

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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 infection on two of four halls and in one of one dining room. Specifically, the facility failed to: -Ensure staff donned (put on) the appropriate personal protective equipment (PPE) for a resident requiring enhanced barrier precautions (EBP) when obtaining vital signs; -Ensure vital signs equipment was sanitized between resident use; and, -Ensure staff performed hand hygiene while providing meal assistance. Findings include: I. EBP failures A. Professional reference Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), 4/2/24, was retrieved 6/9/26. It read in pertinent part, EBP expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for EBP include: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; and, wound care: any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions, undated policy was provided by the nursing home administrator (NHA) on 6/4/26 at 4:15 p.m. It read in pertinent part, (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistant organisms to residents. EBP's employ targeted gown and glove use during high contact resident care activities when precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity. EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices. EBP's remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. C. Observations On 6/1/26 at 1:45 p.m. an unidentified certified nurse aide (CNA) entered a resident's room on Hall A who was on EBP. The CNA did not don PPE before obtaining the resident's vital signs. -The unidentified CNA failed to don PPE for a resident who was on EBP. On 6/2/26 at 9:00 a.m. during medication pass licensed practical nurse (LPN) #1 entered a resident's room on Hall D, who was on EBP related to an indwelling device. When LPN #1 entered the room she did not don PPE. She had a blood pressure machine that she placed next to the resident's bed. With bare hands she placed the blood pressure cuff on the resident's bare arm touching the resident's skin with her hands. LPN #1 leaned on the bed rail with her bare arm while the resident took their medications. -LPN #1 failed to don PPE for a resident who was on EBP. D. Staff interviews LPN #1 was interviewed on 6/2/26 at 9:30 a.m. LPN #1 said she did not don PPE when she obtained the blood pressure and administered medications to the resident on EBP because they were to only wear the PPE when they changed the resident's catheter. LPN #2 was interviewed on 6/3/26 at 8:25 a.m. LPN #2 said when a resident was on EBP it was because the resident had a catheter, an intravenous (IV) device, or a wound that would be open to the potential for germs to enter their body. She said it was to protect the resident and staff from passing on germs to others. She said obtaining a resident's blood pressure who was on EBP would be considered direct contact because you would be touching the resident and the equipment would need to be sanitized after use. CNA #1 was interviewed on 6/3/26 at 10:10 a.m. She said a gown and gloves were supposed to be worn when they were providing direct care or emptying catheters for a resident that was on EBP to prevent spreading germs. CNA #2 was interviewed on 6/3/26 at 1:15 p.m. She said when a resident was on EBP they were to don PPE prior to entering the room when they were providing direct care to the resident, such as incontinence care, bathing, or emptying catheters. She said the PPE was removed in the room and hands were to be washed. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 6/4/26 at 9:00 a.m. She said any resident who had an open wound that required a dressing change should be placed on EBP. E. Facility follow-up On 6/2/26 the DON provided documentation of an inservice on enhanced barrier precautions for all departments. Twenty staff attended. The education included: Enhanced Barrier Precautions (EBP) expand the use of personal protective equipment (PPE) to include the use of gown and gloves during high-contact resident care activities -- activities that provide opportunities for the transfer of MDROs to staff hands and clothing. EBP requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or transmitting an MDRO. This includes: residents known to be infected or colonized with an MDRO; residents with an indwelling medical device including central venous catheter, urinary catheter, feeding tube , tracheostomy/ventilator status; and, residents with a chronic wound, regardless of their MDRO status. Additional comments included for staff to perform hand hygiene and don appropriate PPE (gowns/gloves) when required for all care provided, especially when touching a resident. II. Vital sign failures A. Facility policy and procedure The Infection Control Equipment Sanitation policy, revised 3/12/18, was provided by the NHA on 6/4/26 4:15 p.m. It read in pertinent part, Procedure: Blood pressure cuffs, pulse oximeter (to measure oxygen saturation), stethoscopes, and treatment scissors - wipe with cavicide (disinfectant) wipes, place in the appropriately numbered basket, and allowed to air dry for a minimum of 2 minutes before the next use. B. Observations On 6/1/26 at 9:00 a. m. an unidentified male resident was seated near the nurses' station and an unknown staff member obtained his blood pressure placing the cuff on his bare arm. The staff member did not sanitize the vital signs machine before or after obtaining the blood pressure then placed the machine against a wall near the nurses' station. On 6/1/26 at 1:45 p.m. an unidentified CNA, used a vital signs machine that was near the nurses' station to take a residents vital signs. Without sanitizing the machine, she entered a resident's room on Hall A, who was on EBP to take their vital signs. The unidentified CNA did not sanitize the machine prior to use and obtained a blood pressure on the bare arm of the resident. The unidentified CNA exited the room with the vital signs machine, did not sanitize it, and placed it next to the wall near the nurses' station. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/26 at 8:50 a.m. LPN #1 was observed during medication pass administering medications to a resident on Hall D. LPN #1 removed a pulse oximeter from the pocket of her uniform top, she did not sanitize it, and placed it on the resident's finger. After the oxygen saturation reading was obtained LPN#1 did not sanitize the device and placed it back into the pocket of her uniform top. On 6/2/26 at 9:00 a.m. during medication pass LPN #1 used a stethoscope that had been hanging around her neck and placed the diaphragm (chest piece) on the antecubital (inner bend of elbow) space on the resident's right arm and obtained the blood pressure reading. LPN #1 then placed the stethoscope back around her neck without cleaning the diaphragm. C. Staff interviews LPN #1 was interviewed on 6/2/26 at 9:30 a.m. She said the blood pressure cuff and vital sign equipment needed to be sanitized after each resident use. The DON was interviewed on 6/4/26 at 9:00 a.m. The DON said she filled the role of the infection preventionist. She said when staff were caring for a resident on EBP, and having direct contact with them, such as wound care, catheter care, and obtaining vital signs they were to don the appropriate PPE-gowns and gloves. She said the vital signs machines were to be sanitized between resident use. She said if nurses used their own stethoscope or pulse oximeter, those items should be cleaned as well and not placed around their neck or in the pocket of their uniform top. III. Hand hygiene failures A. Professional reference According to The CDC Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 6/8/26 from https://www.cdc.gov/cleanhands/hcp/clinical-safety/index.html, included the following recommendations for hand hygiene, Hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of germs, including those resistant to antibiotics. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings. B. Observations On 6/1/26 at 8:36 a.m. in the main dining room several residents were finishing their breakfast meal. Three unidentified residents were sitting at one table in the main dining room receiving meal assistance from an unidentified CNA. The unidentified CNA was wearing a pair of disposable gloves, and was observed providing bites to each of the three residents. -The CNA did not perform hand hygiene between offering bites of food to each resident. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation of the lunch meal in the main dining room on 6/1/26, beginning at 11:40 a.m. and ending at 12:40 p.m., the following was observed: At 12:19 p.m. Resident #26 received his lunch meal tray. Resident #26 grabbed his fork and began placing food on his fork using his fingers before using the fork to feed himself. At 12:20 p.m. Resident #5 was served his lunch meal tray. CNA #3 sat down between Resident #5 and Resident #26 and began helping Resident #5 cut his food. At 12:26 p.m. CNA #3 was assisting Resident #26 by offering him bites of his food using his silverware. At 12:27 p.m. CNA #3, using the same hand, used Resident #5's spoon to cut up his fruit before handing him his spoon so the resident could continue feeding himself. At 12:28 p.m. CNA #3 used the same hand to continue to offer bites of food to Resident #26. CNA #3 stood up, walked over to another table where there was a bottle of hand sanitizer and sanitized her hands before sitting in another seat next to Resident #26 to get into a better position to help with his meal assistance. -CNA #3 did not perform hand hygiene between offering bites of food to each resident, and no hand sanitizer was available at the table for CNA #3 to use. C. Staff interview The DON, who also acted as the facility's infection preventionist was interviewed on 6/4/26 at 12:55 p.m. The DON said facility staff performed hand hygiene upon entry into the dining room and should perform hand hygiene before sitting down to assist residents with meals. The DON said staff members should only assist one resident at a time and should perform hand hygiene between residents if they do need to switch between assisting two different residents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that residents received proper treatment and assistive devices to maintain hearing abilities for one (#31) of four residents reviewed for hearing services out of 23 sample residents. Specifically, the facility failed to ensure Resident #31's missing hearing aids were replaced in a timely manner. Findings include: I. Resident #31A. Resident status Resident #31, age [AGE], was admitted on [DATE] and readmitted [DATE]. According to the June 2026 computerized physician's orders (CPO) diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. The 4/29/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS assessment indicated the resident had difficulty hearing and did not have hearing aides. -However, record review revealed the resident required hearing aides, but they were missing (see record review and interview below). B. Resident interview and observation Resident #31 was interviewed on 6/1/26 at 2:07 p.m. At the time of the interview, she was not wearing hearing aids. The resident said her hearing aids were lost some time ago. She said she had not received an update on getting new ones. She said without them she missed parts of conversations and had trouble hearing the television. She said she really wanted to get them back. C. Record review Resident #31's hearing care plan, initiated 3/5/26, revealed the resident had impaired hearing and her bilateral hearing aids were missing. The care plan indicated she had hearing evaluations with audiology 3/20/23 and 2/26/26. The care plan revealed the medical necessity certification form to obtain new hearing aids through post eligibility treatment of income (PETI) was submitted to the facility corporate business office on 3/3/26. Review of Resident #31's electronic medical record (EMR) revealed the following: A physician's order, dated 5/4/24, indicated staff were to assist the resident with placing the hearing aids in the morning. The physician's order indicated it was on hold. The audiologist's hearing evaluation report, dated 2/26/26, indicated Resident #31's left ear had moderate hearing loss in the low pitches that decreased to a severe hearing loss in the high pitches which could cause general conversation, loud speech, and some environmental sounds to be very soft or entirely inaudible. The note documented speech understanding might be particularly troublesome when trying to communicate in the presence of background noise, if the speaker was at a distance, or when the conversation was not face-to-face. The right ear had mild hearing loss in the low pitches decreasing to a severe hearing loss in the high pitches. The audiologist documented that the resident had bilateral hearing aids and the resident reported the current hearing aids were lost. The audiologist indicated new hearing aids would need to be ordered. The note documented the resident reported more trouble hearing and was concerned that her hearing had changed. The note documented recommendations included bilateral amplification. The note documented the resident was not provided a hearing amplification device. The annual care conference summary, dated 4/29/26, indicated the resident had bilateral hearing aids and the facility was waiting on the PETI approval for new hearing aids. -However, on 3/11/26 a letter was submitted to the facility that indicated payment for new hearing aids had been denied. The social services progress note, dated 1/27/26, documented the audiology company indicated that for the PETI to be submitted Resident #31 would need another hearing evaluation. That evaluation was scheduled for 2/26/26. The social services progress note, dated 2/4/26, documented the resident's hearing aids were missing and she had a hearing aid evaluation scheduled for 2/26/26. The resident was in need of a new evaluation per the PETI guidelines for processing of payment for the hearing aids. The social (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services progress noted, dated 4/30/26, documented that Resident #31's hearing was impaired, and the facility was waiting on PETI approval for new bilateral hearing aids even though the facility had received a payment denial letter on 3/11/26 that indicated the request for PETI nursing facility services had been denied related to the hearing aids having been replaced on 10/17/24 and per state rule hearing aids could only be replaced every five years. -Review of Resident #31's electronic medical record (EMR) did not reveal any further documentation regarding the replacement of Resident #31's hearing aids.II. Staff interviewsThe social services director (SSD) was interviewed on 6/3/26 at 3:30 p.m. She said when a resident's hearing aids went missing in the facility, the staff looked for them. She said she would then meet with the management team to decide what to do, whether to replace them or try to get them paid for through the PETI process. The SSD said the central business office processed the PETI form requests. She said the nursing home administrator (NHA) was ultimately responsible for deciding whether to pay for the replacements or not. She said she should have followed up on the status of Resident #31's hearing aid replacements after she documented the 4/30/26 progress note. The NHA was interviewed on 6/3/26 at 4:30 p.m. She said when a resident's hearing aids were lost in the facility the process was started to see if they could get them paid for through the PETI process. The NHA said if the request was denied then the facility was responsible for payment and replacement of the hearing aids. She said once the denial was received the SSD was supposed to request an invoice from the audiology company for the cost of the replacements. The NHA said once the central office received the invoice then the replacement hearing aids would be purchased. She said the ball was dropped and she had not been made aware of Resident #31's missing hearing aids. She said the SSD should have followed up frequently on the status of the PETI request to eliminate any unnecessary delays.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#6) of five residents out of 23 sample residents received the nutritional care and services necessary to maintain their highest practicable level of well-being. Specifically, the facility failed to implement effective, person-centered interventions for Resident #6 who was experiencing weight loss. Findings include: I. Facility policy and procedure The Food and Nutrition Services policy and procedure, revised 2/19/18, was received from the nursing home administrator (NHA) on 6/4/26 at 4:15 p.m. It read in pertinent part, Multidisciplinary staff, including the nursing staff, the attending physician and the dietitian, will assess each resident's nutritional needs, food likes and dislikes, eating habits, as well as physical, functional and psychosocial factors that affect eating and nutritional intake and utilization. Reasonable efforts will be made to accommodate resident choices and preferences. Nursing staff will ensure that assistive devices are available to residents as needed. II. Resident #6A. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes, anemia, major depressive disorder, generalized muscle weakness, adult failure to thrive, chronic heart failure, pressure ulcer and protein-calorie malnutrition. The 4/16/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff assistance for most activities of daily living (ADL) and needed setup or cleanup assistance for eating. The assessment documented the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months. B. Resident interview and observations Resident #6 was interviewed on 6/2/26 at 12:07 p.m. Resident #6 said he loved Spanish and Mexican food, coffee, and milk. Resident #6 said he did not like the chocolate flavor of his nutritional supplements, but did like the strawberry and vanilla flavors. Resident #6 said the facility gave him Ensure (nutritional supplement) for protein because he had lost a lot of weight. Resident #6 said he looked at himself and asked himself how he ever got so skinny. Resident #6 said the nursing staff also gave him a straight protein drink (Prostat), which did not taste very good. Resident #6 said he wanted to put weight back on and get his strength back. Resident #6 was observed lying in bed. Resident #6 was visibly emaciated, with each of his arm and finger bones visibly prominent. C. Record review The nutrition care plan, revised 4/19/26, revealed Resident #6 had a nutritional problem due to his diagnoses of diabetes, malnutrition and respiratory failure. Resident #6 experienced a significant weight loss of 6.2% of his body weight in 30 days on 4/19/26. Pertinent interventions included providing Resident #6's diet as ordered, monitoring and recording his intake at each meal, offering whole milk at each meal, providing snacks as ordered, and the registered dietitian (RD) evaluating the resident and making diet change recommendations as needed. Resident #6's weights were documented in the electronic medical record (EMR) as follows: -On 4/3/26, the resident weighed 133.0 pounds (lbs); -On 4/7/26, the resident weighed 132.6 lbs; -On 4/14/26, the resident weighed 124.8 lbs; -On 4/29/26, the resident weighed 116.4 lbs; -On 5/6/26, the resident weighed 110.0 lbs; -On 5/13/26, the resident weighed 116.4 lbs; -On 5/19/26, the resident weighed 119.8 lbs; -On 5/26/26, the resident weighed 117.6 lbs; and, -On 6/4/26, the resident weighed 116.8 lbs. -The resident sustained a 17% (23 lbs) weight loss, from 4/3/26 to 5/6/26, in one month, which was considered severe. -The resident sustained a 12% (16.2 lbs) weight loss, from 4/3/26 to 6/4/26, in two months, which was considered severe. Review of Resident #6's June 2026 CPO revealed the following physician's orders: -Mirtazapine (an antidepressant medication also used to stimulate appetite) 30 milligram (mg) (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablets, give 30 mg by mouth at bedtime for major depression, ordered 4/3/26;-Admit to hospice with diagnosis of moderate protein-calorie malnutrition, ordered 4/3/26;-Regular diet, regular texture, regular consistency, ordered 4/3/26;-Obtain weights/vital signs per facility protocol, ordered 4/3/26;-Glucerna (nutritional supplement) two times daily, ordered 4/3/26; and,-Protein oral liquid, give 30 milliliters (ml) by mouth two times a day to help with wound repair to the left foot, ordered 4/10/26.Review of Resident #6's April 2026 medication administration record (MAR), from 4/3/26 through 4/30/26, revealed the following:-Resident #6 refused his Glucerna 24 times out of 53 possible opportunities; and,-Resident #6 refused the protein oral liquid 27 times out of 40 possible opportunities.Review of Resident #6's May 2026 MAR, from 5/1/26 through 5/31/26, revealed the following:-Resident #6 refused his Glucerna 29 times out of 62 possible opportunities; and,-Resident #6 refused the protein oral liquid 57 times out of 62 possible opportunities.Review of Resident #6's June 2026 MAR, from 6/1/26 through 6/4/26, revealed the following:-Resident #6 refused his Glucerna 3 times out of 6 possible opportunities; and,-Resident #6 refused the protein oral liquid five times out of seven possible opportunities.-However, review of Resident #6's electronic medical record (EMR) did not reveal documentation indicating the facility addressed the residents frequent refusals of the oral nutritional supplements. A dietary profile, dated 4/3/26, revealed the dietary manager (DM) met with Resident #6 to assess his dietary preferences. In the food allergies/intolerances section, the DM documented Resident #6 would not answer the question, and it was unclear if Resident #6 did not know the answer or did not want to answer. Resident #6 did not respond when asked about his food likes or dislikes. The DM documented Resident #6 did not respond to most of his questions, and that the DM would try to get more answers from the resident at a later time.-However, review of Resident #6's electronic medical record (EMR) did not reveal any other attempts to assess the resident's food preferences.A progress note, dated 4/10/26 at 10:02 a.m., revealed the facility dietitian recommended Resident #6 receive Megace for appetite stimulation. Resident #6 was on hospice, and when the nursing staff communicated with the hospice staff, it was revealed Megace was not covered by the resident's insurance and the hospice company would not fill an appetite stimulant. The director of nursing (DON) was notified.-However, the facility did not attempt to implement a different nutritional intervention to assist with the resident's weight loss.A progress note, dated 4/10/26 at 11:06 a.m., revealed Resident #6 was seen by a hospice registered nurse (RN) for a follow-up. Resident #6 had poor appetite and abdominal discomfort. The note documented the facility's dietitian requested Megace as an appetite stimulant for Resident #6. The note documented the hospice agency would monitor the resident before moving forward.A progress note, dated 4/12/26 at 2:36 a.m., revealed Resident #6 ate 50% or less for two or more meals in one day. Resident #6 declined all snacks that were offered before bed. Resident #6 drank 25% of his Glucerna with staff encouragement. The note documented staff would continue to offer Resident #6 his preferred foods and encourage increased nutritional intake.A social services note, dated 4/22/26 at 4:31 p.m., revealed Resident #6 participated in his initial care conference. Resident #6's Mirtazapine dose was discussed during the care conference, at which point Resident #6 expressed he did not feel like eating, but said he was motivated to get better. A nutrition note, dated 4/24/26 at 11:21 a.m., revealed Resident #6 was being followed in the facility's nutrition at risk meetings due to being a new admission and having a significant weight loss of 6.2% of his body weight in 30 days. Resident #6 was receiving hospice care. Resident #6's intake of meals ranged from 0 to 25%. Resident #6 had orders for Glucerna twice a day, which was accepted 20% of the time. Resident #6 also had a diabetic ulcer on his left ankle and a pressure ulcer on his left heel which were not improving. Resident #6 would continue to be followed during the nutrition at risk meetings.-However, no new interventions were initiated for Resident #6 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	despite his low meal and Glucerna acceptance rates.A progress note, dated 4/24/26 at 8:08 p.m., revealed Resident #6 refused his evening Glucerna. Resident #6 told the nurse he knew she put that protein stuff in it, to which the nurse assured the resident she did not put the liquid protein in his Glucerna. The nurse offered to open a new bottle of Glucerna for Resident #6, but the resident refused that as well and said the nurse would put the liquid protein in it when he was not looking. Resident #6 refused the liquid protein and any other snacks.A progress note, dated 4/26/26 at 9:27 a.m., revealed Resident #6 continued to refuse his meals. Resident #6 said he was grossed out by the food and said everything tasted funny. The note documented Resident #6 did not like the taste of the liquid protein and suspected staff of putting it in his food and drinks. The nurse documented she had to make his coffee and show Resident #6 it was free of the liquid protein before he would even take a sip of it.A progress note, dated 4/27/26 at 9:22 a.m., revealed Resident #6 took the liquid protein supplement that morning, but was upset with the nurse. The nurse documented the staff had offered the liquid protein supplement in different juices and drinks but Resident #6 insisted the supplement tasted terrible. Resident #6 was reeducated by the nursing staff on the importance of him taking the supplement to help with his wound healing, but the resident said the supplement was gross and made him feel nauseated.A nutrition note, dated 5/29/26 at 10:57 a.m., revealed Resident #6 was being followed in the facility's nutrition at risk meetings due to his diagnosis of moderate protein-calorie malnutrition and his wounds to his left lower extremity. The note documented Resident #6's trending weight was increasing since his admission. Resident #6 was receiving hospice care. Resident #6's intake of meals averaged 58%. Resident #6 had orders for Glucerna twice a day, which was accepted 25 to 50% of the time and Prostat liquid protein which was accepted 0 to 25% of the time. -However, no new interventions were initiated or discussed for Resident #6 despite his and Glucerna and Prostat acceptance rates.III. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 6/3/26 at 10:56 a.m. CNA #1 said Resident #6 liked Mexican food and always talked with her about it. CNA #1 said Resident #6's appetite depended on the day, and said he was able to feed himself if he set himself up right. CNA #1 said she offered Resident #6 snacks often and when he asked for them. CNA #1 said Resident #6 told her the supplements did not taste very good. Licensed practical nurse (LPN) #2 was interviewed on 6/3/26 at 1:04 p.m. LPN #2 said Resident #6's appetite had not been great but was starting to improve. LPN #2 said Resident #6 was a very picky eater and only wanted Mexican food. LPN #2 said sometimes Resident #6's family brought in Mexican food, or the nursing staff would make food and bring it in. LPN #2 said Resident #6 received Glucerna once a day and usually accepted it well. LPN #2 said Resident #6 liked the chocolate flavor of Glucerna. LPN #2 said Resident #6 also had orders for liquid protein but hated it and refused it quite a bit, even when the nursing staff tried mixing it with apple juice.CNA #2 was interviewed on 6/3/26 at 2:32 p.m. CNA #2 said Resident #6's appetite had improved lately and said he ate well especially when eating Mexican food. CNA #6 said Resident #6 liked chocolate and Oreo cookies.The DM was interviewed on 6/4/26 at 10:45 a.m. The DM said he had started talking with all of the residents about their dietary preferences when he started his position a few months prior. The DM said his meetings with the residents about their dietary preferences had been more informal, and he was starting to document them more in their EMRs as he was not previously familiar with their EMR software. The DM said he had spoken with Resident #6 about his dietary preferences and said the resident enjoyed mandarin oranges, cauliflower, salisbury steak, cottage cheese and fruit. The DM reviewed Resident #6's EMR and said he was not able to find any updated dietary preference sheet for him.The registered dietitian (RD) was interviewed on 6/4/26 at 11:32 a.m. The RD said she had been working with the facility since mid-May 2026 and had not yet reviewed Resident #6's case. The RD said generally any resident (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experiencing a significant weight loss of greater than 5% of their body weight in one month or 10% over 180 days would automatically be triggered for monthly chart reviews. The RD said the facility also had a nutrition-at-risk committee. The RD said she generally reviewed residents at risk for weight loss at least monthly if not more frequently. The RD said when she reviewed residents for weight loss she would talk with the nursing staff to see what feedback the resident was giving them about their supplements and meals. The RD said sometimes residents did not like the flavor of the supplements they received, or sometimes they did not want to drink their supplements and wanted more food-forward interventions. The RD said if a resident was not accepting their supplements she would discontinue or decrease the supplement they were refusing, because sometimes residents became overwhelmed by the frequency of interventions being offered. The RD said she would meet with Resident #6 to discuss what interventions he wanted to continue with. The DON was interviewed on 6/4/26 at 12:03 p.m. The DON said Resident #6 was admitted to the facility with hospice services and said his appetite was okay. The DON said she had spoken with Resident #6 and asked him if he wanted food from home or Mexican food, so the facility started ordering burritos for him, but the resident said he just felt gross and did not want to eat. The DON said Resident #6's appetite had slowly gotten better and the resident was eating bigger portions and eating a lot of cream of wheat. The DON said Resident #6 was on Prostat to help with wound healing and also received Glucerna. The DON said Resident #6 had gotten better with accepting the Prostat since she educated him on why it was important for him to take. The DON said Resident #6 did not accept the Prostat previously as he did not like it and thought it was not doing anything for him. The DON said the administration had been getting ready to discontinue Resident #6's Prostat order but wanted to sit down with him and explain why it was important for him to give it another try, and said he had been more compliant with accepting it over the last two to three weeks. The DON said Resident #6 liked all the flavors of Glucerna and asked for different flavors each time. The DON said the DM created a baseline care plan with resident's dietary preferences on admission and created a dietary preference sheet for each resident in their EMR.-However, Resident #6's dietary preferences had not been documented after his admission on [DATE].		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure one (#21) of six residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing out of 23 sample residents. Specifically, the facility failed to identify, implement and care plan interventions for Resident #21 who had a history of trauma and suicidal ideation. Findings include: I. Facility policy and procedure The Mental Health policy and procedure, revised 2/19/18, was received from the nursing home administrator (NHA) on 6/4/26 at 4:15 p.m. It read in pertinent part, Any member of the facility is allowed to report suicidal comments, ideation or attempts. The charge nurse is responsible for notifying the physician for orders, implementing safety measures, protocol, and charting of steps/actions taken. The Behavioral Health Services policy and procedure, dated 5/22/18, was received from the NHA on 6/4/26 at 4:15 p.m. It read in pertinent part, The facility will ensure that residents' individualized behavioral health needs are met through the resident assessment instrument process. All areas are to be addressed through care plan development and evaluation. II. Resident #21A. Resident status Resident #21, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included major depressive disorder, dementia without behavioral disturbance and suicidal ideations. The 5/13/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. The resident required partial to moderate assistance from staff for most activities of daily living (ADL) and needed setup or cleanup assistance for eating. The assessment documented the resident felt down, depressed or hopeless, felt bad about herself, and had thoughts that she would be better off dead or of hurting herself in some way nearly every day of the two week assessment period. B. Resident interview and observations Resident #21 was interviewed on 6/1/26 at 2:36 p.m. Resident #21 said she wanted to die and said she was tired of the staff pushing her around. Resident #21 said the staff asked her if she wanted to go outside, but she refused. Resident #21 said she did not leave her room and had her meals brought into her room. Resident #21 said she wished she would just die and end her suffering. Resident #21 continued to talk about a truck and her brother, but the conversation was largely unintelligible. Resident #21 became repeatedly tearful and distressed during the interview. C. Record review The grief care plan, initiated 3/5/26 and revised 4/27/26, revealed Resident #21 was grieving the loss of her husband who died in January 2026. Resident #21 was sad because she did not get to say goodbye to him because she was in the hospital. Pertinent interventions included encouraging Resident #21 to attend activities of her choice, encouraging the resident to verbalize her feelings, encouraging the resident to participate in counseling service to work through her grief, providing reassurance and emotional support as needed. The mood and behavior care plan, revised 2/24/26, revealed Resident #21 was dependent on staff for emotional, intellectual, physical and social stimulation due to her decreasing mood and forgetting when/where activities were held. Pertinent interventions included staff conversing with Resident #21 while providing care, approaching the resident calmly and explaining the cares being offered, encouraging ongoing family involvement, ensuring activities Resident #21 attended were compatible with her physical and mental capabilities, inviting and assisting the resident to activities, and offering alternatives to cares. The behavior care plan, revised 6/1/26 (during the survey process), (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #21 isolated in her room, refused to come out of her room for meals, and refused to take her medications or let nursing staff provide wound care. Resident #21 also made false accusations toward staff due to her dementia and adjusting to living in a nursing home. Pertinent interventions included administering medications as ordered, inviting Resident #21 to food-related activities and offering food or beverages of choice to encourage intake, and providing a calm, quiet atmosphere for eating. The psychosocial well-being care plan, revised 2/24/26, revealed Resident #21 had a potential or actual and/or potential inability to cope with her medical conditions, lifestyle changes and/or limitations in her functional abilities due to her new admission to a nursing facility and loss of independence. Pertinent interventions included introducing Resident #21 to other residents with similar backgrounds or interests, giving the resident opportunity to communicate her feelings regarding her nursing home placement, encouraging family involvement, and encouraging the resident to participate in activities of choice. The suicidal ideation care plan, initiated 6/3/26 (during the survey process), revealed on 5/18/26 Resident #21 responded to a patient health questionnaire (PHQ-9) question which asked if she had thoughts of hurting herself or that she would be better off dead by saying yes. Resident #21 said she would never hurt herself as that was against God and said she did not have a plan or intent. Resident #21's physician and a psychiatrist were both notified, counseling was offered and declined. Pertinent interventions included taking Resident #21 seriously if she made suicidal comments, assessing her cognition and mood, assessing her lethality by asking if she had a plan, encouraging her to express her feelings and listening attentively, offering counseling and monitoring for any further suicidal ideation. The suicidal ideation care plan was not initiated until 6/3/26 (during the survey), despite the resident admitting with a history of suicidal ideations and ongoing suicidal statements during the residents stay at the facility. Hospital discharge notes, dated 1/15/26, revealed Resident #21 was admitted to the hospital after a welfare check was conducted when the resident reportedly told her family member she was going to drink bleach. The hospital psychiatrist gathered information from Resident #21's family members and documented the resident had a history of depression as well as several suicide attempts. Resident #21's reported several significant psychosocial concerns including her incarceration, losing custody of her children due to abuse concerns and significant alcohol use throughout her life. The psychiatrist's note revealed Resident #21 had endorsed passive, then active suicidal ideation, then the resident denied any suicidal ideation in the span of one conversation. A social history trauma screening, dated 1/28/26, revealed distressing events in Resident #21's past included serious illness, suicidal ideation and the recent loss of her husband. Resident #21's social evaluation revealed the resident was sad, depressed, emotional and cooperative. A progress note, dated 1/30/26 at 12:05 a.m., revealed Resident #21 told an unidentified certified nurse aide (CNA) that she would miss her very much because she was going to die soon. Resident #21 said she was going to commit suicide, because she had no place to live. The CNA told the resident she could live at the facility and the staff would take care of her. Resident #21 thanked the CNA and told her she was glad she could live in the facility, calmed down and went back to sleep. The note documented the nursing staff would continue to monitor Resident #21. Review of Resident #21's electronic medical record (EMR) did not reveal Resident #21's physician or the social services director (SSD) were notified about the resident's statement of suicidal ideation. A progress note, dated 3/5/26 at 1:50 p.m., revealed Resident #21 had been isolating in her room, eating in her room and refusing to take medications. Resident #21 was tearful and angry. Resident #21 lost her husband in January 2026 while she was in the hospital. Resident #21 did not know where her daughter or sister were which caused her extreme distress. Counseling services were offered and declined. Resident #21's physician recommended having the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident evaluated by a psychiatrist.A progress note, dated 3/26/26 at 9:04 a.m., revealed Resident #21 told her nurse she did not want to take any medications because they did not help. The nurse educated Resident #21 that without her blood pressure medication she could have a stroke, to which the resident responded good, maybe she would just have a stroke and die. Resident #21 said she did not want to take any more medication because she wanted to die. Emotional support was provided, and by the nursing staff, and Resident #21's physician and the facility administration were notified of the resident's statements.A social services note, dated 3/26/26 at 5:56 p.m., revealed the SSD had met with Resident #21 for a one-on-one. Resident #21 became tearful as she talked about her spouse who had passed away in January 2026 and felt sad she did not get to say goodbye to him. Resident #21 also talked about her worries in not knowing where her sister or daughter were. The SSD discussed with the resident that taking her medications would help her feel better, to which the resident said the medications did not help. The SSD asked Resident #21 if she had thoughts that she would be better off dead or thoughts of harming herself, to which the resident said she was about to die and she could just feel it. Resident #21 said she just wanted to go to her house and get her things and she would be ready. Resident #21 denied any active thoughts of harming herself and promised she never would. Resident #21 said she was ready to be with her husband in heaven. The note documented the SSD would continue to monitor Resident #21's mood and behaviors.A progress note, dated 4/3/26 at 11:18 a.m., revealed Resident #21 had an appointment with her physician's assistant. Resident #21 said she wanted to go back to her home city to put her husband's truck in her brother's name, that she would not take any medications, and said she just wanted to die. The note documented the nursing staff would continue to monitor the resident.-Review of Resident #21's EMR did not reveal the SSD or physician was notified about the resident's statement of suicidal ideation. A progress note, dated 4/10/26 at 3:42 p.m., revealed Resident #21 was informed of her psychiatric appointment that day by the SSD. Resident #21 said she probably would not attend the appointment as she was going back to her home in another city. Resident #21 then started getting angry and intermittently crying as she talked about her life circumstances. Resident #21 said she wanted to go to her home city to get her truck back and give it to her nephew. Resident #21 then talked about missing her husband who had recently passed away and said she was ready to be with him in heaven. Resident #21 calmed down after she was able to express her feelings and the SSD offered emotional support. The SSD asked Resident #21 if she would like counseling, to which the resident replied what for? I'm not going to be here. Resident #21 denied having suicidal ideation or thoughts of harming herself, and said it was more of her having a feeling she would die soon.A quarterly social services progress note, dated 5/20/26 at 4:34 p.m., revealed Resident #21 had a difficult time adjusting to living in a nursing home. Resident #21 refused care, medications, and cursed and screamed at staff. Resident #21's mood ebbed and flowed, with her getting tearful then angry and repeating herself when talking about her family and life situation. Resident #21 became more agitated with redirection. Resident #21 was mourning the loss of her husband and was distressed because she did not know where her daughter or sister were. Resident #21 was offered counseling but declined it. Resident #21 scored a 17 on the PHQ-9 assessment, which was considered moderate to severe depression. Resident #21 said she had thoughts she would be better off dead but did not have any plans, and stated she would never hurt herself.III. Staff interviewsThe NHA was interviewed on 6/1/26 at 2:59 p.m. the NHA said Resident #21 had come to the facility from another city after attempting to drink bleach when her husband passed away. The NHA said Resident #21 was very resistant to care and medications.CNA #1 was interviewed on 6/3/26 at 10:56 a.m. CNA #1 said she tried to learn what Resident #21 liked and what would put her in a better mood. CNA #1 said she sometimes played Spanish music for Resident #21 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since she enjoyed it. CNA #1 said Resident's moods varied but her mood was usually worse in the mornings. CNA #1 said sometimes Resident #21 felt like she was a burden to the facility staff, so they tried to encourage her. CNA #1 said when Resident #21 was in one of her moods they usually checked on her but otherwise let her be. CNA #1 said Resident #21 used to talk about her husband when she first admitted but recently started talking about her brother and his wife which made her upset, and talking about something to do with her house or her truck. Licensed practical nurse (LPN) #2 was interviewed on 6/3/26 at 1:04 p.m. LPN #2 said Resident #21 was usually grumpy, but her mood varied. LPN #2 said Resident #21 had a hard morning the other day during which she said she felt like a burden and was feeling sorry. LPN #2 said sometimes just staff walking into Resident #21's room would annoy her and she would yell at them to get out. LPN #2 said Resident #21 could be redirected with Boost nutritional shakes or just with conversation. LPN #2 said Resident #21 liked to talk about her husband passing away, or trying to find her brother, daughter and sister-in-law. LPN #2 said Resident #21 was constantly looking for her family members and asking for them. LPN #2 said Resident #21 had expressed she wanted to die and was waiting to die. LPN #2 said when Resident #21 gets into a mood where she begins expressing those thoughts, conversation seems to get her out of her mood momentarily before the mood returns and lasts for a while. CNA #2 was interviewed on 6/3/26 at 2:32 p.m. CNA #2 said Resident #21's mood was usually good when she was the one working with her, but said the resident could become hateful and begin refusing care if someone else was in the room with her. CNA #2 said if staff spoke Spanish with Resident #21 she would be their best friend. CNA #2 said Resident #21 liked bubble gum, and said she could get her to participate in care by saying she would give her bubble gum afterward. CNA #2 said she was not sure what interventions were in Resident #21's care plan or Kardex (a care reference tool), and said she just knew these interventions from working with her. CNA #2 said Resident #21 talked about her husband and her truck constantly. The SSD was interviewed on 6/3/26 at 3:20 p.m. The SSD said when residents were admitted with mental health issues, she would offer counseling, one-on-one visits, and ask them about their activity interests. The SSD said she conducted a trauma screening on admission, and the information from the screening would be put into the resident's care plan. The SSD said a resident's trauma care plan generally included their triggers and what their goals might be. The SSD said Resident #21 was very anxious, and was on two antidepressants when she first admitted to the facility. The SSD said Resident #21 refused to take the antidepressant medications so they were discontinued. The SSD said Resident #21 had a psychiatric evaluation scheduled but had refused to attend the appointment. The SSD said Resident #21 did not want any interventions and only wanted to go see her brother. The SSD said sometimes Resident #21 could be very calm, and generally stayed in her room and watched television. The SSD said Resident #21 became agitated depending on the staff's approach with her. The SSD said she did not know if Resident #21 had any other triggers besides her husband passing away in January 2026. The SSD said adult protective services had been involved with Resident #21's case because in her home city a friend may have taken advantage of her and her husband. The SSD said conversation with Resident #21 usually worked to calm her down and was helpful for her, and said that intervention was on her care plan and Kardex (staff directive tool). The SSD said Resident #21 had suicidal ideation when she first admitted to the facility and said she would be better off dead. -However, the facility failed to implement a person centered care plan related to the resident's history and ongoing statements of suicidal ideations. The SSD said Resident #21 never had a plan to actually commit suicide and said it was against her religion to do anything to herself. The SSD said she thought she had made a suicidal ideation care plan for Resident #21. The SSD said a care plan for suicidal ideation would include interventions such as observing the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's mood and behaviors, asking if they wanted to call their family, asking if they had a plan and assessing their lethality risk. The SSD said she thought she may have conducted a lethality assessment for Resident #21 when she first admitted but was not sure since she said she did not have a plan. The SSD said she performed a lethality assessment when a resident expressed suicidal ideation w to see if the resident's risk for a suicide attempt was high or low. The SSD was interviewed a second time on 6/3/26 at 3:50 p.m. The SSD said she had mixed Resident #21 up with someone else, and said Resident #21 had not expressed suicidal ideation until the month prior (May 2026). -However, review of the hospital discharge paperwork, the 1/28/26 social trauma assessment and progress notes revealed the resident had suicidal ideations prior to May 2026 (see record review above). The SSD said she had not put in a suicidal ideation care plan for Resident #21. The SSD said she had not performed a lethality assessment on Resident #21 after she expressed suicidal ideation. The director of nursing (DON) was interviewed on 6/4/26 at 12:03 p.m. The DON said Resident #21 had on and off days. The DON said some days Resident #21 would come out of her room and joke around, other days she was mourning her husband, saying no one did anything for her, and screaming and throwing things at staff if they tried to sit and talk with her. The DON said Resident #21 had a history of trauma including her husband dying while she was in the hospital and her not getting to say goodbye, moving to the facility from her home city, and people coming into her house and taking advantage of her. The DON said Resident #21 had mentioned she wanted to die to be with her husband. The DON said Resident #21 did not have a plan and did not want to kill herself, but just wanted to be with her husband. The DON said the facility tried to have Resident #21 evaluated by a psychiatrist but the resident refused and said the doctors were trying to kill her. The DON said Resident #21's triggers included loud noises and how staff approached her. The DON said Resident #21 did not like being told what to do but did better when staff gradually coaxed her and kept their care on her terms. The DON said Resident #21 could be redirected with country and Spanish music, snacks including gum and soda, or sitting and talking with her about her husband and letting her express her feelings. The DON said these triggers and interventions were mostly communicated face-to-face with the nursing staff and were added to the resident's care plan if they were used successfully several times.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#7) of four residents reviewed, out of 23 sample residents received timely dental services. Specifically, the facility failed to ensure Resident #7 received replacement of missing dentures in a timely manner. Findings include: I. Facility policy and procedure The Lost or Damaged Dentures policy, revised 3/12/18, was provided by the nursing home administrator (NHA) on 6/4/26 at 4:15 p.m. It read in pertinent part, To ensure that residents obtain needed dental services; to ensure the facility provides the assistance needed or requested to obtain these services; to ensure the resident is not inappropriately charged for these services; documentation of the facility is to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. Identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility. When staff discards dentures placed on a meal tray. When staff throws wrapped up dentures in trash. When staff do not adhere to standard nursing guidelines when performing cleaning procedures and drop and break the dentures. When staff does not check the pockets of clothing and sends the dentures to laundry. If it is the responsibility of the facility, when there is loss or damage to a resident's dentures due to carelessness, the facility is then liable. The facility must promptly refer residents with lost or damaged dentures for dental services. II. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders, diagnoses included type 1 diabetes mellitus with hyperglycemia (high blood sugar), age related physical debility, and need for assistance with personal care. The 4/1/26 minimum data set (MDS) assessment indicated Resident #7 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required set up assistance with personal hygiene and he had no natural teeth. B. Resident interview Resident #7 was interviewed on 6/1/26 at 11:07 a.m. He said his dentures went missing at least six months ago and he had not gotten a resolution yet. He said he had placed the dentures in a cup before he went to bed one evening and when he got up the next morning they were gone. He said no one had followed up with him on the status of denture replacement and the facility said they would pay for the dentures, but that had not happened. He said he had not been able to eat everything he would like because of the missing dentures. He said his diet order included ground meats, but now his gums were sore and there had been no change on his diet order to make things easier to chew. He said he thought he had lost some weight. Resident #7 was interviewed again on 6/3/26 at 8:50 a.m. He said he needed his dentures because his gums were getting sore. He said his diet was not changed from ground meats after the dentures went missing in December 2025. He said he wished they had changed his diet order so that meats would have been easier to chew. C. Record review Resident #7's dental care plan, initiated 3/6/26 documented the resident had oral and dental health problems due to all teeth having been extracted on 3/11/25. The care plan documented he received new dentures on 3/19/25. The care plan documented his dentures got lost in December 2025 and he was in the process of getting new dentures. The care plan documented his health insurance denied coverage on 12/2/25 and 2/25/26. The care plan documented the social services director (SSD) was to process the claim for payment of new dentures through the post eligibility treatment of income (PETI) medical necessity certification form program. The care plan documented the resident complained of gum irritation on 2/27/26 at which time the dentist ordered an antibiotic. Pertinent interventions included coordinating (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arrangements for dental care and transportation as needed, providing the diet as ordered, consulting with a dietitian and changing diet order if chewing or swallowing problems are noted and monitoring, documenting, and reporting any signs or symptoms of oral pain. The nutrition at risk care plan initiated 5/22/24 and revised on 8/21/25 included interventions that the resident was to be offered a sandwich at meals for increased intake and to provide and serve diet as ordered (diabetic, ground meats, regular liquids). The 7/9/25 SSD progress note indicated the resident's dentures had been cutting his mouth, so a dental appointment was desired. The 1/8/26 SSD progress note indicated the resident was edentulous because his dentures got lost. The facility was looking into replacing them and he was seen by the dentist. The 1/9/26 SSD progress note indicated a call was made to the dentist for an update on the dental authorization. The note documented no determination had yet been made. The 1/21/26 SSD progress note indicated the resident had received the final decision that the denial for denture replacement was upheld because of benefit limitations. The dental company said the resident could qualify for a grant and was supposed to send the application and invoice for processing of the grant. Otherwise, the facility could see if PETI would cover the cost of replacing the dentures. The 3/6/26 SSD progress note documented a PETI form for dentures that was sent to the dental company. -The form was not sent for 10 weeks after the denial in January 2026. The 4/2/26 SSD note indicated the resident was edentulous and was in the process of getting new dentures. The note documented the facility was waiting on PETI approval. The 6/2/26 (during the survey) SSD progress note documented the facility central business office would resubmit the dental PETI request. The 6/3/26 (during the survey) SSD progress note documented an email had been sent to the dental company to send a statement or invoice for resident's dentures as soon as possible in the morning for PETI. On 6/4/26 (during the survey) the SSD documented an attempt was again made to contact the dental company but she was unable to talk to anyone. On 12/9/25 an insurance denial letter was submitted to the facility indicating the replacement of the dentures would not be covered. The denture request form completed on 2/2/26, indicated the resident said his dentures went missing in December 2025. He said he had placed the dentures in a cup next to his bed and the next morning they were gone. On 2/25/25 an insurance denial letter for upper and lower denture replacement was submitted to the facility. The emergency dental checklist, completed on 2/27/26, indicated the resident was having pain rated at eight to nine out of 10 with pressure sensitivity and swelling of his gums. On 3/25/26 a final insurance denial letter was submitted to the facility indicating the replacement of the dentures would not be covered. III. Staff interviews The SSD was interviewed on 6/3/26 at 3:30 p.m. She said when a resident's dentures went missing, the staff looked for them. She said then her and the management team got together to decide what to do, whether to replace them or try to get them paid for through the PETI process. The facility's central business office processes the PETI forms. She said she should have followed up regularly on the status of Resident #7's denture replacement. She said the NHA was responsible for deciding to pay for the replacement of dentures. The NHA was interviewed on 6/3/26 at 4:30 p.m. She said when a resident's dentures were lost in the facility the process was started to see if they could get paid for through the PETI process and if the request got denied then the facility was responsible for paying for replacements. She said once the denial was received the SSD was supposed to request an invoice from the dental company for the cost of the replacement and once the central business office received the invoice then the replacement dentures would be purchased. She said the ball was dropped and she did not follow up with the SSD on the status of this resident's denture replacement. The registered dietitian (RD) was interviewed on 6/4/26 at 11:33 a.m. She said she was new to the facility and had not reviewed Resident #7. She said when a resident's dentures were (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Crowley County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Idaho Ave Ordway, CO 81063	
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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing she would visit with the resident and collaborate with speech therapy as well as the interdisciplinary team to determine what would be best for the resident as far as diet texture to best maintain weight and chewing ability. She said if a resident's diet order was for ground meats and the resident was still having trouble chewing and his gums were becoming sore the diet could have been changed to minced and moist to facilitate easier chewing. She said when she made her visit to the facility she would check in with the resident to see how he was doing and would make any diet changes necessary.		