STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065309	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure one (#1) of three residents received treatment and care in accordance with professional standards of practice out of three sample residents.Specifically, the facility failed to ensure Monitor Resident #1's blood sugar after long acting insulin was administered to ensure the effectiveness of the medication. Findings include:I. Professional ReferenceAccording to the manufacturer, Sanofi, Patient Information Lantus Insulin Glargine Injection, 2025, retrieved on 2/20/26 from https://www.lantus.com/new-to-insulin/starting-insulin The most common side effect of insulin, including [NAME], is low blood sugar (hypoglycemia), which may be serious and life threatening. It may cause harm to your heart or brain. Symptoms of serious low blood sugar may include shaking, sweating, fast heartbeat, and blurred vision.II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to February 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease and unspecified dementia, unspecified severity, with mood disturbance.The 1/21/26 minimum data set (MDS) revealed that the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. The resident required partial to moderate assistance with activities of daily living. The assessment indicated the resident's insulin order changed. B. Record review Review of Resident #1's electronic medical record (EMR) revealed the resident's blood sugar level measured on 1/8/26 with the value of 439 milligrams per deciliter (mg/dL). Review of the January 2026 CPO revealed the following physician's order:Lantus, subcutaneous solution pen injection 100 unit/ milliliter (ml). Inject 5 units one time a day for type 2 diabetes, ordered on 1/8/26.Review of Resident #1's EMR did not reveal documentation regarding the resident was monitored after being administered Lantus, which was a newly prescribed medication, to evaluate the effectiveness of the treatment and necessary monitoring for possible side effects of the new medication. C. Staff interviewsThe physician was interviewed on 2/10/26 at 1:00 p.m. The physician said the nurse called to report the high blood sugar value for Resident #1 on 1/8/26. The physician said she ordered of Resident #1 to receive 5 units of Lantus. The director of nursing (DON) was interviewed on 2/10/26 at 1:03 p.m. The DON said upon a review of Resident #1's EMR, there was no follow up for re-evaluation of Resident #1 elevated blood sugar value post receiving the 5 units of Lantus per physician's order by licensed practical nurse (LPN) #2. The DON said In addition she confirmed that there is no documentation regarding the incident and receiving the order in the Resident #1 and Resident #3 electronic health records.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065309	A. Building B. Wing	02/10/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain an infection control and prevention program designed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections.Specifically, the facility failed to follow proper infection control practices during insulin injection via insulin pen by using Resident #3 insulin pen to inject insulin to Resident #1. Findings include:I. Professional referenceThe Centers for Disease Control and Prevention (CDC), Considerations for Blood Glucose Monitoring and Insulin Administration (revised 8/7/24) was retrieved on 2/17/26 from https://www.cdc.gov/injection-safety/hcp/infection-control/. It read in read in pertinent part, Insulin pens and other medication cartridges and syringes are for single patient use only. Never use them for more than one person. II. Facility policy and procedureThe Insulin Pen Use Policy, dated November 2025, read in pertinent part Insulin pens contain multiple doses of insulin but are used for a single elder only. III. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to February 2026 computerized physician orders diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease and unspecified dementia, unspecified severity, with mood disturbance.The 1/21/26 minimum data set (MDS) revealed that the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. The resident required partial to moderate assistance with activities of daily living. The MDS assessment indicated there was a change in the insulin order. B. Record reviewThe facility's investigation, dated 1/9/26, documented Resident #1 was prescribed 5 units of Lantus (insulin). Licensed practical nurse (LPN) #2 looked in the emergency kit of the facility and it did not contain Lantus. LPN #2 then used Resident #3's insulin pen for Lantus, using a new needle, to inject the 5 units of Lantus to Resident #1. On 1/9/26 the LPN #2 was re-educated and disciplined by the director of nursing (DON) regarding proper use of the insulin pen. -However, the re-education for the LPN #2 failed to address infection control in regards to safe medication administration pertaining to infection control, specifically bloodborne pathogens. In addition, the re-education dated 1/9/26 for all other nurses failed to address infection control in regards to safe medication administration pertaining to infection control, specifically bloodborne pathogens. IV. Staff interviewsLPN #1 was interviewed on 2/10/26 at 12:50 p.m. LPN #1 said the facility had an emergency kit for medication. LPN #1 said the emergency kit was supplied with both short and long acting insulin for emergency use. She said if a new high risk medication (blood thinner, insulin, antibiotic) was ordered by the physician and the medication was not in the emergency kit, the pharmacy could deliver the medication with a STAT status within two hours at the latest. LPN #1 said that if the medication was not available at the pharmacy, there were two nearby hospitals that could provide the medication. LPN #1 said the pharmacy was 45 minutes away. She said there was a hospital within 30 minutes of the facility.The DON was interviewed on 2/10/26 at 1:03 p.m. The DON said she completed an investigation on 1/9/26 when she learned about the incident which occurred in the evening of 1/8/26. The DON said insulin pens should never be used for more than one person because of risk for contamination with blood borne pathogens. She said all of the other nurses received training on The Insulin Pen Use policy. The DON said Resident #1 and Resident #3 were tested for hepatitis B and C with negative results.