

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Juniper Village - the Spearly Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2205 W 29th Ave Denver, CO 80211	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured and labeled in accordance with accepted professional standards for three of five medication storage carts and one of three medication storage rooms. Specifically, the facility failed to:-Ensure a Schedule IV controlled medication was properly stored in a refrigerator;-Ensure medications were labeled with open dates; and, -Ensure expired medications were properly disposed of. Findings include:I. Professional reference PharMerica (1/12/25) Abridged List of Medications with Shortened Expirations Dates, was retrieved on 12/8/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://pharmerica.com/wp-content/uploads/2025/01/PI it revealed in pertinent part, Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's Package Insert (PI) under the 'How Supplied/Storage & Handling' section. A drug product's Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening (see BUD Notes below), whichever comes first. These In-Use medications should be labeled such that the 'date opened' is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration.Pharmcare USA (4/9/23) Medication Disposal Practices in Assisted Living and Long Term Care, was retrieved on 12/8/25 from https://pharmcareusa.com/education/medication-disposal-practices-in-assisted-living-ltc/#:~:text=As%20an%2 It revealed in pertinent part, When medications are not disposed of correctly, they can pose serious threats to both human health and the environment. Improper disposal can lead to accidental ingestions, overdose and even death.II. Facility policy and procedureThe policy for skilled medication storage, undated, was received from the nursing home administrator (NHA) on 12/4/25 at 12:09 p.m. The policy read in pertinent part, Expired, discontinued and/or contaminated medications will be removed from the medication storage area and disposed of in accordance with community policy. Medications requiring refrigeration will be stored in a refrigerator that is maintained between two and eight degrees Celsius (36 to 46 degrees Fahrenheit).III. Observations On 12/2/25 at 1:10 p.m. the Juniper hallway medication cart was observed with registered nurse (RN) #1. The following was observed: -Three insulin glargine (long acting insulin pens were opened and in the cart with no open date labeled on the pen. -One insulin Lantus (long acting insulin) pen was opened and in the cart with no open date labeled on the pen.-Umeclidinium inhalation powder (long acting inhaler) 62.5 micrograms (mcg) had no open date on it. -Wixela (fluticasone propionate and salmeterol powder, a long acting inhaler) 250mcg /50mcg had no open date on it. RN #1 said the insulin pens and inhalers should be labeled with an open date. She said she was going to check with her unit manager on what to do with them and check on the date they came to the facility from the pharmacy. On 12/2/25 at 1:36 p.m. the front side of Spruce hallway medication cart was observed with licensed practical nurse (LPN) #1 and assistant director of nursing (ADON) #1. The following was observed: -Two bottles of (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Visine eye drops (medication to relieve dry eyes) with open dates of 9/2/25 and 9/20/25. -A bottle of polyethylene glycol 400 1% tetrahydrozoline HCL 0.05% (medication to relieve dry eyes) opened 8/16/25. -A bottle of systane complete eye drops (medication to relieve dry eyes) opened 10/1/25. -A bottle of prednisolone acetate 1% eye drops opened 9/30/25. ADON #1 said over the counter eye drops expired within 60 days of opening the bottle. She said prednisolone eye drops expire within 30 days of opening the bottle. She said she was going to dispose of the eye drops that were opened past those expiration dates. On 12/2/25 at 2:30 p.m., the back side of Spruce hallway medication cart was observed with licensed practical nurse (LPN) #3 and RN #5. The following was observed: - Generic fiber powder expired July 2025. -Geri-Lanta regular strength (antacid medication) expired April 2024. -Metoprolol 25 milligram (mg) tablet expired 10/31/25. -Potassium tablet 10 mill equivalent (mEq) expired 11/30/25. -Insulin glargine 100 unit/ml vial opened 10/1/25 (expired 28 days after opening). -Equate Dry eye relief eye drops opened 9/1/25. -[NAME] colon helper (stool softener supplement) had no expiration date on the bottle. -A bottle of liquid lorazepam 2 milligrams/milliliter (mg/ml) was stored in the medication cart with instructions to keep it refrigerated. LPN #3 said she took it out at about 8:00 a.m. and had kept it stored in the medication cart since then. RN #5 said he was going to dispose of the bottle of Lorazepam and order a new one. He said he was going to dispose of the additional medications that had expired. On 12/3/25 at 10:15 a.m. Juniper hallway medication storage room was observed with RN #4. The following was observed: -A risperidone injection (antipsychotic medication) 37.5 mg was expired June 2025. RN #5 said he was going to give the medication to the unit manager to see what to do with it. IV. Staff interviews The director of nursing (DON) was interviewed on 12/3/25 at 2:26 p.m. The DON said that all medication carts and storage rooms were audited and all expired medications were disposed of. The DON was interviewed on 12/4/25 at 9:50 a.m. He said the individuals that opened a medication were responsible for labeling the medication with an open date. He said all medications aside from the cards that came from the pharmacy should be labeled with an open date. He said the ADON's were responsible for auditing the medication carts and storage rooms on a weekly basis. He said the importance of labeling medications with open dates is so that you know when they are expired. He said it was important to dispose of expired medications so they are not being administered to the residents.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of three units Specifically, the facility failed to:-Ensure Resident #122's oral stimulator was kept in a sanitary location;-Ensure housekeeping staff performed hand hygiene while cleaning resident rooms;-Ensure housekeeping staff wait the appropriate amount of dwell time. Findings include: I. Failure to keep Resident #122's oral stimulator in a sanitary location A. Facility policy and procedure The Infection Control policy and procedure, undated, was provided by the nursing home administrator (NHA) on 12/4/25 at 12:09 p.m. It read in pertinent part, Associates will be educated related to all infection control procedures, including personal hygiene requirements. The Community will follow guidelines for the prevention and control of Nosocomial Infections and standard precautions as provided by the Center for Disease Control in Atlanta Georgia. The Environmental Services- Housekeeping policy and procedure, undated, was provided by the NHA on 12/4/25 at 12:09 p.m. it read in pertinent part, Associates working in resident areas will follow strict hand washing procedures. General cleaning agents used must be effective in removing all types of germs and bacteria. Clean and disinfect environmental and medical equipment surfaces on a regular basis by using EPA-registered disinfectants in accordance with manufacturer's instructions. Clean surfaces contaminated with body substances; perform low-to intermediate-level disinfection on cleaned surfaces with an EPA-registered disinfectant in accordance with the manufacturer's instructions. The Hand Hygiene policy and procedure, revised 1/01/22 was provided by the NHA on 12/4/25 at 12:09 p.m. it read in pertinent part, Associates will wash their hands, after cleaning a room, after handling waste or linen, before and after applying gloves, anytime hands have possibly become contaminated, after contact with furnishings or medical equipment in the immediate vicinity of a resident. A. Observations On 12/2/25 at 12:39 p.m. Resident #122 was sitting in the common area in her wheelchair. Resident #122 was grinding her teeth. A red rubber device (later identified as an oral stimulator) was hooked to her wheelchair by a lanyard. Two different, unidentified staff members offered Resident #122 the oral (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stimulator to chew on using their bare hands and did not use hand hygiene before touching it and offering it to her. The staff members were clearing dishes from the dining room prior to touching the oral stimulator. Resident #122 put the oral stimulator in her mouth. On 12/3/25 at 8:51 a.m. Resident #122 was sleeping in her bed. The oral stimulator was attached to her wheelchair with the lanyard. The oral stimulator was touching the seat of the wheelchair. On 12/3/25 at 10:50 a.m. the lanyard was connected to Resident #122's wheelchair. Resident #122 was sitting up in her wheelchair on top of her Hoyer lift sling. Certified nurse aide (CNA) #2 pulled on the lanyard and the oral stimulator was no longer attached to the lanyard. CNA #2 then reached underneath Resident #122 and the Hoyer lift sling and pulled out the oral stimulator. B. Staff interviews The hospice registered nurse was interviewed on 12/3/25 at 10:54 a.m. She said Resident #122 grinds her teeth and said she had seen the restorative staff give her the oral stimulator to chew on. She said she had not seen it connected to her wheelchair before. The director of rehabilitation (DOR) was interviewed on 12/3/25 at 11:13 a.m. He said the device that Resident #122 was seen chewing on was called an oral stimulator. He said the device was used to help stimulate the tongue to help with swallowing. He said he was unaware that Resident #122 was still using the device. He said he would not recommend having it attached to the wheelchair. He said he would recommend the device be kept separate and cleaned after use. He said if the device was recommended by speech therapy, there would be a program and oversight. Licensed practical nurse (LPN) #4 was interviewed on 12/3/25 at 1:30 p.m. He said that sometimes Resident #122 put random things in her mouth. The speech therapist (ST) and the DOR were interviewed together on 12/3/25 at 1:43 p.m. The ST said she wrote for the use of the oral stimulator in July 2025 and August 2025 and it was discontinued in August 2025 when she stopped working with Resident #122. She said she was working with her for swallowing. She said the only time Resident #122 had the oral stimulator was when she was working with her and she would clean after each use. She said nursing staff was looking for something to help Resident #122 with grinding her teeth. She said the oral stimulator was mentioned that it could be used however, she did not recommend it for use. The infection preventionist (IP) was interviewed on 12/4/25 at 9:45 a.m. He said Resident #122 had an issue with grinding her teeth. He said speech therapy wanted to try the oral stimulator to see if it would help with Resident #122's grinding issue. He said he had spoken to the hospice staff and said that they were going to bump up her anti-anxiety medication which should also help with her grinding. He said he was also waiting to hear back from the DOR to see if there was a better option for her grinding. He said they were also going to see if they could get a dentist to assess her next week for a mouthguard. He said there were infection control issues with multiple staff touching the oral stimulator after removing dirty dishes and not washing their hands and trying to have her chew on it. He said the oral stimulator should be stored in a denture cup, cleaned and have it hanging so it is available for her to use but not have it filthy. The DOR was interviewed on 12/4/25 at 2:10 p.m. He said he would recommend the oral stimulator be cleaned before use. He said he would recommend using a small container, like a denture cup and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soaking the oral stimulator with water and a denture tablet. He said if the lanyard were to be used with the oral stimulator, then the lanyard should be attached to the person and not the wheelchair. II. Failure to ensure hand hygiene and dwell time of chemicals was completed during cleaning of resident rooms A. Professional reference According to the Diversey (2025) product insert for Oxivir Five 16 Concentrate One-Step Disinfectant Cleaner, was retrieved on 12/8/25 from: Chrome-extension://efaidnbmninnibpcjpcglclefindmkaj/https://asset.productmarketingcloud.com/api/assetstor: Use directions include spray surfaces and let the solution remain on the surface for a minimum of five minutes. Air dry, wipe surfaces to dry and remove any residue or rinse with portable water as necessary. B. Facility policy and procedure The Hand Hygiene policy and procedure, revised 1/1/22, was received from the NHA on 12/4/25 at 12:09 p.m. It documented in pertinent part, Associates will wash their hands before and after applying gloves. The Environmental Services/Housekeeping policy, undated, was received from the NHA on 12/4/25 at 12:09 p.m. It documented in pertinent part, Associates working in resident areas will follow strict hand washing procedures. C. Observations During a continuous observation on 12/3/25, beginning at 1:00 p.m. and ending at 1:20 p.m., the following was observed: Housekeeper (HK) #1 and HK #2 were cleaning resident room [ROOM NUMBER]. HK #1 began by donning (putting on) clean gloves. HK #1 sprayed down the windows with a window washer. HK #1 wiped down the windows with a rag. HK #1 removed the soiled gloves and donned clean gloves without performing hand hygiene. HK #1 sprayed down the bed and dresser with the window washer solution. HK #1 immediately wiped down each surface after she sprayed them with a clean rag. HK #1 removed her soiled gloves and without performing hand hygiene donned clean gloves. HK #1 sprayed down the sink and vanity area with Oxivir Five 16 concentrate solution. HK #1 immediately wiped down the sink area with a clean rag. HK #1 removed the soiled gloves and without performing hand hygiene donned clean gloves. HK #2 sprayed down the toilet with Oxivir Five 16 concentrate solution and immediately wiped it down. HK #2 cleaned the inside of the toilet with a bathroom cleaner. HK #2 removed her soiled gloves and donned clean gloves. HK #1 mopped the floor of the bedroom followed by the bathroom. HK #1 removed her soiled gloves and washed her hands. -HK #1 and HK #2 failed to perform hand hygiene between glove changes. -HK #1 and HK #2 failed to wait the dwell time for the Oxivir Five 16 concentrate solution. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interviews The maintenance supervisor (MS) was interviewed on 12/4/25 at 9:45 a.m. He said the dwell time for the Oxivir Five 16 concentrate solution was five minutes. The director of nursing (DON) was interviewed on 12/4/25 at 9:50 a.m. He said it was important to follow the appropriate dwell time while cleaning with chemicals so that the chemical was effectively cleaning the surfaces. He said hand hygiene should be completed before and after donning gloves to prevent the spread of germs.		