data accuracy, reviewing agency documentation, performing pre-submission audit, submitting PBJ data to CMS, sending submission receipt to the facility and maintaining documentation.The plan documented data would be shared, findings would be reviewed quarterly and adjustments would be made based on outcomes at the facility's quality assurance performance improvement (QAPI) meetings.The documented plan to maintain long-term compliance included continued quarterly pre-submission validation, monitoring CMS updates to PBJ policy, and coordinating upgrades or changes to payroll and human resource systems allowing for (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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	review and verification of PBJ data in advance of the submission timeline, allowing for corrections if needed, and successful resubmission.III. Staff interviewsThe NHA was interviewed on 5/27/26 at 10:00 a.m. The NHA said the facility submitted data for the quarter to CMS prior to the submission deadline, however, the submission was rejected due to an issue with the data submitted.The facility's operations resource was interviewed on 6/2/26 at 4:18 p.m. The operations resource said the PBJ information for the quarter had to be submitted by 2/15/26. He said the data was submitted on 2/13/26 at 6:30 p.m., however, the submission was rejected by CMS on 2/14/26 at 12:46 a.m. The operations resource said the facility did not recognize the submission had not been accepted until 2/16/26. The operations resource said the submission was rejected because of a coding error for one of the facility's employees. The operations resource said the facility's payroll system changed in January 2026, which led to a coding error which was not recognized prior to submission, and this caused the PBJ information to be initially rejected. The operations resource said the facility had completed a process improvement plan to ensure consistent and timely PBJ quarterly submission and acceptance, and he said the PBJ information for the most recent quarter (1/1/26 to 3/31/26) was submitted on 5/2/26 and again on 5/11/26 and was accepted on time (see record review above). The operations resource said the facility's goal was to submit the PBJ quarterly information at least five days prior to deadlines to ensure adequate time to make corrections if not initially accepted.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to ensure an ongoing program of meaningful, structured activities was provided to meet the interests and physical, mental, and psychosocial well-being of three out of three units on weekends.Specifically, the facility failed to ensure activities were consistently provided on the weekends to meet the recreational needs of the residents.Findings include:I. Facility policy and procedureThe Activities policy, revised December 2024, was provided by the nursing home administrator (NHA) on 6/2/26 at 12:07 p.m. It read in pertinent part,It is the policy of this facility to ensure that residents have the right to choose the types of activities and social events in which they wish to participate.Daily activities, including those on the weekends and holidays, are provided, as well as scheduled religious and social activities. II. Record reviewA review of the facility's April 2026 and May 2026 activity calendar revealed the following schedule of activities provided on Saturdays and Sundays: On 4/4/26 (Saturday):8:00 a.m. Daily chronicles;10:30 a.m Puzzle of the day;2:00 p.m. Snack cart;and 4:00 p.m. Fun on the run activity cart.On 4/5/26 (Sunday):8:00 a.m. Daily chronicles;10:00 a.m. Weekly devotional;1:00 p.m. Church service in the high peak dining room;2:00 p.m. Bingo; and, 4:00 p.m. Jigsaw puzzle.On 4/11/26 (Saturday):8:00 a.m. Daily chronicles; 10:30 a.m. Puzzle of the day;2:00 p.m. Drink cart; and,4:00 p.m. Fun on the run activity.On 4/12/26 (Sunday):8:00 a.m. Daily chronicles;10:00 a.m. Weekly devotional;1:00 p.m. Church service; 2:00 p.m. Bingo; and, 4:00 p.m. Tabletop activity.On 4/18/26 (Saturday):8:00 a.m. Daily chronicles;10:00 a.m. Coloring pages;11:00 a.m. Read current events;2:00 p.m. Snack cart; and,4:00 p.m. Fun on the run activity. On 4/19/26 (Sunday):8:00 a.m. Daily chronicles;10:00 a.m. Weekly devotional;1:00 p.m. Church service;2:00 p.m. Bingo and,4:00 p.m. Jigsawpuzzle.On 4/25/26 (Saturday):8:00 a.m. Daily devotional;10:30 Puzzle of the day;2:00 p.m. Drink cart;4:00 p.m. Fun on the run activity cartOn 4/26/26 (Sunday):8:00 am. Daily chronicles;10:00 a.m. Weekly devotional;1:00 p.m. Church service;2:00 p.m. Bingo; and,4:00 p.m. Table activities.On 5/2/26 (Saturday):8:00 a.m. Daily chronicles; 10:00 a.m. Coloring pages;11:00 a.m. Read current events;2:00 p.m. Coloring page;3:30 p.m. Daily puzzle; and,5:00 p.m. Dinner and a movie. On 5/3/26 (Sunday):8:00 a.m. Daily Chronicles;10:00 a.m. Daily affirmation;1:00 p.m. Church service;2:00 p.m. Bingo;3:00 p.m. Daily puzzle; and,4:00 p.m. Fun on the run activity cart.On 5/9/26 (Saturday):8:00 a.m. Daily chronicles;10:30 Puzzle of the day;11:00 p.m. One-on-one friendly visits;2:00 p.m. Snack cart; and,4:00 p.m. Fun on the run activity cartOn 5/10/26 (Sunday)8:00 a.m. Daily chronicles;10:00 a.m. Wish a mom happy mother's day;1:00 p.m. Church service;2:00 p.m. Bingo; and,4:00 p.m. Jigsaw puzzle.On 5/16/26 (Saturday):8:00 a.m. Daily chronicles;10:00 a.m. Weekend devotional;11:00 a.m. One-on-one friendly visits;2:00 p.m. Coloring page;3:30 p.m. Daily puzzle; and,5:00 p.m. dinner and movie.On 5/17/26 (Sunday):8:00 a.m. Daily chronicles;10:00 a.m. Veterans club;1:00 p.m. Church service;2:00 p.m. Bingo; 3:30 p.m. Daily puzzle; and,4:00 p.m. Fun on the run activity cart.On 5/23/26 (Saturday):8:00 a.m. Daily chronicles;10:00 a.m. Drink cart;11:00 a.m. Current events;1:00 p.m. Friendly visits;2:00 p.m. Coloring page; and, 3:30 p.m. Daily puzzle. On 5/24/26 (Sunday):8:00 a.m. Daily chronicles;10:00 a.m. Weekly devotional;11:00 a.m. one-on-one friendly visits;1:00 p.m. Church service;3:30 p.m. Daily puzzle; and,4:00 p.m. Fun on the run activity cart.On 5/30/26 (Saturday):8:00 a.m. Daily chronicle;10:00 a.m. Drink cart;11:00 a.m. Current events;1:00 p.m. One-to-one friendly visits;2:00 p.m. Coloring page; and,3:30 p.m. Daily puzzle. On 5/31/26 (Sunday):8:00 a.m. Daily chronicles;10:00 a.m. Daily affirmation;11:00 a.m. One-to-one friendly visits;1: 00 p.m. Church service; 2:00 p.m. Bingo; and,4:00 p.m. daily puzzle.-However, interviews with the residents and the receptionist, who worked on the weekends, revealed the activities calendar was not regularly adhered to (see interviews below).A request was made for the activity participation logs for the weekends in April 2026 and May 2026. However, the facility failed to provide the logs.III. Resident group interviewA group interview was conducted on 6/2/26 at 10:10 a.m. with five residents (#15, #24, #42, #46 and #50) who were identified as alert and oriented through facility and assessment. Resident #15 and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #24, Resident #46 and Resident #50 said they attended the resident council meetings regularly.Resident #42 said she was recently admitted and had not attended a meeting. Resident #15 said the weekends at the facility were incredibly long and boring. Resident #15 said there was absolutely nothing to do except sit in his rooms or the hallway. Resident #15 said the activity staff members left on Friday afternoon and did not come back until Monday morning.Resident #15 said that the sole activity assistant scheduled to work weekends left her employment on 1/1/26, and the facility had not replaced her. Resident #15 said that due to the lack of weekend activity staff, he occasionally had to call the numbers for Bingo himself in order for the residents to have a Bingo game on Saturdays and Sundays. The rest of the residents present at the meeting all agreed that the lack of activity staff on weekends affects the scheduled activities on the activities calendar. Resident #42 said she was admitted recently, but had noticed the lack of meaningful activities on the weekends.IV. Staff interviewsAA #2 and AA #3 were interviewed together on 6/1/26 at 2:15 p.m. AA #2 said she was a certified nursing aide (CNA) and recently began working in the activity department. AA #2 said she worked Monday through Friday. AA #2 said there were currently three activity staff members, which included the activity director who was on leave. AA #2 said there were only two staff members available to run activities at the moment, and both were off on the weekends.AA #3 said she was new to working at the facility. She said as far as she was aware, there was no activity staff scheduled for the weekend.The receptionist was interviewed on 6/2/26 at 12:55 p.m. The receptionist said she was scheduled Sunday through Wednesday for one week and Sunday through Tuesday the following week. The receptionist said her primary duty on Sundays was to manage and monitor the front desk. She said she also assisted residents with some activities. The receptionist said she assisted with passing the daily chronicles. The receptionist said that due to her front desk responsibilities, she struggled getting all the activities done and sometimes relied on the residents to engage in activities without a staff member. The NHA was interviewed on 6/2/26 at 12:33 p.m. The NHA said AA #1 managed and monitored the front desk and supported resident activities on the weekends. The NHA said he was unaware that Resident #15 felt obligated to call the Bingo numbers on weekends due to low activity staffing levels. The NHA said he would provide the last three months of activity participation logs for the facility.-However, the requested activity participation logs were not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure respiratory care was provided in accordance with professional standards for three residents (#62, #54, and #29) of six out of 42 sample residents.Specifically, the facility failed to ensure oxygen was administered according to physician's orders for Resident #62, Resident #54 and Resident #29. Findings include: I. Facility policy and procedure The Oxygen Administration, Storage, and Handling policy, dated July 2017, was received from the nursing home administrator (NHA) on 6/2/26 at 12:07 p.m. It revealed in pertinent part, It is the policy of this facility to promote Resident safety with oxygen administration. Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain medical gases shall be trained on the risks associated with their handling and use. II. Resident #62 A. Resident status Resident #62, age greater than 65, was admitted to the facility on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included critical illness myopathy (a disorder that causes severe muscle weakness and wasting), type 2 diabetes, congestive heart failure, hypertension, anxiety disorder, depression, restlessness, and agitation. The 3/31/26 minimum data set (MDS) assessment revealed the resident was cognitively intact, with a brief interview for mental status (BIMS) score of 13 out of 15. Resident #62 received oxygen therapy and required substantial to maximum assistance with activities of daily living (ADLs). B. Observations On 5/27/26 at 10:14 a.m. Resident #62 was lying on her bed. She was wearing a nasal cannula connected to an oxygen concentrator set to 3 liters per minute (LPM). On 5/28/26 at 2:05 p.m. Resident #62 was lying in bed with her oxygen concentrator set to 3 LPM. On 6/1/26 at 9:20 a.m. Resident #62's oxygen was set to 3 LPM. On 6/2/26 at 11:25 a.m. Resident #62's oxygen was set to 3 LPM. C. Resident interview Resident #62 was interviewed on 6/1/26 at 5:14 p.m. Resident #62 said she did not know the liter flow she was receiving. Resident #62 said she was unable to reach the concentrator. She said the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility staff managed the liter flow of her oxygen. D. Record review Review of the June 2026 revealed the following physician's orders: Apply oxygen via nasal cannula at 2 LPM continuously to keep saturation above 90 percent, ordered 10/24/25. -However, observations revealed the resident's oxygen was set to 3 LPM (see observations above). The oxygen therapy care plan, revised 3/16/26, documented the resident had oxygen therapy related to congestive heart failure. Interventions included administering oxygen as ordered, monitoring for signs and symptoms of respiratory distress, and reporting to the medical director (MD). The care plan indicated the resident was to receive oxygen via nasal cannula at 2 LPM continuously to keep saturation at or above 90 percent. The vital signs record on 2/10/26 documented Resident #62's oxygen saturation at 95% on 3 LPM. The vital signs record on 2/19/26 documented Resident #62's oxygen saturation at 94% on 3 LPM. The vital signs record on 2/20/26 documented Resident #62's oxygen saturation at 93% on 3 LPM. The vital signs record on 3/21/26 documented Resident #62's oxygen saturation at 95% on 3 LPM. The vital signs record on 3/22/26 documented Resident #62's oxygen saturation at 94% on 3 LPM. The vital signs record on 5/27/26 documented Resident #62's oxygen saturation at 99% on 3 LPM. The vital signs record on 5/28/26 documented Resident #62's oxygen saturation at 99% on 3 LPM. The vital signs record on 6/1/26 documented Resident #62's oxygen saturation at 95% on 3 LPM. The vital signs record on 6/2/26 documented Resident #62's oxygen saturation at 95% on 3 LPM. -However, there was no documentation indicating the resident needed more oxygen based on the documented oxygen saturations (see observations above). III. Resident #54 A. Resident status Resident #54, age greater than 65, was admitted on [DATE]. According to the June 2026 CPO, Diagnoses included type 2 diabetes mellitus with diabetic nephropathy, depression, chronic respiratory failure with hypoxia (a condition where the body is consistently unable to maintain enough oxygen in the blood), dementia, and weakness. The 5/3/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. Resident #54 was receiving oxygen therapy and needed partial assistance with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADLs. B. Observations On 5/27/26 at 3:39 p.m. Resident #54 was sitting in her wheelchair in her room with a nasal cannula on and her oxygen was set to 2 LPM. On 5/28/26 at 1:24 p.m. Resident #54 was sitting in her wheelchair with her oxygen set at 2 LPM. C. Resident interview Resident #54 was interviewed on 5/28/26 at 1:24 p.m. Resident #54 said she had always been on 2 LPM of oxygen. Resident #54 said approximately one week ago, she was lying in her recliner when she suddenly felt a rush of oxygen. Upon opening her eyes, she observed two staff members in her room. Resident #54 said the staff informed her that her oxygen was set to 3.5 LPM when she asked them to check the concentrator. The resident said she had previously instructed staff members not to tamper with her oxygen flow, but that they did not listen to her requests. D. Record review Review of the June 2026 CPO revealed the following physician's orders: Apply oxygen via nasal cannula at 1 LPM continuous to keep saturation at or above 90%, ordered 3/4/23. The oxygen care plan, revised 3/10/26, revealed the resident had an altered respiratory status, difficulty breathing related to chronic respiratory failure. Interventions included monitoring for signs and symptoms of respiratory distress and reporting to the physician any increased respirations, decreased pulse oximetry, and increased heart rate. The care plan directed staff to administered oxygen via nasal cannula at 2 LPM continuously to keep saturation at or above 90% and providing oxygen as ordered. -However the physician's order dated 3/4/23 required 1 LPM of continuous oxygen via nasal cannula. (see physician order above). Oxygen settings: Via nasal cannula at 2 LPM continuous to keep saturation at or above 90 percent. The vital signs record on 4/11/26 documented Resident #54's oxygen saturation at 100% on 1 LPM. The vital signs record on 4/20/26 documented Resident #54's oxygen saturation at 100% on 1 LPM. The vital signs record on 5/2/26 documented Resident #54's oxygen saturation at 99% on 2 LPM. The vital signs record on 5/13/26 documented Resident #54's oxygen saturation at 98% on 2 LPM. The vital signs record on 5/27/26 documented Resident #54's oxygen saturation at 99% on 2 LPM. -However, there was no documentation indicating the resident needed more oxygen based on the documented oxygen saturations (see observations above). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Staff interviews Registered nurse (RN) #2 was interviewed on 6/2/26 at 11:25 a.m. RN #2 said oxygen was part of the resident's medication and must have a physician's order. RN #2 said Resident #62's physician's order was for 2 LPM and it was important to follow the physician's order due to Resident #62's diagnoses of chronic respiratory failure. RN #2 said Resident #54 had a diagnosis of chronic respiratory failure and required staff to monitor the use of oxygen and signs and symptoms of any adverse effects and report to the physician. RN #2 said she was not aware that Resident #54's oxygen order had been changed. RN #2 said she did not verify the amount of oxygen each resident was receiving on her shift. The director of nursing (DON) was interviewed on 6/2/26 at 11:40 a.m. The DON said the nursing staff were expected to document any change in oxygen flow rate and the rationale for the change in the residents' electronic medical records (EMR). The DON said the nurses were to verify the oxygen flow of each resident requiring oxygen therapy on their shift. The DON said oxygen was part of the residents' medications and that all physician's oxygen orders needed to be followed. The DON said that failure to follow the physician's order for oxygenation could result in health complications, such as respiratory failure, depending on each resident's condition. The DON said all nursing staff were trained to ensure respiratory compliance. She said however, she did not know why the staff failed to monitor compliance with physician orders. The DON said she would immediately provide education to the nursing staff. The physician assistant (PA) was interviewed on 6/2/26 at 1:22 p.m. The PA said prescribed oxygen was a medication, not a comfort measure. The PA said changing the flow rate outside of a physician's orders can have adverse consequences for a resident with respiratory illness. The PA said if a resident was found adjusting their own oxygen settings, staff should monitor them closely and ensure the equipment was set correctly. The PA said it was critical that the clinical staff thoroughly document every single episode of these encounters and immediately notify the provider. The PA said the resident's care plan should be updated to include interventions for staff to follow. IV. Resident #29 A. Resident status Resident #29, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included COPD, chronic respiratory failure, emphysema, depression and heart failure. According to the 5/1/26 MDS assessment, Resident #29 had moderate cognitive impairment with a BIMS score of 12 out of 15. The MDS assessment identified Resident #29 was independent with eating, personal hygiene and dressing and required supervision for toileting and moderate assistance for showering. The assessment revealed the resident was receiving oxygen therapy. B. Observations and resident interview On 5/27/26 at 4:40 p.m. Resident #29 was sitting in her bed wearing a nasal cannula in her nose and connected to a room oxygen concentrator. The oxygen concentrator was set to an oxygen flow rate of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.5 LPM. On 6/1/26 at 8:55 a.m. Resident #29 was lying in bed. The oxygen concentrator was set to an oxygen flow rate of 3.5 LPM. On 6/1/26 at 1:30 p.m. Resident #29 was sitting on the side of her bed. The oxygen concentrator was set to an oxygen rate of 3.5 LPM. On 6/2/26 at 9:35 a.m. Resident #29 was sitting in her bed. The oxygen concentrator was observed with certified nurse aid (CNA) #1 and was set to an oxygen rate of 4 LPM. CNA #1 then left the resident's room and was observed telling RN #1 that the oxygen level was set to 4 LPM. RN #1 told CNA #1 not to change Resident #29's oxygen setting at that time. -However, the physician's order for Resident #29's oxygen was for 3 LPM (see record review below). Resident #29 was interviewed on 6/2/26 at 9:45 a.m. Resident #29 said she had not turned the oxygen setting up on that day. Resident #29 said she sometimes turned the oxygen setting up, but she told staff when she did. C. Record review A review of Resident #29's respiratory care plan, initiated 1/3/24 and revised 3/16/26, revealed that Resident #29 had altered respiratory status and difficulty breathing related to COPD, chronic respiratory failure and emphysema. Interventions included administering medications as ordered, diagnostic testing as ordered, oxygen therapy, head of bed elevated when in bed, monitor and document changes in orientation, increased restlessness, anxiety, and air hunger, monitor for signs and symptoms of respiratory distress and report to the physician as needed, monitor for shortness of breath when lying flat and monitor and document abnormal breathing patterns. An updated respiratory care plan was provided by the DON on 6/3/26 at 5:10 p.m. (after the survey). The care plan included the addition that the resident chronically self adjusted oxygen in the room and was noncompliant with orders. The care plan did not include additional interventions. A review of Resident #29's May 2026 CPO revealed the following physician's order: Apply oxygen via NC (nasal cannula) 3 LPM every shift related to acute and chronic respiratory failure with hypercapnia (elevated level of carbon dioxide in the bloodstream), ordered 4/9/26 and discontinued 5/28/26, and an identical physician's order was renewed on 5/28/26. D. Staff interview RN #1 was interviewed on 6/2/26 at 9:38 a.m. RN #1 said she had not yet checked Resident #29's oxygen setting that day. RN #1 said Resident #29 sometimes changed the oxygen settings herself. RN #3 said the physician's order was for 3 LPM. RN #3 said the physician assistant was going to visit Resident #29 that day and RN #1 said she would talk with the physician assistant about the resident's oxygen settings when the physician assistant saw the resident. RN #1 did not change the oxygen setting.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection on one of three units, two out of two shower rooms and two of two soiled utility rooms.Specifically, the facility failed to:-Ensure housekeepers performed appropriate hand hygiene when cleaning residents' rooms;-Ensure drains were covered in two of two shower rooms;-Ensure that the biohazard trash was picked up; and,-Ensure the hopper (basin used for rinsing soiled clothes, emptying and rinsing bedpans) was clean.Findings include:I. Failed to ensure housekeepers performed hand hygieneA. Facility policy and procedureThe Infection Prevention and Control policy and procedure, revised November 2024, was provided by the nursing home administrator (NHA) on 5/27/26 at 4:00 p.m. It read in pertinent part, Staff and patient education is done to focus on risk of infection and practices to decrease risk. Universal precautions, handwashing and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment.B. ObservationsOn 6/1/26 at 10:38 a.m., housekeeper (HK) #1 was cleaning the bathroom in room [ROOM NUMBER]. She cleaned the inside of the toilet with a toilet brush and cleaned the outside with a rag and disinfectant. She then came out of the bathroom and went to her cart. She did not change her gloves or perform hand hygiene, she opened a few different compartments on her cart to put away cleaning supplies and put away her dirty rag. She then reached into the mop bucket where she had her mop heads soaking in the cleaner that she uses to mop the floor, using the same gloves that she used when she cleaned the toilet. She then mopped the bedroom floor, went back to the cart and took off the dirty mop head and put it in the dirty container on her cart. She did not change her gloves. She then reached in the clean bucket and pulled out a new mop head and mopped the bathroom. C. Staff interviewsHK #1 was interviewed on 6/1/26 at 10:49 a.m. She said she was not taught to change her gloves after cleaning the toilet. She said she probably should have changed them after cleaning the toilet. The infection preventionist was interviewed on 6/2/26 at 12:40 p.m. She said HK #1 should have changed her gloves after cleaning the toilet. II. Failure to have drain covers in shower roomsA. Professional referenceAccording to The Centers for Disease Control (CDC) Healthcare-Associated infections (2/6/26), retrieved on 6/4/26 from https://www.cdc.gov/healthcare-associated-infections/php/toolkit/water-management.html Recent evidence indicates sinks and other drains, such as toilets or hoppers, in healthcare facilities can become contaminated with multidrug-resistant organisms (MDROs). Because different types of bacteria may contaminate the same drain, drains can serve as sites where antimicrobial-resistant genes transfer between bacterial species.B. ObservationsOn 6/1/26 at 11:13 a.m., during a facility tour the following observations were made:-Shower room [ROOM NUMBER], the drain cover was missing, which left a hole in the floor that was approximately three inches wide. -Shower room [ROOM NUMBER], the drain cover was missing, which left a hole in the floor that was approximately three inches wide.C. Staff interviewsThe housekeeping supervisor was interviewed on 6/1/26 at 11:13 a.m. She said she was unsure of why the drain covers in the shower rooms were missing. She said she was unsure of how long they had been missing. The infection preventionist was interviewed on 6/2/26 at 12:40 p.m. She said the drains should be covered. She said with the drain covers missing it leaves an open hole in the floor and if a resident caught their toe in the drain hole they could get an infection. III. Failure to have biohazard trash picked up regularly and the hopper was cleanOn 6/1/26 at 11:13 a.m., during a facility tour the following observation was made:In soiled utility #1 there was a large pile of filled red biohazard trash bags piled on the floor. There were additional filled red biohazard bags on the counter of the room. The bags were varied in size and there were at least 10 bags. The hopper in soiled utility #1 was empty and clean. In soiled utility #2 the hopper had water in the bowl and there was a thick green film towards the bottom of the bowl and there was a thick (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brown film that was above the green film. B. Staff interviewsThe housekeeping supervisor was interviewed on 6/1/26 at 11:13 a.m. She said the biohazard company did not come the previous week, which was why there were so many bags. She said the bags should not be piled up. She said was unsure how long the bags had been in the room. She said that the maintenance employees were the ones who were responsible for cleaning the hopper. The maintenance director was interviewed on 6/2/26 at 11:03 a.m. He said he flushed the hopper weekly and he was aware that the hopper was dirty. He said housekeeping was responsible for cleaning the hopper. The infection preventionist was interviewed on 6/2/26 at 12:40 p.m. She said the hopper should be cleaned and maintained.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to protect the residents' rights to privacy regarding mail delivered to the facility for one (#15) out of five residents reviewed out of 42 sample residents.Specifically, the facility failed to maintain residents' confidentiality by delivering mail opened.Findings include:I. Facility policy and procedureThe Resident Rights policy, revised May 2022, was received from the nursing home administrator (NHA) on 6/2/26 at 12:07 p.m. It revealed in pertinent part, It is the policy of this facility that all residents rights be followed per state and federal guidelines, as well as other regulatory agencies. The residents have the right to privacy in written communications, including the right to send and promptly receive mail that is unopened, and to have access to stationery, postage and writing implements at the resident's expense.II. Resident #15A. Resident statusResident #15, age greater than 65, was admitted to the facility on [DATE]. According to the May 2026 computerized physician's orders (CPO), diagnoses included an aneurysm of the iliac artery, acquired absence of the right foot, type 2 diabetes mellitus without complications, and adjustment disorder with mixed anxiety and depressed mood.The 5/13/26 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. B. Resident interviewResident #15 was interviewed on 6/1/26 at 10:00 a.m. Resident #15 said the facility failed to maintain the confidentiality of his mail. He said his incoming mail was delivered to him already opened on two separate occasions. Resident #15 said that one of the letters was from the social security administration addressed to him. He said the letter was delivered to him by the business office manager and it was already opened The resident said the business office manager brought the letter to his room and handed him the open envelope. Resident #15 said the business office manager said she opened it by mistake. Resident #15 said he felt his privacy was violated because his letters were personal and should not be opened before he received them.III. Staff interviewsThe business office manager was interviewed on 6/2/26 at 12:19 p.m. The business office manager said the front office receptionist received and sorted all of the incoming mail before it was transferred to her. The business office manager said that she accidentally opened Resident #15's letter from the social security administration. She said she opened the envelope before realizing that it belonged to a resident. She said she then delivered the opened mail to Resident #15. The business office manager said she should have checked before opening the envelope to prevent a breach of the resident's privacy. The business office manager said she did not report the incident to the NHA. However, she said she did offer an apology to Resident #15 at the time of the incident. The NHA was interviewed on 6/2/26 at 12:33 p.m. The NHA said he was just informed by Resident #15 about the concern regarding mail delivery. The NHA said the business office manager should have verified the addressee on the envelope before opening it. The NHA said he believed the mail had been opened by accident and therefore did not constitute a violation of the resident's rights. The NHA said he would immediately provide education for the staff who handle mail delivery.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to prevent misappropriation of property for one (#42) of five residents reviewed out of 42 sample residents. Specifically, the facility failed to prevent the theft of Resident #42's credit card, resulting in unauthorized charges and the theft of approximately $100.00 in cash by a staff member.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 5/27/26 to 6/2/26, resulting in the deficiency being cited as past noncompliance with a correction date of 5/20/26.I. Incident of failure to prevent misappropriation of property for Resident #42 On 5/13/26 at 9:30 p.m. the nursing home administrator (NHA) received a grievance from Resident #42's representative about unauthorized credit card charges on Resident #42's credit card statement, which occurred between 4/30/26 and 5/8/26. Additionally, $100.00 in cash was missing from Resident #42's wallet, which had been stored in her unlocked room cupboard. II. Facility plan of correction The corrective action plan the facility implemented in response to the incident of the misappropriation of property for Resident #42 by a staff member was provided by the NHA on 6/1/26 at 3:30 p.m. The corrective action plan documented the following:A. Immediate action The NHA initiated an internal investigation on 5/13/26 at 9:30 p.m. after Resident #42's family notified the facility of possible unauthorized transactions involving Resident #42's credit card and concerns regarding missing cash from Resident #42's wallet. The facility completed required notifications, including to management, the facility's ombudsman, Adult Protective Services (APS), and law enforcement. Resident #42 was immediately protected from further potential financial exploitation upon identification of the concern. Resident #42's credit card was deactivated by the family and the family removed Resident #42's wallet from her room. Resident #42 was assessed for psychosocial distress and ongoing safety concerns.Resident #42's care plan was updated to reflect increased vulnerability related to cognitive impairment and inability to manage finances safely.Facility staff obtained the transaction information from the family and reviewed the dates, locations, and amounts of the reported charges.The law enforcement investigation identified video footage reportedly showing a facility staff member, certified nurse aide (CNA) #2, utilizing Resident #42's credit card during a transaction at a store. This video was presented to the facility by a local sheriff on the morning of 5/19/26. CNA #2 was terminated from employment.B. Identification of other residents having the potential to be affected by the deficient practiceThe facility conducted interviews with all of the residents regarding concerns related to missing items, valuables and financial exploitation. Residents who reported keeping valuables in their rooms were offered the use of the facility safe and/or lock boxes for valuables. Families, power of attorneys (POA), resident representatives, and guardians of cognitively impaired residents were contacted as appropriate. The facility reviewed information from CNA #2's date of hire, which included all grievances for missing items, to track any trends. The facility documented no trends were identified. A full house audit was completed, which reviewed and updated resident property inventory records. All CNAs and nurses who worked on Resident #42's unit on 4/28/26, 4/29/26, and the morning of 4/30/26 were interviewed regarding direct care they provided to Resident #42 and if they had entered her room during their shifts. Beginning 5/19/26, the facility initiated an all-staff education regarding abuse prevention, misappropriation of resident property and abuse reporting. C. Measures or systemic changes to ensure the deficient practice will not recurThe facility completed a root cause analysis of the occurrence and reviewed practices related to resident valuables, financial protections, and reporting procedures. The facility documented ongoing monitoring and follow-up remained in place.The facility's social services director (SSD) would begin reviewing and updating the resident inventory information at the time of admission and quarterly, and would ask residents at the time of admission and quarterly if they had any valuables and wanted to request a lock box. The facility's plan included additional education to staff on misappropriation by the sheriff's (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	department, which was scheduled on 6/12/26. The facility updated the admission packet provided to residents and representatives, including a resident inventory belongings list which identified the facility process for storage of resident valuables.D. Plan to monitor for sustained compliance The facility administration, or designee documented a plan to audit resident concerns and grievances related to missing property, valuables, and allegations of misappropriation weekly for 12 weeks to ensure concerns were promptly identified, reported, investigated, and addressed. Findings would be reviewed through the facility's quality assurance performance improvement (QAPI) process and additional interventions implemented as indicated. III. Facility policy and procedure The Abuse Prevention and Reporting policy, revised April 2024, was provided by the NHA on 5/27/26 at 4:00 p.m. It revealed in pertinent part, Residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect and exploitation.Exploitation is taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.IV. Resident #42A. Resident status Resident #42, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included diabetes, chronic obstructive pulmonary disease, dementia, and generalized muscle weakness. The 4/15/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The MDS assessment revealed Resident #42 had lower extremity weakness, used a walker for mobility, required substantial assistance for personal care and bathing and had moderate difficulty with hearing and used hearing aides. B. Resident #42's representative interview Resident #42's representative was interviewed on 5/28/26 at 9:00 a.m. Resident #42's representative said Resident #42 had poor short term memory and did not remember any information about the incident of misappropriation. The representative said Resident #42 had her purse and wallet with her when she was admitted to the facility in the middle of April 2026, and these items were stored in an unlocked cupboard in her room. Resident #42's representative said his brother reviewed Resident #42's credit card statement and discovered unauthorized charges were made in an area that Resident #42 could not have made them, because she was living as a resident in the facility at that time. Resident #42's representative said he immediately acted and disabled the credit card and the credit card charges were reversed. Resident #42's representative said about $100.00 in cash also seemed to be missing from Resident #42's wallet. The representative said he reported the incident to the NHA on 5/13/26 and the NHA began an investigation. C. Record review The facility's investigation report was provided by the NHA on 6/1/26 at 3:15 p.m. and revealed the following: The facility's investigation of the incident was initiated on 5/13/26 after the resident's representative notified the facility of possible fraudulent activity involving Resident #42's credit card. The representative documented that on 5/12/26 multiple unauthorized transactions at gas stations and convenience stores, totaling $224.47, were discovered as having occurred between the dates of 4/30/26 and 5/8/26. The representative also informed the facility of Resident #42 missing $100.00 in cash. Resident #42's representative immediately deactivated the affected credit card to prevent additional unauthorized transactions and brought Resident #42's wallet to their family home. The investigation documented Resident #42 was interviewed by the NHA on 5/13/26 and reported she did not believe anything was missing and denied having concerns at that time. Resident #42 was interviewed a second time on 5/19/26 with her representative present, and she denied knowledge of missing items. The resident stated she felt safe in the facility and denied additional concerns regarding her care or belongings. All CNAs and nurses who were scheduled to work on the unit where Resident #42 resided, on 4/28/26, 4/29/26 and the morning of 4/30/26, were interviewed to determine whether they provided direct care to Resident #42 and/or entered her room during their shifts. No staff members reported observing valuables in the room, and all denied knowledge of or concerns regarding misappropriation of resident property.The facility's investigation revealed the alleged assailant, CNA #2, said she may have provided care to Resident #42 on 4/28/26, 4/29/26 and/or 4/30/26; however, she said she was not in the room for long periods of time. CNA #2 denied observing valuables, credit (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cards, money, or a wallet left out in Resident #42's room and denied knowledge of anyone taking valuables from Resident #42's room. CNA #2 denied having information regarding the reported missing debit card or money.On 5/19/26 the law enforcement investigation identified video footage reportedly showing a facility staff member, CNA #2, completing a transaction in a store using Resident #42's credit card during the timeframe of the reported unauthorized charges. CNA #2 was terminated from employment at the facility.The nursing care plan, dated 4/20/26, revealed Resident #42 was at risk for financial exploitation or misappropriation and loss of personal belongings related to cognitive impairment, intermittent confusion, impaired judgment, and inability to independently manage finances safely. Interventions included to encourage family involvement with management of resident finances/cards and monitor for/report concerns related to missing belongings, suspicious activity, or psychosocial distress.V. Staff interviews The NHA was interviewed on 6/2/26 at 10:00 a.m. The NHA said he became aware of the misappropriation incident involving Resident #42 on 5/13/26 at 9:30 p.m. when he reviewed the grievance document on his desk completed by the SSD that day. He said the form included the reported concerns from Resident #42's representative about unauthorized charges on Resident #42's credit card. The NHA said an investigation was initiated immediately and required notifications were made, including to Resident #42's representative, the police, APS and the facility's ombudsman. The NHA said all CNA staff and nursing staff, who were scheduled to work on the unit where Resident #42 resided on 4/28/26, 4/29/26 and the morning of 4/30/26, were interviewed to determine whether they provided direct care to Resident #42 or entered her room during their shifts. The NHA said CNA #2 had had a clear background check when she was hired at the facility in February 2026. The NHA said CNA #2 was interviewed on 5/29/26 during the investigation and she said she may have provided care to Resident #42 on 4/28/26, 4/29/26 and/or 4/30/26, but said she was typically not in the room for long periods of time. The NHA said CNA #2 denied observing valuables, credit cards, money or a wallet left out in Resident #42's room and denied knowledge of anyone taking valuables from Resident #42's room. The NHA said it was the video footage provided to the facility from law enforcement on 5/19/26 that confirmed CNA #2 was the staff member responsible for misappropriation of Resident #42's property. The NHA said CNA #2 was terminated from employment at the facility on 5/19/26. The NHA said he spoke with Resident #42's representative and informed the representative that the facility would reimburse the resident for the additional missing cash amount as a result of the incident. The NHA said the admission packet and the process for resident and representative discussion regarding resident valuables, and documenting resident valuables on admission had been updated in order to emphasize the facility's process more clearly regarding keeping residents' valuables in the facility. The NHA said all facility staff completed in-person education with the director of nursing (DON) since the incident to review abuse, misappropriation of property and mandatory reporting. He said the sheriff was scheduled to be at the facility on 6/12/26 to emphasize prevention of abuse and misappropriation and mandatory reporting requirements.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#29) of two residents reviewed for ancillary services, such as dental services, out of 42 sample residents received dental services timely.Specifically, the facility failed to arrange dental services for Resident #29 after she had a broken tooth.Findings include:I. Facility policy and procedureThe Dental Services policy, revised January 2026, was provided by the director of nursing (DON) on 6/2/26 at 12:42 p.m. It read in pertinent part, It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the state plan) and emergency dental care. Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g. taking impressions for dentures and fitting dentures. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate, broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. The dental needs of each resident are identified through the physical assessment and MDS (minimum data set) assessment processes, and are addressed in each resident's plan of care.II. Resident #29A. Resident statusResident #29, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic obstructive pulmonary disease (COPD, a lung disease), chronic respiratory failure, emphysema, depression and heart failure.According to the 5/1/26 MDS assessment Resident #29 had moderate cognitive impairment with a BIMS score of 12 out of 15. The MDS assessment identified Resident #29 was independent with eating, personal hygiene and dressing and required supervision for toileting and moderate assistance for showering.The MDS assessment revealed the resident had no dental issues.-However, Resident #29 had a broken tooth.B. Resident observations and interviewsOn 5/27/26 at 4:40 p.m. Resident #29 was sitting in her bed. Resident #29 said she had a broken tooth that was very sharp. The resident pointed to an upper left front tooth had a jagged edge and was short. Resident #29 said the tooth did not hurt at that time, but it hurt her mouth sometimes. Resident #29 said the tooth was broken months ago and she told staff about it. Resident #29 said no one had asked her if she wanted to see a dentist. Resident #29 said the broken tooth had made it more difficult to eat at times.Resident #29 was interviewed in her room a second time on 6/1/26 at 8:55 a.m. Resident #29 said the facility scheduled a dental appointment for her after they were notified of her broken tooth on 5/28/26. A sign on the wall in Resident #29's room revealed a scheduled dental appointment for Resident #29 on 6/4/26.C. Record reviewA physician progress note on 12/30/26 at 1:54 p.m. documented Resident #29 had broken her tooth on 12/29/26. It documented her pain was well controlled and the resident had no tooth pain at the time. The note documented a recommendation for the facility to arrange for a dentist to see Resident #29. The note documented the broken tooth was a left incisor (to the left of the front tooth).-However, there was no documentation revealing the facility scheduled a dental appointment to evaluate Resident #29's broken tooth.D. Staff interviewsThe social services director (SSD) was interviewed on 6/2/26 at 2:12 p.m. The SSD said she was not been aware of Resident #29's broken tooth. The SSD said the resident had not mentioned this to her. The SSD said she did not know why there was not follow up by the facility related to Resident #29's broken tooth. The SSD said the facility needed a way to communicate the information that was provided in the physician note about the broken tooth.The DON was interviewed on 6/2/26 at 2:12 p.m. The DON said if the physician did not write an order, she would expect the physician to communicate with staff about the need to follow up for a resident's broken tooth. The DON said she did not know who Resident #29 had told about the broken tooth, aside from the physician on 12/30/25, as no nursing staff were aware of the broken tooth. The DON said the facility's process included that she and the assistant director of nursing (ADON) reviewed physician notes on a (continued on next page)

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	065265	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berthoud Care and Rehabilitation	855 Franklin Ave Berthoud, CO 80513

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuous basis. The DON said she did not know why there was not a record of communication about Resident #29's broken tooth after the physician note was written on 12/30/25. The DON said after the facility was notified on 5/28/26 of Resident #29's broken tooth, a dental appointment was scheduled.