STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065272	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Post Acute	1432 Depew St Lakewood, CO 80214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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 that the resident environments remained free from accidents hazards as was possible and that each resident had adequate supervision to prevent accidents for for one resident (#10) of three residents reviewed for falls out of sample 34 residents. Resident #10 was admitted on [DATE] for long term care with diagnoses of emphysema (shortness of breath), dementia (impaired memory and thinking), paranoid personality disorder (mental health condition), epilepsy (neurological disorder) and repeated falls. Resident #10 was identified as a high fall risk. Resident #10 sustained eight falls in three months (October 2025 to January 2026).On 10/25/25, Resident #10 sustained a fall where he hit his head. He was sent to the hospital and was diagnosed with a closed head injury. Observations during the survey revealed the facility failed to consistently implement person-centered fall interventions.Specifically, the facility failed to ensure fall precautions were consistently in place for Resident #10. Findings include:I. Facility policy and procedureThe Falls and Fall Risk, Managing Policy, revised December 2007, was received from the Nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It revealed in pertinent part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.II. Resident #10A. Resident statusResident #10, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO) diagnoses included emphysema, dementia, paranoid personality disorder), epilepsy and repeated falls. The 12/5/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) score of seven out of 15. He required staff supervision for toileting, dressing and ambulation. He needed setup assistance with meals and personal hygiene. He was independent with bed mobility. The MDS indicated resident had sustained falls.B. Record reviewThe 7/12/24 comprehensive care plan documented Resident #10 was at risk for falls with and without injury related to dementia with agitation, cognitive impairment, difficulty in walking, wandering, vision and hearing impairment.Interventions put in place by the facility were:-Call light with in reach (initiated 2/2/25);-Personal items within reach (initiated 2/2/25);-Traction strips and signs posted in the room/bathroom to remind Resident #10 to use call light and wait for assistance (initiated 8/27/25); -Bed in low position (initiated 9/13/25);-Keep the resident's personal belongings with inreach (initiated 9/15/25);-Moving the resident's room closer to nurses' station (initiated 9/25/25);-Hipsters as tolerated (initiated 10/2/25);-Low profile fall mat (initiated 10/13/25); and,-Offer scrum cap when out of bed initiated on 10/15/25.The January 2026 CPO documented the following physician's orders:-Low profile fall mat, ordered on 10/13/25;-Offer scrum cap (protective helmet) when out of bed, ordered on 10/15/25; and,-Apply hipsters in the morning, ordered on 10/2/25.Resident #10's electronic medical record (EMR) revealed the resident sustained falls on:-On (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 0689 Level of Harm - Actual harm Residents Affected - Few	10/1/25 the resident fell while pulling his wheelchair backwards.-On 10/7/25 the resident was found on the floor near his wheelchair.-On 10/11/25 the resident was found on the floor near his bed and wheelchair.-On 10/15/25 the resident had a witnessed fall when he turned too fast, lost his balance and struck his head. -On 10/25/25 the resident had a suspected fall resulting in hematoma to right eye and head.-On 1/12/26 the resident was found on the floor next to the toilet in the bathroom with a call light on in his room.-On 1/17/26 the resident was found on the floor next to his bed.-On 1/19/26 the resident was found on the floor in another resident's room. The 10/11/25 post fall reviews documented the resident was a moderate risk for falls.The 10/25/25 post fall review documented the resident was moderate risk for falls. A progress note on 10/25/25 at 10:45 a.m. documented the resident had a change in condition related to a fall. All parties were notified. The resident was sent to the emergency room for evaluation.A progress note on 10:25/25 at 10:49 a.m. documented Resident #10 was assessed by a registered nurse (RN) at 10:30 a.m. due to a report from a licensed practical nurse (LPN) on the memory care unit. The LPN reported a hematoma (raised bruise) to the resident's lateral upper right eye. Per the LPNs report the resident may have fallen during the previous shift but there was no report or injury on file. Resident #10 endorsed he fell in the dining room or his bedroom. Resident #10 reported he was dizzy when he fell but denied at the time of assessment. The hematoma measured 5 centimeters (cm) by 2.5 cm.A progress note on 10/25/25 at 4:31 p.m. documented the resident returned to the facility. A computed tomography (CT imaging test) scan was performed. The results indicated the resident sustained a periorbital (eye) and left parietal (top rear area of the skull) hematoma.A progress note on 10/27/25 at 4:22 a.m. documented the nurse was told Resident #10 had sustained a fall on her previous shift on 10/25/25. The nurse documented resident remained asleep throughout the night as per his usual pattern, no abnormal sound or activity was noted. The emergency room notes from 10/25/25 documented the resident was seen for a fall with a closed head injury. A resident reported a right sided headache. Imaging showed right periorbital and left parietal scalp hematomas. A physician progress note dated 11/14/25 at 8:18 a.m. documented the physician was requested to see the resident for MRI results of the brain which showed late subacute versus chronic subdural hematoma 11 millimeters (mm). The facility reported that the patient remained neurologically stable without any focal deficits or symptoms. C. Observations and interviewsOn 1/27/26 at 8:40 a.m Resident #10 was lying in bed A (resident was assigned bed B) of the residents room with no fall mat in place. The call light was not in reach of the resident (see care plan interventions and CPOs orders above).On 1/27/26 at 9:27 a.m. the resident's bathroom was observed to have no traction strips on the floor (see care plan interventions above).On 1/27/26 at 4:10 p.m. Resident # 10 was lying in bed A with no fall mat on the floor next to the bed.On 1/28/26 at 8:15 a.m. Resident #10 was rolling around in his bed with no fall mat or callight within reach. III. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 1/28/26 at 1:44 p.m. She said she had only been on the unit a few times but she utilized the computer records for resident care needs. CNA #3 said Resident #10 was not a fall risk and had not had falls. -However, Resident #10 had sustained eight falls in three months (see record review above).CNA #3 said he could wear pads to his hips (hipsters) but she could not find them. CNA #3 said residents with falls sometimes had their bed mid level. CNA #3 said the resident did not need his bed low to the ground. LPN #3 was interviewed on 1/28/26 at 1:57 p.m. LPN #3 said Resident #10 was a high fall risk resident. LPN #3 said the resident should have a fall mat next to his bed, hipsters and scrum cap on as fall interventions. Resident #10's room was observed with LPN #3. Resident #10's fall mat was laying next to bed B in the room. However the resident had been observed sleeping in bed A during the survey.LPN #3 said the mat should be on the side the resident got out of bed on so if he was sleeping in bed A the mat was not in the best position to protect the resident if he were to fall out of bed. LPN #3 said she was unable to locate Resident#10's hipsters or scrum cap in resident's current room. LPN #3 then went to another room, which was Resident #10's old room to look for other interventions ordered for fall prevention. LPN #1 said the resident was moved to his current room over a week ago and maybe his things had (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	not been moved over yet. LPN #3 said she was unsure if the room move was permanent or why his personal belongings were still in his old room. LPN #3 said she located the resident's scrum cap on the dresser and his hipsters in the drawer along with his personal belongings in his old room. -The facility failed to ensure fall interventions were consistently in place. The director of nursing (DON) was interviewed on 1/29/26 at 12:23 p.m. She said the staff could review the resident's care plan or Kardex (staff directive tool) for care needs and interventions needed for keeping residents safe. The DON said if they had any new interventions, there was a binder at each nurses' station to help the staff learn about new interventions put in place for residents. The DON went to the memory care unit and observed Resident #10's current room. She said the resident's room move was permanent and was not sure why his personal belongings were not moved to his new room since it had been over a week since the move. The DON said fall interventions should be used at all times in order to keep residents safe.

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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, record review and interviews, the facility failed to store, prepare, distribute, and serve food in a sanitary manner in the main kitchen and in three of three unit nourishment refrigerators/freezers.Specifically the facility failed to:-Ensure food was labeled and dated appropriately in the main kitchen and in the nourishment room refrigerators; and,-Ensure food was disposed of timely. Findings include:I. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 2/4/26. It read in pertinent part, The day or date marked by the food establishment may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by date based on food safety. (Chapter 3-25) A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter 3-29) B. Facility policy and procedureThe Food Receiving and Storage policy, revised November 2022, was provided by the nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It read in pertinent part, Foods shall be received and stored in a manner that complies with safe food handling practices. Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). PHF (Potentially Hazardous Food)/TCS (Time/Temperature Control for Safety) foods are stored at or below 41 degrees Fahrenheit (F), unless otherwise specified by law. Refrigerated foods are stored in such a way that promotes adequate air circulation around food storage containers. Refrigerators/walk-ins are not overcrowded. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. Uncooked and raw animal products and fish are stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods to prevent meat juices from dripping onto these foods. All food items to be kept at or below 41degrees F are placed in the refrigerator located at the nurses' station and labeled with a use by date. All foods belonging to residents are labeled with the resident's name, the item and the use by. Beverages are dated when opened and discarded after twenty-four (24) hours. Other opened containers are dated and sealed or covered during storage. Partially eaten food is not kept in the refrigerator.C. Observations and interviewsOn 1/26/26 at 8:15 a.m. the initial tour of the main kitchen was conducted with the dietary manager (DM). Observation in the walk-in freezer revealed an opened box of egg rolls with no labeling or dating, the plastic bag in the box was not closed. The DM said it should be labeled and dated when delivered and then when opened and the plastic bag should not be open to air in the freezer.On 1/27/26 at 8:50 a.m. a follow up tour of the main kitchen was conducted with the dietary director who was the registered dietician (RD) for the facility. Observations in the walk-in refrigerator revealed a roll of ground beef in a plastic wrap dated 1/14/26 and use by date of 1/18/26. The RD said she would throw it away to be safe. The RD said cooked food was good for three days and raw/fruit and vegetables were good for five days. Observations in the walk-in freezer revealed a pan of lemon bars with plastic wrap over and dated 10/16/25. The RD said there should also be an expiration date. The RD said she would toss it. There were four pizza flat breads, wrapped in plastic (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wrap, with no label or date. The RD said she would throw it away to be safe. An opened box of ice cream bars was in a tub, there was no label or date. The RD said there should be a date of arrival and expiration date. There was a bucket of approximately six random meats, wrapped in plastic wrap with no label or date. The RD said there should be a date of arrival and expiration and also she would want to know what type of meat it was and that should be written on the label. There were four grilled cheese sandwiches in a plastic bag with no label or date. The RD said she would discard all of the unlabeled products because she was not sure how old it was. On 1/28/26 at 3:17 p.m. the nourishment refrigerators/freezers located at the nurses' station were observed with activities assistant (AA) #1. The Legacy nourishment refrigerator/freezer was observed, there were melted chocolate ice cream streaks in the freezer. The Sarvata kitchenette nourishment refrigerator/freezer was observed, there was an opened square metal container of yellow creamy food with a half covered piece of plastic wrap and a serving spoon inside the food. There was no labeling of the food or date. AA #1 removed the container and said she did not know what it was. The Sarvarta nourishment refrigerator/freezer located at the nurses' station was observed, the refrigerator was tightly packed and overcrowded. There was an opened coffee creamer with no date. There was a tupperware with chili with no name or date. There was a half full plastic container of soda with a straw in it, with no name or date. There was an opened container of yogurt with no name or date. In the freezer there were five ice packs. AA #1 said the kitchen staff was responsible for cleaning and throwing out old food from the nourishment freezers and refrigerators. On 1/28/26 at 3:50 p.m. the Prasada nourishment freezer and refrigerator located at the nurses' station was observed with the RD. Three resident snack and beverage items were pulled from the refrigerator, that included an unknown beverage in a plastic cup, an opened sports drink and snack in a plastic bag. These items were not labeled or dated.D. Staff interviewsThe RD was interviewed on 1/27/26 at 9:00 a.m. The RD said food was delivered on Tuesdays and Thursdays. She said that was when she and the DM would go through the freezer and refrigerator to throw out old products and label new products coming in.The RD was interviewed on 1/28/26 at 3:40 p.m. The RD said she and the DM were responsible for maintaining clean nourishment and kitchen freezers and refrigerators. The RD said they were also responsible for cleaning out and discarding outdated food and beverages. The RD said she had no cleaning logs for the four nourishment freezers/refrigerator or the for the main kitchen walk-in freezer or walk-in refrigerator. The RD said it could get confusing without a cleaning log regarding who had completed the cleaning and if it was getting done. The RD said it should be done one time per week. The RD said all the nourishment and kitchen freezers and refrigerators should only have items in it that were labeled and appropriately dated. She said there should not be any ice packs kept in the freezer. The RD said the square metal container of yellow creamy food found at the Sarvata kitchenette nourishment refrigerator may have been left over macaroni and cheese, however it should have been labeled and dated and she would throw it out. The RD said it had been over three months since she had cleaned the Sarvata nourishment freezer and refrigerator located at the nurses' station. The RD said she would be doing education on food labeling that all foods in the kitchen and nourishment freezers/refrigerators should be labeled with name of item, received date, date of opening, pull date for frozen foods, and date of expiration. The RD said the DM was currently going through/cleaning out the walk-in freezer and refrigerator in the main kitchen to bring it up to date and then they would start on the nourishment freezers and refrigerators.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases on two out of three units.Specifically, the facility failed to:-Ensure housekeepers cleaned and disinfected the residents' rooms in a hygienic manner; -Ensure housekeepers performed hand hygiene while cleaning resident rooms;-Ensure housekeepers cleaned high touch areas; -Ensure dwell times were followed during resident room cleaning; and,-Ensure hand hygiene was conducted appropriately during wound care. I. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 2/2/26 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 2/2/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. According to the Hydrogen Peroxide Cleaner Disinfectants, dated 2026. Retrieved from: https://www.cloroxpro.com/products/clorox-healthcare/hydrogen-peroxide-cleaner-disinfectants/?UTM_Campa on 2/2/26 it was revealed in pertinent part. Wipe the surface until completely wet. To disinfect, keep surface wet for the contact time (1 minute for most bacteria and viruses; 2 minutes for C. auris). According to the Technical Bulletin: Concentrated SPIC and SPAN Disinfecting All-Purpose Spay and Glass Cleaner, updated 7/23/21, was retrevied on 2/2/26 from https://assets.ctfassets.net/xsotn7jngs35/6qI41K6mC3OnnZQcx32AeU/e0c1c6588d8efe3daf05cd1a676226ff/ It revealed in pertinent part, To Sanitize/Disinfect: For visibly soiled areas, a precleaning is required. Spray hard, non-porous surfaces until thoroughly wet. To Sanitize: Treated surfaces must remain visibly wet for 15 seconds before wiping. To Disinfect: Treated surfaces must remain visibly wet for the time indicated for each organism listed under the efficacy section. A rinse is required for surfaces in direct contact with food. According to the Comet Disinfecting-Sanitizing Bathroom Cleaner, updated 9/13/18, was retrieved on 2/2/26 from http://assets.ctfassets.net/xsotn7jngs35/5xJmZUMq9KOiw27ZTOf5rl/3e9635a410c1491ab8da7d19612c390/c It revealed in pertinent part, TOILET BOWLS AND URINALS: Empty water from the toilet bowl or urinal. Hold 6-8 from the surface. Spray exposed surfaces. Brush thoroughly. Let stand for 5 minutes, then flush. B. Facility policy and procedure The Cleaning and Disinfecting Resident Rooms policy, revised August 2013, was received from the nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It revealed in pertinent part, The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur, when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (daily, three times per week) and when surfaces are visibly soiled. The environmental services director and administrator, in conjunction with the infection preventionist, will select appropriate facility disinfectants. Steps in the Procedure for Resident Room Cleaning: 1. Gather supplies as needed. 2. Prepare disinfectant according to manufacturer's commendations. 3. Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solutions. 4. Change mop solution water at least every three (3) rooms, or as necessary. 5. Change cleaning cloth when they become soiled. Wash cleaning cloth daily and allow cloth to dry before reuse. 6. Clean horizontal surfaces (e.g., bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters. 7. Clean personal use items e.g., lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly. The Handwashing/hand Hygiene policy, revised October 2023, was received from the NHA on 1/30/26 at 12:21 p.m. It revealed in pertinent part, This facility considers hand hygiene the primary means to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prevent the spread of healthcare -associated infections.All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Environmental measures are taken to reduce contamination associated with sinks and sink drainage, including:the use of disinfectants that are EPA-registered for biofilm removal to clean sinks and faucets daily. Indications for Hand Hygiene:. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations. II. Observations On 1/28/26 at 9:16 a.m. housekeeper (HK) #1 was cleaning room [ROOM NUMBER], a double occupancy room on the Prasada unit. She [NAME] by sweeping the A side of the room then collected a Spic N Span all purpose disinfectant and a glass spray entered the residents' bathroom and sprayed the toilet down with the Spic N Span. HK #1 returned to her cleaning cart at the entrance of the door, collected two Clorox Hydrogen Peroxide wipes, went to A side of the room, wiped down the night stand then went to bed B side of room and wiped down the bed side table wiping around the resident personal items. She then wiped the legs of the table down to the floor. -HK #1 failed to use a different wipe for each side of the room. The surfaces wiped with the Clorox wipes did not remain wet for the one minute dwell time (see professional reference above). HK #1 then collected the trash from the trash can near the sink and replaced it with a new bag. She collected the toilet bowl brush and one red rag for the housekeeping cart. She then entered the bathroom, scrubbed the toilet bowl with the brush. She then took the red rag, wiping the toilet bowl rim, then seat and then lid. -HK # failed to clean the toilet from the cleanest area to dirtiest areas. HK #1 returned to her cart, collected a dry mop pad, dunked it into the mop bucket, rang it out then went into the restroom and mopped the bathroom. HK #1 went back to her cart, removed the mop pad and repeated the process of dunking the new mop pad in the mop bucket, then mopped the room from the B side to the A side then to the doorway. HK #1 then removed the mop pad, replaced it with a dry mop pad and mopped the floor with a dry pad to dry the floor. -HK #failed to change her gloves and complete hand hygiene after cleaning the toilet. She then reached into the mop bucket where she contaminated the cleaning solution with soiled gloves twice, while wetting each mop pad. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:26 a.m. HK #1 said she was done cleaning room [ROOM NUMBER]. She removed her gloves and moved to the next room. -HK #1 failed to clean high touch areas in the resident room and bathroom like call lights, light switches, bed controls. HK #1 failed to clean the resident sink area. HK#1 moved her cart to room eight, a triple resident room at 9:28 a.m. She applied clean gloves, knocked on the door and announced herself. -HK #1 failed to perform hand hygiene between rooms and prior to applying clean gloves. HK #1 collected the Spic n Span disinfectant and went to the bathroom sprayed the toilet. She collected the trash by the sink and side A and took it to the cart. She replaced the trash bags in trash cans and collected two Clorox hydrogen peroxide wipes. She wiped the bedside table, the night stand on the B side. She then went to the C bed night stand and wiped it down. The surface dried in 30 seconds. -HK #1 did not wipe bed A's night stand or bed side table. H K#1 also used the same Clorox wipe for both B and C beds. HK #1 failed to ensure the surface remained wet for the dwell time for the Clorox (see professional references above) HK #1 collected Spic n Span disinfectant all purpose spray and glass cleaner. She sprayed the sink then the mirror. She wiped the mirror then the sink handles then, then the sink bowl, she then wiped the counter top with the same rag. -HK #1 failed to clean the sink area from cleanest to dirtiest. HK #1 returned to her cart, collected the toilet bowl brush, brought it into the bathroom, scrubbed the toilet bowl then took it back, re entered the room, touched the light switch at the sink then returned to cart collected a roll of toilet paper and placed it into the bathroom. -HK #1 touched areas in the room, items on the cleaning cart with soiled gloves used to clean the toilet bowl. HK #1 collected a new rag from the cart, re entered the bathroom, wiped the toilet and returned to her cart. HK #1 changed gloves. -HK #1 changed her gloves but failed to perform hand hygiene between changes. HK #1 then took a new mop pad, dunked it into the mop water, rang it out then mopped the bat II. Failure to perform hand hygiene per professional standards of practice A. Observation On 1/28/26 at 2:15 p.m. the IP was preparing to provide catheter care to Resident #54. She performed hand hygiene. She left the room to get a Foley catheter bag. She washed her hands and donned (put on) personal protective equipment (PPE). She undid the secure tabs of his adult disposable brief. She took off the old drain sponge, grabbed a clean washcloth and placed it in the warm, soapy water. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	washed the supra pubic area. She then grabbed a second clean washcloth and cleaned the area a second time. She grabbed a clean washcloth, placed it in the warm water, and rinsed the area. She grabbed a clean washcloth and dried the area. She placed a new drain sponge on the supra pubic catheter site. She reattached the secure tabs of his adult disposable brief. She took off her PPE and disposed of it. She washed her hands, and she put on gloves, and grabbed the garbage bag from the resident's waste basket, along with PPE and an old Foley catheter bag, to take to the garbage disposal area. -The IP failed to change her gloves and perform hand hygiene after removing the soiled drain sponge. And failed to place the old Foley catheter bag in a red bag for bodily fluids. C. Staff interviews The IP was interviewed on 1/28/26 at 2:30 p.m. The IP said she did not normally perform supra pubic catheter care. She said the nurse assigned to the resident was having an issue with the catheter care and asked her to complete the care. She said gloves should be changed after removing the dirty dressing. The DON was interviewed on 1/28/26 at 2:50 p.m. The DON said the nurse should remove the old dressing, remove gloves, wash hands and place clean gloves on to complete the Foley catheter care. She said the nurse should place the dirty Foley catheter bag into a red biohazard bag to discard it.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observation and interviews, the facility failed to ensure residents had the right to have reasonable access to the use of a telephone and a place in the facility where calls could be made without being overheard on two of three units.Specifically, the facility failed to have a private area for residents to make and receive telephone calls and inform the resident of these areas on the Prasada and Legacy units. Findings include:I. Facility policy and procedureThe Resident Right to Privacy in Communication policy, undated, was provided by the nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It read in pertinent part, It is the policy of this facility to support and facilitate a resident's right to privacy in communications with individuals and entities within and external to the facility. Reasonable access means that telephones, computers and other communication devices are easily accessible to residents and are adapted to accommodate resident's needs and abilities, such as hearing or vision loss. Policy Explanation and Compliance Guidelines: Have reasonable access to private telephone conversations. The facility will provide residents with reasonable access to the use of a telephone, including TTY (Teletype) and TDD (telecommunications device for the deaf) services, where calls can be made without being overheard. Reasonable access should include: Placing telephones at a height accessible to residents who use wheelchairs; Adapting telephones for use by residents with impaired hearing; Prior to or upon admission, the social service designee, or another designated staff member, will inform the resident of provisions the facility has made for access to the use of a telephone and privacy in communications.II. ObservationsThe facility had three units.The secured behavioral health unit (Prasada) downstairs had one public landline telephone placed at the nurses' station/dining area with no private area for a phone call.The secured memory care unit (Legacy) on the main level had one public landline phone at the nurses' station with no private area for a phone call.III. Resident observations and interviewsOn 1/26/26 at 12:05 p.m. an unidentified resident was in the dining room of the secured behavioral health unit (Prasada) and was standing at the nurse's station making a personal phone call to his mother. It was during lunchtime and the resident's conversation was overheard by all the residents sitting in the dining room.Resident #21 was interviewed on 1/26/26 at 1:30 p.m. Resident #21 said he wanted to call his family member and ask her to get him some more things. Resident #21 said he made his phone calls at the Prasada nursing station/dining room area, which was the only public phone for the residents to use since there was no portable phone. Resident #21 said having a phone call with privacy would be great but presently that was not an option. Resident #56 was interviewed on 1/26/26 at 2:39 p.m. Resident #56 said today was his birthday and he had talked to his grandma on the phone at the Prasada nurses' station. Resident #56 said he would have liked it better to talk to his grandma more privately and it had been a long time since he had his own phone. Resident #56 said he did not know if it was an option to have a private phone conversation. On 1/28/26 at 2:26 p.m. Resident #5 was at the nurses' station in the secured memory care unit (Legacy). Resident #5 was having a personal phone call to a family member. There were three residents standing around and one unidentified certified nurse (CNA) at the nurses' station sitting across from Resident #5, all were able to hear the residents' conversation and the phone call was on speaker. IV. Group meeting interviewThree residents (#67, #70 and #75) were interviewed on 1/28/26 at 12:37ˆp.m. Resident #67 and Resident #70 attended the resident council meetings regularly and Resident #75 did not attend the meetings regularly. The residents were identified as alert and oriented by the facility and assessment. Resident #67 said he received and made phone calls on the Legacy unit. Resident #67 said the phone was located at the nurses' station and there was not a room or phone available for private calls. Resident #67 said he did not have a personal phone due to the expense. Resident #75 said he did not need to make a phone call on the Prasada unit. Resident #75 said there was a phone located in the dining room by the nurses' station. Resident #75 said it was the only phone available to the residents and they did not have a private location for a call.Resident #70 said he made phone calls on the Sarvata unit in the computer (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room that could be used to make private calls. Resident #70 said he did not have a personal phone. V. Staff interviewsThe activities director (AD) was interviewed on 1/27/26 at 4:25 p.m. The AD said the residents used the phone sitting at the nurses' station/dining room area and it was easily accessible because they could walk right up to it on the Prasada unit.CNA #5 was interviewed on 1/27/26 at 4:30 p.m. CNA #5 said the residents used the telephone at the nurses' station/dining room area and there was not a private phone for the residents to use on the Prasada unit.CNA #6 was interviewed on 1/27/26 at 4:35 p.m. CNA #6 said the residents used the phone at the nurses' station/dining room area. CNA #6 said that families could call in to talk to a resident and the staff would go get the resident to talk at the nurses' station. CNA #6 said there was no private phone for the residents to use on the Prasada unit.CNA #7 was interviewed on 1/27/26 at 4:45 p.m. CNA #7 said the residents used the phone at the nurses' station and there was not a private phone on that unit for the residents to use on the Legacy unit. Licensed practical nurse (LPN) #5 was interviewed on 1/27/26 at 4:50 p.m. LPN #5 said the residents used the phone at the nurses' station and the unit did not have a private phone on the Legacy unit.The social services director (SSD) was interviewed on 1/28/26 at 9:40 a.m. The SSD said there was a room on the Sarvata unit where residents could make a private phone call. The SSD said on the other two units (Legacy and Prasada) there was a landline phone the residents could use at the nurses' station with unlimited access. The SSD said there should be a place on each unit where phone calls could be made without being overhead. The SSD said privacy of communication was important because it was just one of those needs and a resident right. The SSD said she was not aware that some residents did not know that having a private phone conversation was an option. The SSD said she would provide education on that at the next resident council meeting. The SSD said there may be space to make private phone calls happen and she understood the residents perspective. The SSD said she would get together with the NHA and the environmental services director and see what the facility could do.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of four medication carts. Specifically, the facility failed to ensure there were no loose pills in the medication cart. Findings include:I. Facility policy and procedureThe Storage of Medication policy, 2001, and revised on 11/2020, was received from the nursing home administrator on 1/30/26 at 12:21 p.m It revealed in pertinent part, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.II. ObservationsOn 1/27/26 at 1:15 p.m., medication cart B was observed with licensed practical nurse (LPN) #1. There were three loose pills in the drawers. LPN #1 said one of the pills was Advil. On 1/27/26 at 1:30 p.m., medication cart A was observed with RN #1. There were twenty loose pills in the drawers. RN #1 was unable to identify any loose pills. III. Staff interviewsLPN # 1 was interviewed on 1/27/26 at 1:25 p.m. She said the night nurses were responsible for cleaning the medication carts, but all nurses were responsible for ensuring the cart was clean.RN #1 was interviewed on 1/27/26 at 1:45 p.m. RN #1 said all nurses were responsible for ensuring the medication carts were clean.The director of nursing (DON) was interviewed on 1/28/26 at 1:50 p.m. She said that the unit manager nurse was overseeing the task of cleaning the medication cart. The DON said the medication carts were assigned to be cleaned once a week by the nurse manager. The DON said nurses should be cleaning the medication cart on their shift as well. The DON said, The task was not getting done. The risk is that a resident could find a loose pill and take it.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interviews, the facility failed to ensure the resident was treated with respect and dignity and care was provided in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life and recognized the resident for one of three units for dignity.Specifically, the facility failed to treat the resident with dignity during meals. Findings include:I. Facility policy and procedureThe Dignity policy, dated February 2021, was received from the nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It revealed in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their rights. For example, residents are: provided with a dignified dining experience.The Assistance With Meals/Mealtime policy, undated, was received from the NHA on 1/30/26 at 12:21 p.m. It revealed in pertinent part, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.II. ObservationsDuring a continuous observation of the lunch meal on the memory care unit (MCU) on 1/26/26, beginning at 11:45 a.m. and ending at approximately 12:30 p.m. the following was observed: At 11:58 a.m. certified nurse aide (CNA) #4 was assisting Resident #26. CNA #4 was standing between Resident #26 and Resident #5 as she assisted Resident #26 with eating by spooning food into his mouth. Resident #5 told CNA #4 to sit down, CNA #4 responded that there were no chairs to sit on.Observations in the dining room revealed there was one open chair at another table.At 12:27 p.m., licensed practical nurse (LPN) #4 was passing out meal trays in the MCU and then assisted Resident #40. LPN #4 stood next to Resident #40 despite there being a chair not in use at the table.On 1/27/26 at 11:32 a.m. continuous observation of the MCU lunch was observed. CNA #3 was standing next to Resident #5. After he attempted to stand from his wheelchair she began assisting him to eat with his spoon while she stood over him. At 11:49 a.m. CNA #3 was assisting Resident #40 with eating while standing over him. CNA #3 then went to assist Resident #42 and remained standing while assisting him to eat.III. Staff interviewsCNA #3 was interviewed on 1/28/26 at 1:44 p.m. She said she had only worked at the facility for about a month and part of her job was to assist residents in the dining room with eating. CNA #3 said when assisting residents to eat she should be seated in order to see their mouth to ensure food reached their mouth. CNA #3 said she did not realize she had stood over residents while assisting them. LPN #3 was interviewed on 1/28/26 at 1:57 p.m. She said there were about three to four residents on the MCU who required meal assistance. LPN #3 said staff should assist residents with eating while sitting to ensure they were at eye level and be able to interact with them. The director of nursing (DON) was interviewed on 1/29/26 at 12:38 p.m. She said the CNAs and the nurses on the floor were to provide meal assistance to residents. The DON said staff should be sitting at eye level when assisting residents to eat and communicating with them as well.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#21 and #32) of five residents reviewed were kept free from abuse out of 34 sample residentsSpecifically, the facility failed to protect Resident #21 from physical abuse by Resident #32. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2021, was provided by the nursing home administrator (NHA) on 1/26/26 at 2:10 p.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.II. Incident of physical abuse by Resident #32 towards Resident #21 on 1/5/26A. Facility investigation The facility investigation was provided by the NHA on 1/27/26 at 3:44 p.m. The investigation documented on 1/5/26, two residents (Resident #21 and Resident #32) experienced an unwitnessed altercation inside their room. According to the investigation at approximately 1:45 p.m., Resident #32 exited his room and reported to a certified nurse assistant (CNA) that he hit his roommate (Resident #21) in the head because he was told to by voices. The investigation documented the CNA was able to separate the two residents to prevent further escalation and an additional CNA notified the nurse on duty. The investigation documented Resident #21 sustained no injuries after the altercation on 1/5/26. The investigation documented interventions to prevent additional occurrences included placing the residents on frequent checks, social services following up with the residents and a room change. The investigation documented Resident #21 was interviewed on 1/5/26 at 3:02 p.m. and said Resident #32 went crazy. It documented Resident #21 denied feeling fearful or distressed. The investigation documented Resident #32 was interviewed on 1/5/26 at 2:54 p.m. It documented Resident #32 stated the voices were in his head. It documented Resident #32 was provided with and declined the crisis line phone number. It documented no psychosocial concerns. The facility interviewed additional residents who could not identify what happened between Resident #21 and Resident #32 on 1/5/26, and no other residents expressed concern about their safety. According to the investigation, the altercation was substantiated as both residents confirmed the incident took place. According to the investigation, the incident did not cause injury or psychosocial stress to either resident, and interventions were successful in preventing additional incidents. III. Resident #32 (assailant)A. Resident statusResident #32, age less than 65, was readmitted on [DATE]. According to the January 2026 computerized physician orders (CPO), the diagnoses included unspecified schizoaffective disorder, unspecified affective mood disorder, type 2 diabetes mellitus, generalized muscle weakness and nicotine dependence. The 1/17/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. The MDS assessment indicated the resident had hallucinations and exhibited behavioral symptoms. The resident was independent with bed mobility, transfer, and locomotion. The resident was taking antipsychotic and anticonvulsant medication. B. Resident interviewResident #32 was interviewed on 1/26/26 at 12:34 p.m. Resident #32 said he was involved in a resident-to-resident altercation with his roommate. Resident #32 said he suddenly started flipping out and punched his roommate in the face while he was lying in bed. Resident #32 said he felt safe and was happy with his room change. C. Record reviewThe behavior care plan, revised 1/6/26, documented Resident #32 exhibited, or had potential for verbally/physically aggressive or violent behaviors towards staff, peers, or self that placed himself and others at risk for harm or distress related to his schizoaffective disorder. Interventions included administering medications as ordered (initiated 11/7/25), applying de-escalation protocols (initiated 11/7/25), moving the resident into a private room on 1/14/26 and providing a calming area for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redirection when agitated as the resident permits (initiated 11/7/25). The schizoaffective disorder care plan, revised 8/4/25, documented Resident #32 had schizoaffective disorders and targeted behavior symptoms, including: internal stimuli, auditory hallucinations, delusions, and physical/verbal aggression. Interventions included obtaining authorization for sitter services as needed (initiated 6/13/25), providing mental health services (initiated 8/4/25), encouraging the resident to express his feelings appropriately (revised 8/7/24), and providing a program of activities of interest to the resident (revised 8/7/24).-Review of the schizoaffective disorder care plan revealed documentation the resident was recently involved in two separate resident to resident altercations.A nurse note, dated 1/5/26 at 2:20 p.m. documented at approximately 1:45 p.m., the resident left his room and reported to a CNA he hit his roommate, Resident #21, in the head approximately two to three times because he heard voices tell him to. It documented that the CNA separated the residents, and another CNA reported the incident to the nurse. It documented Resident #32 was placed on frequent checks and sat in a different area away from Resident #21. It documented Resident #32's provider and mental health case worker were notified. A facility provider note, dated 1/6/26 at 5:36 p.m., documented Resident #32 was evaluated after an altercation with his roommate. It documented Resident #32 punched Resident #21 in the face three times. It documented Resident #32 stated he was angry when asked why he did it, and the resident refused to elaborate due to embarrassment. It documented the treatment plan included management by outpatient psychiatric and mental health services, repeat lab work and medication review and adjustment.III. Resident #21 (victim)A. Resident statusResident #21, age over 65, was admitted on [DATE], and readmitted [DATE]. According to the January 2026 CPO diagnoses included intracranial injury, dementia, post-traumatic stress disorder, and major depressive disorder.The 12/17/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. He required supervision/touch assistance with toileting hygiene, oral hygiene, bathing/showering and personal hygiene. He required set up/clean up assistance with eating, upper and lower body dressing and rolling right and left. He was independent with walking and sitting to stand transfers.The MDS assessment indicated the resident did not display behavioral symptoms or rejection of care. B. Resident interviewResident #21 was interviewed on 1/26/26 at 1:00 p.m. Resident #21 said that his old roommate had hit him in the head while he was sleeping. Resident #21 said he moved to another room and had a different roommate now. Resident #21 said he was okay after he was hit and was not hurt or afraid. Resident #21 said his old roommate just hit him and he did not know why. Resident #21 said he was not concerned about the incident or hurt about it and was happy with his new room.C. Record reviewThe trauma-informed care plan, revised 6/25/25, revealed the resident was at-risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to transportation accident. Interventions included allowing him time to make choices in care and encourage active decision making, approaching the resident in a calm, reassuring manner, encouraging the resident to verbalize his feelings, encouraging the resident to participate in activities of choice, monitoring for signs/symptoms of decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing and report abnormal findings to physician. A nurses note, dated 1/5/25 at 2:37 p.m., documented the nurse was notified by a CNA that Resident #32 admitted to hitting Resident #21 two to three times in the head while he was sleeping in bed. The CNAs separated the residents and put them on frequent checks. When the nurse assessed Resident #21 he denied any pain or loss of consciousness. Resident #21 was asked if he was in fear and he stated no and said his roommate just went crazy. The doctor was notified of the incident and Resident #21's guardian attempted to be notified but his voicemail was full and was unable to leave a message at the time. IV. Staff interviewsCNA #9 was interviewed on 1/28/26 at approximately 10:05 a.m. CNA #9 said Resident #32 was easily agitated. CNA #9 said Resident #32 was involved in a resident-to-resident altercation two to three weeks ago, when he (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	punched his roommate. CNA #9 said the altercation was not observed. She said Resident #32 reported it himself. CNA #9 said Resident #21 was moved into a different room after the 1/5/26 altercation occurred. CNA #9 said Resident #32 was moved into a different room approximately one week prior, however he was unsure why. Registered nurse (RN) #2 was interviewed on 1/28/26 at 2:01 p.m. RN #2 said Resident #32 was initially placed on one-to-one observations after the altercation occurred. RN #2 said the resident was recently moved into a separate room as an intervention for the altercation. RN #2 said she was unsure why there was a delay in the room change occurring. RN #2 said Resident #32's triggers included hearing voices related to his medical condition. RN #2 said facility management would come onto the unit and alert staff of any changed care plan interventions. RN #2 said care interventions could be found in the resident's care plan or on the 24 hour nurse report sheets. RN #2 said updating the resident's care plan timely was important for resident safety and continuity of care. The social services director (SSD) was interviewed on 1/29/26 at 1:49 p.m. The SSD said Resident #32 stated he hit Resident #21 due to uncontrollable anger that came up. The SSD said Resident #32 did have a history of resident-to-resident altercations. She said in the past, the reported root cause was his auditory hallucinations. The SSD said moving Resident #32 to a different room was delayed due to a different resident occupying it, and the facility needed to provide a five day room change notification. The SSD said the social services team was responsible for managing the resident's behavior care plans. The NHA was interviewed on 1/29/26 at 3:09 p.m. The NHA said Resident #32 participated in facility activities and received frequent visits from social services. The NHA said he was unable to state what interventions were put in place to manage Resident #32's anger related outbursts after the resident-to-resident altercation on 1/5/26.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 that two residents (#1 and #23) of the three residents reviewed for oxygen received proper respiratory care and services in accordance with professional standards of practice, the residents' care plan, and the residents' choice out of 34 sample residents. Specifically, the facility failed to:-Ensure Resident #1 was provided with continuous oxygen supplementation per the physician's orders; and, -Ensure Resident #23's nebulizer was cleaned appropriately. Findings include: I. Facility policy and procedure The Oxygen Administration policy, revision date October 2010, was received from the nursing home administrator (NHA) on 1/28/26 at 4:55 p.m. It revealed in pertinent part, Review the physician's orders or facility protocol for oxygen administration. Assemble the equipment and supplies as needed. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included bipolar disorder (severe mood swings from extreme high to extreme lows), vascular dementia (cognitive decline caused by reduced blood flow to the brain), chronic obstructive pulmonary disease (COPD), type 2 diabetes (chronic condition that the body does not produce enough insulin), congestive heart failure (chronic condition where the heart cannot pump enough blood to meet the bodies needs), kidney disease stage 3 (kidneys have moderate damage and are less able to filter waste), muscle weakness and wheelchair dependence. The 12/10/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident required supervision or touching assistance with activities of daily living (ADL). The MDS assessment revealed that the resident required continuous oxygen at 2 liters per minute (LPM) via a nasal cannula. B. Observations and resident interview On 1/26/26 at 11:30 a.m. Resident #1 was in her room with oxygen flowing at 2 LPM via nasal cannula. She said she was getting ready to go to the dining room for lunch. She said she did not have a portable oxygen tank. She said she only needed to have oxygen in her room. Resident #1's room did not have a portable oxygen tank for the resident to use. On 1/27/26 at 8:20 a.m. Resident #1 was in the dining room eating breakfast without a portable oxygen tank or nasal cannula. On 1/27/26 at 11:35 a.m. Resident #1 was in the dining room without a portable oxygen tank and nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/26 at 8:45 a.m. Resident #1 was in the dining room, coloring with markers in her marker book with no portable oxygen tank. On 1/28/26 at 10:45 a.m. Resident #1 was in the dining room, coloring with markers in her book with no portable oxygen tank. C. Record review Review of Resident #1's January 2026 CPO revealed the following physician's order: Oxygen at 2 LPM via nasal cannula continuously, ordered 1/6/24. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 1/28/26 at 10:40 a.m. LPN #1 said Resident #1 had a physician's order for oxygen at 2L nasal cannula continuously. LPN #2 was interviewed on 1/28/26 at 10:45 a.m. LPN #2 said Resident #1 had the right to refuse a portable oxygen tank. LPN #2 said she asked Resident #1 if she wanted to have a portable oxygen tank and Resident #1 said yes. LPN #2 said she went and got a newly sanitized portable oxygen, filled the tank and got her a nasal cannula. LPN #2 said she turned on the oxygen to 2 LPM and placed the nasal cannula on the resident. The DON was interviewed on 1/28/26 at 1:50 p.m. The DON said Resident #1 was on 2 LPM of oxygen via a nasal cannula continuously. The DON said each resident should be issued a portable tank and a regulator for their room when an oxygen order was written for the resident. The DON said it was important to follow the physician's orders because the resident could have low oxygen saturation. III. Resident #23 A. Manufacturer's instructions The [NAME] Compressor Nebulizer System instructions for use, undated, was provided by the nursing home administrator (NHA) on 1/28/26 at 4:14ˆp.m. It read in pertinent part, Converts liquid medicine into a mist by using compressed air technology, suitable for all ages for the treatment of the upper and lower respiratory tract. Cleaning: Following the cleaning instructions after each use will prevent any remaining medication in the bottle from drying, resulting in the device not nebulizing effectively, and will help prevent infections. Wash the nebulizer parts after each use. Dry the parts immediately after washing. Remove the inhalation accessory (mask or mouthpiece) from the nebulizer kit. Disconnect the air tubing from the nebulizer. Gently twist the inhalation top counterclockwise and lift to separate the nebulizer into two sections. Remove the baffle. Discard remaining medication. Rinse all the parts of the accessories (nebulizer kit, the mouthpiece and mask) in warm water and a mild detergent. Rinse thoroughly with warm water. Hand dry or air dry in a clean environment using a soft, clean lint-free cloth. Cleaning the device and the tube's outer surface: Use a cloth dampened with antibacterial detergent (non-abrasive and free of solvents of any kind). Assemble the nebulizer and store the nebulizer kit appropriately. Caution: The nebulizer kit should be replaced every six months. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Disinfecting: You can disinfect daily by soaking the parts in medical disinfectant which is commercially available in some pharmacies. If your physician or respiratory therapist specifies a different cleaning procedure, follow their instructions. Effective disinfection is only possible if the nebulizer has been cleaned. Disinfect accessories (nebulizer kit, mask, mouthpiece) after the last treatment of the day. Disconnect all parts according to the above 1-5 steps. Fill a container, suitable to contain all the individual components to be disinfected, with a solution of drinking water and disinfectant, while respecting the proportions indicated on the packaging of the disinfectant itself. Completely immerse each individual component in the solution, taking care to avoid the formation of air bubbles in contact with the components. Leave the components immersed for the period of lime indicated on the packaging of the disinfectant, and associated with the concentration chosen to prepare the solution. Remove the components now disinfected and rinse thoroughly with lukewarm drinking water. Hand dry or air dry in a clean environment using a soft, clean lint-free cloth. Assemble the nebulizer and store the accessories in a dry, sealed bag. B. Resident status Resident #23, age greater than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses include vascular dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, sleep apnea, dependence on supplemental oxygen and long term (current) use of inhaled steroids. The 11/17/26 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of five out of 15. She was dependent on one person for oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing and personal hygiene. She required supervision or touching assistance for rolling right and left, lying to sitting transfers and wheeling wheelchair. She required partial/moderate assistance for sit to stand transfers, chair to bed transfers, toilet transfers and shower transfers. The assessment indicated the resident received oxygen treatment. B. Observations On 1/26/26 at 1:24 p.m. Resident #23 had a nebulizer unit sitting on the television (TV) stand with the mask and tubing connected and sitting on the table. There was no storage bag. Resident #23 was lying in bed with her oxygen on via nasal cannula. On 1/27/26 at 9:31 a.m. Resident #23 was in the dining room area using a portable oxygen tank connected to her wheelchair. The nebulizer unit was on the TV stand and leaning against the TV. The face mask used for the nebulizer treatments was turned upside down and sitting on the TV stand. The tubing and mask was hooked up and connected to the nebulizer unit. C. Resident interview Resident #23 was interviewed on 1/28/26 at 12:35 p.m. Resident #23 said after a nebulizer treatment, which occurred four times a day, the nurse just left everything on the TV stand table. Resident #23 said she had never seen the nurses clean it. D. Record review (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's oxygen therapy care plan, initiated 1/30/25, revealed the resident required the use of oxygen continuously due to COPD. Interventions included to administer oxygen at 4 LPM via nasal cannula, dietary referral as indicated, completing labs as ordered and to report abnormal findings to physician, maintaining the head of bed elevated to level of comfort to promote oxygenation, monitoring and reporting signs of hypoxia (deficiency in the amount of oxygen reaching the tissues) to physician and observing oxygen precautions. -The care plan failed to include cleaning frequency for the nebulizer unit/accessories or cleaning instructions. Review of Resident #23's respiratory care plan, initiated 1/31/25, revealed the resident experienced shortness of breath (SOB) and trouble breathing with exertion and when lying flat due to COPD, obesity and obstructive sleep apnea (OSA). Interventions included in pertinent part, to administer medications as ordered and monitor for side effects/adverse reactions and effectiveness, monitor for shortness of breath, irregular respiration, wheezing, crackles, rhonchi, excessive secretions, coughing spells, decreased energy, rapid breathing, complaint of chest tightness or hurting, tightness of neck or chest muscles, malaise or fatigue and inform physician promptly, monitor vital signs, skin color, oxygen saturation, airway functioning and report abnormal findings to physician, position with head of bed elevated to prevent episodes of shortness of breath while lying flat. -The care plan failed to include cleaning frequency for the nebulizer unit/accessories or cleaning instructions. Review of Resident #23's additional respiratory care plan, initiated 1/31/25, revealed the resident was at risk for complications with the respiratory system due to COPD, OSA, obesity, oxygen dependence, and nicotine dependence. Interventions included in pertinent part, completing labs/chest Xray as ordered and reporting abnormal results to physician, monitor for shortness of breath and inform physician promptly, monitoring vital signs, skin color, oxygen saturation, and airway function, and providing oxygen therapy as ordered. -The care plan failed to include cleaning frequency for the nebulizer unit/accessories or cleaning instructions. Review of Resident #23's January 2026 CPO did not reveal physician orders indicating instructions on how to clean the nebulizer unit. Review of Resident #23's January 2026 medication administration record/treatment administration record (MAR/TAR) did not reveal documentation that cleaning was being completed. III. Staff interviews Unit manager #1 was interviewed on 1/28/26 at 12:40 p.m. Unit manager #1 said she was the unit manager of the secured behavioral health unit (Prasada). Unit manager #1 said she did not administer the treatments in her current role. She said she was aware of the treatments and had been trained on nebulizer treatments. Unit manager #1 said after a nebulizer treatment the nurse would rinse the accessories with water and let air dry on a cloth at the sink. Unit manager #1 said it was important to clean the nebulizer unit and accessories to rinse off particles, germs and leftover medication. Certified nurse aide (CNA) #8 was interviewed on 1/28/26 at 1:09 p.m. CNA #8 said she wiped (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment down on the unit such as blood pressure machines, tables in the dining room and walkers, but she did not clean the nebulizer units. Registered nurse (RN) #2 was interviewed on 1/28/26 at 1:50 p.m. RN #2 said she administered the treatments. RN #2 said she knew the nebulizer unit was working properly because when she pushed the green button the unit came on and she could hear it and see it puff during treatment. RN #2 said after administering the nebulizer treatment to Resident #23, she hung the mask on the hook of the machine which was sitting on the TV stand. RN #2 said she thought the night shift washed out the nebulizer/accessories and put on a towel to air dry. RN #2 said she had not seen an order for the night nurse to clean the unit. RN #2 said it was important to clean the nebulizer/accessories after each treatment to prevent an infection. The director of nursing (DON) was interviewed on 1/28/26 at 1:49 p.m. The DON said the nebulizer treatment process was to get medication from the cart as ordered, put the medication vial in the nebulizer unit, put the mask on the resident, and push start. The DON said after the nebulizer treatment, the nurses were responsible for cleaning the mask with running water, but not the tubes. She said then the nurse put it on the bedside table to air dry on a wash cloth. The DON said she thought the way to sanitize the unit was to use sani-wipes. -However, according to the manufacturer's recommendations the nebulizer machine should have been cleaned after each use by rinsing all the parts of the accessories (nebulizer kit, the mouthpiece and mask) in warm water and a mild detergent. Rinse thoroughly with warm water, hand dry or air dry. Disinfect daily by soaking the parts in medical disinfectant which is commercially available in some pharmacies, after the last treatment of the day (see manufacturer's recommendations above). The DON said it was important to clean the mask to prevent infections. The DON reviewed Resident #23's electronic medical record (EMR) and said she did not see any guidance or physician's orders on cleaning the nebulizer unit/accessories and there was nothing in Resident #23's care plan either. The DON said she would want physician's orders and a care plan to be there to prevent infections. The DON said she would do nurse education today to clean after every use and she would also add that to the care plan and get physician orders.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement policies and procedures related to influenza immunizations for one (#5) of five residents reviewed for immunizations out of 34 sample residents. Specifically, the facility failed to provide the influenza 2025/2026 vaccine to Resident #5. Findings include:I. Professional referenceAccording to the Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices - United States, 2025-26 Influenza Season, dated [DATE]. Retrieved on [DATE] from https://www.cdc.gov/mmwr/volumes/74/we/mm7432a2.htm?s_cid=OS_mm7432a2_w. It revealed in pertinent part, For most persons who require only one dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the influenza season as long as influenza viruses are circulating and an unexpired vaccine is available.II. Facility policy and procedureThe Influenza Vaccination policy, undated, was received from the nursing home administrator (NHA) on [DATE] at 12:21 p.m. It revealed in pertinent part, The policy of this facility to minimize the risk of acquiring, transmitting or experiencing complicationsfrom influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. Influenza vaccinations will be routinely offered annually from [DATE]st through [DATE]st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. Additionally, influenza vaccinations will be offered to residents upon availability of the seasonal vaccine until influenza is no longer circulating in the facility's geographic area. Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record or the staff's medical file.III. Resident #5A. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO) diagnoses included dementia (decline in memory), hypertension (high blood pressure), atrial fibrillation (abnormal heart function) and epilepsy (abnormal electrical impulses resulting in seizures).The [DATE] minimum data set (MDS) related the resident was severely cognitive impaired with a brief interview of mental status (BIMS) score of three out of 15. The MDS indicated the resident had received the influenza vaccine outside the facility. -However, review of Resident #5's electronic medical record (EMR) did not reveal the resident was administered the influenza vaccine (see record review below).B. Record reviewReview of Resident #5's vaccine records failed to indicate residents had received the 2025/2026 influenza vaccine. Review of Resident #5 EMR revealed a consent form that indicated the resident requested to receive the influenza vaccine upon admission ([DATE]). Review of the [DATE], [DATE] and [DATE] CPO did not reveal the resident had a physician's order for the influenza vaccine to be administered. The [DATE] CPO failed to have the influenza vaccine order until [DATE] (during the survey) when Resident #5 was administered the influenza vaccine by the facility. IV. Staff interviewsThe infection preventionist (IP) and the director of nursing (DON) were interviewed on [DATE] at 11:00 a.m. The IP said vaccines were looked up in the state immunization portal and tracked in the residents' medical records. The IP said all residents were asked annually and upon admission if they would like the Influenza vaccine. The IP said the facility held a flu vaccine clinic on [DATE]. The IP said after review Resident #5's vaccine records there was an error. The IP said it appeared he had received the vaccine from an outside provider but after further review (during the survey) it was found he had not received the vaccine. The DON said Resident #5 had received his influenza vaccine on [DATE] (during the survey).