STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065331	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larchwood Health and Rehab LLC	2845 N 15th St Grand Junction, CO 81506

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions in the main kitchen.Specifically, the facility failed to ensure staff followed appropriate hand hygiene practices during the meal service.Findings include:I. Professional referenceAccording to the Colorado Retail Food Regulations (3/16/24), chapter 2-301.12, retrieved on 5/29/26, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.14)II. Facility policy and procedureThe Handwashing/ Hand Hygiene policy, revised November 202s, was provided by the director of nursing (DON) on 5/26/26 at 11:13 a.m. The policy read in pertinent part, Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. Employees must wash their hands during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens.III. Observations 1. Kitchen meal serviceDuring a continuous observation of the lunch meal service in the kitchen on 4:05 p.m. beginning at 4:05 p.m. and ending at 5:38 p.m., the following was observed:At 4:38 p.m. cook #1 began plating residents' meals. At 5:11 p.m. cook #1 left the steam table. She pulled soup from a box with her gloved hands, touching the bottom shelf and the outside of the box. She returned to the steam table and continued to plate food.At 5:22 p.m. the dietary manager (DM) placed her left gloved hand to touch her shirt collar and wipe her cheek. The DM removed her gloves and pulled out a pan of mancotti from the oven with pot holders. She did not perform hand hygiene after removing her gloves. At 5:25 p.m. cook #1 pushed the trash down in the bin with her gloved hands, she removed the gloves and donned new gloves without performing hand hygiene. At 5:26 p.m. with the same gloved hands, cook #1 used the thermometer to take the temperature of the pan of manicotti. 2. Room tray deliveryDuring a continuous observation of the lunch meal service in the a resident hall on 5/18/26 beginning 12:50 p.m. and ending at 1:30 p.m., the following was observed:At 1:05 p.m. certified nurse aide (CNA) #5 picked up a cart delivered to the first room tray room. She did not use hand hygiene before collecting the tray. CNA #5 proceeded to help set up the resident's meal for her. CNA #5 exited the resident's room and filled another resident's water cup without performing hand hygiene. CNA #5 collected another resident tray out of the food cart without (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	performing hand hygiene. She exited the room and performed hand hygiene. At 1:20 p.m. CNA #5 pulled out another room tray without hand hygiene, shut the cart door with her foot and served the meal to a resident. She exited the room, picked up an item off the floor, knelt down with her hands on the floor near the cart. She stood up, pulled another tray out of the room cart without performing hand hygiene.At 1:25 p.m. CNA #5 delivered the tray to a resident's room. She exited the room without hand hygiene, picked up another tray and entered another resident's room without hand hygiene. At 1:30 p.m. CNA #5 performed hand hygiene and delivered the last room tray. V. Staff interviewsThe DM was interviewed on 5/21/26 at 3:21 p.m. The DM said hand hygiene should be completed thoroughly for 30 seconds, conducted after every task change and before putting new gloves on. The DM said she saw cook #1 not perform hand hygiene in between glove changes. Room tray observations were shared with the DM. She said staff should perform hand hygiene in between passing trays in resident rooms. She said she had not conducted recent staff training with staff on hand hygiene during meal service and delivery.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure the resident environment remained as free of accident hazards as possible for two (#60 and #84) out of six residents reviewed out of 41 sample residents and eight of 12 resident rooms reviewed. Specifically the facility failed to:-Implement a fall risk care plan for Resident #60;-Ensure thorough root cause analysis were completed for Resident #84 after multiple falls; -Ensure Resident #84's fall interventions were consistently in place and documented on his care plan; and, -Ensure tap water in the facility was kept within a safe temperature range.Findings include: I. Fall failures A. Facility policy and procedure The Falls-Clinical Protocol policy, revised March 2018, was provided by the director of nursing (DON) on 5/21/26 at 11:53 a.m. It documented in pertinent part, The staff and the physician Will identify pertinent interventions to try to prevent subsequent Falls to address the risk of clinically significant consequences of falling. If underlying issues cannot be readily identified a corrected staff will try various relevant interventions, based on assessment of nature or category falling, until falling reduces or stops or until a reason is identified for its continuation. The staff with the physician's guidance will follow up on a fall with associate injury until the resident is stable and delayed complications such as a late fracture or hematoma have been ruled out or resolved. The staff and the physician will monitor and document the individual's response to the interventions intended to reduce falls or consequences of falling . If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the position whether these measures are still needed, for example if the problem required the intervention has been resolved by addressing the underlying cause. If the individual continues to fall, the staff and physician will reevaluate the situation and reconsider possible reasons for the residents falling and also reconsider the current interventions. B. Resident #60 1. Resident status Resident #60, age [AGE], was admitted on [DATE]. According to the January 2022 computerized physician orders (CPO) diagnoses included asthma, heart failure and cerebrovascular accident (CVA) stroke. The 3/17/26 minimum data set (MDS) assessment revealed Resident #60 had moderate cognitive (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required minimal assistance with activities of daily living (ADL). 2. Record review The ADL care plan, dated 4/5/26, documented the resident had a decrease in independence with physical mobility related to CVA. Pertinent interventions included giving the resident reminders to use a walker and monitor for any signs or symptoms of immobility. -Review of Resident #60's comprehensive care plan failed to reveal a fall care plan that included person centered fall interventions. The nurse note, dated 5/10/26, documented Resident #60 told a staff member that he went to the bathroom and on his way back to bed he got dizzy and fell hitting the right side of his head on the bedside table. The resident sustained an abrasion and a raised purple bruise. The skin check note, dated 5/11/26, documented the resident had an abrasion noted to the right side of resident's head with a long purple raised bruise. The fall risk evaluation note, dated 5/11/26, documented no falls in the past three months. He had a fall risk score of 5, which showed low to moderate risk. -However, the evaluation failed to include that Resident #60 sustained a fall on 5/10/26. 2. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/20/26 at 2:02 p.m. She said when a resident had a fall, an assessment was completed by the registered nurse (RN), vital signs were taken and treatment was provided as needed. She said the resident was interviewed to find out what happened if the fall was unwitnessed and staff members. The director of nursing (DON) was interviewed on 5/20/26 at 4:20 p.m. She said Resident #60 had a fall on 4/5/26. She said the interdisciplinary team (IDT) met weekly to discuss falls to determine new interventions. She said the resident had a sign in his room that read Remember to use your walker. She said there was no other interventions added except to keep a close eye on the resident which was told verbally to the staff. C. Resident #84 1. Resident status Resident #84, age greater than 65, was admitted on [DATE] . According to the May 2026 CPO, diagnoses included end stage renal disease with dependence on renal dialysis, age-related osteoporosis without current pathological fracture, unspecified dementia, mild without behavioral disturbance, psychotic disturbances or mood disturbances, and repeated fall The 4/21/26 MDS assessment revealed Resident #84 had severe cognitive impairment with a BIMS score of four out of 15. He did not have wandering behaviors or rejection of care. He used a wheelchair for mobility. He was dependent on staff for lower body dressing and toileting hygiene. He (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required moderate assistance for getting on and off the toilet, chair to bed transferring and sit to stand. The MDS assessment documented Resident #84 was frequently incontinent of bowel and bladder and was not on a toileting program. 2. Observations On 5/19/26 at 4:24 p.m. Resident #84 was in the hallway in his wheelchair without his lap buddy on his chair. At 4:29 p.m. Resident #84 was assisted to the dining room table. At 4:37 p.m. Resident #84 self propelled himself out of the dining room and down the hall towards his room. Certified nurse aide (CNA) #3 walked passed Resident #84 in the hallway. Resident #84 entered his room and shut the door. At 4:47 p.m. an unidentified dietary aide entered the room to bring the resident's roommate a room tray. Resident #84 was in the restroom and his wheelchair was in the doorway to the bathroom. At 4:48 p.m. an unidentified CNA entered the room and observed Resident #84 alone in the restroom. The CNA entered the restroom and assisted the resident. At 5:01 p.m. the unidentified CNA assisted Resident #84 out of his room and back into the dining room. On 5/20/26 at 5:57 p.m. Resident #84 was in his wheelchair in the commons area. He did not have his lap buddy on. 3. Record review The fall care plan, revised 4/25/26, documented that Resident #84 was at risk for falls related debility, weakness and altered balance with poor safety awareness. According to the care plan, Resident #84 needed prompt response to all requests for assistance. Interventions initiated on 3/4/26 directed staff to anticipate and meet the resident's needs; ensure his call light is within reach and encourage the resident to use it for assistance as needed; educate the resident/family/caregivers about safety reminders, what to do if a fall occurs and causation of the falls; follow the facility fall protocol; and, review information on past falls and attempt to determine cause of falls, record possible root causes and alter/remove any potential fall contributing factors if possible. Interventions revised on 3/16/26 directed staff to provide the resident with a motion electronic alarm and ensure the device is in place as needed. Interventions revised on 3/23/26 directed staff to ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in his wheelchair; ensure flooring surface was even and free floor clutter; provide glare-free light, a working and reachable call light, and a bed in low position at night with his personal items within reach. According to the the revised 3/23/26 interventions, Resident #84 needed to be evaluated for and supplied with appropriate adaptive equipment or devices and re-evaluate as needed for continued (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriateness and to ensure least restrictive device or restraint. Interventions initiated on 4/17/26 directed staff to place a sign in his room to remind Resident #84 to use the call light so he did not fall and provided him with anti-rollback brakes to increase safety with transfers. Interventions initiated on 4/25/26 identified Resident #84 was to use a lap buddy (a wheelchair positioning device) when out of his room and in his wheelchair. According to the intervention, staff was to ensure it was in place every 15-minutes and release it every two hours for safety. a. Fall on 4/6/26 - unwitnessed The 4/6/26 incident report was provided by the DON on 5/21/26 at 11:53 a.m. The incident report documented Resident #84 had an unwitnessed fall on 4/6/26 at 8:30 a.m. According to the incident report, he was ambulating without assistance and lost his footing when he fell and obtained a skin tear to his right scapula (back). The incident report revealed the immediate action/intervention following the fall was to remind him to use his call light. The 4/7/26 interdisciplinary (IDT) risk note documented the resident told the staff he was trying to go to the bathroom. The IDT risk note documented the root cause of the fall was the resident's attempt to use the bathroom and he had a recent room change. The note documented interventions put in place were to remind staff to place assistive devices within reach when he was in bed and remind staff to ensure motion alarm was in place and functioning properly. According to the IDT note, new interventions included offering the resident a urinal as needed and informing therapy and restorative nursing of the fall. The note documented therapy and restorative was notified of the incident. -The fall documentation did not identify the size or severity of the skin tear to his back. -The fall documentation did not identify if his call light was within reach or if his motion sensor was on and working properly, if the resident was in bed or in his wheelchair prior to his fall or when the resident was last toileted or if he was incontinent at the time of the fall. b. Fall on 4/7/26 - unwitnessed The 4/7/26 incident report was provided by the DON on 5/21/26 at 11:53 a.m. The report documented Resident #84 had an unwitnessed fall at 10:30 p.m. According to the incident report, he was ambulating without assistance, confused and lost his footing when he fell. The report documented the resident told the staff he had tried to get up. The 4/8/26 progress note identified Resident #84 was found parallel to the bed on the floor (on 4/7/26). An assessment was completed, no new injuries were found and he was assisted back to bed. According to the note, Resident #84 was very impulsive, would not use his call light and was very unsteady while up. The 4/8/26 IDT risk note documented staff added velcro to his bedside alarm and he was going to move to the long term care side of the facility. The note documented therapy and restorative was notified of the incident. -The fall documentation did not identify when the resident was last toileted or if he was incontinent at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the time of the fall or if the resident was last checked on by staff. c. Fall on 4/11/26 - witnessed The 4/11/26 incident report was provided by the DON on 5/21/26 at 11:53 a.m. The report documented the nurse and CNAs were in shift report when Resident #84 walked out of his room holding his shoes when he fell next to the wall without injury. The report identified the resident fell at 6:15 a.m. The 4/13/26 IDT risk note documented the root cause of the witnessed fall on 4/11/26 was very poor safety awareness and impaired cognition. According to the risk note, Resident #84 was in a transition process for the staff and the resident to get to know each and for staff to know his routine after he moved into a new room. The note identified the intervention after the fall was to remind staff of the resident's increased fall risk and provide more frequent checks on him, especially in the early morning hours and around 10:00 p.m. The note documented therapy and restorative was notified of the incident. d. Fall on 4/14/26 - witnessed The 4/14/26 incident report was provided by the DON on 5/21/26 at 11:53 a.m. The report documented Resident #84 was witnessed to stand up out of his wheelchair in the dining room at 6:33 a.m. The wheelchair moved backwards and the resident fell on his buttocks without injury. The 4/16/26 IDT risk note documented the root cause of the fall. According to the note, Resident #84 stood up from his wheelchair without locking his breaks first and the wheelchair rolled backwards. The identified intervention was to screen him for an anti-roll back device on his wheelchair for safety. The note documented therapy and restorative was notified of the incident. e. Fall on 4/16/26 - witnessed The 4/16/26 incident report documented Resident #84 fell in his room at 7:50 p.m. The report documented the resident was attempting to ambulate without assistance. The fall was witnessed by a CNA. He was assessed by his nurse and assisted back into his wheelchair. The resident received a 5 centimeter (cm) skin tear on his right elbow as a result of the fall. The 4/30/26 IDT risk note for the fall on 4/16/26 documented Resident #84 stood up from his wheelchair and took one step and fell to the floor. According to the note, the resident said he was trying to go to the bathroom. The note documented the interventions after the fall included ensuring his call light was within reach; frequently reminding the resident to utilize the call light system and to wait for staff to assist. The note documented the staff were reminded to avoid leaving the resident in his room alone, encourage him to participate in activity of choice and sit in the commons area of the facility, socializing with other residents or watch television. The note documented therapy and restorative was notified of the incident. -The interventions directing staff to avoid leaving the resident in his room alone, encourage him to participate in activity of choice and sit in the commons area of the facility, socializing with other residents or watch television was not included in the residents care plan (see care plan above). -The fall documentation did not identify when the resident was last toileted or if was incontinent at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the time of the fall. -The IDT note identified the resident's 4/16/26 fall was reviewed by IDT two weeks after the fall and after the resident had multiple falls (see below). f. Fall on 4/23/26 - unwitnessed The 4/23/26 nursing note identified Resident #84 was found next to his wheelchair, laying on his right side. He was bleeding from his right eye brow and he had a lump on his right cheek bone. The resident was alert and was able to be turned on his back so pressure could be applied to his eye brow laceration. He was assessed back into his wheelchair and wound care was provided to the laceration. The second nursing note on 4/23/26 identified Resident #84 was sent to the hospital for an evaluation of his head injury at 7:10 p.m. and returned back to the facility at 9:45 p.m. According to the note, a CT (computed tomography) scan of his head and neck and there were no underlining concerns. The 4/23/25 incident report documented the 4/23/26 fall occurred at 6:45 p.m. in the dining room and was unwitnessed. According to the report, factors of the fall included poor memory, confusion, gait imbalance and ambulating without assistance. The 4/24/25 at 12:23 a.m. skin check identified Resident #84 had bruising/hematoma right lateral back of thigh, down to his right lower leg. The 4/24/26 IDT note documented Resident #84 had poor safety awareness and was not able to say what he was doing that led to the unwitness fall on 4/23/26. The note indicated the interventions put into place after the fall was for staff to encourage the resident to sit in the commons area where he is more visible to staff and encourage the resident to attend activities of choice. The note documented therapy and restorative was notified of the incident. The 4/26/26 post fall evaluation note documented the 4/23/26 fall was witnessed by a CNA in his room that resulted in injuries to a right eye laceration, and bruising to his arm, leg and back and a visit to the emergency room. According to the evaluation, the resident was wearing shoes at the time of the fall and his bedside light was on and his bathroom and his personal light was sounding when he was found. -The fall documentation documented two different scenarios of the 4/23/26 fall. The progress note and the incident reported documented the fall was unwitnessed. The incident report documented the resident fell in the dining room. The post evaluation documented he was in his room and his fall was witnessed by a CNA. -The fall documentation did not identify if he was offered an activity or another location that would be more supervised/visible by staff, prior to the fall or if the resident was continent at the time of fall or when he was last toileted. g. Falls on 4/24/26 witnessed and unwitnessed The 4/24/26 nursing note identified the resident had another fall on 4/24/26. According to the note, Resident #84 was sitting in his wheelchair taking his clothes off when the nurse entered the room. The resident started to lean forward, when his wheelchair cushion slid forward at an angle and he (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident mostly out of bed. She entered the room and the resident grabbed her and would not let her go so she lowered him down to the floor without injury. The interventions documented after the floor were Ensure the motion alarm is in the proper place and functioning properly. Ensure call light is within reach and frequently remind the resident to utilize the call light system and wait for staff to assist. Ensure bed is in the lowest position -The fall documentation did not identify the resident was assessed by a nurse before he was moved off the floor and into a reclining chair by the CNA or if the bed was in a low position. i. Fall on 4/28/26 - witnessed The 4/28/26 incident report was provided by the DON on 5/21/26 at 11:53 a.m. The report identified Resident #84 had another fall. The report identified the fall was witnessed on 4/28/26 at 3:15 p.m. According to the incident report, a nurse was sitting at the computer at the nursing desk when she heard a gasp and commotion. The nurse got up saw Resident #84 on the floor of the commons area, laying on his left side and in front of his wheelchair. The foot petals were on the wheelchair. The report indicated the resident was brought back to the facility from an outside provider and staff was not notified that he returned. The incident report documented the resident had a large skin tear on his upper left arm that was bleeding and measured 7 cm long and 8 cm wide. The 4/30/26 IDT risk note documented the 4/28/26 fall root cause. According to the note, he was left unattended in the commons area after he was returned from an outing with an outside provider/care team. The facility staff was not aware that he had returned to the facility and placed in the common area. The note documented the facility worked with the outside care team to communicate with the facility staff when the resident was returned to the facility so the facility could ensure oversight and supervision. The note indicated the staff would be encouraged to place the resident in a reclining chair in the common area for comfort. The note documented therapy and restorative was notified of the incident. 4. Staff interviews The DON, the MDS coordinator and the therapy director were interviewed on 5/21/26 at 9:38 p.m. Resident #84 repeated falls and intervention, clarification of the fall on 4/23/26 that resulted in the resident going to the hospital, and the above observations were reviewed. The DON said on 4/23/26 the resident fell in the dining room and not in his room. She said the fall was witnessed by a family member of another resident and was not witnessed by the staff. She said the investigation did not identify where the staff was when he fell in the dining room. The DON said the investigation did not include staff or the family member's interview. She said the investigation was not clear if the family member actually witnessed the fall or if they were the ones who found the resident in the dining room. She said she did not know what the resident was doing prior to the fall, if he needed to use the restroom or when he was last toileted. The therapy director said she was made aware of the repeated falls, but did not receive orders from his outside provider/care team to evaluate him for therapy until 4/28/26, after the resident had the 10 falls in April 2026. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS coordinator said there was a long process to approve and receive orders from his outside care team. The DON said the facility should have reviewed the concern and delay with the medical director to help with the timeliness of the request. The therapy director said therapy was able to evaluate the resident on 4/29/26. The DON said the facility could have looked into one to one supervision to help decrease the risk of falls while the facility was waiting on therapy orders. The DON said Resident #84 would remove the lap buddy but should be encouraged to use it. She said based on observations made on 5/19/26. The DON said the staff should have asked him if he needed to use the restroom and provided assistance when they observed him leave the dining room table, go down the hall and enter his room. The MDS coordinator said some of the April 2026 fall interventions were not care planned to ensure staff communication. The MDS coordinator said one of the nurses told her that Resident #84 liked to sit in the reclining chair and a drink/snack. She said the resident seemed to enjoy the fall intervention. She said she would add it to the care plan and spread the information to other staff that work with him. She said she would continue to encourage staff to let her know what interventions were working to help prevent falls. The DON said there were patterns to the falls that were not fully identified. She said the investigations needed to be more thorough and include relevant information such as when Resident #84 was last toileted and checked on. She said the investigations should have included what the staff was doing at the time of the unwitnessed fall and who witnessed the falls. She said interviews with the staff who were working with Resident #84 at the time of the fall would help identify more factors and information related to falls. The DON and the MDS coordinator said thoroughly completed investigations could help prevent recurrence of the falls. The DON the resident has had no new falls since 4/28/28 but she would implement fall training to help decrease Resident #84 and other residents' risk for falls. 5. Facility follow up The fall in-service conducted on 5/21/26 through 5/26/26 was provided by the DON on 5/26/26 at 11:49 a.m. (after the survey exit) via email. The inservice identified the 29 members of the nursing department who were educated on fall prevention techniques and communication to include identification of routines, preferences, toileting needs and abilities, motivation to more and need for supervision. The inservice directed staff to communicate and document the observations of residents they were working with. II. Failure to ensure safe water temperatures A. Professional reference According to the Consumer Product Safety Commission (CPSC) Safety Alert, Avoiding Tap Water Scalds, retrieved on 5/27/26 from https://www.cpsc.gov/s3fs-public/5098.pdf The majority of injuries and deaths involving tap water scalds are to the elderly and children under the age of five. The U.S. Consumer Product Safety Commission (CPSC) urges all users to lower their water heaters to 120 degrees Fahrenheit (F). B. Facility policy and procedure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Test and Log Hot Water Temperatures policy, undated, was provided by the DON on 5/22/26 at 12:47p.m. via email The policy read in pertinent part, The facility must ensure that the residents' environment remains free of accidents as much as possible and each resident receives adequate supervision assistance to prevent accidents. For burn prevention, federal guidelines advise you to keep domestic water temperatures below 120 degrees Fahrenheit although this temp can still cause burns if exposure reaches 5 minutes. C. Observations and resident interviews The tap hot water temperatures from resident rooms were obtained on 5/21/26 between 9:15 a.m. and 9:50 a.m. The hot water in each resident room ran for approximately one minute prior to taking the water temperature. The hot water temperatures were as follows: -At 9:19 a.m. the water temperature from the sink in room #E6 registered at 120 degrees F. One resident who resided in room #E6 said the water took a while to warm up and he liked it hot. -At 9:23 a.m. the water temperature from the sink in room #F1 registered at 123 degrees F. -At 9:26 a.m. the water temperature from the sink in room #F2 registered at 122 degrees F. One resident who resided in room #F2 said the water got pretty hot. -At 9:31 a.m. the water temperature from the sink in room #A12 registered at 128 degrees F. One resident who resided in room #A12 said the water got pretty hot. -At 9:41 a.m. the water temperature from the sink in room #A5 registered at 129 degrees F. -At 9:48 a.m. the water temperature from the sink in room #B13 registered at 128 degrees F. One resident who resided in room #B13 said the water took a while to get hot and should get hotter faster. -At 9:50 a.m. the water temperature from the sink in room #B5 registered at 128 degrees F. D. Record review The resident room water temperature log for February 2026, March 2026 and April 2026 was provided by the DON on 5/21/26 at 4:48 p.m. The water temperature log documented water temperatures were taken monthly in one resident room in each hall. In February 2026 the hot water temperature ranged from 107 degrees F to 114 degrees F. In March 2026 the hot water temperature ranged from 107 degrees F to 115 degrees F. The water temperature logs documented the facility's most recent water temperature audit was conducted on 4/10/26, with hot water temperatures ranging from 107 degrees F to 113 degrees F. E. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance assistant was interviewed on 5/21/26 at 1:35 p.m. The maintenance said the hot water tanks were usually set at 113 degrees F. He said the water temperatures ranged between 105 degrees F and 113 degrees F. He said they should keep water temps under 120 for safe resident use. He said he obtained the temperature of the water in the sink in room #A12 today (5/21/26) at 12:00 p.m. He said the resident sink water was 128 degrees F, which was too hot for a resident room. He said looked at the water heater and it was leaking, which was potentially affecting water temperatures. He said he turned the water heater temperature down. He said in the past there was a drip, but the drip stopped. He said with the 5/21/26 identification of the leak, the facility learned they need a new hot water heater. The DON was interviewed on 5/21/26 at 5:00 p.m. The DON said the hot water heater had a significant leak identified by maintenance on 5/21/26. She said there had not been any burns or injuries related to the hot water. F. Facility follow-up An email provided by the DON on 5/26/26 at 2:20 p.m. (after the survey exit) documented a plumber inspected the hot water heater and determined the bottom of the heater was rusted and needed to be replaced. According to the email, the maintenance department adjusted the temperature valve to compensate for the deficiency and are doing two hour checks to ensure it was staying in the appropriate temperature range until the heater could be replaced.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide and document sufficient discharge preparation for two (#111 and #12) of two residents reviewed for a safe and orderly discharge out of 41 sample residents. Specifically, the facility failed to ensure a written discharge bed hold notice was provided to Resident #111 and Resident #12 or their representative completed at the time Resident #111 and Resident #12 were transferred to the hospital. Findings include: I. Facility policy and procedure The Bed Holds and Return policy, revised October 2022, was provided by the director of nursing on 5/20/26 at 6:55 p.m. It read in pertinent part, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided with written notice about these policies at least twice: well in advance of any transfer (in the admission packet); and at the time of transfer (or, if the transfer was an emergency, within 24 hours). The written bed-hold notices provided to the residents/representatives explain in detail: the duration of the state bed-hold policy, if any, during which the resident is permitted to return and. resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents); the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility return policy. II. Resident #111 A. Resident status Resident #111, age greater than 65, was admitted on [DATE] and discharged to the hospital on 3/12/26. According to the May 2026 computerized physician orders (CPO), diagnoses included acute kidney failure, and congestive heart failure. The 3/27/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. B. Record review The 3/22/26 progress note documented Resident #111 was transported to the hospital emergency room at 11:43 a.m. per the on-call doctor. The 3/22/26 nursing progress note revealed Resident #111 received an update from the power of attorney (POA) the resident was admitted to hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic medical record (EMR) failed to show a written bed hold form was completed with the resident or the POA upon transfer to the hospital. A request for the bed hold form for Resident #111 5/21/26. The social service director (SSD) said she did not have a bed hold form for Resident #111 (see interviews below). III. Staff interviews Registered nurse (RN) #2 was interviewed on 5/21/26 at 2:05 p.m. RN #2 said he always asked for help with discharges, because he did them infrequently. He said he has someone from administration look over his work for discharges. He said when a resident was discharged to the hospital a bed hold form needed to be completed. He said a staff member from administration provided the forms. He said he did not know why residents had to sign a bed hold form, and he always assumed the resident's bed was always held . The SSD was interviewed on 5/21/26 at 2:20 p.m. The SSD said Resident #111 was transferred to the hospital on 3/22/26. She said a bed hold form was not provided to the resident when she was discharged . She said the facility had not utilized this form as they should. She said it had been the standard to hold the bed open for the resident until they find out the disposition of the resident. She said despite the facility holding the bed, they still needed to have a signed bed hold form. The SSD said it was the resident's right to be informed of the requirements of the bed hold policy. III. Resident #12 A. Resident status Resident #12, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 CPO diagnoses included acute and chronic respiratory failure, pulmonary hypertension and respirator virus. The 5/19/26 MDS assessment revealed Resident #12 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was dependent on mobility with the use of a wheelchair. B. Record review The nursing progress note, dated 5/13/26, revealed Resident #12 discharged to the hospital for shortness of breath. Review of Resident #12's EMR did not reveal a bed hold notice was provided when Resident #12 was transferred to the hospital on 5/13/26. C. Staff interview Licensed practical nurse (LPN) #2 was interviewed on 5/21/26 at 11:50 a.m. LPN #2 said the assistant director of nursing (ADON) reviewed the bed hold policy with her today (5/21/26). She said the ADON explained to her the importance of completing the bed hold form when residents were sent to the hospital. She said the form was just added to the discharge packet. She said Resident #12 did not have a bed hold form prior to leaving for the hospital on 5/13/26.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to prevent and treat pressure injuries for one (#9) of six residents reviewed for pressure injuries out of 41 sample residents.Specifically, the facility failed to ensure staff consistently implemented care planned interventions for Resident #9, who had an unstageable pressure injury to her right heel.Findings include:I. Professional referenceAccording to Basic Nursing third edition; [NAME] S. Treas, [NAME], [NAME] H. [NAME] (2022), page 1214-1215, Healthy people regularly shift position to maintain comfort. However, many patients are unable to move without assistance. They require a change of position at least every two hours to prevent skin breakdown, muscle discomfort. People who are immobile are more prone to pressure injury as a result of reduced circulation, impaired oxygen exchange to the tissues and edema.According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.p on 5/28/26,Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate ?at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.II. Facility policy and procedureThe Pressure Ulcer Skin Breakdown policy, revised April 2018, was provided by the director of nursing (DON) on 5/20/26 at 2:00 p.m. It read in pertinent part, The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers, for example, immobility, recent weight loss, and a history of pressure ulcers. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions, identify the type of an ulcer and define any complications related to pressure ulcers. Healing or prevention likely: The resident's underlying physical condition, prognosis, personal goals and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. Healing or prevention possible: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. Monitoring during resident visits: The physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker. III. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included osteoporosis, chronic obstructive pulmonary disease, peripheral vascular disease and anxiety. The 4/14/26 minimum data set (MDS) assessment revealed Resident #9 had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. She needed partial to moderate assistance for activities of daily living (ADL). The MDS assessment indicated the resident had a pressure injury and she had a pressure reducing mattress. B. ObservationsOn 5/19/26 at 8:59 a.m. Resident #9 was lying in bed on her back and her protective podus boot was laying on the floor next to the bed. During a continuous observation on 5/20/26, beginning at 9:21 a.m. and ending at 11:38 a.m., Resident #9 was lying in bed on her back. The resident's protective podus boot was laying on the floor next to the bed. -No staff members entered the room during the two hour and 17 minute observation. On 5/21/26 at 8:38 a.m. Resident #9 was lying in bed on her back and her protective podus boot was laying on the floor next to the bed. C. Record review The pressure ulcer care plan, initiated 10/28/25 and revised 3/11/26, revealed Resident #9 had a pressure ulcer to the right heel related to immobility. The pressure ulcer would show signs of healing and remain free from infection. The resident would have intact skin, free of redness, blisters or discoloration through the next review date. Interventions included administering treatments as ordered and monitoring for effectiveness, providing an alternating air mattress with fitness setting three continuously, assessing, recording and monitoring wound healing weekly and as needed, measuring length, width and depth of the wound where possible, assessing and documenting the status of the wound perimeter, wound bed and healing progress, reporting improvements and declines to the medical director (MD), educating the resident, family and caregivers as to causes of skin breakdown, including transfer and positioning requirements; importance of good nutrition and frequent repositioning, following facility policies and protocols for the prevention and treatment of skin breakdown, heel protectors on the resident's bilateral feet and reminding the resident and assisting the resident to turn and reposition at least frequently.A nurse skin assessment note, dated 10/25/26, revealed Resident #9's right heel had an approximately four centimeter (cm) diameter dark red and purple discoloration that was tender to the touch. No broken skin was noted to the area. The surrounding skin area was pink and blanching (turning pale or white). Recommendations were to apply skin prep to the area, float the resident's heels while in bed and place protective (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	booties on her heels. The resident's heels were to be floated at all times to mitigate potential pressure. A nurse skin assessment note, dated 11/6/25, revealed Resident #9's right heel wound was unstageable and measured at 2.6 cm long by 3.2 cm wide and 3.2 cm deep. The resident had an air mattress placed and had heels floating.A nurse skin note, dated 1/14/26, revealed the skin to Resident #9's heel wound was dry and no drainage was noted. The wound nurse covered the area with a bordered foam dressing after measuring the wound to be 1.54 cm long by 2.11 cm wide by 0.4 cm deep. The resident removed her protective podus boots and had to be reminded to wear them. -However the care plan did not reflect the resident's refusals or removal of the podus boots (see care plan above).A nurse skin note, dated 2/17/26, revealed Resident #9's wound bed had minimal slough (soft tissue), no eschar (dead tissue) and epithelial (damage) tissue to the wound. The wound had improved. A new dressing was in place and boots were on the resident's heels. Skin issue education was provided to staff to turn the resident every two hours.-However, observations revealed staff did not consistently reposition the resident (see observations above).A nurse note, dated 5/14/26, revealed the nurse was called to Resident #9's room because the resident had removed the blue foam boot and the heel protector pad. The nurse made a foam heel cup instead of a slip-on protector covered the entire foot with a stockinette secured at the ankle to attempt to keep the dressing in place longer and reapplied foam boot. The resident stated she would leave the dressing alone.-However the care plan did not address the resident's noncompliance to leave the dressing and the podus boot on.Review of Resident #9's May 2026 CPO revealed the following physician's orders: Wound care right heel: make sure podus boots are applied and heels are floated, every day and night shift, ordered 12/19/25 and discontinued 5/8/26. Wound care right heel: make sure socks and heel protectors are on and heels are floated every day and night shift, ordered 5/8/26. IV. Staff interviewsThe infection preventionist was interviewed on 5/19/26 at 7:50 a.m. The infection preventionist said she was responsible for the wound care for the residents. She said she was alerted when a resident had a skin issue and she completed the risk assessments and the Braden scale She said she educated the staff on new interventions when needed, such as air mattresses, heel or elbow protectors, when to float heels and repositioning residents. She said Resident #9 often peeled her dressings off her heel and took her protective boots off. She said was repositioned every two hours and she was encouraged to keep her podus boots on her feet. -However, observations revealed staff were not consistently ensuring the resident's podus boot was on (see observations above).Certified nurse aide (CNA) #1 was interviewed on 5/20/26 at 11:25 a.m. CNA #1 said residents were repositioned every two hours on average. She said the nurse would let her know when a new skin injury occurred for a resident and what to do to help with the care. She said the staff kept a close eye on Resident #9 because she removed her podus boots and threw them on the floor.-However, observations revealed staff were not consistently ensuring the resident's podus boot was on (see observations above). Licensed practical nurse (LPN) #1 was interviewed on 5/20/26 at 2:02 p.m. LPN #1 said verbal education was given to the CNAs for positioning and offloading areas with pressure for residents. LPN #1 said Resident #9 was problematic because she would take her boots off. She said the resident refused to keep her heel protectors on and staff reminded her to keep them on but the resident forgot. -However, observations revealed staff were not consistently ensuring the resident's podus boot was on (see observations above). LPN #2 was interviewed on 5/21/26 at 11:50 a.m. LPN #2 said the first line of any skin redness was to use skin barriers to avoid further breakdown. She said residents were monitored every shift and staff made sure the resident was repositioned at least every two hours. CNA #2 was interviewed on 5/21/26 at 11:45 a.m. CNA #2 said the nurses would verbally tell her when a resident had a pressure wound and staff would turn the resident every two hours and use pillows for positioning.Registered nurse (RN) #1 was interviewed on 5/21/26 at 2:32 p.m. RN #1 said residents who had pressure injuries were followed by the wound nurse and sometimes the wound doctor. She said the residents required frequent turning and had pressure relieving devices to keep pressure off the site. She said Resident #9 wore protective boots but she (continued on next page)

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	065331	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larchwood Health and Rehab LLC	2845 N 15th St Grand Junction, CO 81506

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	liked to rip them off at times. She said staff did frequent checks to make sure the boots were kept on.-However, observations revealed staff were not consistently ensuring the resident's podus boot was on (see observations above). The DON was interviewed on 5/21/26 at 3:15 p.m. The DON said any reddened skin was reported to the nursing staff and monitoring began. She said barrier cream was started with repositioning. She said the wound nurse was notified and interventions put into place. The DON said interventions included pressure relieving devices, such as an air mattress for the bed, or cushion for the chair. The DON said the interdisciplinary team (IDT) met weekly to discuss any new concerns and to follow up on any current resident needs, to include skin with pressure injuries. She said the IDT brainstormed for any new interventions needed for the resident. She said the facility tried to ensure preventative measures for pressure wounds were reviewed for implementation. The DON said she was responsible for educating the staff to anticipate the needs of the resident. She said staff were getting better on how to capture the residents' refusals with documentation. She said Resident #9 continued to take off her protective boots and due to her cognition and inability to remember to keep them on, the IDT thought they would try a recliner chair as a new positioning technique. She said the resident's wound could decline from poor or inconsistent interventions.

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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. Based on observations, record review and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on one out of six units.Specifically, the facility failed to ensure hand hygiene was conducted appropriately during wound care for Resident #9 and Resident #55.Findings include:I. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 5/27/26 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. Clean your hands before and after changing wound dressings or bandages. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings.II. Facility policy and procedureThe Wound Care policy, revised October 2010, was provided by the director of nursing (DON) on 5/20/26 at 6:47 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the procedure: wash and dry your hands thoroughly. Put on exam gloves. Loosen tape, remove dressing and pull soiled gloves over the dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. Put on gloves. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Remove disposable gloves and discard them into designated containers. Wash and dry your hands thoroughly. Wipe reusable supplies with alcohol as indicated outsides of containers that were touched by unclean hands, scissor blades). Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. Wash and dry your hands thoroughly. Notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice.III. Observations On 5/19/26 at 10:17 a.m. the wound doctor was completing wound care for Resident #55. The wound doctor donned a mask, gloves and a gown. He removed the soiled wound dressing. He then moved his glasses to the top of his head with his gloved hands, touched his mask and the resident's headboard. Without changing gloves and performing hand hygiene, he cleaned the wound with a wound spray and applied lidocaine gel (topical pain medication). With the same gloved hands, he picked up the camera and took pictures of the wound. He then used the sterile utensils brought into the room earlier to debride the wound, placed a sterile medicated packing material inside the wound bed and covered it with a bordered bandage. He opened the door of the resident's room with the same gloved hands and stepped out of the room before doffing mask, gown and gloves. He cleaned the camera with a disinfectant wipe and then washed his hands in the residents sink. -The wound doctor failed to change gloves and perform hand hygiene when his gloves became contaminated. On 5/19/26 at 10:45 a.m. The wound doctor was completing wound care for Resident #9 He donned a mask and gown and reached into his pocket for the gloves, he put the gloves on and entered the resident's room. He opened the sterile utensil package upon entering the resident room and placed this on the bedside table. He doffed the gloves he had in his pocket and put on a new pair of gloves found in the resident's room, without performing hand hygiene. He took off the soiled dressings from three different areas of the resident's foot and cleaned the areas with a wound cleanser. He then applied lidocaine gel to the heel wound. He took pictures of the wound and then used the sterile utensils to debris the wound, placed a sterile medicated packing material inside the wound bed and covered it with a bordered bandage. He doffed the gown and gloves, cleaned his camera with a disinfectant wipe and washed his hands in the resident's sink. -The wound doctor failed to change gloves and perform hand hygiene when his gloves became contaminated. IV. Staff interviewsThe wound doctor was interviewed on 5/19/26 at 11:10 a.m. He said the process for infection control was to keep dirty items from clean items. He said that was why he brought the sterile kit into the resident's room, so he would not contaminate the wound cart and to keep the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound clean. The infection preventionist was interviewed on 5/20/26 at 2:55 p.m. The infection preventionist said hand hygiene was completed between glove use, going in out of resident rooms, during incontinence care, prior to meals and when hands come in contact with soiled material. She said during wound care she would expect gloves to be changed from dirty to clean procedures with hand hygiene in between. She said she had not completed any education with outside agencies coming into the facility on hand hygiene nor PPE use. The DON was interviewed on 5/21/26 at 3:15 p.m. She said staff completed hand hygiene in between resident cares and glove use. She said outside agencies, such as the wound doctor, that came into the facility were not regulated by them. She said however, she said she would hope they followed professional standards with wound care and hand hygiene procedures.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program to include antibiotic use protocols and a system to monitor antibiotic use for one (#92) of two residents reviewed for antibiotic stewardship out of 41 sample residents. Specifically, the facility failed to ensure Resident #92's antibiotic therapy for doxycycline medication was reviewed for continued use on an ongoing basis.Findings include: I. Facility policy and procedure The Antibiotic Stewardship Review and Surveillance policy, revised December 2016, was provided by the director of nurses (DON) on 5/19/26 at 10:17 a.m. It read in pertinent part, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee' The infection preventionist or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. Therapy may require further review and possible changes if: therapy was ordered for prolonged surgical prophylaxis and clinical findings do not indicate continued need for antibiotic. At the conclusion of the review, the provider will be notified of the review findings. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include, symptoms, start date of antibiotics, site of the infection, total days of therapy, outcome, adverse events and stop date. II. Resident statusResident #92, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO) diagnoses included Alzheimer disease, infection with inflammation to a reaction with an internal orthopedic device and osteomyelitis. The 3/20/26 minimum data set (MDS) assessment revealed Resident #92 had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She was dependent on activities of daily living (ADL). The assessment indicated she was on an antibiotic. III. Record reviewThe May 2026 CPO revealed the following physician's order:Doxycycline 100 milligrams (mg) one tablet orally daily for osteomyelitis related to infection with inflammation to a reaction with an internal orthopedic device, ordered on 6/15/23. The nurse practitioner note, dated 1/9/25, was provided by the director of nursing (DON) on 5/20/26 at 8:30 a.m. The note revealed Resident #92 was on doxycycline as a suppressive therapy (continued use of medication) from an infected hardware to the left ankle. The medical director note, dated 1/20/25, was provided by the DON on 5/20/26 at 8:30 a.m. The note revealed Resident #92 was on doxycycline for infected hardware in the ankle, with associated osteomyelitis. On suppressive antibiotics and tolerating the medication well.-Review of Resident #92's electronic medical record (EMR) did not reveal any further documentation regarding justification or monitoring of the continued use of the doxycycline. The medication regimen review dated 7/30/25 and 2/26/26 were provided by the DON on 5/20/26 at 7:09 p.m. -The medication reviews did not reveal the doxycycline was reviewed. IV. Staff interviewsThe infection preventionist was interviewed on 5/19/26 at 1:47 p.m The infection preventionist said Resident #92 was on a prophylactic antibiotic for inflammation from an infected internal hardware. She said the nurse practitioner assessed the need for the continued medication and recommended any changes. She said she reviewed progress notes and talked to the interdisciplinary team for follow up. She she had not followed up with the antibiotic use for Resident #92 since the order was originally placed in 2023The DON was interviewed on 5/21/26 at 3:15 p.m. The DON said the facility completed medication reviews right after the interdisciplinary team meetings. She said the medical director talked to families and looked at the medical history before making any changes to the medications. She said when a resident was on antibiotics, they used the McGeers (identify and track infection) criteria and discussed each case with the physician for (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued use or discontinuation. She said they had not looked at Resident #92 antibiotic regimen regularly to see if the medication continued to be appropriate. V. Facility follow-up A facsimile (fax) dated 5/20/26 which was sent to the physician, was provided by the DON on 5/20/26 at 3:30p.m. The fax documentedResident #92 was on doxycycline medication 100 mg one tablet daily for osteomyelitis related to infection with inflammation to a reaction with an internal orthopedic device. The fax documented she started the medication on 6/15/23. The fax asked the physician to review if the resident was still appropriate to be on the medication at this time, if there were any concerns or or if a risk versus benefit was needed.-However, record review revealed Resident #92's antibiotic use had not been reviewed since January 2025 (see record review above).-The facility did not provide follow-up from the physician.