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	07/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations and interviews, the facility failed to ensure residents had the right to a dignified existence.Specifically, the facility failed to provide an environment of engagement and promote quality of life for residents.Findings include:I. Facility policy and procedureThe Quality of Life: Dignity policy and procedure, reviewed on 2/23/24, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It revealed in pertinent part, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining or enhancing his or her self-esteem and self-worth. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her preferred name and not ‘labeling' or referring to the resident by his or her room number, or by using terms such as ‘dear' or ‘honey. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed, and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. Staff shall maintain an environment in which confidential clinical information is protected, for example: verbal staff to staff communications (change of shift reports) shall be conducted outside the hearing range of any residents and visitors.II. Resident interviewsResident #3 was interviewed on 7/13/25 at 10:40 a.m. Resident #3 said the staff were not very compassionate with him and never took the time to talk to him. He said the facility staff would just come into his room, ask what was needed, complete the task and then leave. He said the staff did not interact with the residents who resided in the facility unless they had to.A resident group interview was conducted on 7/15/25 at 10:00 a.m. Resident #13 said she felt like the facility staff did not enjoy spending time with the residents. She said the facility staff were good at their job when asked, but did not feel an emotional connection to the residents.Resident #22 and Resident #27 said the facility staff members were not chatty with the residents and it felt lonely to live at the facility. Resident #22 said the staff were good at providing care when you asked, but other than that, they did not ever have any interactions with the residents.Resident #27 said no one just sat and talked to the residents and sometimes the residents just wanted someone to sit and care. The group of residents said they felt bad for residents who were not able to speak up for themselves because they received even less staff interaction than those that were able to ask for assistance.III. ObservationsDuring a continuous observation of the A unit on 7/13/25, beginning at 9:45 a.m. and ending at 3:00 p.m., the following was observed:At 10:30 a.m. Resident #2 was observed lying in bed, sleeping. The resident was dressed in a hospital gown.At 12:25 p.m. certified nurse aide (CNA) 1 entered Resident #2's room. He placed the resident's lunch meal tray down on the overbed table that was positioned to the side of the bed and not within reach of the resident. He did not speak to Resident #2, nor attempt to arouse the resident, who was still sleeping.At 1:08 p.m. CNA #1 entered Resident #2's room again. He did not speak to the resident. He uncovered the resident's lunch meal and left it open to air. He exited the room and told the nurse on the unit he was going on his lunch break.At 1:44 p.m. CNA #1 entered Resident #2's room a third time. He did not speak to the resident, picked up the meal tray and removed it from the room.-Resident #2 did not receive any form of verbal interaction from facility staff from 10:30 a.m. until 3:00 p.m., a period of four and a half hours.During the same continuous observation, Resident #6 was sitting in the common area on the unit in front of the television. The television volume was not turned on and Resident #6 was sitting with her head down and sleeping.At 11:15 a.m. Resident #6 was wheeled from the common area on the unit and taken to the dining room by an unidentified staff member. The unidentified staff member did not speak to the resident nor tell her where they were going.At 1:07 p.m. Resident #6 was brought from the dining room and placed back in front of the television in the unit's common area. The volume on the television was not turned on.Throughout the continuous observation, multiple staff members were observed walking in between Resident #6 and the television, however, no staff member was observed interacting with the resident.During the same continuous observation, the following was additionally observed:At 9:45 a.m. Resident #13 was lying in her bed, facing the wall and window. The blinds were closed.At 10:45 a.m. Resident #16 was sitting in a recliner chair in his room, staring off, not looking at the television. CNA #1 delivered the resident's lunch meal tray at 12:30 p.m. on the over bed table and left the room. He did not interact with the resident. The resident did not have any meaningful staff interaction during the continuous observation.On 7/13/25 at 11:20 a.m. Resident #30 was sitting in the common area of the C unit. There was a television in front of Resident #30 but it was not turned on. Resident #30 kept looking up at the ceiling, directly into the sun coming in

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate allegations related to an injury of unknown origin and incidents of resident-to-resident physical and verbal altercations for two (#35 and #18) of eight residents reviewed out of 27 sample residents.Specifically, the facility failed to:-Ensure an investigation was conducted for incidents of physical and verbal altercations involving Resident #35; and,-Ensure a complete and thorough investigation was completed for injuries of unknown origin on the wrist for Resident #18. Findings include:I. Facility policy and procedureThe Abuse Investigations including Resident-to-Resident Altercation policy, reviewed 3/6/25, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It read in pertinent part, The community will investigate all suspicions or allegations of abuse, neglect, or misappropriation of resident property/funds. All staff are required to immediately report to the director of nursing (DON) and/or NHA (nursing home administrator)/ED any of the following: Any allegations of abuse, neglect or misappropriation of resident property verbalized/expressed by residents, families and/or other staff, even if they do not feel the act actually occurred; any physical signs of abuse which necessitate further investigation as a potential or actual abusive situation, resident exhibiting new fears/behaviors with employees, unexplained bruises/cuts, injuries inconsistent with explanation, non-specific complaints about an employee. The employee(s) involved or suspected to be involved will have their statements obtained related to the situation and then be placed on immediate suspension until completion of the investigation. The DON or NHA/ED will notify the appropriate state regulatory agencies of the incident as soon as possible but not to exceed 24 hours of the allegation. The NHA/ED will complete the investigative process with the assistance of the DON as necessary. No investigation should be conducted by a person directly involved in the allegation. The individual(s) conducting the investigation will: Review the resident's medical record to determine events leading up to the incident, if any; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident (if cognitively able to make a statement). As a method of validation a second person should also interview the resident to ascertain consistency of the reported incident; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors, as indicated; interview other residents to whom the accused employee provides care or service, as indicated. Each interview will be conducted separately and in a private location. Witness statements shall be written by each individual. Witnesses will be required to sign and date all statements. If two residents are involved in an altercation, the community staff will: Separate the residents, and institute measures to calm the situation; evaluate all involved residents for any injuries and provide/request medical treatment as indicated; identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; consult with the attending physician to identify contributing conditions and possible psychological/psychiatric evaluation and treatment for both involved residents; and complete an incident report.II. Resident-to-resident altercationsA. Resident #351. Resident statusResident #35, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (lack of blood supply to the brain), respiratory failure, hepatic failure (liver failure), vascular dementia (brain damage due to multiple strokes) and type 2 diabetes mellitus.The 5/15/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. She needed set up assistance for meals and was dependent on assistance for all other activities of daily living (ADL).2. Record reviewResident #35's behavior care plan, initiated 8/14/24, documented she had a behavior problem related to hitting staff during care. The care plan documented the resident had a history of being aggressive towards another resident. Pertinent interventions, initiated 6/10/25, included the resident would come to activities but would have a safe distance between her and other residents during meals and other activities. The care plan indicated the physician and the DON were notified.A 5/4/25 behavior note documented Resident #35 was in the dining room for lunch. While in the dining room, the resident threw dishes on the floor and was calling her tablemate names. The resident was removed from the dining room and brought to the unit.A 5/26/25 behavior note documented that while at an activity for Memorial Day, Resident #35 snatched glasses off of another resident's face and snatched the other resident's food from the resident. The other resident did not want to stay in the activity and asked to be taken back to her room. Resident #35 stayed in the activity but

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#6 and #2) of five residents who required assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities out of 27 sample residents.Specifically, the facility failed to:-Conduct a safe transfer, develop a communication plan to ensure the resident was provided interaction in her native language and ensure timely incontinence care and repositioning was provided for Resident #6;-Ensure timely incontinence care, repositioning and eating assistance was provided for Resident #2; and,-Ensure Resident #2's comprehensive care plan was revised to accurately depict the resident's current level of care with ADLs. Findings include:I. Facility policy and procedureThe Activities of Daily Living policy and procedure, reviewed 3/13/23, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It revealed in pertinent part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the assistance necessary to maintain good nutrition, grooming, and personal hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care); mobility (transfer and ambulation), bowel and bladder elimination (toileting), dining (meals and snacks); and communication (speech, language, and any functional communication systems). A resident's ability to perform ADLs will be measured using clinical tools, including the MDS (minimum data set) assessment. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: Independent: resident completed activity with no help or staff oversight at any time during the last seven days. Supervision: oversight, encouragement or cueing provided three or more times during the last seven days. Limited assistance: resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance of three or more times during the last seven days. Extensive assistance: while the resident performed part of the activity over the last seven days, staff provided weight-bearing support. Total dependence: full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over the entire seven day look back period. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assisted needs, preferences, stated goals and recognized standards of practice.The Resident Need for Translator/Interpreter Services policy and procedure, reviewed 2/23/24, was provided by the ED on 7/17/25 at 2:18 p.m. It revealed in pertinent part, The community will ensure that residents or personal representatives with limited English proficiency, or who have hearing or sight impairments, shall have meaningful access to information and services provided by the community in a manner in which they can understand.The Care Plan Process policy and procedure, reviewed 2/23/24, was provided by the ED on 7/17/25 at 2:18 p.m. It revealed in pertinent part, To ensure the timeliness of each resident's person-centered baseline and comprehensive care plan and to ensure that care plans are reviewed and revised by an interdisciplinary team (IDT) composed of individuals who have knowledge of the resident and his/her needs, and that each resident and representative, if applicable, is involved in developing the care plan and making decisions about his or her care.II. Resident #6A. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, protein-calorie malnutrition and dementia without behavioral disturbance. The 6/5/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She was dependent upon staff assistance with transfers, bed mobility, oral hygiene, toileting, bathing, dressing and personal hygiene. The 3/5/25 MDS assessment documented the resident's activity preferences were not assessed. B. ObservationsDuring a continuous observation on 7/13/25, beginning at 9:45 a.m. and ending at 3:45 p.m., the following was observed:At 9:45 a.m. Resident #6 was sitting in the common area on the A unit in front of the television. The television volume was not turned on and Resident #6 was sitting with her head down and sleeping.At 11:15 a.m. Resident #6 was wheeled from the common area on the unit and taken to the dining room by an unidentified staff member. The unidentified staff member did not speak to the resident nor tell her where they were going. The unidentified staff member did not offer Resident #6 incontinence care

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure activities designed to support residents' physical, mental and psychosocial well-being were provided for two (#6 and #30) of three residents out of 27 sample residents.Specifically, the facility failed to provide a program of meaningful activities for Resident #6 and Resident #30.Findings include: I. Facility policy and procedure The Basic Program Requirements policy and procedure, reviewed 2/3/25, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It revealed in pertinent part, “The overall purpose of an activity program is to provide residents with opportunities for continued functioning and quality of life. The community will have an activity program suited to the needs and interest of the residents. Programs will address the physical, intellectual, emotional, spiritual, social and vocational needs of the residents. “Programs/activities shall be available seven days per week, evenings and holidays.” II. Resident #6 A. Resident status Resident #6, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included Alzheimer’s disease, protein-calorie malnutrition and dementia without behavioral disturbance. The 6/5/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She was dependent upon staff assistance with transfers, bed mobility, oral hygiene, toileting, bathing, dressing and personal hygiene. The 3/5/25 MDS assessment documented the resident’s activity preferences were not assessed. B. Observations During a continuous observation on 7/13/25, beginning at 9:45 a.m. and ending at 3:45 p.m., the following was observed: At 9:45 a.m. Resident #6 was sitting in the common area on the unit in front of the television. The television volume was not turned on and Resident #6 was sitting with her head down and sleeping. At 11:15 a.m. Resident #6 was wheeled from the common area on the unit and taken to the dining room by an unidentified staff member. At 1:07 p.m. Resident #6 was brought from the dining room by an unidentified staff member and placed back in front of the television in the unit’s common area. She was looking around and not focused on the television. She was not provided any meaningful independent activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:00 p.m., Resident #6 was still sitting in front of the television in the common area. -No one was observed interacting with Resident #6 during the continuous observation. -Additionally, during the continuous observation, the activity calendar documented a 10:00 a.m. church service, Game Time: Dominos at 11:00 a.m. and a Name That Tune activity at 2:00 p.m. However, Resident #6 was not invited to attend any of the group activities. During a continuous observation on 7/14/25, beginning at 8:30 a.m. and ending at 3:00 p.m., the following was observed: At 8:30 a.m. Resident #6 was in the dining room for breakfast. At 9:00 a.m. Resident #6 was taken from the dining room to the common area by an unidentified staff member. She was placed in front of the television with the sound not turned on. She had a baby doll in her arms. Resident #6 was not offered any meaningful activities. At 10:39 a.m. an activity staff member was observed inviting one resident on the unit to a group activity. Resident #6 was not asked if she wanted to attend and continued to sit in front of the television with no interaction from staff members. At 11:21 a.m. the nurse on the unit walked over to Resident #6 and asked her if she wanted to be able to hear the television and if she wanted to watch a movie. Resident #6 nodded her head, indicating “yes” and the nurse turned up the volume and put on a movie. At 11:55 a.m. certified nurse aide (CNA) #1 asked Resident #6 if she was ready to go to lunch. He began wheeling her down to the dining room before she was able to answer. At 1:19 p.m. Resident #6 was taken from the dining room to the common area on the unit. Upon reaching the unit, the resident was placed in the common area in front of the television. She was not offered any meaningful activities. At 2:12 p.m. an activity staff member approached Resident #6 and asked her if she wanted to attend the group exercise activity and then BINGO. Resident #6 nodded enthusiastically, “yes” and was taken to the exercise program. At 2:19 p.m., seven minutes later, the activity assistant took Resident #6 from the group exercise program back to the unit to sit in the common area in front of the television. She did not speak to the resident, and it was unclear why the resident left the activity early and was not taken to BINGO. At 3:00 p.m. Resident #6 was still sitting in the common area in front of the television without any meaningful activities. At 3:23 p.m. CNA #1 wheeled Resident #6 to her room and said he was going to provide her with incontinence care. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the continuous observation, the activity calendar documented Game Time at 11:00 a.m., Exercise program at 2:30 p.m. and BINGO at 3:00 p.m. -However, Resident #6 was brought back to the common area from the exercise group seven minutes after an activity assistant took her to the group activity and she did not attend BINGO, despite the activity assistant asking her if she wanted to attend (see observation above). On 7/16/25 at 1:54 p.m. Resident #6 was sitting in the activity room. Another resident, whose primary language was the same as Resident #6’s primary language of Japanese, was sitting across from her and they were verbally interacting. Resident #6 was smiling and visibly enjoying herself. The activity director (AD) was observed grabbing an IPad (electronic device) and pulling up a digital translator. The AD spoke into the device, the device translated it into Japanese and the AD then spoke to the resident. The resident spoke back and the AD had a full conversation with Resident #6. The AD said, “Next time, I will get a translator for you.” -This interaction with Resident #6 was the first time, during the survey process, that facility staff were observed using a translation device to interact with Resident #6 in her native language (see staff interviews below). Cross reference F677: the facility failed to ensure Resident #6 was provided activities of daily living according to her plan of care and developed a communication plan for the resident to receive interactions in her native language. Cross reference F550: The facility failed to provide an environment of engagement and promote quality of life. C. Record review The activities care plan, revised 5/7/25, documented Resident #6’s primary language was Japanese, but she was also able to understand English. The resident’s family said she enjoyed both group and independent activities such as coloring, painting, crosswords, puzzles, watching HGTV (home and garden television network) and the food network, going outside, music, making jewelry and being around others. The interventions included providing Resident #6 with leisure materials as well as assisting her to all activities of her interest in the community due to her cognitive, visual, language, pain and physical limitations and providing signs in her preferred language so she could more easily communicate her needs with staff due to a language barrier. The 5/29/25 quarterly activities review documented the resident participated in independent and group activities daily and enjoyed coloring, puzzles, games, making jewelry and watching television. D. Staff interviews CNA #1 was interviewed on 7/15/25 at 3:11 p.m. CNA #1 said Resident #6 was completely dependent upon staff for all activities of daily living (ADL). He said she was unable to propel herself in a wheelchair and required staff assistance. He said Resident #6 usually spent all day in the common area in front of the television on the “A” unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said Resident #6’s native language was Japanese but she was able to understand some English. He said she could answer yes and no questions, but he did not know how much she understood. He said he did not speak to her too often because she could not hold a conversation in English. He said he had used a digital translator once but he had not used it since. He said he thought there was another resident in the facility who spoke Japanese, but he was not sure. He said he was not aware of any communication boards in Japanese to be used for the resident to be able to communicate. CNA #1 said there was a baby doll in Resident #6’s room, but he did not know too much about it. He said one day, the baby doll just appeared. He said Resident #6 was happy holding the baby doll, but he did not know if she knew it was a toy or if she thought it was real. He said he thought she knew it was a toy. He said he did not know the purpose of the baby doll. He said he had never been given a report about it, so he did not know if it was part of her plan of care. He said if she wanted it he would give it to her, but she did not often ask for the baby doll. CNA #1 said Resident #6 would attend group activities at times, but did not attend all group activities. The activity director (AD) was interviewed on 7/16/25 at 10:25 a.m. The AD said she was responsible for the development of the activity calendar, completing assessments and participating in care conferences. She said the activities assistants were responsible for inviting residents and running all group activities. She said she had worked at the facility for the past three months and had begun to make changes in the activity department. She said documentation of resident participation in group activities was documented on a new computer system that her staff was still learning. She said she had two full-time activity staff members so activities were provided seven days per week. The AD said Resident #6 spoke Japanese but she was able to understand some English as long as the question was yes or no. She said she had not used a digital translator prior to that day (7/16/25) for Resident #6. She said Resident #6 had resided at the facility for approximately four to five months. She said Resident #6 was able to carry on a complete conversation with the use of the digital translator that day, 7/16/25. The AD said a resident on another unit also spoke Japanese. She said she did not know how often the two residents got together to interact. She said it was not part of Resident #6’s comprehensive care plan. The AD said staff should try and interact with each resident in their native language. She said the facility staff had access to a digital translator to assist with different languages and should use it every day with Resident #6. The AD said the baby doll was provided by Resident #6’s family. She said when Resident #6 resided in a memory care unit, she would take all the baby dolls in the facility and hide them in her room, so when she was admitted to the facility, Resident #6’s son provided her with a baby doll. She said it had been at the facility for about a month. She said the doll should be provided to the resident every morning so she was able to take it with her everywhere she went during the day. She said Resident #6 did not like it when other people would touch the baby doll. The AD said she did not know how the baby doll intervention or the digital translator was communicated with the nursing staff. She said she was not aware of a clear process. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD said all residents should be invited to group activities. She said inviting Resident #6 to all group activities was part of her plan of care. She said Resident #6 was not included in the one-to-one activity program. The ED was interviewed on 7/16/25 at 2:19 p.m. The ED said all residents should be invited to group activities. She said it was a collaborative effort across all the departments, not just activities. The ED said communication should be provided to each resident in their native tongue. She said the facility staff had access to communication boards in multiple languages as well as access to a digital translator. She said Resident #6’s native language was Japanese. She said the facility staff should have been using a digital translator since her admission, so the resident was able to interact with others. The ED said there should be communication between the activities department and nursing to ensure each resident’s socialization needs were being met. She said this included an understanding of Resident #6’s use of the baby doll. III. Resident #30 A. Resident status Resident #30, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included cerebral infarction (lack of blood flow to the brain), epilepsy (abnormal electrical activity in the brain), dysphagia (difficulty swallowing) and type 2 diabetes (abnormal blood sugar level). The 6/27/25 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of eight out of 15. He required maximum staff assistance with dressing and toileting. He required moderate staff assistance with personal hygiene, bed mobility and transfers. He required supervision for eating. The MDS assessment indicated it was very important to the resident to get fresh air, somewhat important to be around animals and not very important to participate in religious services and books. B. Observations On 7/13/25 at 11:20 a.m. Resident #30 was sitting in the common area of the C-pod. There was a television in front of Resident #30 but it was not on. Resident #30 kept looking up at the ceiling, directly into the sun coming in through the skylights. Staff were observed to walk past him with no conversation and only spoke to him when he was attempting to self propel his wheelchair. -The facility failed to ensure Resident #30 had meaningful activities available while he was sitting in the common area of the C-pod. On 7/14/25 at 10:30 a.m. Resident #30 was left sitting in his wheelchair in the common area of the C-pod by an unidentified therapy staff member. Resident #30 remained sitting in the common area for 15 minutes just looking around before he was spoken to by anyone. The television in the common area was not on and there was nothing for the resident to do while he was sitting in the common area. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility failed to ensure Resident #30 had meaningful activities available while sitting in the common area of the C-pod. On 7/15/25 at 9:40 a.m. Resident #30 was again in the common area of the C-pod. Resident #30 was slouched over with his eyes closed in his wheelchair. There was an unidentified hospice nurse sitting in an arm chair slightly behind Resident #30 on his right side. The unidentified hospice nurse was talking on the phone about another resident in the facility. The unidentified hospice nurse finished her call and left the C-pod. There were no other staff members in the common area of C-pod. The television in front of Resident #30 was not on and there were no other meaningful activities available. Resident #30 picked up his head three different times, looked around and then would slouch back over when he did not see anyone. -Resident #30 was not provided with any meaningful activities while he was sitting in the common area of the C-pod. C. Resident’s representative interview Resident #30’s representative was interviewed on 7/14/25 at 11:40 a.m. The representative said Resident #30 was an avid reader and was active in his faith. She said she was unsure if Resident #30 had been provided with any reading material by the facility, but she said she had not seen a book in his room. She said she was not sure if Resident #30 had been provided an opportunity to engage in faith-based activities since coming to the facility. D. Record review The activities care plan, initiated 6/21/25, revealed Resident #30 enjoyed playing board games, reading western books and watching television and movies. Resident #30 enjoyed his family visits and enjoyed time outside, weather permitting. The activities goals identified on the care plan revealed Resident #30 would engage in watching television programs of choice weekly (initiated 6/26/25) and he would participate in religious services/practices weekly (initiated 6/23/25). Interventions included encouraging Resident #30 to engage in religious programs/services that were offered in the community, inviting, encouraging and assisting Resident #30 to all activities occurring in the community, providing Resident #30 with a television guide and ensuring his television and remote were properly working and within reach, encouraging and assisting Resident #30 to go outside when the weather permitted. -However, observations revealed Resident #30 was sitting in the common area of the C-pod but the television was not on (see observations above). On 7/16/25 at 10:50 a.m. the activities director (AD) provided a copy of Resident #30’s activity participation log for June 2025. The log revealed the only program being tracked was daily program and chronicle/leisure cart pass out. The AD was unable to provide an activities log for Resident #30’s participation for July 2025. The AD said the facility had changed their charting system for the activities department and she did not know how to pull a report. Review of the activities calendar for July 2025, provided by the ED on 7/21/25 at 12:46 p.m. (after the survey exit), revealed there were no scheduled religious services for residents who were Catholics. There were catholic communion visits scheduled on Thursdays at 1:00 p.m. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, review of Resident #30’s activity participation log did not reveal that the resident attended the catholic communion visits (see above). E. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/15/25 at 2:07 p.m. LPN #1 said the activities staff would give her a list of residents who wanted to participate in an activity and she would help facilitate getting the residents to the activity. LPN #1 said she knew which residents on her C-pod would attend which activities, but she said she did not go ask all of the residents if they wanted to attend. She said Resident #30 admitted to the facility very weak and slept a lot but he had since started to be more active and social. LPN #1 said she was not sure what Resident #30’s preferences were for activities other than family visits. The AD was interviewed on 7/16/25 at 10:25 a.m. The AD said the facility currently did not offer religious services for residents. The AD said the facility had a volunteer who came on Thursdays to provide catholic communion for residents. -The AD reviewed her activities log for resident participation. She said Resident #30 was not on her list of residents for catholic communion to be provided to. The AD said Resident #30 slept a lot and he had not been assessed to see if he would like to be woken up for activities. The AD said Resident #30 was nonverbal and struggled to communicate. The AD said she was unaware that Resident #30 would respond to yes or no questions.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#3 and #33) of two out of 27 sample residents with limited range of motion (ROM) received appropriate treatment and services. Specifically the facility failed to:-Ensure parameters were clearly identified to indicate the length of time, how often and by whom the brace should be donned (put on) and doffed (taken off) by Resident #3;-Ensure staff were monitoring the skin condition under the brace for Resident #3;-Follow physician's orders for Resident 33's contracture management; and,-Ensure Resident #33's carrot split was included on the care plan, monitored and reviewed for effectiveness. Findings include: I. Facility policy and procedure The Care Plan Process policy, revised 2/23/24, was received from the executive director (ED) on 7/17/25 at 2:18 p.m. It revealed in pertinent part, “To ensure the timeliness of each resident’s person-centered baseline and comprehensive care plan, and to ensure that care plans are reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. “A comprehensive care plan must describe the following: The services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.” The Weekly Skin Review policy and procedure, revised 3/6/25, was received from the ED on 7/17/25 at 2:18 p.m. It revealed in pertinent part, “The facility must have a system in place to evaluate skin condition (skin color, moisture, temperature, integrity, and turgor) at least weekly. “The nursing staff must be aware of any devices that were in use that may cause pressure.” II. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO) diagnoses included cerebral infarction (lack of blood supply to the brain), dysphagia (difficulty swallowing), hemiplegia (decrease in mobility) affecting left side and hypertension (high blood pressure). The 6/6/25 minimum data set (MDS) assessment revealed the resident was moderately cognitive impaired with a brief interview of mental status (BIMS) score of nine out of 15. He was dependent on staff for dressing, toileting, personal hygiene and transfers. He required moderate staff assistance with eating. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment did not indicate Resident #30 used a brace/splint or had a contracture. -However, record review revealed the resident had a physician’s order for removal of splint (see record review below). B. Observations On 7/13/25 at 10:40 a.m. Resident #3 was lying in his bed. Resident #3 was not wearing a brace to his left hand. The brace was lying on a chair in the corner of Resident #3’s room. At 2:45 p.m. the resident was not wearing a brace to his left hand. On 7/14/25 at 10:35 a.m. Resident #3 was lying in his bed with no brace in place to his left hand. C. Resident interview Resident #3 was interviewed on 7/13/25 at 10:40 a.m. He said he had limited mobility on his left side of his body related to a stroke. Resident #3 said he usually wore a brace on his left hand but it was not on at the time of interview. Resident #3 said he needed to wear the brace to help prevent his hand from curling under into his palm and getting stuck in that position. Resident #3 said he did not know if he was to wear the brace during the day or night but that he should wear it every day. He said the staff usually helped him put it on whenever they get the time to put it on. D. Record review Resident #3’s skin care, revised 5/24/25, revealed the resident had the potential for alteration in skin integrity related to fragile skin. Interventions, initiated on 6/23/25, included removing the immobilizer/brace/splint every shift and as needed (if ordered okay to do so) and reviewing skin for any non-blanching, redness, skin alterations and implementing treatment as indicated. Review of July 2025 CPOs revealed the following physician’s orders: -Remove hand splint at bedtime every day, ordered 7/3/25. -The resident was to wear a wrist brace during the day Monday through Friday as tolerated. The brace was to be applied by occupational therapist/physical therapist and removed by care staff at bedtime, upon resident requests, bathing or hygiene. Skin check to be completed daily, ordered 7/15/25 (during the survey). -The resident was to wear a left wrist brace during the day, as tolerated, apply upon rising and remove at bedtime, at resident requests, bathing or hygiene tasks. Skin check to be completed every shift, ordered 7/16/25 (during the survey). -The facility failed to have physician’s orders in place for donning the wrist brace and monitoring skin under brace prior to the survey. The July 2025(7/1/25 to 7/15/25) treatment administration record (TAR) revealed documentation was completed for the hand splint to be removed at bedtime since order was initiated on 7/3/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However there was no order in place to don the splint to resident #3. Review of the occupational therapy (OT) notes (6/9/25 to 7/15/25) revealed: The 6/9/25 OT progress note documented Resident #30 was given initial instructions regarding donning/doffing assessed for new orthotic device and adjusted. The 6/19/25 OT note documented the splint was applied following manual treatment to reposition fingers and wrist. The note documented the resident had a contracture following a period without splint in addition to increase in pain. The 6/26/25 OT note documented instructions were provided to the resident in the wearing scheduling and the orthotic (splint) was assessed for fit and adjustments were made following manual treatment, heat and exercise for improved joint positioning in left upper extremity. The 7/1/25 OT note documented the splint was adjusted and training was completed with the resident. Resident #30 demonstrated self donning with minimal assistance. New splint measurements were obtained and training was completed with the family to facilitate order of new more supportive splint/brace to prevent and manage left upper extremity contracture. The 7/3/25 OT note documented the initial instructions were provided to the resident in donning and doffing splint. Initial instructions were provided to resident for wearing splint and scheduling. The note documented a new brace was assessed for fit and issued to the resident. The new brace was applied successfully after manual treatment and fingers placed into splint. -The facility failed to obtain a physician’s order indicating resident schedule for wearing brace and to identify who was responsible for donning splint. E. Staff interviews Licensed practical nurse (LPN) # 1 was interviewed on 7/15/25 at 2:18 p.m. She said Resident #3 used a brace to his left hand. LPN #1 reviewed Resident #3’s physician’s orders and was unable to find any physician's orders for donning brace or monitoring of resident skin in the electronic medical record (EMR). LPN #1 said there should be a physician’s order to don the brace. LPN #1 said staff needed to know who was donning the brace, when it should be placed and for how long. She said the staff needed to know if they needed to monitor the brace for anything in particular. LPN #1 said she did not know who was responsible for donning the brace to Resident #3’s left hand. LPN #1 said she reviewed Resident #3’s care plan and was only able to locate the use of the brace being mentioned in the skin integrity section of his care plan (see record review above). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on 7/16/25 at 1:26 p.m. He said if a resident required the use of brace/splint they should be wearing it to prevent a contracture and to improve or maintain range of motion. The DOR said there should be a physician’s order for placement of brace and skin monitoring. The DOR said staff should be trained to apply the brace and the nursing staff were to monitor the skin for breakdown. The DOR said it was the responsibility of the occupational therapist to train staff on use of brace. The DOR said Resident #3’s wrist brace was ordered after his admission to the facility and it was recommended he wear his wrist brace daily. The DOR said Resident #3 was missing physician's orders for the brace for application and monitoring but had orders in place now. The DOR said the occupational therapist had taken it upon himself to apply the brace to residents when in the facility. The DOR said the occupational therapist did not work weekends. -However, there was no monitoring of when the brace was applied by the occupational therapist (see record review above). The executive director (ED) was interviewed on 7/16/25 at 3:24 p.m. She said there should be physician's orders in place for the use of braces on a resident. The ED said if a brace was not worn the contracture could worsen and the resident could lose activities of daily living capabilities. III. Resident #33 A. Resident status Resident #33, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included encephalopathy (brain dysfunction), altered mental status, chronic kidney disease stage 3, dementia and left hand contracture. The 5/9/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of four out of 15. She required supervision while eating and was dependent on help or needed maximal assistance with activities of daily living (ADL). The assessment documented her functional limitation in range of motion was impaired on one side of her upper extremity (shoulder, elbow, wrist and hand). B. Observations On 7/13/25 at 12:30 p.m. Resident #33 was seated at a dining room table. The resident had a drink cup with a straw and no lid. A staff member asked her if she wanted to try something else for lunch. -The resident did not have a drink with a two handled cup for her drink. On 7/14/25 during a continuous observation, from 11:11 a.m. to 11:37 a.m., Resident #3 was seated in the common area with a bedside table in front of her. She had a drink in a clear cup with a straw and no lid. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:15 a.m. licensed practical nurse (LPN) #3 poured more soda into the resident's cup. Resident #33 attempted to pull her cup toward her to drink four times. The resident was able to use her bent pointer fingers slightly and pull the cup toward her with the mouthpiece of the cup, lean forward and drink from a straw. The resident was unable to grab the cup with her open hands and could only guide the cup with her two bent pointer fingers. -The resident did not have a two handled cup for her drink. On 7/15/25 at 2:03 p.m. Resident #33 was observed in her wheelchair in the common area. She had a drink in front of her with a straw and no lid. -The resident did not have a drink with a two handled cup for her drink. C. Record review The ADL care plan, revised 4/24/25, documented Resident #33 had an ADL self-care performance deficit related to her diagnoses of encephalopathy, altered mental status, dementia, history of falling, weakness, contracture of the left hand, chronic kidney disease and malnutrition. Pertinent interventions, revised 4/24/25, documented the resident needed set up assistance from one staff member to eat. The nutrition risk care plan, revised 5/9/25, documented the resident was at greater risk for nutritional decline related to her advanced age, inadequate oral intake and dementia status. Pertinent interventions, revised 8/23/24, recommended the resident to be in the dining room at an assisted feeding table and have two handled cups with meals per occupational therapy recommendations. -The resident’s comprehensive care plan did not include a care plan or intervention for the use of a carrot splint for the resident’s left hand contracture, nor did the care plan include the resident’s refusal to use the splint (see physician’s orders and interviews below). A review of the July 2025 CPO revealed the following physician’s orders related to Resident #33’s contractures: Please apply a left hand carrot splint as tolerated, to maintain skin integrity due to left hand contracture, ordered 8/20/24; and, Provide a two handled cup for liquids to improve resident independence and hydration with drinking, ordered 8/23/24. -However, the July 2025 (7/1/25 to 7/16/25) medication and treatment administration record (MAR/TAR) failed to include documentation to indicate Resident #15's splints had been applied. -A review of the 6/17/25 to 7/15/25 certified nurse aide (CNA) task documentation failed to reveal documentation indicating the resident's splints were being applied per the physician orders. D. Staff interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed on 7/15/25 at 10:15 a.m. LPN #3 said Resident #33 had a soft carrot shaped splint, and the splint was designed for the resident to hold in her hand. LPN #3 said the resident often refused the splint or pulled it out of her hand. LPN #3 said the resident’s splint use was easier to track if the order was on the MAR/TAR. LPN #3 said the resident could open her hand slightly and would either take the splint out or refuse to have it in her hand. LPN #3 said the resident could not open her hand enough that the splint could fall out of her hand. LPN #3 said she was unsure how often the resident was supposed to use the splint without its specified order. LPN #3 said ideally the resident's use of the splint was recorded in nursing in the MAR/TAR and tasks so the staff can record the task was completed. -However, the physician’s order did not specify parameters for use of the splint and the resident’s record did not document her use or refusals of the splint. CNA #2 was interviewed on 7/15/25 at 11:28 a.m. CNA #2 said she tried to keep the splint in the Resident #33’s hand all day but she did not force it. CNA #2 said she received direction from her nurse to use the splint and did not see the resident’s splint order as a CNA. CNA #2 said when the resident refused the splint, the resident would just keep her hand grip shut. CNA #2 said if the resident refused the splint she might mention it to the nurse or will try the splint again in a little bit. CNA #2 said the resident often refused the splint. CNA #2 said the resident did not refuse the splint all day but in the mornings she would not open that hand to grip the splint. CNA #2 said the resident used the splint better while in bed and while the resident slept. CNA #3 was interviewed on 7/16/25 at 10:18 a.m. CNA #3 said Resident #3 used a double handled sippy cup and she had a difficult time with a regular cup because of her hands. CNA #3 said she went to the kitchen to get a double handled cup for the resident if there was not one at the nurses’ station. CNA #3 said if the resident was given a small amount of something to drink the staff might hold the cup for her. LPN #4 was interviewed on 7/16/25 at 10:31 a.m. LPN #4 said she was aware the resident had a physician’s order for the double handled cup to be placed at meal times. LPN #4 said she never had difficulty getting a two handed cup for the resident. The registered dietitian (RD) was interviewed on 7/16/25 at 10:45 a.m. The RD said the kitchen staff put the adaptive equipment on the top of the meal cart sent to the units. The RD said a CNA would also provide the drink for the resident in the dining room, however the staff might not see the resident’s meal ticket that included the double handled cup prior to getting the resident their drink. The director of rehabilitation (DOR) was interviewed on 7/16/25 at 1:45 p.m. The DOR said Resident #33 struggled with grasping things and was previously doing well with the two handled mug to improve intake. He said the resident liked to keep her hand in the clenched posture and there was a time she clenched so much that was how the carrot came into place. The DOR said the carrot splint was also used to prevent skin breakdown and to maintain skin integrity. He said it would be up to the nursing team to include the splint on the resident’s care plan and if the resident used and was offered the splint or not. He said the physician’s order included ‘as tolerated’ sometimes the resident would allow it or not. He said there should be some type of tracking for use of the splint and the splint was recommended by the previous occupational therapist. He said consistent use of the carrot splint would help delay worsening of the resident’s contracture. (continued on next page)

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Liberty Heights	12205 Gunstock Dr Colorado Springs, CO 80921

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ED was interviewed on 7/16/25 at 2:20 p.m. The ED said the nurse was responsible for updating the care plan. The ED said the best practice was to monitor to see if care planned interventions were effective. E. Facility follow-up A review of Resident #33’s July 2025 CPO revealed an updated physician order: Please apply a left hand carrot splint as she will allow every morning, remove at bedtime and inspect the integrity of the hand. This is to maintain skin integrity due to a left hand contracture, ordered 7/15/25 (during the survey).

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure accurate assessments and informed risks were in place for three (#18, #3 and #7) of five residents with bed rails out of 27 sample residents. Specifically, the facility failed to:-Ensure Resident #18, Resident #3 and Resident #7 were assessed for the use of bed rails and less restrictive alternatives were attempted prior to use; and,-Ensure the risks of bed rails were explained to and informed consent for use was obtained from Resident #18, Resident #3 and Resident #7.Findings include: I. Facility policy and procedure The Use of an Enabler policy, reviewed 5/21/25, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It read in pertinent part, “The community will ensure accurate and timely completion of an enabler review in the resident’s medical record and evaluation for the appropriate and safe use of an enabler device. The community is to have a protocol in place to look at the device in use and at the effect the device has on the resident and their ability. Enabler devices are pieces of equipment or technology that assist a person with a disability or impairment to improve their function or independence. “Each resident shall have an enabler review in their medical record completed when an enabler is placed on admission and when triggered by the admission review. This review will automatically be triggered to be completed at a minimum quarterly and as needed (PRN). If the device is placed after the initial admission review then the community staff will be required to manually start this review to be completed. The review shall include: identification of specific symptoms and diagnosis that warrants the use of an enabler, the ruling out of other possible interventions, identify the least restrictive intervention, and obtain a physician order for the use of the device. “The interdisciplinary team (IDT) shall evaluate all factors leading to the consideration of the device, investigate that all alternative measures have been exhausted and found to be unsuccessful, weigh the risk and benefits of the enabler to be used, and determine if the resident’s safety is compromised by not using the device. “A comprehensive plan of care shall be developed that included input from the resident/personal representative, was based on informed choice, addressed safety issues as a result of the enabler being used, specified the type of enabler to be used and was reviewed and evaluated for continued use as necessary, at a minimum quarterly. The determination must include whether the resident is capable of independently removing the enabler and whether the device restricts the residents freedom of movement. The resident’s care plan should be updated to reflect any changes in the community’s interventions. Interventions must be individualized to the resident’s specific needs.” II. Manufacturing instructions (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The manufacturing instructions for the facility’s assist bars were provided by the ED on 7/15/25 at 11:42 a.m. It read in pertinent part, “The purpose of the assist bar was to provide the resident a grab bar in which they could assist themselves from a sitting position to standing while exiting a long-term care bed. Clinical staff must decide whether a resident would benefit from the use of the aid. Vulnerable patient needs should be considered before using the product. The manual must be given to the user of the product before using the product. “Conditions such as restlessness, mental deterioration and dementia or seizure disorders (uncontrolled body movement), sleeping problems, and incontinence can significantly impact a patient's risk of entrapment. Monitor patients with these conditions frequently. To avoid patient entrapment from the use of an assist par in the up position, only use the assist position while attending to the resident and return the assist bar to the storage down position when unattended. III. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (lack of blood supply to the brain), respiratory failure, hepatic failure (liver failure), vascular dementia (brain damage due to multiple strokes) and type 2 diabetes mellitus. The 5/15/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. She needed set up assistance for meals and was dependent on assistance for all other activities of daily living (ADL). The MDS assessment documented bed rails were not used. -However, observations and interviews revealed bed rails were being used (see below). B. Observations On 7/13/25 at 10:39 a.m. a rounded assist bar was on each side at the head the resident's bed. On 7/14/25 at 12:19 p.m. Resident #18 was in her bed and her meal tray was delivered to her room. The meal tray was set up on the residents bedside table and placed in front of her while in bed. An assist bar was on each side of the resident’s bed. On 7/14/25 at 12:37 p.m. and 12:50 p.m. Resident #18 was leaning her head on the right assist bar and holding the bar with both hands. On 7/15/25 at 12:28 p.m., 12:50 p.m., 1:04 p.m. and 1:21 p.m. Resident #18 was leaning her head on the right assist bar and holding the assist bar with both hands. C. Record review Resident #18’s ADL care plan, revised 10/28/24, documented the resident had an ADL self-care (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performance deficit related to diagnoses of cerebral infarction, history of falling, venous insufficiency (improper functioning of vein valves in the leg) and vascular dementia. Pertinent interventions, revised 10/28/24, documented the resident required assistance by one staff member to turn and reposition in bed and needed the assistance of one person for transferring. Resident #18’s fall care plan, initiated 11/22/24, documented the resident was at risk for falls due to gait and balance problems, being unaware of safety needs, history of falls, and seizures. Pertinent interventions included the resident having signs placed in her room to remind her to ask for assistance with all transfers (initiated 11/22/24) and a defined perimeter mattress was delivered by hospice (initiated 4/14/25). -Resident #18 did not have a care plan or care planned intervention for the use of an assist bar. A 7/14/25 (completed during the survey) enabler review (assist bar) documented Resident #18 required assistance to move in bed, assistance to transfer, and assistance to stand. The assessment documented she had behavior issues impairing safety and judgement, had a recent history of falls and other assistive devices were unsuccessful. -The assessment did not document other alternatives or assistive devices attempted prior to the assist bar. The 7/14/25 enabler review documented it was determined to initiate a grab bar due to the resident’s decreased strength and endurance, to promote a higher level of physical and mental functioning and the benefits outweighed the risks at the time of the assessment. -The assessment did not document the risks of using the grab bar, or if the risks were explained to the resident or the resident’s representative, and if informed consent was obtained. D. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 7/15/25 at 10:15 a.m. LPN #3 said the nursing staff checked the assist bars to ensure the bars were used for mobility and for optimal level of functioning while the residents were in bed. LPN #3 said upon admission the staff talked to the residents and sometimes the residents requested to have an assist bar if it was needed to move around in bed or the staff noticed the resident might benefit from an assist bar and try to promote more independence. LPN #3 said the staff would then notify the maintenance department and get the bar attached and the facility completed an enabler assessment. LPN #3 said the enabler review was in the assessments tab in the resident’s record. LPN #3 said the initial nursing assessment documented if the resident asked for an assist bar and then staff can initiate an enabler assessment to be completed. LPN #3 said the resident should be assessed prior to getting the bar for safety so the resident did not hurt themselves. LPN #3 said she was not sure of the risk or injury associated with the assist bar. Certified nurse aide (CNA) #2 was interviewed on 7/15/25 at 11:30 a.m. CNA #2 said the enabler bar had been on Resident #18’s bed for a few months. CNA #2 said the resident used the enabler bar independently. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of rehabilitation (DOR) was interviewed on 7/16/25 at 1:25 p.m. The DOR said as long as a resident needed assistance and did not have precautions to use the bar, the facility would use the bar to maximize independence. He said the bar was used to regain strength, assist the resident to sit up and then as the resident improved the facility tried to minimize use of the bar. The DOR said his team notified him when a resident would use an assist bar and the installation was added to the maintenance list for installation. The DOR said alternatives offered to the bed rail would depend on the goal of the resident. The director of rehabilitation said he was not sure who obtained informed consent for the use of the assist bar. The ED was interviewed on 7/16/25 at 2:20 p.m. The ED said Resident #18 did not have an enabler assessment completed prior to installation because the need for the assessment was not triggered by the initial nursing assessment. The ED said informed consent was not obtained for the assist bars because the bars were not considered restraints. IV. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the July 2025 CPOs diagnoses included cerebral infarction , dysphagia (difficulty swallowing), hemiplegia (decrease in mobility) affecting left side and hypertension (high blood pressure). The 6/6/25 MDS assessment revealed the resident was moderately cognitive impaired with a (BIMS score of nine out of 15. He was dependent on staff for dressing, toileting, personal hygiene and transfers. He required moderate staff assistance with eating. The MDS assessment documented bed rails were not used. -However ,observations and interviews revealed bed rails were being used (see below). B. Observations On 7/13/25 at 10:40 a.m. Resident #3 was lying in bed with bilateral bed canes attached to the bed near the head of the bed. On 7/14/25 at 10:35 a.m. Resident #3 was lying in bed with bilateral bed rails. C. Resident interview Resident #3 was interviewed on 7/13/25 at 10:40 a.m. He said he has had assist bars on his bed for a while now and that he used them to aid in rolling in bed. Resident #3 said he was unable to recall if staff had talked to him about the risk of using an assist bar. D. Record review (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3’s ADL care plan, revised 6/18/25, documented the resident had an ADL self-care performance deficit related to cerebral infarction, dysphagia, weakness left side, atrial fibrillation (abnormal heart function), insomnia (impaired sleep), history of falling and generalized pain. Pertinent interventions documented resident required one to two staff members to turn and reposition in bed. Resident #3 used enabler bars to maximize independence with turning and repositioning. Review of the July 2025 CPO revealed the following physician’s Enabler bars to bed to assist residents with turning and bed mobility, ordered 7/15/25 (during the survey). -The facility failed to have physician’s order in place prior to enabler bars being installed on Resident #3’s bed. The 7/14/25 (during the survey) enabler review documented Resident #3 required assistance to move in bed, assistance to transfer, and assistance to stand. It documented other assistive devices that were not unsuccessful. -The review did not identify alternative assistive devices attempted prior to the enabler bars. The review determined enabler bars to both sides of the bed were needed for mobility in bed and getting out of bed related to left sided weakness from cerebral infarction to promote higher level of physical and mental functioning. -The review did not document the risk of using the enabler bars. -Review of Resident #3’s electronic medical record (EMR) did not reveal documentation indicated consent was obtained for use of the grab bars/enabler bars to the resident bed. V. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO diagnoses included dementia (memory issues), hypertension (high blood pressure) and heart failure. The 3/31/25 MDS assessment revealed the resident was severely cognitive impaired with a BIMS score of two out of 15. She was dependent on staff for toileting, personal hygiene and dressing. She required maximal staff assistance with bed mobility, transfers. She required set up assistance with eating. The MDS assessment documented bed rails were not used -However, observations and interviews revealed bed rails were in use (see below). B. Observations (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/13/25 at 1:18 p.m. there were bilateral bed rails towards the head of the bed and were rounded on Resident #7’s bed. Both of the bars were wobbly. On the left side of the bed, on the opposite side of the window, there was approximately a two to three inch gap between the bar and the mattress. On 7/14/25 at 3:13 p.m. there were bilateral bed rails on Resident #7’s bed. On 7/15/25 at 2:07 p.m. LPN #1 observed Resident #7 bed rails and said the grab bars were wobbly and that there was a gap between the bar and the mattress. C. Record review Resident #7’s ADL care plan, revised 7/14/25 (during the survey), revealed document the resident Resident #7 had an ADL self-care performance deficit related to weakness, dementia, and pain. Pertinent interventions, included Resident #7 required moderate to maximum assistance from one to two staff to assist to turn and reposition in bed and ensuring enabler bars on the resident bed to assist residents with turning and bed mobility (initiated 7/14/25). Review of the July 2025 CPO revealed the following physician’s order: Enabler bars to bed to assist residents with turning and bed mobility, ordered 7/15/25 (during the survey). -The facility failed to have physician’s order in place prior to enabler bars being installed on Resident #7’s bed. -The facility failed to ensure the use of the enabler bars were documented on the resident’s care plan. The 7/14/25 (during the survey) enabler review documented the resident required assistance to move in bed, transfer, stand and ambulate. She had behavior issues impairing safety and judgment and a history of falls. It documented other assistive devices that were unsuccessful. -The review did not document what alternatives assistive devices were attempted prior. The enabler review documented it was determined to initiate grab bars to both sides of the bed to treat decreased safety awareness. To promote bed mobility, getting out of bed, higher level of physical and mental functioning. -The enabler review did not document risk of using the enabler bar, or if the risk were explained to Resident #7 or responsible party for consent to use the enabler bars. Review of Resident #7’s EMR did not reveal documentation indicated consent was obtained for use of the grab bars/enabler bars to the resident bed. VI. Staff interviews (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 7/15/25 at 2:07 p.m. She said the enabler bars on beds were in place to increase resident mobility in bed. LPN #1 said a resident could be assessed on admission by nursing staff or later by the therapy department. LPN #1 said staff needed to complete an enabler bar assessment prior to the installation of the bars. LPN #1 said it was the responsibility of the maintenance department to install them and do periodic safety checks. LPN #1 was not sure how often the grab bars were assessed for safety. LPN # 1 said if she was assisting a resident and noted an issue with the grab bars she would notify maintenance to assess them as soon as possible. LPN #1 said she was not aware the gap between the mattress and the enabler bar was a safety concern. LPN #1 said the bars fit differently on beds depending on what type of mattress was being used by the resident. LPN #1 said she was unaware consent was to be obtained from the resident or responsible party for the use of enabler bars on a resident’s bed. The DOR was interviewed on 7/16/25 at 1:26 p.m. He said the facility used enabler bars to increase resident mobility in bed to maximize the residents independence, regain strength and then remove them from resident use once they are no longer needed. The DOR was unaware who was responsible for obtaining a consent for the use of enabler bars. The DOR said Resident #3 initially came to the facility and was assessed by the therapy department on 5/23/25 and it was determined then he would benefit from the use of enabler bars. The DOR said Resident #3 was still receiving therapy services and still required the use of enabler bars at this time. The DOR said Resident #7 was no longer on therapy case load, but had been previously. The DOR said Resident #7 required enabler bars and was assessed by therapy for them 7/25/24. The DOR said Resident #7’s goal was to return to assisted living at that time which made her a good candidate for use of the enabler bars to increase independence.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#18) residents of six residents was free from significant medication errors out of 27 sample residents.Specifically, the facility failed to ensure Resident #18 was administered Keppra oral solution (for seizure prevention) per physician's orders. Findings include:I. Professional referenceAccording to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment.Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:-The right medication;-The right dose;-The right patient;-The right route;-The right time;-The right documentation; and,-The right indication.II. Facility policy and procedureThe Medication Administration policy, reviewed 2/23/24, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It read in pertinent part, Medications shall be administered in a safe and timely manner and as prescribed by a physician or other authorized practitioner. Medications shall be administered in accordance with the physician/authorized practitioner orders, including any required time frames. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate in the medication administration record the appropriate/related corresponding code and also complete a progress note in the resident record. If critical medication is not given, such as Coumadin (blood thinner), Digoxin (blood pressure medication), Lasix (medication used to treat water retention), the licensed nurse will be responsible for informing the physician of such. Exception to this will be that the defined parameters have been established by the physician for holding the medication ordered. The licensed nurse will be responsible for informing the physician of related (three day) non-critical medication refusal by the resident.III. Resident #18A. Resident statusResident #18, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician's orders (CPO), diagnoses included cerebrovascular disease (conditions affecting blood flow to the brain), history of falling, history of transient ischemic attack (TIA - temporary disruption of blood flow to the brain), vascular dementia, weakness, seizures and depression.The 5/6/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. She was dependent or needed maximal assistance with activities of daily living (ADL) and supervision with eating.The assessment documented the resident was prescribed an anticonvulsant. B. Record reviewThe seizure disorder care plan, initiated 10/25/24, documented she had a seizure disorder related to history of a stroke. Pertinent interventions, initiated 10/25/24, documented to give seizure medication as ordered by the doctor; and, monitor and document the side effects and effectiveness. A review of Resident #18's July 2025 CPO revealed the resident had physician's orders for the following medication:Keppra oral solution 100 milligrams/milliliter (mg/mL). Give 5 ml by mouth two times a day for seizure prevention per hospice, ordered 1/15/25.Review of Resident #18's February 2025 (2/1/25 to 2/28/25) and March 2025 (3/1/25 to 3/31/25) medication administration record (MAR) revealed the resident did not receive the Keppra oral solution as ordered on 2/28/25 and 3/1/25.A 2/28/25 medication administration note documented at 11:06 p.m. revealed Resident #18's Keppra oral solution was not administered and the medication was not available.A 3/2/25 medication administration note documented at 12:43 a.m. revealed Resident #18's Keppra oral solution was not administered (on 3/1/25 in the evening) and the medication was not available.-There were no progress notes documented to indicate the pharmacy, hospice or the physician had been contacted or notified that Resident #18's Keppra oral solution medication was not available and had not been administered to the resident on 2/28/25 and 3/1/25. IV. Staff interviewsLicensed practical nurse (LPN) #3 was interviewed on 7/15/25 at 10:15 a.m. LPN #3 said Resident #18's medications were provided by hospice, her family and the pharmacy. LPN #3 said the Keppra solution was provided by hospice. LPN #3 said the facility should notify hospice if they needed a medication refilled. LPN #3 said there should have been a phone call to notify the physician the medication was not available. LPN #3 said the physician would give a recommendation and that recommendation would be documented. LPN #3 said she would document in the resident's record if she spoke with a person, what that person said and if they gave her an order. LPN #3 said the facility notified the resident's physician regardless

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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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#6 and #2) of two residents received a sufficient amount of drinks to maintain hydration out of 27 sample residents.Specifically, the facility failed to ensure Resident #6 and Resident #2 were offered and provided hydration.Findings include:I. Facility policy and procedureThe Management of Dehydration policy and procedure, reviewed 4/19/24, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It revealed, in pertinent part Residents will receive adequate fluids to prevent dehydration. Fresh water should be available at the resident's bedside 24 hours a day, unless there is an order for fluid restrictions. Ensure adaptive devices needed, such as a sippy cup, are available. Staff should offer residents fluids with each interaction/care task performed.II. Resident #6A. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), the diagnoses included Alzheimer's disease, protein-calorie malnutrition and dementia without behavioral disturbance.The 6/5/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. She was dependent upon staff assistance with transfers, bed mobility, oral hygiene, toileting, bathing, dressing and personal hygiene. B. ObservationsDuring a continuous observation on 7/13/25, beginning at 9:45 a.m. and ended at 3:45 p.m., Resident #6 was sitting in the common area on the A unit in front of the television. The television volume was not turned on and Resident #6 was observed with her head down and sleeping. A water pitcher was not present.-At 11:15 a.m. Resident #6 was assisted from the common area on the unit and taken to the dining room by an unidentified staff member. Resident #6 was served cranberry juice and hot chocolate in eight ounce (oz) cups. She struggled to drink the beverages by herself and did not receive any assistance from staff members. She struggled to grip her hand to get the liquid to her lips. Resident #6 consumed four oz of cranberry juice and four oz of hot chocolate during lunch. -At 1:07 p.m. Resident #6 was assisted from the dining room by an unidentified staff member and was seated in front of the television. She was not provided nor offered a water pitcher.-At 3:00 p.m. Resident #6 remained sitting in front of the television in the common area. She had not been provided or offered any hydration since lunch.During a continuous observation on 7/14/25 beginning at 8:30 a.m. and ended at 3:00 p.m. Resident #6 was observed in the dining room for breakfast.-At 9:00 a.m. Resident #6 was assisted from the dining room to the common area by an unidentified staff member. She was seated in front of the television with the sound not turned on. She was not provided with or offered a water pitcher.-At 10:07 a.m. the nurse provided a nutritional supplement in a cup with a straw. The resident consumed 100 percent (%) the nutritional supplement.-At 11:09 a.m. the nurse filled a plastic four oz cup halfway with water from the medication cart and asked Resident #6 if she wanted a drink. She shook her head yes and proceeded to take multiple drinks through the straw. She consumed the entire half cup, 2 oz. The nurse did not offer or provide a water pitcher for Resident #6.-At 11:55 a.m. certified nurse aide (CNA) #1 assisted Resident #6 to the dining room. She was served an eight oz cup of cranberry juice that was only filled halfway and an eight oz cup of hot chocolate, filled halfway.Resident #6 picked up the cup of hot chocolate and brought it toward her face very slowly. She stuck her tongue out trying to lick the liquid until she was able to bring the cup to her mouth. She was unable to turn the cup to get access to the liquid. She placed it back down on the table and used a spoon to stir the hot chocolate.Resident #6 then picked up the eight oz cup of cranberry juice that was filled halfway. She was able to bring the cup to her mouth and take a small sip and then put it down on the table. She did this four more times in succession, trying to get more of the beverage. She was only able to take small sips at a time.-At 12:34 p.m. Resident #6 attempted to take a drink from the coffee cup. She had difficulty bringing it to her face. She moved her lips like she was drinking; however the cup was not close to her face. After 45 seconds, she was able to put her mouth to the cup, took a sip and set it back down on the table.Resident #6 attempted to drink both the cranberry juice and the hot chocolate multiple times throughout the meal with the same result. By the end of lunch, there was a quarter cup of cranberry juice and hot chocolate left in the cups. She consumed approximately two oz of cranberry juice and two oz of hot chocolate. Staff did not provide assistance to the resident with drinking her beverages.-At 1:19 p.m. Resident #6 was taken from the dining room to the common area on the unit. Upon reaching the unit, the resident was placed in the common area in front of the television. She was not provided a water pitcher.-At 2:12 p.m. an unidentified activity staff member approached Resident #6 and asked her if she wanted to attend the group

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, record review and interviews, the facility failed to store, prepare and distribute food in a sanitary manner in the main kitchen.Specifically, the facility failed to ensure employees performed hand hygiene appropriately during meal service and avoided cross contamination. Findings include:I. Professional referenceThe Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)II. Facility policy and procedureThe Hand Hygiene versus Alcohol based Hand Rub policy, reviewed 10/23/24, was provided by the executive director (ED) on 7/17/25 at 2:18 p.m. It read in pertinent part, Staff should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to residents including before resident contact; after contact with blood, body fluids, or contaminated surfaces (even if gloves are worn); before invasive procedures; and after removing gloves (wearing gloves does not replace hand hygiene). Indications for hand washing: when hands are visibly dirty, contaminated, or soiled, wash with soap and water. Duration of the entire procedure: 20 to 30 seconds, or sing happy birthday twice. Specific indications for hand washing: after known or suspected exposure to spores such as c-diff (clostridium-difficile - bacteria causing intestinal infection), before eating, preparing, or serving food.III. ObservationsDuring a continuous observation of the evening meal on 7/15/25, beginning at 4:25 p.m. and ending at 5:40 p.m., the following observations were made: At 4:47 p.m. cook (CK) #1, while wearing gloves, cut a piece of cooked chicken on a cutting board, put the cut chicken in the food processor and ground the chicken. CK #1 discarded and removed his gloves, without performing hand hygiene, donned (put on) new gloves and put the ground chicken on a plate. CK #1 took the food processor to the dish room, placed it on a dish rack, pushed the rack into the dish machine and then closed the dish machine door. CK #1 returned to the line and donned a new pair of gloves. CK #1 picked up the resident meal tickets and set the tickets back on the counter. Wearing the same gloves, CK #1 touched a ready to eat quesadilla held in a steam table pan. CK #1 removed and discarded the gloves.-CK #1 did not wash his hands after removing gloves donning new gloves, and touched a ready to eat food item with contaminated gloves.CK #1 donned on a new pair of gloves and picked up the meal tickets and set the mail tickets on the cutting board. CK #1 removed and discarded his gloves and donned new gloves. Wearing the same gloves, CK #1 touched ready to eat French fries held in a steam table pan. CK #1 removed and discarded the gloves. -CK #1 did not wash his hands after removing gloves donning new gloves, and touched a ready to eat food item with contaminated gloves.CK #1 walked to the dish room, opened the dish machine door and removed the food processor from the dish machine and returned to the front of the kitchen. CK #1 donned a clean glove on his left hand and removed the meal tickets that previously placed on the cutting board and placed a chicken breast on the same cutting board. CK #1 cut the chicken and while holding the chicken with his left hand placed the chicken in the food processor. CK #1 wiped the blade of the knife on his left glove. CK #1 removed and discarded the glove on his left hand and assembled a resident's meal plate. CK #1 took the food processor to the dish room, sprayed the food processor and placed it in the dish machine. CK #1 removed and discarded his glove, returned to the front of the kitchen and donned a pair of new gloves. CK #1 used tongs to place a chicken breast on the cutting board. CK #1 cut the chicken, holding the chicken with his left gloved hand and cutting the chicken with the knife in his right hand. CK #1 removed and discarded his gloves.At 4:56 p.m. CK #1 used his sanitizer towel to wipe off his cutting board. CK #1 donned a glove on his left hand. CK #1 used a utensil to place vegetables on the cutting board and cut the vegetables on the cutting board, touching the vegetable with his left hand and holding the knife in his right hand.-CK #1 did not wash his hands after removing gloves donning new gloves, and touched a ready to eat food item with contaminated gloves.CK #1 removed and discarded his glove and donned a new glove on his left hand. CK #1 picked up the meal tickets with his left hand. CK #1 used tongs to place a chicken and on the cutting board, cut the chicken on the

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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. Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infections.Specifically, the facility failed to:-Ensure resident rooms were cleaned in hygienic manner;-Ensure housekeeping staff performed hand hygiene appropriately during room cleaning;-Ensure linen and resident clothing were transported in hygienic manner;-Ensure dirty linen was transported appropriately; and, Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing direct care to residents who should be on enhanced barrier precautions (EBP).Findings include: I. Housekeeping failures A. Professional reference The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 7/22/25 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. B. Facility policy and procedure The Housekeeping and Laundry- Resident Room Cleaning policy, revised 5/14/2020, was received from the executive director (ED) on 7/17/25 at 2:18 p.m. It revealed in pertinent part, “Resident rooms, including bathrooms, are cleaned and disinfected on a regularly scheduled basis, and per chemical manufacturer instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	“Skilled nursing, cleaning frequency daily. Living areas disinfect all high touch surfaces, including appliances and bed frames as appropriate. Dust/wipe down personal belongings, windows and window coverings. Change bedding and towels, mop floor using neutral disinfectant or vacuum carpet where appropriate. Bathroom clean and disinfect vanity, countertop, sink bathtub/shower and toilet. Mop floor with neutral disinfectant. Clean the mirror and other surfaces.” The Hand Hygiene versus Alcohol Based hand run policy and procedure, revised 12/23/24, was received from the ED on 7/17/25 at 2:18 p.m. It revealed in pertinent part, “Staff should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to residents including before resident contact; after contact with blood, body fluids, or contaminated surfaces (even if gloves are worn); before invasive procedures; and after removing gloves (wearing gloves does not replace hand hygiene). “Alcohol-based hand rubs are the preferred routine method of hand hygiene if hands are not visibly soiled. Guidelines developed by the Centers for Disease Control and Prevention (CDC) and infection-control organizations recommend that healthcare workers use an alcohol-based hand rub (a gel, rinse, or foam) with at least 60% alcohol to routinely clean their hands between resident contact, as long as hands are not visibly contaminated. Use an alcohol-based hand-rub: before having direct contact with residents; after having direct contact with a resident’s skin; before performing an aseptic task or handling invasive medical devices; after having contact with wounds or broken skin; before moving from work on a “soiled” body site to a “clean” body site on the same resident; after touching equipment or furniture near the resident; after handling any soiled clothing or linens (if clothing/linens were contaminated with blood, use soap and water to wash hands); and after removing gloves.” C. Observations During a continuous observation on 7/15/25, beginning at 10:04 a.m. and ending at 10:33 a.m. the following was observed: At 10:04 a.m. housekeeper (HK) #1 was cleaning resident room C-12, a single occupancy room. HK #1 applied gloves without performing hand hygiene, reached into a bucket that was on her cleaning cart that contained multiple rags in a cleaning solution called DNC-15. HK #1 collected one rag, rang it out and entered the resident room and began cleaning the sink by cleaning the rim then the bowl and back to wiping the rim then the sink handles and wiping the bowl again. HK #1 collected trash from the trash can, placed a new bag and returned to wiping the sink bowl and the rim of the sink three more times. -HK#1 failed to perform hand hygiene prior to applying gloves and she failed to clean the sink in hygienic manner from cleanest to dirtiest. Without changing gloves or performing hand hygiene, HK #1 then entered the resident’s bathroom. She touched the resident’s wheelchair and the light switch with solid gloves. HK #1 began wiping the toilet seat, then the rim of the toilet and then stopped to tie the trash bag in the bathroom. HK #1 returned to her cleaning cart with trash that she had collected from the resident’s room. While she was at the cart she grabbed the broom. Without changing gloves or performing hand hygiene, HK #1 swept the resident’s room from the window towards the main doorway moving the resident’s fall mat. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	HK#1 returned to her cleaning cart with debris from sweeping. HK #1 then removed her gloves and applied new gloves, without performing hand hygiene. -HK #1 failed to perform hand hygiene after removing dirty gloves and failed to change her gloves after cleaning the toilet. Without performing hand hygiene, HK #1 grabbed a new rag from the bucket, rang it out and entered the resident’s room. She wiped down the bedside table around the resident’s personal items and wiped the heater and window seal. HK #1 returned to her cart, without changing gloves, she grabbed a mop pad out of a bucket that had multiple clean mop pads in a cleaning solution. HK #1 rung out the mop pad from the bucket and mopped the resident’s room starting by the window moving towards the entrance of the room, mopped the bathroom and finished mopping the room. -HK #1 failed to perform hand hygiene prior to putting her hands in the mop pad bucket and she mopped the room and bathroom with one mop pad. HK #1 returned to her cleaning cart after mopping, removed her gloves and indicated she had completed cleaning the resident room at 10:16 a.m. -HK #1 failed to clean high touch areas in the resident’s room like call light, bed control, light switches and the handles to dresser or doors. At 10:18 a.m., without performing hand hygiene after cleaning room C-12, HK #1 began cleaning a single occupancy resident room, C-9. Without performing hand hygiene, HK #1 applied gloves and collected one rag from the bucket of rags on her cleaning cart prior to entering the resident’s room. -HK #1 failed to perform hand hygiene between resident rooms or prior to applying new gloves. HK #1 started wiping down the sink rim, then the bowl took water and splashed it onto the mirror. HK #1 then took a paper towel and wiped the mirror down. HK #1 went to the bathroom and began wiping down the toilet riser seat and rise handles then rim of toiler. -HK #1 failed to use a separate rag for the bathroom and failed to clean the toilet and riser from the cleanest area to the dirtiest areas. Without changing gloves or performing hand hygiene, HK #1 returned to her cleaning cart and collected a broom and dust pan. HK #1 swept the residents’ room from the window towards the main door stopping short at bathroom swept bathroom bringing debris from bathroom into the room and swept into debris collected from the rest of room. HK #1 collected debris from the room and discarded it into the trash compartment on the cleaning cart. -HK #1 failed to change her gloves and perform hand hygiene after cleaning the toilet. Without changing gloves or performing hand hygiene, HK #1 reached into her mop pad bucket to retrieve a mop pad and rung it out, then began mopping the resident room from the window to the bathroom entrance then mopped the bathroom and entry way of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-HK #1 failed to change her soiled gloves prior to collecting a clean mopping pad from the bucket and she mopped the entire room and bathroom floor using the same mop pad. HK #1 said she completed cleaning the resident's room, closing the resident room door with soiled gloves. HK #1 removed her gloves while the housekeeping director (HKD) placed a wet floor sign outside of the resident room. -HK #1 failed to clean high touch surfaces in the resident room. D. Staff interviews HK #1 was interviewed on 7/15/25 at 10:27 a.m. She said she recently started her position a few months ago. She said upon hire another HK showed her the housekeeping process. She said the other HK showed her to wipe the sink, toilet, sweep and mop the floor. HK #1 said she should use at least two rags to clean a resident’s room, one for their room and one for the bathroom. HK #1 said one mop pad was to be used in a private room. HK #1 said high touch areas in the resident’s room were the sink, bedside tables, toilet and door handles and the high touch areas should be cleaned daily to prevent spread of infection and germs. HK #1 said she was to complete hand hygiene prior to entering a resident’s rooms and was not aware she needed to perform hand hygiene with each glove change. HK #1 said she was not aware that she placed her soiled gloves into the mop bucket when collecting a mop pad. The housekeeping director (HKD) was interviewed on 7/16/25 at 11:42 a.m. She said the housekeepers were trained upon hire to follow a step by step of room cleaning. She said these steps were kept in a binder in the housekeeping cart for them to reference. The HKD said the staff should perform hand hygiene and apply new gloves prior to entering a resident’s room. The HKD said the housekeeper should enter the room and begin cleaning from the furthest point in the room from the doorway, clean from top to bottom or from the cleanest area to the dirtiest area. The HKD said it was important to clean from the cleanest area to dirtiest to prevent moving contamination from the dirtiest area to a cleaner area. The HKD said high touch areas in a resident’s room included the lights, blinds, heater, night stands, phones, remotes, bed side tables, sink, counters, hand rails, toilet floor, light switches, handles/knobs and call light. The HSD said high touch areas should be cleaned daily to prevent the spread of infection. The HKD said provided HK #1 education regarding proper cleaning techniques. The minimum data set coordinator (MDSC), who was covering for the infection preventionist (IP) at time of survey, was interviewed on 7/16/25 at 2:12 p.m. The MDSC said housekeeping staff should perform hand hygiene upon entering a resident’s room, during glove changes and on completion of cleaning resident rooms to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The MDSC said high touch areas in resident rooms were the call light, door knobs, light switches and bed side tables and these areas should be cleaned daily to prevent spread of infection. The MDSC said the housekeeper should clean resident rooms from the cleanest area to dirtiest to prevent contaminating a cleaner area. II. Linen and clothing transportation A. Professional reference The Guidelines for Environmental Infection Control in Health Care Facilities: Laundry and Bedding, (revised 1/8/24) was retrieved on 7/23/25 from https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html#cdc_generic_section_3-3-collecting-transporting-and-sorting-cotaminated-textiles-and-fabrics, It revealed in pertinent part, “Collecting, Transporting, and Sorting Contaminated Textiles and Fabrics: The laundry process starts with the removal of used or contaminated textiles, fabrics, and/or clothing from the areas where such contamination occurred, including but not limited to patients' rooms, surgical/operating areas, and laboratories. Handling contaminated laundry with a minimum of agitation can help prevent the generation of potentially contaminated lint aerosols in patient-care areas. “Contaminated textiles and fabrics are placed into bags or other appropriate containment in this location; these bags are then securely tied or otherwise closed to prevent leakage. Single bags of sufficient tensile strength are adequate for containing laundry, but leak-resistant containment is needed if the laundry is wet and capable of soaking through a cloth bag. Bags containing contaminated laundry must be clearly identified with labels, color-coding, or other methods so that health-care workers handle these items safely, regardless of whether the laundry is transported within the facility or destined for transport to an off-site laundry service. “Contaminated textiles and fabrics in bags can be transported by cart or chute. Loose, contaminated pieces of laundry should not be tossed into chutes, and laundry bags should be closed or otherwise secured to prevent the contents from falling out into the chute. Health-care facilities should determine the point in the laundry process at which textiles and fabrics should be sorted.” B. Facility policy and procedure The Laundry and Linen policy and procedure, revised 4/29/2020, was received from the ED on 7/17/25 at 2:18 p.m. it revealed in pertinent part, “The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. “Bagging and Handling Soiled Linen: All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. Do not sort or pre-rinse soiled linens in resident or resident-care areas. Place any linen saturated with blood or body fluids into a leak-resistant bag before placing it into the hamper. Handle soiled linen as little as possible to prevent agitation. Hold laundry out away from your body. Do not shake dirty laundry. If laundry chutes are used, only closed and leak-resistant bags will be put into the chute. Do not place loose items in the laundry chute. Clean and disinfect clothes hampers. (continued on next page)

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	065305	A. Building B. Wing	07/16/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	“Sorting Soiled Linen: Employees sorting or washing linen must wear a gown and gloves. A mask may be worn if aerosolization is expected. Use heavy-duty rubber gloves for sorting laundry. Always wash hands after completing the task and removing gloves. “Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. “Remove barrier attire when leaving the soiled linen area.” C. Observations On 7/13/25 at 12:19 p.m. an unidentified staff member was transporting personal clothing items without a cover over the clothing in the A-pod. On 7/13/25 at 1:25 p.m. an unidentified laundry staff member was transporting linen to the A-pod via a three level cart without covering the linen. On 7/15/25 at 12:08 p.m. an unidentified laundry aide was rolling a laundry cart with personal clothing items for residents. The cart was not covered and she parked the cart near the entrance to the B -pod common area. The unidentified laundry aide then would walk to individual rooms delivering clothing from the stationed cart throughout the B-pod. On 7/16/25 at 8:22 a.m. a laundry aide was in the B-pod with a large grey container on wheels. She was wearing a rubber apron. She reached into the soiled linen container on the B-pod, pulling out loose blankets and sheets from the bin and placing them into the grey container. Once the bin was empty she closed the lids to both containers and walked down the hall with the grey container on wheels towards the other pods. D. Staff interviews The laundry aide was interviewed on 7/15/25 at 10:55 a.m. She said she took a grey bin on wheels to the different pods to collect soiled linen from the bins on the pods. She said she then brought the bins to the soiled laundry room. She said she applied PPE to sort linen to be washed according to recommendations. She said once as the laundry was washed and dried she folded it or hung the clothes on a rack to be delivered to the resident’s rooms. The laundry aide said when she was delivering linen or clothing to the resident’s rooms or the linen closet, the clothes and linens needed to be covered at all times to prevent contamination when in transit. The HKD was interviewed on 7/16/25 at 11:42 a.m. She said soiled linen was collected by the laundry aides. The HKD said the laundry aide should perform hand hygiene, apply gloves and water proof apron and go to each pod with a grey bin on wheels and collect linen from the bins on each pod. The HKD said the linen should be in a bag and the bag should be tied up and removed and placed into the grey bin the laundry aide brought with them. The HKD said the laundry aide returned to the soiled laundry room to sort the linen as needed based on washing recommendations. The HKD said the residents’ soiled laundry was placed into mesh laundry bags in their rooms and can be transported to the laundry room either by nursing staff or the laundry aide to be washed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/14/25 at 11:29 a.m. certified nurse aide (CNA) #2 and licensed practical nurse (LPN) #3 were in the common area. Resident #29 was in his wheelchair and LPN #3 told Resident #29 they were going to sit him on the couch so that he would be more comfortable. CNA #2 retrieved a gait belt from the desk in the common area and put the gait belt around Resident #29’s waist. LPN #3 said they were going to stand on the count of three. LPN #3 and CNA #2 counted to three, CNA #2 grabbed the gait belt, with her arm under Resident #29’s arms and transferred Resident #29 to the couch. -LPN #3 and CNA #2 did not don PPE prior to providing direct care to Resident #29, who was on EBP. On 7/14/25 at 2:58 p.m. Resident #29 was in the common area and said he had to go to the bathroom. CNA #2 left the common area, returned with a wheelchair and placed the wheelchair in front of Resident #29. CNA #2 removed the gait belt from the seat of the chair and placed the gait belt around the resident's waist. CNA #2 placed her arms under the residents arms, and LPN #3 grabbed the resident’s gait belt and transferred the resident into the wheelchair. CNA #2 assisted Resident #29 to his room in the wheelchair and CNA #2 assisted Resident #29 to his bathroom. -LPN #3 and CNA #2 did not don PPE prior to providing direct care to Resident #29, who was on EBP. On 7/14/25 at 3:34 p.m. Resident #29 was in his wheelchair. CNA #2 attached a gait belt to Resident #29 around his waist and asked him to lift his feet. CNA #2 pulled the resident’s wheelchair forward next to the couch. CNA #2 held the gait belt with her arms under Resident #29’s arms and transferred the resident to the couch. -LPN #3 and CNA #2 did not don PPE to transfer Resident #29 who had a stage 2 pressure ulcer and required EBP. C. Staff interviews CNA #3 was interviewed on 7/16/25 at 10:18 a.m. CNA #3 said when a resident needed to be on EBP but did not have the PPE in front of their door, a nurse or nurse manager could also tell the staff the resident was on EBP. CNA #3 said she would follow the EBP if she was told about the resident requiring EBP regardless if an EBP sign was posted or not. CNA #3 said she referred to the EBP sign before she entered a resident's room to provide care and followed the instructions on the sign. CNA #3 said she would put on a gown to transfer a resident or assist the resident to the toilet or commode if the resident were on EBP. LPN #4 was interviewed on 7/16/25 at 10:31 a.m. LPN #4 said the infection preventionist or director of nursing (DON) would put the PPE in front of a resident's door if a resident was on EBP. LPN #4 said if she noticed PPE was needed she could put the PPE out herself as the facility had containers of PPE ready to go in each of the linen closets. LPN #4 said EBP was needed for any open area that would require wound care or a catheter. LPN #4 said Resident #29 should be on EBP due to his pressure ulcer and staff should wear a gown for his two person transfer. The MDSC was interviewed on 7/16/25 at 2:12 p.m. She said the facility currently only had residents that were on EBP. She said the staff should apply PPE when providing direct care to prevent coming in contact with the area of concern. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ED was interviewed on 7/16/26 at 2:20 p.m. The ED said staff should put on a gown to transfer a resident on EBP and PPE was available for staff to use and place at a resident’s room for EBP.