STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065292	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Sandalwood, The	3835 Harlan St Wheat Ridge, CO 80033

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 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, 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 cleaned high touch areas; -Ensure hand hygiene was completed during room cleaning; and,-Ensure dwell times were followed per manufacture recommendations. Findings include:I. Professional referenceThe Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised [DATE]) was retrieved on [DATE] 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 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 on [DATE]. from: https://www.cloroxpro.com/products/clorox-healthcare/hydrogen-peroxide-cleaner-disinfectants/?UTM_Campa on [DATE] 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).II. Facility policy and procedureThe Infection Control: Disinfection of Rooms and Terminal Cleanings policy, undated, was received from the nursing home administrator (NHA) on [DATE] at 2:32 p.m. It revealed in pertinent part, It is the policy of this facility to: Follow checklist for Deep Clean, Isolation, Cleared, and Discharge instructions checklist created based on long term care (LTC) infection Control guidelines. Check list: Collect trash and soiled linens from the room.Remove soiled linens and put them in a bag and take them to the soiled utility room. Collect trash and place it in a garbage bag. Clean trash can inside and out. Clean and disinfect room: Disinfect all surfaces with 10 to 1 bleach solution (wet time 10 minutes). Then, use the antibacterial All Purpose cleaner: doorknobs/ handles; door surfaces; bed rails; headboards; foot boards; nurse call button and cord; phone and phone cord; night stand and bed table (Make sure to clean underneath the bed table all the way to the wheels); television remote; light switches; all furniture; recliner; window sills and curtain rods; mop floor (make sure you use moping procedures as stated in the bathroom except, use a new mop). Clean and (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disinfect bathroom: mirror; lights; sink; faucets; walls and handrails; tub/ shower; toilet level/ flusher; toilet horizontal surface/seat; check hand soap and paper towels. Fill if necessary; and mop the floor (use a different mop than the bedroom).The Hand Hygiene policy revised [DATE], was received from the NHA on [DATE] at 2:32 p.m. It revealed in pertinent part, It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Hand hygiene is one of the most effective measures to prevent the spread of infection. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: After contact with objects (medical equipment) in the immediate vicinity of the resident and after removing gloves.III. ObservationsOn [DATE] at 9:49 a.m. housekeeper (HK) #1 was observed cleaning resident room [ROOM NUMBER], a double occupancy room. HK #1 performed hand hygiene with alcohol based hand rub (ABHR) and applied clean gloves. HK #1 collected two rags, hydrogen peroxide spray, and Comet cleaner. She applied Comet cleaner to the toilet bowl brush container at the cleaning cart. HK #1 entered the resident's room and went straight to the bathroom where she began spraying the hydrogen peroxide solution to the toilet and took out her phone to time the one minute dwell time (amount of time the surface must remain wet to be effective in disinfecting a surface). While waiting her one minute dwell time she sprayed a dry rag three times with the hydrogen peroxide solution then she wiped down the and rails in the bathroom.-The hand rails failed to remain wet for the one minute dwell time after wiping them down. HK #1 then went back to the toilet, took the toilet bowl brush out of its container, brushed the toilet bowl and replaced it back into her container. She took the same rag that she used to wipe the grab bars and began wiping the toilet rim of the bowl then the lid/seat then outside the toilet to the floor. HK #1 then removed her gloves and returned to her cart. -HK #1 failed to clean the handles of the toilet and failed to clean from cleanest to dirtiest areas. At the cleaning cart HK #1 collected a trash bag and placed the soiled rags into it. HK #1 then washed her hands with soap and water in the room's sink. HK #1 had left the toilet bowl brush and hydrogen peroxide spray on the vanity in the room. She then applied new clean gloves and grabbed a handful of dry clean rags, placed them on a chair in the room near the sink. HK #1 then sprayed the sink with hydrogen peroxide at 9:54 a.m. She then immediately turned on the water at the sink while holding her phone and sprayed the sink again with hydrogen peroxide spray after turning the water off. HK #1 then took a green scrub pad from the same container which held the toilet bowl scrub brush, and began scrubbing the sink bowl, then the handles, turned on the water again splashing water from the faucet onto the handles. HK #1 then took a dry rag and wiped down the sink handles, then the rim of the sink, the vanity counter top and a small shelf over the sink. -HK #1 failed to clean the area from cleanest to dirtiest areas and failed to wait the one minute dwell time before turning on the water or scrubbing the sink.HK #1 used a second dry rag and began cleaning bed B side of the room. HK #1 moved the resident's personal items from the bed side table and sprayed the table with the hydrogen peroxide spray. HK #1 waited the one minute dwell time then wiped down the resident bed side table from top to bottom then replaced personal items back in place. -HK #1 failed to change and perform hand hygiene after cleaning the sink and moving to resident bed B side. HK #1 touched bed B personal items with soiled gloves used to clean the sink area.HK #1 collected trash from bed B, the sink area and then collected bed A's trash and took to the cleaning cart. While wearing the same gloves HK #1 collected the broom and went and swept bed A floor to the door then went to bed B side of the room sweeping debris towards the door. HK #1 then went to the bathroom and swept debris out of the bathroom to the main doorway using a dust pan to collect all debris from all three areas of the room. The toilet bowl brush remained sitting on a chair in the room. After sweeping she collected the stack of rags that were not used in the room and placed them in a soiled bag on the cart. Then collected the toilet bowl brush container and the hydrogen peroxide spray and replaced them back in her cart. HK #1 then reached into her mop bucket and collected one mop pad rung it out and placed it on the floor she began mopping from the door to the sink then bed B then to bed A side of the room around the resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who was sitting in wheel chair in bed A then back to the doorway. HK #1 then went and mopped the bathroom floor.-HK #1 failed to change her gloves after cleaning the sink area, and after cleaning bed B side of the room. HK #1 contaminated her mop bucket solution when she reached in with soiled gloves to obtain a mop pad. HK#1 also failed to use a different mop pad for resident A room and resident B room and another mop pad for the bathroom. HK #1 removed her gloves, performed hand hygiene with ABHR and placed a sign at the door for the wet floor. HK #1 said she was done cleaning this resident room at 10:02 a.m.-HK #1 failed to clean bed A's side of the room and did not ask the resident who was present during cleaning if she could clean her area. HK #1 failed to clean high touch surfaces in the room like, call buttons, light switches, handles to any door within the room and television remotes. HK #1 was observed to clean a second double occupancy room at 10:03 a.m. HK #1 moved her cleaning cart to room [ROOM NUMBER]. HK #1 performed hand hygiene with ABHR then applied clean gloves. Collected two dry rags and one trash bag. She applied Comet to the toilet bowl brush and green scrub pad and the hydrogen peroxide spray. HK #1 knocked on the door resident in bed A was still eating her breakfast. HK#1 went to the bathroom and began spraying the toilet rise and toilet. HK #1 moved the toilet riser scrubbed the toilet bowl with toilet bowl brush flushed toilet. She then began wiping the toilet after one minute dwell time was completed. HK #1 wiped the toilet riser first starting with the seat of the riser, then rim then lifted the lid and lastly she wiped the handles of the riser. HK #1 moved the toilet riser further out of her way to access the toilet. Using the same rag she began wiping the toilet bowl rim then wiped the toilet on the outside to the floor. -HK #1 failed to clean the riser and toilet in a hygienic manner from the cleanest area to dirtiest areas. HK #1 took a new rag and moved the toilet riser back into place. She then sprayed the dry rag three times with hydrogen peroxide spray. She then wiped down the grab bars and a small shelf in the bathroom. -HK #1 failed to follow the one minute dwell time for the hydrogen peroxide on the grab bars and shelf.HK #1 removed a trash bag with soiled rags from the room, removed her gloves, completed hand hygiene with soap and water then collected trash from the trash can at the sink then bed B and last bed A trash. HK #1 placed trash onto her cart. She then applied ABHR to her hands then applied clean gloves. Collected two new rags and went to the sink, where she had left the toilet bowl brush and green scrub pad on the sink counter. HK #1 then sprayed the sink with the hydrogen peroxide. She then took the green scrub pad from the container wiping the sink rim then bowl then the handles. She used the green scrub pad to wipe down the soap dispenser, paper towel dispenser then the counter top of the vanity and re scrubbed the sink bowl again.HK #1 then collected a dry rag, wiped the sink counter, rim of sink, then the bowl and the handles last. HK #1 then collected another dry rag, went to bed B side of the room, removed emptied dishes from the bed side table and placed them on the personal protective equipment (PPE) cart just outside the resident room. HK #1 then sprayed the bedside table with hydrogen peroxide, waited the one minute dwell time then wiped the bedside table from top to bottom. HK #1 then collected the toilet bowl brush container, hydrogen peroxide spray and rags and returned to her cart. -HK #1 failed to clean the sink in a hygienic manner.HK #1 collected the broom from her cart, swept bed B side of the room to the bathroom, swept the bathroom and finished with bed A side of the room moving all debris from all three areas to the doorway where she collected debris in the dustpan.HK #1 then reached into her mop bucket, pulled one mop pad out and rang it out. Mopped the floor from the doorway to under the sink then bed B side of the room to the bathroom. She mopped the bathroom and continued mopping the floor of bed A side of the room. The resident in bed A was still eating her breakfast and picked up her plate to move around so HK #1 could mop the area she was sitting in. -HK #1 failed to change her gloves after cleaning the sink area and prior to moving to clean bed B side of the room. HK #1 failed to use a different mop pad for each of the three areas of the resident room and she contaminated her mop water again when she reached in with soiled gloves to obtain the mop pad. HK #1 removed her gloves, performed hand hygiene with ABHR and said the room was finished at 10:17 a.m. HK #1 placed a wet floor sign at the door and reminded the residents the floor was wet. IV. Staff interviews HK #1 was interviewed on [DATE] at 10:18 a.m. after (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observations of her cleaning two double occupancy rooms in the facility. She said every resident room was cleaned daily. HK #1 said she performed deep cleaning of rooms only when a resident has expired or moved to another room. HK #1 said deep cleans meant they cleaned everything in the room down to the mattress, closet and any drawers in the room. HK #1 was unsure what high touch surfaces in a resident's room were. She said call lights, light switches and door handles were all cleaned during deep cleans. HK #1 said it was important to clean the resident room to help prevent the spread of infections. HK #1 said the hydrogen peroxide was the disinfectant the facility used. She said the surface had to remain wet for one minute to be effective. She said she was unaware the grab bars and shelves in the bathroom and above mirror did not remain wet for the required one minute. She said she did not know she did not clean from top to bottom or from cleanest areas to dirtiest areas. HK 31 said she should clean from cleanest to dirtiest to help prevent the spread of germs from dirtier areas to cleaner areas.HK #1 said she had been working in the facility for 18 years and this was how she was shown to clean resident rooms. She said she was not provided any education on how to clean resident rooms in her native language. The environmental service director was interviewed on [DATE] at 10:30 a.m. He said new staff came in and were paired with a housekeeper to observe and learn how to clean a resident room after they complete the basic orientation with human resources. The environmental service director said the hydrogen peroxide disinfectant needed to remain wet on the surface for one minute to be effective per the manufacturer guidelines. He said rooms were to be cleaned daily along with high touch surfaces/areas that should be cleaned daily. The environmental service director identified the following areas as high touch surfaces/areas: call light, door knobs, grab bars, hand rails, call lights, phones, bed controls and light switches. He said disinfecting them daily helps prevent the spread of infection.The environmental service director said rooms were to be cleaned in this order. He said the staff should start in the bathroom and have rags just to be used in the bathroom, along with trash bags to place dirty rags into after use. He said then they should spray the bathroom down with disinfectant and wait the one minute most of his staff pull their phone out to time the one minute. He said then they could start wiping from the bottom of the toilet upwards. The environmental service director said staff could clean from the floor around the toilet outside to the rim and then the toilet bowl should be scrubbed with Comet and toilet bowl scrub brush. He said the toilet needed to be flushed after being scrubbed. He said then staff should obtain a new clean reg and wipe down the door handles, doors and walls especially if anything was visibly soiled. Staff should then move to the mirror and dust the bathroom light fixtures. He said the last item staff were to clean in the bathroom was the floor. The environmental service director said the bathroom got its own mop pad.The environmental service director said staff should remove their gloves and wash hands with soap and water or use ABHR before applying new gloves to start the resident rooms. He said the HKs could clean a resident's room with the resident in the room but needed to ensure the spray did not land/touch the resident. He said the HKs were to spray and wipe down surfaces and work around resident personal items as some residents do not like HK to touch their personal belongings. He said staff should start on bed B side of the room and make progress towards the main doorway. He said then the room could be mopped with one mop pad; it did not matter if it was a double occupancy room. The environmental service director said he did not provide HK with training information in their native language but relied on other staff to assist with translation. The infection prevention (IP) and the regional clinical resource were interviewed on [DATE] at 11:15 a.m. The RCR said housekeeping staff were educated during outbreaks but most education and training for housekeepers came from the environmental service director. The regional clinical resource said education was not provided to staff in their native languages. The regional clinical resource said high touch areas in a resident's room were to be disinfected daily to prevent the spread of infection.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide a resident choices regarding their personal funds for one #11) of two residents reviewed for personal funds out of 35 sample residents. Specifically, the facility failed to provide resident choices for storage of funds. Findings include:I. Facility policy and procedureThe Accounts Receivable policy, dated 1/1/26, was provided by the nursing home administrator (NHA) on 2/12/26 at 4:41 p.m. The policy reads in pertinent part: The resident has the right to manage their financial affairs. Residents are not required to deposit their personal funds into the facility resident trust account.II. Resident #11A. Resident statusResident #11, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included cancer, type two diabetes, heart failure and chronic kidney disease.The 11/29/25 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. He required substantial/maximal assistance with transfers.B. Record reviewA progress note log activity note written by the business office manager (BOM) ,dated 1/27/26 at 12:47 p.m., documented the BOM left a message for Resident #11's power of attorney (POA) concerning money that Resident #11 was keeping in his room and suggested depositing it into the resident fund management system (RFMS). A progress note log activity note written by the BOM, dated 1/27/26 at 1:32 p.m., documented the POA would call Resident #11. The note documented if the BOM did not get the resident's money by the next day, the BOM would give her a call back.A progress note log activity note written by the BOM, dated 1/29/26 at 1:56 p.m, documented Resident #11 deposited money into his RFMS account.A resident statement from resident fund management service, dated 2/11/26, documented Resident #11's account was opened on 11/26/25 and had a current balance of $210.00C. Resident interview/observationsResident #11 was interviewed on 2/11/26 at 4:07 p.m. Resident #11 said the facility currently held his money in an account. Resident #11 said he could take out $50.00 a day when requested.Resident #11 said he wanted to keep his money in his room. Resident #11 said a couple of days before Thanksgiving last year, the facility had let him keep a bundle of cash, about $200.00 to $300.00, in his room in a locked drawer. He said they gave him a key to lock his drawer. Resident #11 held up a blue spiral keychain-bracelet with a key hanging on it. Resident #11 said his POA called him and told him that someone at the facility told her to tell him to open an account. Resident #11 said about a day after he started using the locked drawer, a staff member told him he had to bring his bundle of cash to the front desk. Resident #11 said he did not know the name of the person who directed him to bring the cash to the front. Resident #11 said he thought it was a nurse. Resident #11 said he wanted to keep his money in his room. Resident #11 said this made him mad. Resident #11 said he had to request cash when he needed it. Resident #11 said it was easier for him to buy things before, when he had cash on hand.III. Staff interviewsThe business (BOM) was interviewed on 2/11/26 at approximately 4:00 p.m. The BOM said residents who have accounts could access their money by going up to the front desk and asking the receptionist for money. She said the receptionist created a receipt which the residents sign and then receive their requested cash amount. The BOM said residents could pull out $50 a day and could take out more if they requested. The BOM said residents had the option to keep their money in their rooms, but they discouraged it. She said they discouraged it because people were coming and going throughout the facility, and other residents were present too. She said occasionally things were taken, so they tried to keep jewelry, money, and other things of value safe. The BOM said if residents wanted to keep their money in their room they have the right to do so. The BOM said residents had drawers with locks on them anThe BOM said the facility staff did not know that Resident #11 had cash at first. She said they later they saw Resident #11 had a lot of money and activities staff asked the resident if the facility could keep his money in the bank. The BOM said she called the POA and told her the facility was concerned about the potential (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of him losing money. The BOM said the POA said Resident #11 had done this before and that she did not realize he had money on him again. She said the POA told her she would call him and talk to him about it. The BOM said afterward, the resident brought his money up to the front for deposit. The BOM said she believed the activities staff spoke to him and told him they had a banking system. She said she also spoke to the resident about the locked drawers. The BOM said if the resident wanted to keep his money in his room, he could. She said it caused them concern, but he could if he wanted to. The receptionist was interviewed on 2/11/26 at 4:30 p.m. The receptionist said she remembered that Resident #11 had a decent amount of cash, about $200.00 worth. She said that some staff members were worried that Resident #11 would misplace his cash. The receptionist said Resident #11 was encouraged to put his money into an account. She said she did not know who was worried about his cash, but she thought it was the BOM and some nurses. She said Resident #11 called her and asked how to set up an account, for which she directed the resident to the BOM. The receptionist said later, Resident #11 came up to the front desk and said he was told to bring his money to the front. She said she then helped Resident #11 sign the necessary forms and get his money deposited into an account.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that services provided or arranged in accordance with the resident's plan of care were delivered by individuals who have the skills, experience and knowledge to do a particular task or activity for one (#80) of five residents reviewed for quality of care out of 35 sample residents. Specifically, the facility failed to ensure Resident #80 was assessed by a registered nurse (RN) following a fall on 12/13/25. Findings include:I. Facility policy and procedureThe Fall Management System policy and procedure, revised 1/20/26, was provided by the nursing home administrator (NHA) on 2/12/26 at 4:41 p.m. It read in pertinent part, It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs. When a resident sustains a fall, a physical assessment will be completed by a registered nurse, with results documented in the medical record.II. Resident #80 A. Resident statusResident #80, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included cerebral atherosclerosis (narrowing and hardening of the brain arteries), epilepsy, dementia, heart failure and a history of falling. The 1/20/26 minimum data set (MDS) assessment revealed Resident #80 had short term and long term memory problems per staff assessment. The assessment further revealed she was severely impaired in her daily decision making. The MDS assessment revealed Resident #80 was dependent on staff for all of her activities of daily living (ADL). B. Record reviewResident #80's fall care plan, initiated 12/1/25, documented she was at risk for falling due to confusion, deconditioning, incontinence, poor communication and comprehension, unaware of safety needs, restlessness, and agitation. Pertinent interventions included anticipate and meet needs, call light within reach, appropriate footwear, if restless staff to encourage resident to sit at nurse's station for more direct observation, keep needed items in reach (initiated 12/1/25), if resident is sleepy after meals offer her to lie down (initiated 12/15/25), educate daughter to tell staff when she is leaving for the day, commode to be removed from bedside and placed in bathroom when not in use for safety, keeping the wheelchair out of line of sight (initiated 12/26/25), reach out to hospice to ask for assistance to sit with resident (initiated on 2/2/26), reach out to hospice about a bolster mattress and completing a medication review by pharmacist (initiated 2/5/26). The fall risk assessment, dated 12/13/25, documented Resident #80 was a high fall risk. A review of Resident #80's electronic medical record (EMR) revealed the following progress note:A nursing progress note documented by a licensed practical nurse (LPN), dated 12/13/25 at 2:17 p.m., documented that Resident #80 fell while the LPN was on break. The note further documented that the LPN found Resident #80 sitting in a chair. The note documented that Resident #80 denied pain, was able to move all of her extremities. -However, the note did not document that an RN completed an assessment or was consulted regarding the fall. III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 2/10/26 at 5:25 p.m. She said when a resident fell she would call for an RN to come and do an assessment prior to moving the resident. Certified nurse aide (CNA) #5 was interviewed on 2/11/26 at 9:56 a.m. She said when a resident fell she called for the nurse and stayed with the resident. The director of nursing (DON) and the regional clinical resource were interviewed together on 2/11/26 at 5:50 p.m. They said they had an extensive plan of correction (POC) in place for falls that was implemented on 12/23/25. They said the POC went over getting the staff trained on lifts, gait belts and got more staff hired for better continuity of care. They said the POC covered how interventions were communicated between staff members. They said the RN assessment was not part of their POC.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide assistance with activities of daily living (ADL) to ensure the highest practicable quality of life and care, for two (#12 and #70) of three residents reviewed for ADLs out of 35 sample residents.Specifically, the facility failed to:-Ensure denture care was provided for Resident #12; and,-Ensure Resident #70 received meal assistance. Findings include: I. Facility policy and procedure The Activities of Daily Living policy, dated 7/1/24, was provided by the nursing home administrator (NHA) on 2/12/26 at 4:41 p.m. The policy read in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. II. Resident #12 A. Resident status Resident #12, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (constricting of the airways and difficulty breathing), chronic kidney disease, alzheimer's disease (a progressive neurodegenerative disorder causing dementia) and muscle weakness. The 1/13/26 minimum data set (MDS) assessment revealed the resident was mildly cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. She required setup or clean up assistance in order to complete oral hygiene. B. Interviews and observations On 2/5/26 at 10:47 a.m. Resident #12 took out her top denture. The area of the denture which fits to the palate of the mouth was coated with whitish yellow matter. Resident #12 said she cleaned her dentures herself and that she used tabs and soaked them. On 2/9/26 at 4:26 p.m. Resident #12's top denture was caked with white and yellow film along the palate side and along the tooth/gums sides. On 2/10/26 at 8:18 a.m. Resident #12 took out her top denture. The denture was coated with a yellow film along the area which fit with the palate as well as the tooth and gum sides. Resident #12 said It feels funny as she looked at the denture. Resident #12's family member was interviewed on 2/10/26 at 5:12 p.m. The family member said (continued on next page)

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	065292	A. Building B. Wing	02/11/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 did not have a lower denture and that she did need help cleaning her top denture. The family member said, more often than not, Resident #12's denture did not seem clean because she could see stuff on the resident's denture when she visited. The family member said she also supplied Resident #12 with denture tablets and the number of tablets rarely goes down Certified nursing aide (CNA) #7 was interviewed on 2/11/26 at 9:02 a.m. Resident #12 showed CNA #7 her top denture. CNA #7 said it looked dirty. CNA #7 asked Resident #12 if she could brush her denture for her. Resident #12 looked at her denture and said it looked gross. CNA #7 brushed Resident #12's denture. When done brushing it, the denture was pink and had no yellow or white coating on it. D. Record review The ADL care plan, dated 12/30/25, documented that the resident required partial assistance from staff with personal hygiene and oral care. Review of the February 2026 point of care charting documented the resident only received oral hygiene care once a day on 2/4/26, 2/5/26 and 2/9/26. Review of the February 2026 point of care charting documented that on 2/5/26, the resident completed oral hygiene care independently. -However, Resident #12's MDS documented she needed set up or cleanup assistance. Review of the February 2026 point of care charting documented that on 2/10/26, the resident was offered oral hygiene care one time, at 12:59 p.m. The resident refused oral hygiene care. No additional oral hygiene care was documented as offered or completed that day. E. Staff interviews CNA #7 was interviewed on 2/10/26 at 9:06 a.m. CNA #7 said staff should approach Resident #12 and explain why they wanted to help her with care. CNA #7 said Resident #12 was more willing to let staff complete care if she understood why it was important. CNA #7 said staff cleaned her dentures and that Resident #12 did not do her own denture. CNA #7 said she generally brushed the denture and used a toothbrush and toothpaste to brush it. CNA #7 said she would also rinse them and put them back in the residents cup or the resident would put them back into her mouth. The NHA and the regional clinical resource were interviewed together on 2/11/26 at 6:00 p.m. The regional clinical resource said any nursing staff including CNAs were responsible for brushing residents' teeth or dentures. She said oral hygiene should be performed at least daily but if they want to brush their teeth after every meal, their teeth should be brushed after every meal. The NHA said oral hygiene was important to promote hygiene and prevent infections, thrush, or sores. She said oral hygiene care was documented in ADL tasks and on the resident's care plan. III. Resident #70 A. Resident status Resident #70, older than 65,was admitted to the facility on [DATE]. According to the February 2026 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CPO, diagnoses included hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) following cerebral infarction (blood flow to the brain was interrupted, leading to brain tissue damage) affecting left dominant side, dysphagia (difficulty swallowing) following cerebral infarction, and muscle weakness. The 1/5/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The assessment revealed the resident was dependent on staff assistance with toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The assessment revealed the resident required substantial/maximal assistance while eating. The assessment revealed the resident did not exhibit any behavior related to rejection of care. B. Resident representative interview Resident #70's representative was interviewed on 2/5/26 at 1:25 p.m. The representative said Resident #70 needed one-to-one feeding assistance. She said she did not observe staff providing that assistance. She said the staff entered the room, placed the meal tray on the table and left. She said it took an extended period of time for staff to return. C. Observations During a continuous observation on 2/9/26, beginning at 1:15 p.m. and ending at 6:15 p.m., the following was observed: At 1:16 p.m. Resident #70 was attempting to feed herself during lunch. No staff entered her room or were observed providing one-to-one assistance with her meal. At 3:13 p.m. the lunch tray was still on the table. The resident stopped her attempts to eat for a while. Staff had not entered the resident room since the beginning of the observation. At 5:51 p.m. CNA #3 passed the dinner tray in Resident #70's room. CNA #3 put aside the lunch tray and place the dinner tray on the table. She unwrapped the food plate, cleaned resident hands and just asked if Resident #70 needed anything else and left. At 6:02 p.m. CNA #1 entered the resident's room, just asked if the resident needed anything, then left with the lunch tray. CNA #1 came back bringing a drink and left. No one-on- one meal assistance was provided. The family member was not observed providing one-to-one meal assistance to the resident. At 6:15 p.m. no staff entered the resident's room or were observed providing assistance with her meal. D. Record review The ADL care plan, initiated 12/31/25 and revised 1/6/26, documented Resident #70 had ADL self care performance deficit related to limited mobility. Intervention included providing substantial assistance with eating by one staff member. The nutrition care plan, initiated 12/31/25 and revised 1/23/26, documented Resident #70 had potential nutritional problem related to dysphagia. Pertinent interventions included providing (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one-to-one assistance with meals and protein shakes, and providing assistance or cueing with meals as needed. The nutrition evaluation, dated 12/31/25, documented Resident #70 had swallowing/chewing difficulties due to dysphagia. The registered dietitian recommended providing one-to-one assistance with meals. The evaluation documented Resident #70 required total dependence for dining ability. -However, the care plan was not updated to indicate the resident required set-up assistance. The occupational therapy progress report, from 12/31/25 to 1/17/26, revealed Resident #70 had set a short-term goal for eating from substantial/maximal assistance to partial/moderate assistance. The report documented Resident #70 was demonstrating slow progress but required significant assistance with all transfer, mobility, dressing, toileting, bathing, grooming/hygiene, and feeding tasks. A nursing progress note, dated 2/9/26, documented the speech therapist recommended Resident #70 was cleared for set up assistance with meals and did not require one-to-one meal assistance. Staff were educated to check on Resident #70 frequently and provide assistance with meals once Resident #70 became too fatigued to continue eating independently. She was not at a choking risk. E. Staff interviews CNA #1 was interviewed on 2/10/26 at 5:36 p.m. CNA #1 said she reviewed the Kardex (staff directive tool) to determine which residents needed meal assistance. She said she also asked other CNAs during shift change about residents who needed meal assistance. CNA #1 said Resident #70 needed meal assistance but she did not need to be fed based on the information provided by the assistant director of nursing (ADON). She said staff would check on the resident while she was eating. CNA #1 said the Kardex for Resident #70 indicated she needed substantial assistance by one person for meals. Registered nurse (RN) #1 was interviewed on 2/10/26 at 5:55 p.m. RN #1 said he determined if residents needed meal assistance based on speech therapy evaluations, personal assessments after speaking with the residents and hospital referral documentation. RN #1 said Resident #70 needed meal assistance. He said sometimes Resident #70 could feed herself as she could use the silverware. RN #1 said the nurse report indicated the resident needed one-to-one assistance. RN #1 said the resident's husband came to help her at dinner time. He said staff should be expected to assist her during breakfast and lunch time. The ADON was interviewed on 2/11/26 at 8:09 a.m. The ADON said CNAs identified residents who require meal assistance based on therapy service evaluations, physician's orders and verbal communication during the report. She said Resident #70's meal assistance was just set up and supervision. The ADON said upon admission Resident #70 received one-to-one meal assistance throughout the entire meal service. The ADON said the resident had since gained strength and was able to feed herself using her right hand, requiring only supervision. The ADON said if Resident #70 became fatigued, staff could provide assistance but sometimes she did not allow staff to assist her. She said Resident #70 just needed staff to set up the table, not physically being there to feed her. The RD was interviewed on 2/11/26 at 2:05 p.m. She said Resident #70 required one-to-one meal assistance upon admission due to a choking risk related to dysphagia. She said based on the speech therapy evaluation, dated 2/6/26, Resident #70 was no longer at risk of choking and did not require (continued on next page)

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