STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065305	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Heights	12205 Gunstock Dr Colorado Springs, CO 80921

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents out of three sample residents received food prepared in a form designed to meet individual needs.The facility failed to ensure Resident #1 was served the correct diet texture as ordered by the physician. Resident #1, who was diagnosed with Barrett's esophagus (a condition where the tissue lining the esophagus changes to resemble intestinal lining), Zenker's diverticulum (a pouch that forms at the top of the esophagus, in the throat, due to a weak spot where the throat muscles and esophagus meet, often caused by the upper esophageal muscle not relaxing properly during swallowing, leading to trapped food), difficulty swallowing, regurgitation, bad breath, risk of aspiration, dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD) and dementia, was admitted to the facility on [DATE] with a physician ordered dysphagia diet, level 6 - soft and bite sized. The facility failed to input the diet order into the resident's medical record, document the correct diet on the baseline care plan and communicate with the dietary department to ensure the resident was served the medically appropriate diet. Once the diet order was communicated to the dietary department on 12/25/25, the resident continued to receive the incorrect diet texture for dinner.Resident #1 received regular textured food, which included pork loin and sausage links, between 12/24/25 (date of admission) until after breakfast on 12/25/25. The meat was not altered to be soft and bite sized per the physician's order. An interview with the speech language pathologist (SLP) revealed that even if the meat was cut up, it was still the incorrect texture. The meat should have been soft and able to be depressed with a fork from a cube to flat. After the resident's diet order was communicated to the dietary department (dysphagia level 6 - soft and bite sized), Resident #1 was still served an egg salad sandwich with whole bread and a bag of potato chips for dinner on 12/25/25. The SLP said the resident should have been evaluated prior to consuming the potato chips and the crust on the bread no longer made the sandwich dysphagia appropriate.On 12/26/25, the family arrived at the facility, felt the resident had decompensated and requested for him to be sent to the hospital for evaluation. At the hospital, on 12/26/25, an upper GI (gastroenterology) endoscopy was performed with a noted bleeding Zenker's diverticulum with a large opening with impacted food, which required surgical intervention.The facility's failure to ensure residents received the physician ordered diet texture placed residents at risk for serious harm or death if not corrected immediately. Findings include:I. Immediate jeopardyA. Situation of immediate jeopardyThe facility failed to ensure Resident #1 was served the correct diet texture as ordered by the physician. Resident #1, who was diagnosed with Barrett's esophagus, Zenker's diverticulum, dysphagia, GERD and dementia, was admitted to the facility on [DATE] with a physician ordered dysphagia diet, level 6 - soft and bite sized. The facility failed to input the diet order into the resident's medical record, document the correct diet on the baseline care plan and communicate with the dietary department to ensure the resident was served the medically appropriate diet. Once (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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the diet order was communicated to the dietary department on 12/25/25, the resident continued to receive the incorrect diet texture for dinner.The facility's failure led to Resident #1's change of condition and surgical intervention to remove the impacted food in the Zenker's diverticulum.The facility's failure to ensure residents received the physician ordered diet texture placed residents at risk for serious harm or death if not corrected immediately.B. Facility notice of immediate jeopardyOn 1/7/26 at 12:20 p.m., the nursing home administrator (NHA), the executive director (ED) and the director of nursing (DON) were notified of the immediate jeopardy situation created by the facility's failure to ensure Resident #1 received the physician ordered diet texture.C. Facility plan to remove immediate jeopardyOn 1/7/26 at 4:27 p.m., the facility submitted a plan for the immediate jeopardy. The plan read:1. Corrective actionThe identified resident, Resident #1 no longer resides in the community.2. Action planThe facility conducted an audit on 1/6/26 at 12:30 p.m. to identify other residents who may be receiving the incorrect diet texture. Physician orders and dietary tickets were reviewed. No other issues were identified.The DON or designee provided education of the following: therapeutic (mechanically altered) diets, admission process regarding diet order transcription to the medical record and communication of diet to the dietary department and accurate documentation in the baseline care plan of the resident's physician ordered diet. Education was provided to all nursing and dining staff on 1/7/26 currently working in the facility and will continue to provide education until all staff have been re-educated. Staff will not be permitted to work until they have received the required education.The speech language pathologist (SLP) provided education of therapeutic (mechanically altered) diet textures according to the International Dysphagia Diet Standardization Initiative (IDDSI) guidelines on 1/7/26 to all dietary staff working on those coming onto shift. Education will continue until all dietary staff have been educated prior to working.Education was provided on 1/7/26 to nursing staff by the DON on how to read the resident's tray card, and how to properly identify correct altered textured diets. All training was completed by DON for staff on shift. Education is to continue to ensure all staff are sufficiently trained and will be completed by DON/designee.All new staff hired post 1/7/26 will be given the same training prior to working in the kitchen or serving any residents their food, snack or beverage.The DON reviewed all identified residents with altered diet texture care plans on 1/7/26 and updated it accordingly to reflect each resident's specific dietary interventions and needs.3. Systemic changesThe DON or designee will review all new admissions within 24 hours beginning 1/7/26 for two meals per week for four weeks to validate that the meals are being prepared and served according to the residents' specific dietary requirements. Any issues identified will be corrected immediately and will also be reported to the NHA.4. MonitoringThe DON or designee will conduct three random resident meal observations per week for four weeks, then weekly for eight weeks using an audit tool to ensure residents are receiving the appropriate therapeutic diet as ordered by the physician. Any issues identified will be corrected immediately and will be reported to the NHA.D. Removal of the immediate jeopardyOn 1/7/26 at 4:27 p.m., the NHA, the DON and the ED were notified that the facility's plan to remove immediate jeopardy was accepted based on the facility's plan to implement the measures above. However, the deficient practice remained at a G level, actual harm.II. Facility policy and proceduresThe Therapeutic Diet Orders policy and procedure, reviewed 10/22/25, was provided by the NHA on 1/7/26 at 4:00 p.m. It revealed in pertinent part, The facility provides all residents with food in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Examples include soft solids, pureed foods, ground meat, and thickened liquids. Therapeutic diet is a diet ordered by the physician, or delegated registered or licensed dietitian, as part of treatment for a disease or clinical condition. It also may be ordered to eliminate, decrease or increase specific nutrients in the diet. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to: inadequate nutrition; nutritional deficits; weight loss; medical conditions such as diabetes; renal disease; or heart disease; swallowing difficulty. The reason for a therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.The Therapeutic Diets - Transmission of Diet Orders policy and procedure, reviewed 8/20/18, was provided by the NHA on 1/7/26 at 4:00 p.m. It revealed in pertinent part, The dietary department should be notified, in writing, of all diet orders and changes by the nursing department. Upon admission, a dietary form should be completed and dated by the dining services director or designee. Food preferences, allergies, and diets should be noted. The information from the dietary form should be transferred to the master serving list or other designated form. The master serving list notes the resident's name, diet, preferences, and allergies. It is used on the tray line.The IDDSI Soft and Bite Sized, dated January 2019, was provided by the NHA on 1/7/26 at 4:00 p.m. It revealed in pertinent part, Level 6: soft and bite sized foods: soft, tender and moist, but with no thin liquid leaking/dripping from the food. Ability to bite off a piece of food is not required. Ability to chew bite sized pieces so they are safe to swallow is required. Bite sized pieces no bigger than 1.5 centimeters (cm) x 1.5 cm in size. Food can be mashed/broken down with pressure from a fork. A knife is not required to cut this food. Level 6 - soft and bite sized food may be used if you are not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow. Soft and bite sized foods need a moderate amount of chewing, for the tongue to collect the food into a ball and bring it to the back of the mouth for swallowing. The pieces are bite sized to reduce choking risk. To make sure the food is soft enough, press down on the fork until the thumbnail blanches to white, then lift the fork to see that the food is completely squashed and does not regain its shape. Meat cooked tender and chopped so pieces are no bigger than 1.5 cm x 1.5 cm lump size. If can not serve soft and tender, serve as minced and moist. No regular dry bread due to high choking risk.III. Professional referencesAccording to the IDDSI reference https://www.iddsi.org/faqs/q-do-all-foods-at-level-6-%E2%80%93-soft-bite-sized-adult-guidelines-need-to-mee by 1.5cm-particle-size-requirements, retrieved on 1/7/26, All foods (sandwiches included) need to meet the particle size requirements for Level 6 - soft and bite sized. The relationship between particle size and risk of asphyxiation has been identified in the literature. In order to avoid asphyxiation, particles should be small enough to pass through rather than block the trachea. The average tracheal size for adult males is 22 millimeters (mm) and for adult females, 17 mm. Particle sizes of 15 mm size are therefore more likely to pass through the trachea, than block it. IDDSI appreciates that provision of food like sandwiches is very difficult at this particle size and asks clinicians and carers to consider providing soaked breads as an alternative. For example, finely chop bread and add equal amounts of water and butter to create a softened bread texture, re-shape and service. The combination of the water and fat content reduces stickiness and improves bolus cohesion.IV. Failure to ensure a resident was served the physician ordered diet textureA. Resident #1 (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	statusResident #1, age [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included acute respiratory failure with hypoxia, dysphagia, Barrett's esophagus, Zenker's diverticulum (esophageal diverticulum), influenza type A, pneumonia and dementia. According to the 12/24/25 admission assessment, Resident #1 required total assistance of one staff member for eating. B. Resident representative interviewResident #1's representative was interviewed on 1/6/26 at 11:15 a.m. Resident #1's representative said Resident #1 had a history of Barrett's esophagus and Zenker's diverticulum (esophageal diverticulum) since 2022 and was recently diagnosed with dementia within the past year. She said Resident #1 had significant cognitive impairment.Resident #1's representative said the resident was admitted to the facility on [DATE]. She said she specifically asked if the facility was able to handle the resident's diet restrictions because of the holiday. She said she was told the facility was able to handle a dysphagia diet and to trust us to provide the correct care for the resident.She said on 12/24/25, her husband and herself sat with the resident in the dining room waiting to be served. She said because of the time and how long it was taking, they had to leave prior to him being served dinner. She said they left the facility and returned a couple hours later. She said Resident #1 could not verbalize what he had for dinner. She said prior to leaving the facility that night, she reminded the certified nurse aide (CNA) Resident #1 had a bad swallowing problem and was assured he would be taken care of.She said she did not return to the facility until Christmas Day (12/25/25) with Resident #1's spouse. She said Resident #1 was served a boxed dinner with a full egg salad sandwich, with the crust and bread intact and a side bag of potato chips. She said Resident #1 had consumed a good portion of the meal when she had arrived. She said she looked for a staff member, but was unable to find anyone. She said Resident #1's spouse was becoming agitated and restless, so she had to leave to take her home.She said the following morning (12/26/25), she attempted to call the facility multiple times, however no one answered the phone. She said when she arrived at the facility, she saw Resident #1 sitting on the couch on the unit he resided. She said he was having difficulty breathing and felt his condition had worsened. She said the nurse told her he was fine, but she insisted the physician be called and wanted him to be sent to the hospital for further evaluation.She said he was admitted to the hospital on [DATE] and had surgery to remove impacted food from the resident's Zenker's diverticulum.C. Record review1. Resident history prior to admissionThe 12/17/25 history and physical hospital notes documented that the resident had dementia with Influenza A, right lower lobe infiltrate and hypoxemic respiratory failure. The resident was diagnosed with both Influenza A and pneumonia. The resident had a past medical history of Barrett's esophagus and Zenker's diverticulum. The radiology studies were pertinent for a patchy right lower lobe infiltrate for which he was admitted to the intensive care unit (ICU). The 12/20/25 GI consult physician progress notes documented the resident had dysphagia for two years and failed the barium swallow twice. He was able to tolerate a regular diet at his previous facility but now had failed the barium swallow studies. The 12/23/25 hospital physician progress notes documented Resident #1 required inpatient hospitalization for further evaluation of dysphagia. The esophagram documented the following: thick barium was given to the resident, however despite multiple requests, the resident would not swallow. The resident had difficulty following instructions and tolerating positions for modified esophagram. Multiple positions were attempted and the resident requested to discontinue esophagram. The impression revealed an incomplete esophagram, as the resident could not tolerate positioning or follow directions for the exam. Partial imaging of a rounded structure which could represent esophageal diverticulum.The 12/24/25 swallow assessment documented the resident had ongoing oral and suspected pharyngeal dysphagia (swallowing (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	difficulties in the mouth and throat area) with overt signs and symptoms of laryngeal penetration and aspiration on thin liquids and regular solids. The precautions for the resident included sit upright as possible (preferably in a chair), take small single bites/[NAME] at a slow rate, no straws, full supervision with meals, provide frequent oral care and the resident must be fully awake/alert for by mouth intake to eliminate distractions during meals.The diet recommendations included soft and bite sized, dysphagia diet level 6 with thin liquids.The 12/24/25 hospital discharge summary documented Resident #1's discharging diagnosis was dysphagia. The resident's discharge had been delayed due to concerns with dysphagia and aphasia. The resident was discharged from the hospital on a dysphagia diet.2. Failure of the facility to ensure Resident #1 received the correct meal textureThe functional care plan, initiated on 12/24/25, documented Resident #1 required total assistance with one person physical assistance with eating.The 12/24/25 admission progress note documented Resident #1 was confused, disoriented, had disorganized thinking with unclear speech. The resident had short-term and long-term memory impairment and was only oriented to himself.It indicated Resident #1 had difficulty chewing, swallowing at times and required assistance with eating as needed.The baseline care plan, initiated on 12/24/25, documented Resident #1's physician prescribed diet was regular texture with thin liquids, with specifications for the resident to eat two bites and then drink some water.-However, based on hospital discharge documentation and the hospital SLP recommendation, the resident should have received a dysphagia level 6 - soft and bite sized diet.-The facility failed to ensure the baseline care plan had accurate documentation regarding Resident #1's diet texture, which was documented in the discharge instructions and notes from the hospital.A review of Resident #1's medical record did not reveal a physician order for diet texture.-The facility failed to transcribe the physician ordered diet for Resident #1 from the hospital discharge orders.The 12/24/25 nursing progress note, documented as a late entry on 12/29/25 at 11:57 a.m., revealed the resident was observed sitting upright in the dining room with family at the dining table. Resident #1 consumed small, bite-sized dinner. During the meal, the resident was noted to pocket small pieces of food in his cheek. The nurse provided repeated reminders to take one bite followed by a sip of liquid to promote safe swallowing.-However, according to the interview with Resident #1's representative, the family had left prior to the resident being served his meal. Additionally, the nursing progress note was documented five days later (12/29/25).The 12/26/25 nursing progress note documented Resident #1's representative came to visit the resident and reported the resident was in worse condition than he was at his admission to the facility. She and the resident's power of attorney (POA) said the resident was coughing and having pain swallowing. They requested the resident be sent to the hospital for evaluation. The physician was notified and agreeable.The 12/28/25 communication progress note written by the NHA documented he was notified Resident #1's family had concerns regarding the resident's re-hospitalization. The family was unable to speak with the NHA regarding their concerns.3. Resident #1's change of conditionThe 12/26/25 hospital physician notes documented the resident presented with suspected aspiration pneumonia in the setting of dysphagia with suspected esophageal diverticulum. The resident was currently stable and on antibiotics. The chest Xray revealed a right lower lobe infiltrate, which was present on the resident's previous admission to the hospital, however the resident presented with new and elevated leukocytosis (new or recent finding of a high white blood cell count often indicating the body is fighting an infection).The 12/26/25 upper GI endoscopy findings revealed a bleeding Zenker's diverticulum with a large opening with impacted food.The 12/30/25 hospital progress notes documented the resident failed the SLP evaluation. The impacted food was removed from the diverticulum.V. Staff interviewsThe registered dietitian (RD) was interviewed on 1/6/26 at 3:20 p.m. The RD said (continued on next page)

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