STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065332	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Aurora	14101 E Evans Ave Aurora, CO 80014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 possible development and transmission of infectious diseases on three of four units.Specifically, the facility failed to:-Ensure housekeepers cleaned and disinfected the residents' rooms in a hygienic manner;-Ensure housekeepers performed hand hygiene appropriately while cleaning resident rooms;-Ensure chemical dwell times were followed during resident room cleaning;-Ensure resident vital signs equipment was disinfected; and,-Ensure staff followed enhanced barrier precautions (EBP) precautions while providing direct resident care. Findings include: I. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 4/13/26 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 4/13/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. According to Sealed Air Diversey Care's Virex Tb Ready-To-Use Disinfectant Cleaner, revised 2017, retrieved on 4/13/26 from https://pdf.[NAME].com/operatingguides/807174540727_oper.pdf, Spray the area until it is covered with the Virex tuberculin (Tb) ready-to-use disinfectant cleaner. Allow the product to penetrate and remain wet for five minutes to kill all bacteria including Methicillin-resistant staphylococcus aureus (MRSA), Methicillin-resistant staphylococcus epidermidis (MRSE) and Vancomycin-resistant enterococci (VRE), norovirus (gastrointestinal virus), Tb, hepatitis B virus and HIV-1 viruses (acquired immunodeficiency syndrome - AIDS virus). Wipe the area with a clean cloth, sponge or paper towel. For heavily soiled areas, thoroughly clean the surface prior to disinfecting the area. A potable water rinse is required for surfaces in direct contact with food. B. Facility policy and procedure The Housekeeping policy, dated 4/1/26, was provided by the nursing home administrator (NHA) on 4/9/26 at 6:26 p.m. It read in pertinent part, It is the responsibility of the executive director through the environmental services director to assure that housekeeping policies are implemented and followed. All associates are required and expected to carry out all procedures safely and as instructed. C. Observations On 4/8/26 at 1:53 p.m. housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER], a single occupancy room in the skilled nursing unit on the first floor. HK #1 entered the resident's room with two clean rags and Diversey Virex Tb disinfectant spray. He sprayed one of the rags with the disinfectant spray then immediately wiped the surface of the resident's dresser/vanity. -HK #1 did not allow the disinfectant spray to make direct contact with the surface of the dresser/vanity and remain on the surface for the recommended five minute dwell time. HK #1 moved the resident's items off the bedside table before he sprayed the disinfectant spray on the surface. He immediately wiped the surface of the bedside table with a clean rag, then used the same rag to quickly wipe the call light. -HK #1 failed to allow the disinfectant to remain on the surface of the bedside table and the call light for the recommended five minute dwell time. At 2:06 p.m. HK #1 began cleaning the resident's bathroom. He sprayed the countertop around the sink, all surfaces of the sink, grab bars, toilet riser and toilet. At 2:06 p.m. HK #1 wiped the countertop, sink faucet handles and the interior of the sink with a rag. He collected a clean rag and re-wiped the countertop and all surfaces of the sink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the chemical dwell time was three minutes. -However, according to the product's recommendations, the dwell time was five minutes (see professional reference above). HK #2 was interviewed on 4/9/26 at 9:58 a.m. HK #2 said the chemical dwell time for the Diversey Virex Tb disinfectant spray was five minutes. She said following the dwell time meant the surface had to be wet for five minutes and it was important to follow the dwell time to kill bacteria. HK #2 said the dwell time was maybe two to three minutes when she cleaned the sink and surrounding counter areas in room [ROOM NUMBER], but five minutes when she cleaned the toilet. She said she should have changed her gloves after cleaning the toilet and before touching the mop handle. The HKS was interviewed again on 4/9/26 at 11:00 a.m. The HKS said the process for cleaning included working from the cleanest area to the dirtiest area, so the bathrooms should be cleaned last as they were the dirtiest. He said the disinfectant spray should be sprayed on all surfaces and the surfaces should be allowed to remain wet for five minutes before being wiped with a rag. The HKS said it was important to follow chemical dwell times in order to kill all possible pathogens. The HKS said it was important to change gloves after touching the toilet to prevent cross contaminants, such as clostridium difficile (c. diff - bacteria that causes severe diarrhea) or norovirus around the room or within the facility. He said housekeeping staff were expected to change their gloves after dusting, taking out the trash, in between cleaning the bathroom and the main room and after cleaning the toilet. II. Failed to ensure resident vital signs equipment was disinfected and ensure staff followed EBP while providing direct resident care A. Professional reference According to the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO), (4/2/24), retrieved on 2/5/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ target gown and glove use during high contact resident activities.kj EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. 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), wound care (any skin opening requiring a dressing). B. Facility policy and procedure The Standard, Enhanced Barrier, and Transmission-Based Precautions policy, revised 6/2/25, was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided by the NHA on 4/9/26 at 6:02 p.m. It read in pertinent part, The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Additionally it said it was the goal to Ensure associates follow the IPCP's (Infection Prevention and Control Program) standards, policies and procedures (hand hygiene and appropriate use of PPE - personal protective equipment). C. Observations On 4/6/26 at 3:53 p.m. an unidentified nursing staff member entered a resident's room who was on EBP. The unidentified nursing staff member put on gloves and took the resident's vital signs and then left the resident's room. -The unidentified nursing staff member failed to put on a gown while taking the resident's vital signs. -The unidentified nursing staff member failed to sanitize the vital signs machine after taking the resident's vital signs. On 4/8/26 at 11:27 a.m an unidentified nursing staff member was observed assisting Resident #94 back into bed. A sign on the resident's door indicated the resident was on EBP. -The unidentified nursing staff member failed to put on gloves and a gown when assisting the resident back into bed. On 4/8/26 at 12:28 p.m. an unidentified nursing CNA and certified nurse aide (CNA) #5 entered Resident #77's room. The resident was on EBP for a pressure ulcer. The unidentified CNA and CNA #335 assisted Resident #77 from his wheelchair into his bed and brushed the resident's teeth. The unidentified CNA and CNA #5 exited the resident's room, after brushing his teeth, with a small trash bag containing incontinence supplies and the resident's lunch tray. -The unidentified CNA and CNA #5 failed to put on gloves and a gown while performing Resident #77's direct care. On 4/8/26 at 2:19 p.m. CNA #5 and an unidentified nursing staff member transferred Resident #26 from her bed to her wheelchair. There was a sign on the resident's door that indicated the resident was on EBP. -The unidentified nursing staff member and CNA #5 failed to put on a gown while transferring Resident #26. On 4/8/26 at 2:34 p.m. CNA #5 entered Resident #26's room and began assessing her vital signs using a vital signs machine. -CNA #5 did not perform hand hygiene or don any PPE prior to entering Resident #26's room. On 4/9/26 at 10:05 a.m. an unidentified nursing staff member was observed using a vital signs machine on a resident in their room. When the unidentified nursing staff member finished using the vital signs machine, the staff member wheeled the machine out of the resident's room and directly behind the nurses' station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The unidentified nursing staff member failed to disinfect the vital signs machine prior to wheeling it behind the nurses' station. On 4/9/26 at 10:38 a.m. two unidentified nursing staff members were getting a resident up from bed using a mechanical lift. There was a sign on the resident's door indicating the resident was on EBP. -The unidentified nursing staff members failed to put on a gown or gloves prior to transferring the resident with the mechanical lift. On 4/9/2026 at 10:44 a.m. a vital signs machine was sitting in the hallway with no disinfectant supplies observed in the area. D. Staff interviews CNA #4 was interviewed on 4/9/26 at 12:30 p.m. CNA #4 said after obtaining vital signs for each resident, CNAs should sanitize vital signs machines with disinfectant wipes to prevent contamination. CNA #7 was interviewed on 4/9/26 at 12:36 p.m. CNA #7 said each CNA should clean vital signs machines with a bleach solution after obtaining residents' vital signs. CNA #7 said CNAs hands were to be washed before and after obtaining residents' vital signs. CNA #8 was interviewed on 4/9/26 at 12:45 p.m. CNA #8 said the vital signs machine was to be sanitized after each use, including the blood pressure cuff, pulse oximeter and thermometer. The infection preventionist (IP) was interviewed on 4/9/26 at 2:04 p.m. The IP said residents who had indwelling devices, such as catheters, feeding tubes, intravenous (IV lines and/or wounds should be on EBP. The IP said residents on EBP had signage on their doors which indicated they were on EBP and the appropriate PPE that staff were required to wear.The IP said staff should wash their hands and put on a gown and gloves when providing care to residents on EBP. The IP said staff should remove the PPE and wash their hands after exiting a room where the resident was on EBP. The IP said staff did not need to wear PPE for a resident on EBP if the staff members were not providing direct resident care. The IP said CNAs should disinfect the vital signs machine with a bleach solution or the blue top sanitizing wipes between obtaining vital signs on each resident. The IP said the sanitizing wipes should be on the vital signs cart.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement a comprehensive care plan for one (#87) of seven residents reviewed for care plans out of 49 sample residents. -Specifically, the facility failed to ensure individualized, person centered interventions were identified and documented in Resident #87's behavior/mood care plan.Findings include:I. Facility policy and procedureThe Care Planning - Baseline, Comprehensive and Routine Updates policy, revised 12/4/25, was provided by the nursing home administrator (NHA) on 4/9/26 at 6:26 p.m. It read in pertinent part, Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems and risks. Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial).II. Resident #87A. Resident statusResident #87, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included Alzheimer's dementia, depression, limited mobility progressive neurological conditions and multiple chronic conditions. The 4/2/26 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 resident used a manual wheelchair for mobility and had impairment to one side of the upper extremity and lower extremity. The MDS assessment revealed the resident reported frequent pain she received scheduled and as needed medication for pain management.The MDS assessment revealed the resident had a PHQ-9 (patient health questionnaire - a multi-purpose tool used for screening, diagnosing, monitoring and measuring the severity of depression) score of 12 out of 27, which indicated moderate depression.B. Record review Resident #87's behavior/mood care plan, initiated 7/17/25 and revised 3/21/26, revealed the resident was at risk for a change in mood or behavior due to medical conditions documented as Alzheimer's/dementia. The care plan documented the resident was assessed by a primary care provider and primary care network and the medication regimen had been managed for chronic pain syndrome (a complex, long-term condition where persistent pain is often accompanied by symptoms such as depression, anxiety, fatigue, and functional disability which can severely diminish quality of life).Interventions included administering medications, anticipating the resident's needs and consulting with the resident on preferences regarding customary routine.-However, the care plan failed to include recommendations from direct care staff regarding resident-specific interventions which were effective for managing the resident's behaviors (see interviews below).III. Staff interviewsRegistered nurse (RN) #3 was interviewed on 4/9/26 at approximately 3:00 p.m. RN #3 said she regularly provided care for Resident #87 and was familiar with her needs. RN #3 said she could not remember when she had last provided input into Resident #87's behavior/mood care plan.RN #3 said Resident #87 responded positively to personal, individual care. RN #3 said she did not rush with the resident's care.RN #3 said Resident #87 was diagnosed with dementia and sometimes asked for help she may have already requested. RN #3 said the resident did not display behavior problems if staff provided personal and kind care for the resident. RN #3 said she responded quickly every time Resident #87 called for help, which helped to keep the resident's trust in her care. RN #3 said privacy was very important to Resident #87. RN #3 said she was careful not to discuss the resident's medication or other personal care in public areas in the facility. She said she respected the privacy of Resident's #87 and always knocked before entering the resident's room and closed the door as requested when leaving the resident's room to show her respect for the resident's privacy requests.RN #3 said clean hygiene and appearance was very important to Resident #87. RN #3 said she always responded to the resident's request for personal care support and ensured the resident and her oxygen and catheter equipment had been kept clean. RN #3 said she frequently checked Resident #87's oxygen tubing and settings in order to alleviate the resident's anxiety about possible problems with the oxygen.-However, the resident-specific (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions were not updated on Resident #87's behavior/mood care plan (see record review above).The social services assistant was interviewed on 4/9/26 at approximately 4:30 p.m. The social services assistant said she was not certain about the development of the behavior/mood care plans and how interventions were determined for residents. She said the facility's social services director would have more information about the care plans, but she was currently out of the office and unavailable. The director of nursing (DON) was interviewed on 4/9/26 at approximately 6:20 p.m. The DON said individualized, person-centered care plans for residents were important. He said he was not specifically aware of Resident #87's behavior/mood care plan and the generalized, nonspecific interventions included on the resident's care plan. He said the social services staff helped to develop the residents' behavior/mood care plans.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received necessary respiratory care and services per physician orders for one (#77) of two residents reviewed for respiratory care out of 49 sample residents.Specifically, the facility failed to administer Resident #77's supplemental oxygen per physician's orders.Findings include:I. Resident #77A. Resident statusResident #77, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included cognitive communication deficits, acute respiratory failure with hypoxia (inability of the respiratory system to maintain an adequate blood oxygen level), congestive heart failure, shortness of breath, sleep apnea and dependence on supplemental oxygen.The 2/6/26 minimum data assessment (MDS) assessment revealed the resident had significant cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The resident required supervision to maximal assistance from staff for most activities of daily living (ADL).B. ObservationsOn 4/6/26 at 11:26 a.m. Resident #77 was lying flat on his bed wearing a nasal cannula. Resident #77's room oxygen concentrator was on and the oxygen flow rate was set on 4.5 liters per minute (LPM). At 3:33 p.m. Resident #77 was lying in bed with the head of his bed elevated and his nasal cannula on. Resident #77's oxygen concentrator was set to a flow rate of 4.5 LPM.On 4/7/26 at 9:24 a.m. Resident #77 was sitting up in his wheelchair with his nasal cannula on. Resident #77's oxygen concentrator was set to a flow rate of 4.5 LPM.At 1:07 p.m. Resident #77 was lying in bed with the head of his bed elevated and his nasal cannula on. Resident #77's oxygen concentrator was set to a flow rate of 4.5 LPM.On 4/8/26 at 12:47 p.m. Resident #77 was lying in bed with the head of his bed elevated and his nasal cannula on. Resident #77's oxygen concentrator was set to a flow rate of 4.5 LPM.On 4/9/26 at 8:43 a.m. Resident #77 was sitting up in his wheelchair eating breakfast and wearing his nasal cannula. Resident #77's oxygen concentrator was set to a flow rate of 4.5 LPM.At 12:58 p.m. registered nurse (RN) #6 entered Resident #77's room, adjusted the resident's oxygen flow rate on his room concentrator, and said the resident's flow rate was at 4 LPM. RN #6 then turned Resident #77's flow rate on his room oxygen concentrator to 2 LPM before leaving the resident's room see interviews below).C. Record reviewThe oxygen care plan, revised 9/18/25, revealed Resident #77 received oxygen therapy due to his diagnoses of congestive heart failure and acute respiratory failure. Pertinent interventions included having Resident #77's oxygen settings at 2 LPM via nasal cannula continuously, administering medications as ordered and observing the resident for any signs or symptoms of respiratory distress and reporting them to the resident's physician.Review of Resident #77's April 2026 CPO revealed the following physician's orders:-Oxygen at 2 LPM continuously per nasal cannula, document every shift, ordered 8/29/25 and discontinued 4/9/26 at 1:34 p.m. (during the survey process); and,-Oxygen at 2 to 4 LPM to maintain oxygen saturations above 90 percent (%) via nasal cannula, document every shift, ordered 4/9/26 at 1:34 p.m. (during the survey process).Review of Resident #77's April 2026 medication administration record (MAR), from 4/1/26 through 4/9/26, revealed the following:The physician's order for Resident #77 to receive 2 LPM continuous supplemental oxygen was marked completed each shift (three times per day) from 4/1/26 to the morning of 4/9/26.-However, observations on 4/6/26, 4/7/26, 4/8/26 and 4/9/26 revealed the resident's oxygen flow rate was set at 4.5 LPM (see observations above). Resident #77's oxygen saturation levels were measured each shift (three times per day) from 4/1/26 to the morning of 4/9/26. Resident #77's oxygen saturation levels were documented as measuring between 93% and 98% each shift during this time period.A progress note, dated 4/8/26 at 2:40 p.m., revealed Resident #77 had generalized weakness and was unable to maintain an upright position for the duration of time he normally could. Resident #77's vital signs were measured and the resident's physician was notified.-However, the progress note did not document Resident #77's oxygen saturation level or any concerns of hypoxia.A progress note, dated 4/8/26 at 10:54 p.m., revealed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77 still had tiredness and fatigue. Resident #77 had bloodwork drawn and the results were pending. The director of nursing (DON) and the resident's representatives were notified.A progress note, dated 4/9/26 at 6:33 a.m., revealed Resident #77's bloodwork results were reported to the physician and no new orders were received from the physician at the time. Resident #77 slept most of the night with even, non-labored respirations. A progress note, dated 4/9/26 at 7:00 a.m., revealed Resident #77 was being monitored by the nursing staff for weakness. Resident #77 slept most of the night, and his plan of care was continued. Resident #77's vital signs were measured and the resident had an oxygen saturation level of 98%.A progress note, dated 4/9/26 at 7:50 a.m., revealed Resident #77 had a change in condition initiated and his representative was notified.A progress note, dated 4/9/26 at 1:20 p.m., revealed Resident #77 had a change in condition initiated the day prior (4/8/26) for generalized weakness. Resident #77 had bloodwork completed, which was reported to the physician. Resident #77 had an occasional cough and wheezing was heard when the resident's lung sounds were auscultated (an exam performed to listen to the sounds of the heart and lungs). Resident #77's supplemental oxygen flow rate was increased to 4 LPM to keep the resident's oxygen saturation level above 90%, and the order was confirmed by the resident's physician. An order for a chest Xray was placed by Resident #77's physician for his wheezing.-However, review of Resident #77's electronic medical record (EMR) did not reveal any oxygen saturation levels below 90%.A change in condition evaluation, dated 4/8/26 at 3:52 p.m., revealed Resident #77 was being evaluated for a change in condition due to generalized weakness. The change in condition started on 4/8/26. Resident #77's oxygen saturation level was measured to be 94% at the time. The assessment documented no respiratory changes were noted. Resident #77's physician was notified on 4/8/26 at 11:00 a.m., and new interventions included encouraging oral intake of food and beverages.-The change in condition evaluation did not document any respiratory changes for Resident #77.-Review of Resident #77's EMR did not reveal any documentation of his supplemental oxygen flow rate needing to be titrated up, or any documentation revealing the resident's physician was contacted regarding his oxygen needing to be titrated.II. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 4/9/26 at 9:15 a.m. CNA #5 said oxygen was a medication, so the CNAs could not adjust the residents' oxygen flow rates. CNA #5 said if a resident's oxygen flow rate needed to be adjusted, a nurse would need to do so. CNA #5 said Resident #77's oxygen flow rate was set to 4 LPM.-However, observations during the survey revealed the resident's oxygen flow rate was set at 4.5 LPM (see observations above).-Additionally, the resident's physician's order for oxygen revealed the resident's oxygen flow rate was to be set at 2 LPM (see physician's orders above).CNA #6 was interviewed on 4/9/26 at 11:08 a.m. CNA #6 said the CNAs did not adjust residents' oxygen flow rates. CNA #6 said the facility nurses had to check the residents' oxygen flow rates and ensure they were receiving the correct oxygen flow rate or adjust it.RN #2 was interviewed on 4/9/26 at 12:26 p.m. RN #2 said residents receiving supplemental oxygen had to have physician orders for the oxygen. RN #2 said the facility's nursing staff needed to know what the resident's baseline oxygen need was and the condition the oxygen was being used to treat. RN #2 said nurses needed to check the residents' oxygen saturation levels and communicate with their doctor consistently. RN #2 said in order to titrate a resident's supplemental oxygen flow, the nurse needed to have a physician's order to titrate the oxygen and a reason to titrate the oxygen. RN #2 said she would then need to communicate with the resident's physician to let them know the resident's oxygen needed to be titrated up and begin figuring out what was causing the resident to desaturate (a drop in blood oxygen saturation). RN #2 said oxygen was a medication.RN #6 was interviewed on 4/9/26 at 12:44 p.m. RN #6 said CNAs could set up residents' oxygen and nasal cannulas. RN #6 said if a resident needed to have their oxygen flow rate titrated up, the nursing staff would assess the resident to see why they had an increased oxygen need and call the resident's physician in order to get a physician's order to titrate the oxygen. RN #6 said Resident #77's oxygen never needed to be titrated up or down, and said the resident was on a continuous oxygen flow rate. RN #6 said he was not sure what LPM Resident #77's physician (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered but said he could check the resident's EMR. RN #6 reviewed Resident #77's EMR and said the resident's April 2026 CPO had a physician's order for 2 LPM continuous oxygen. RN #6 said he did not see any physician's orders to titrate Resident #77's oxygen, and said he wanted to ask the unit manager about the titration orders. RN #6 entered Resident #77's room and said he was receiving 4 LPM of supplemental oxygen, then turned his oxygen flow rate down to 2 LPM before leaving the room (see observations above). The unit manager was interviewed on 4/9/26 at 1:03 p.m. The unit manager said Resident #77 was having a change in condition as of the day prior (4/8/26) and was being monitored by the nursing staff. The unit manager said Resident #77 had a fluid overload and his oxygen saturations tended to drop as a result. The unit manager said she was waiting for the physician to provide orders to titrate Resident #77's oxygen flow rate. -However, Resident #77 had been observed receiving a higher oxygen flow rate than what was ordered by his physician on 4/6/26 and 4/7/26, prior to his documented change in condition.The DON was interviewed on 4/9/26 at 4:15 p.m. The DON said supplemental oxygen orders were typically received from the hospital on admission and verified with the resident's physician. The DON said the facility generally tried to avoid using oxygen flow rate ranges, and tried to use one continuous numeric flow rate for the residents instead. The DON said physicians sometimes added orders to titrate residents' oxygen flow rates to ensure their oxygen saturation levels remained above 90% as needed. The DON said the physician had to provide a physician's order to titrate residents' oxygen in order for the nursing staff to do so. The DON said the nursing staff needed to communicate with the residents' physicians on a daily basis to see how the resident was doing on their current oxygen orders.The DON said oxygen was a medication and the nursing staff's goal was to titrate the residents' supplemental oxygen as low as possible. The DON said a resident should not receive a greater supplemental oxygen flow rate than what their physician ordered, as oxygen was a medication and it would be the same as giving someone too much oxycodone or duloxetine. The DON said the nursing staff and the resident's physician needed to evaluate the root cause of why the resident's oxygen needed to be titrated up.The DON reviewed Resident #77's April 2026 CPO and said he saw there was a physician's order for supplemental oxygen ranging from 2 to 4 LPM, ordered that day (4/9/26). The DON said he would not want to continue using that physician's order as it had a LPM oxygen flow rate range. The DON said the nursing staff were supposed to keep Resident #77's oxygen concentrator set to the flow rate the physician ordered. The DON said Resident #77 was not able to tamper with his oxygen concentrator. The DON said the nursing staff should have contacted Resident #77's physician and documented their conversation regarding titrating the resident's oxygen.

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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 and interviews, the facility failed to ensure two (#7 and #123) of seven 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 49 sample residents. Specifically, the facility failed to ensure Resident #7 and Resident #123, who had identified indicators of depression were provided with mental health services.Findings include: I. Facility policy and procedure The Behavior Health Services policy, reviewed 9/2/25, was provided by the regional support team member on 4/9/26 at 6:26 p.m. It revealed in pertinent part, Each resident must receive, and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care. The facility should identify residents who develop decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, and may have made verbalizations indicating these and evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable. Identify if the resident would benefit based on assessment in conjunction with; mental health history, and current medication regimen additional mental health consultation (psychiatry, psychology, clinical social work). If a determined need is present, the facility should consult with the attending physician to make a referral to a mental health professional for assessment and potential for ongoing follow-up. Initiate Behavior Monitoring, Behavior Management Care Plan, and Kardex (tool used to assist with providing consistent care) as indicated by assessment findings, use of psychoactive medications, resident/responsible party conversations, and observations. The social worker is primarily responsible for initiation of the Behavior Management Care Plan. II. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included thrombotic stroke (brain cell death caused by a blood clot forming in an artery on the brain), left sided hemiplegia and hemiparesis (left sided paralysis and weakness), traumatic hemorrhage (brain bleed), depression and anxiety. The 3/12/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He was dependent on staff for assistance with bathing, dressing, and transferring. The resident was incontinent of bowel and bladder and required two-person total assistance in toileting care. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment indicated the resident had felt down, depressed and hopeless nearly every day (12 to 14 days) during the assessment look-back period. B. Resident observation and interview Resident #7 was interviewed in his room on 4/7/26 at 11:06 a.m. The resident said prior to his stroke, he had been an active firefighter for six years. Resident #7 expressed his pride and sense of accomplishment related to his job and said it was the only job that he had ever loved doing. Resident #7 said it was painful when his fellow firefighters came to visit him in the facility because he did not want them to leave him and it was a reminder of his current health condition. He said his wife and son lived out of state and he had suffered his stroke while working in this state. Resident #7 said he only saw his family one time a week now and it had been very difficult for him to see his son have to be in the position of acting as the power of attorney for him. He said he had an upcoming cranioplasty (a surgery to repair cranial defects caused by injuries or operations) and he expressed fear and concern regarding the upcoming surgery. Resident #7 talked in great length about all his lifelong accomplishments and responsibilities and how much he had lost due to the stroke. He said he had been experiencing depression and sadness that had been escalating, but he said he had not asked for psychological services because he said it was difficult for him to ask for. Resident #7 said he would be willing to visit with a psychologist or counselor to discuss his depression. However, he said the services had never been offered to him. During the interview, Resident #7 became tearful five times. C. Record review The psychosocial care plan, revised 3/16/26, revealed Resident #7 had a diagnosis of depression. Interventions (initiated 3/16/26) included arranging a psychological consultation. Review of the April 2026 CPO revealed the following physician's orders: Duloxetine (an antidepressant medication) 30 milligrams (mg). Give two capsules via gastrostomy tube (a device inserted through the abdomen into the stomach to deliver nutrition and medications) one time a day for depression, ordered 11/11/25. -The April 2026 CPO failed to reveal physician's orders for a psychological consultation or a physician's order to monitor for potential signs and symptoms of depression for Resident #7. Review of Resident #7's electronic medical record (EMR) revealed the following: A long-term care physician note, dated 10/2/25, revealed the nursing staff reported concerns for poorly controlled depression as Resident #7 lacked interest in activities and communicating with staff. His most recent depression score was a 10 out of 27 (indicating moderate depression). The resident was taking mirtazapine (an antidepressant medication) 15 mg daily. The physician increased the mirtazapine to 30 mg daily. A case management note, dated 10/2/25, revealed the case manager had communicated to the physician that Resident #7 was feeling down and would close his eyes when taken to the common area television room. He refused to join activities or leave his room. The resident's antidepressant medication was increased by the physician. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A case management note, dated 10/6/25, revealed the case manager had communicated with the physician that Resident #7 was observed to be crying and preferred to remain in bed. His antidepressant medication had recently been increased and staff were to monitor the resident. A long-term care physician note, dated 10/23/25, revealed Resident #7 reported that the current antidepressant medication was not helping with his depression. The resident reported that the current medication, mirtazapine, did not seem to help with depression and he experienced no noticeable improvement. A case management note, dated 10/28/25, revealed Resident #7's physician's order for mirtazapine was discontinued and replaced with duloxetine 30 mg for depression. A readmission note, dated 12/23/25, revealed Resident #7 had returned from being sent out to the hospital related to his tracheostomy. The resident had a diagnosis of depression and was utilizing duloxetine for mood and behaviors. The resident was to be referred for a psychological evaluation if needed. -However, review of the resident's EMR revealed no further documentation regarding the status or treatment for the resident's depression. -Despite the resident expressing signs and symptoms of depression, the EMR failed to reveal psychological services were offered to Resident #7. III. Resident #123 A. Resident status Resident #123, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included spinal stenosis (narrowing of the spinal canal causing pressure on the spinal cord or nerves), cognitive communication deficits and chronic pain. The 3/26/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required supervision to moderate assistance from staff for most activities of daily living (ADL). The MDS assessment indicated the resident felt down, depressed or hopeless and had trouble falling or staying asleep nearly every day during the assessment look-back period B. Resident interview Resident #123 was interviewed on 4/6/26 at 10:58 a.m. Resident #123 said she did not want to be at the facility and wanted to go back home. Resident #123 said she would be better off dead than at the facility. Resident #123 said her physician wanted her to go see a psychiatrist but she had not wanted to talk to anyone. Resident #123 said she was a loner and did not like to go to activities. Resident #123 was interviewed a second time on 4/8/26 at 12:48 p.m. Resident #123 said her mental health had gone down the toilet since she was admitted to the facility, as the facility felt foreign to her. Resident #123 said nothing at the facility made her happy, and said she would be better off dead than at the facility. Resident #123 said she hated to have to ask for help from the staff, as it made her (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feel not herself. Resident #123 said she had previously never asked anyone for help and did everything on her own. Resident #123 said she felt sad and frustrated and was overall unhappy about living in the facility. Resident #123 said the facility staff had never offered her any mental health or psychiatric services. Resident #123 said her outside physician had offered to refer her to a psychiatrist, but she had declined this at first because she did not like talking to people about her problems. Resident #123 said she had been thinking about accepting the referral because she thought it might be helpful. -However, the resident's outside physician had suggested the referral to the resident instead of the facility. C. Record review The behavior care plan, revised 4/6/26, revealed Resident #123 had a behavior problem and was attention seeking, as evidenced by her using her call light to ask staff what they were doing and attempting to engage them in conversation. Resident #123 made false accusations about staff, saying the staff avoided staying in her room as a companion and saying they did not want to stay in the room with her. Pertinent interventions included encouraging Resident #123 to participate in group/community activities to assist in her psychosocial need of companionship, and observing for behavioral episodes and attempting to determine the underlying cause. The pain medication care plan, revised 11/12/25, revealed Resident #123 received pain medication therapy due to her chronic pain. Pertinent interventions included observing Resident #123 for, and reporting as needed, any adverse reactions, including anxiety or depression. The black box medication (medications which can cause serious adverse effects) care plan, revised 2/26/26, revealed Resident #123 was at risk for adverse reactions due to taking black box medications. Pertinent interventions included observing Resident #123 for possible signs or symptoms of adverse drug reactions, including fatigue, agitation or depression. A PHQ-9 assessment, dated 7/9/25, revealed Resident #123 said she did not feel down, depressed or hopeless. Resident #123's total score on the assessment was zero out of 27, which indicated the resident did not have depression. A physician's note, dated 9/15/25, revealed Resident #123 was seen by her physician to evaluate oral pain. The physician documented Resident #123's mood and affect were not happy. An outside physician's visit note , dated 9/23/25, revealed Resident #123's physician was concerned about her memory and mood. Resident #123 had a PHQ-9 assessment score of 13 out of 27, indicating the resident had moderate depression, when assessed by the outside physician. The physician documented Resident #123 had additional diagnoses of frailty and major depression. The physician documented a follow-up for Resident #123 with psychiatry. A progress note, dated 9/23/25 at 4:39 p.m., revealed Resident #123 had returned to the facility following an outside physician's appointment. Resident #123 came back with a recommendation from her physician to follow up with psychiatry, and a referral for behavioral health services. -However, review of Resident #123's EMR did not reveal any documentation of any attempts made by (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility to schedule the resident for psychiatry or behavioral health services. A PHQ-9 assessment, dated 10/8/25, revealed Resident #123 said she did not feel down, depressed or hopeless. Resident #123's total score on the assessment was zero out of 27, which indicated the resident did not have depression. A PHQ-9 assessment, dated 1/7/26, revealed Resident #123 said she felt down, depressed or hopeless nearly every day. Resident #123 said she had trouble falling or staying asleep nearly every day. Resident #123's total score on the assessment was seven out of 27, which indicated the resident had mild depression. -Review of Resident #123's EMR did not reveal any new interventions related to her increase in the PHQ-9 assessment score. A PHQ-9 assessment, dated 3/25/26, revealed Resident #123 said she felt down, depressed or hopeless nearly every day. Resident #123 said she had trouble falling or staying asleep nearly every day. Resident #123's total score on the assessment was seven out of 27, which indicated the resident had mild depression. IV. Staff interviews CNA #5 was interviewed on 4/9/26 at 9:15 a.m. CNA #5 said Resident #123's mood was hit or miss. CNA #5 said sometimes Resident #123 was calm and nice, but other times the resident exhibited behaviors. Certified nurse aide (CNA) #3 was interviewed on 4/9/26 at 9:57 a.m. CNA #3 said Resident #7 did not have any behaviors and kept to himself in his room. CNA #3 was not aware of what signs or symptoms of depression to observe for or report for Resident #7. The second floor unit manager was interviewed on 4/9/26 at 10:10 a.m. The unit manager said the staff had observed signs and symptoms of depression when Resident #7 first admitted to the facility and it was reported to the physician. The unit manager said the resident had an upcoming cranioplasty appointment that was difficult to secure, so the staff had provided him with numerous updates to give him hope. She said she did not know if he received psychological services or what specific signs to monitor for ongoing depression for Resident #7. CNA #6 was interviewed on 4/9/26 at 11:08 a.m. CNA #6 said when Resident #123 had bad days, the resident had a very bad mood. CNA #6 said Resident #123 had had more periods of having a bad mood over the last month. CNA #6 said Resident #123 had started yelling more during the night, which other residents complained about because they were trying to sleep. Registered nurse (RN) #6 was interviewed on 4/9/26 at 12:44 p.m. RN #6 said Resident #123 complained a lot to the facility staff and asked the staff for things frequently. RN #6 said the nursing staff tried to reassure Resident #123 she was taking the right medications for the health issues she was concerned about, or brought her medications when she requested them. RN #6 said Resident #123 did not really seem sad, but maybe frustrated. The MDS nurse was interviewed on 4/9/26 at 1:04 p.m. The MDS nurse said she had put in the care plan intervention for psychological services for Resident #7 because of his antidepressant use and his (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	circumstances. The MDS nurse said when this happened, she communicated to the social services director (SSD) in the residents at-risk meeting that a referral needed to be sent for behavioral health services. The MDS nurse looked up her meeting minutes from the meeting after she put in the psychological care plan intervention for Resident #7 on 3/16/26. -The meeting minutes, dated 3/26/26, failed to indicate that the MDS nurse mentioned to the SSD in the meeting that Resident #7 needed psychological services for depression. The social services assistant was interviewed on 4/9/26 at 2:00 p.m. The social services assistant said she had been working at the facility for six months in her current role. The social services assistant said the process for setting up psychological services for residents was to request a physician's order and then send a referral to the facility's mental health provider. She said things that would indicate that a resident needed services would be if the resident was having increased behavioral problems, increased depression screening scores or non-verbal signs or symptoms of depression, such as isolating themselves or crying. The social services assistant said the type of questions the resident responded to in the depression screen assessment, such as feeling down, depressed or hopeless would trigger a referral for behavioral health services. -However, the 3/12/26 MDS assessment for Resident #7 indicated he had felt down, depressed or hopeless on multiple days during the assessment look-back period, but the facility failed to offer behavioral health services to the resident (see resident status above). The social services assistant said Resident #7 originally lived in a different state but had driven an hour into this state to work as a firefighter. She said she did know how he was emotionally handling the circumstances of his condition and placement into a nursing facility. The social services assistant said she had not offered the resident psychological services and was not aware of the intervention in his care plan to obtain a consultation for him. She said her department would be responsible for sending the referral and someone like Resident #7 (younger age, unforeseen significant life event, trauma) should have been offered psychological services. She said she would send a referral for him to be seen before his upcoming major surgery. The social services assistant said she had worked with Resident #123 before to help her fill out her dining menus. The social services assistant said Resident #123 had not expressed any depression or concerns to her before. The social services assistant said, based on the information regarding Resident #123's change in PHQ-9 assessment score (see record review above) and the information the resident shared in her interview (see resident interview above), she would want to send out a referral for mental health services for the resident.

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Life Care Center of Aurora	14101 E Evans Ave Aurora, CO 80014

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional standards of practice for one of three medication administration carts and one of two medication storage rooms.Specifically, the facility failed to ensure medications, such as eye drops, inhalers and insulin pens, were labeled and dated appropriately with the resident's name and the date the medication was opened.Findings include:I. Observations and interviewsOn 4/9/26 at approximately 5:00 p.m. the first floor [NAME] medication cart one was observed with registered nurse (RN) #3. The following was observed:-One multi-dose bottle of Latanoprost ophthalmic solution (medication used to treat certain kinds of glaucoma) was stored inside an appropriately labeled pharmacy medication box. -However, the individual bottle of medication inside the box was not labeled with the resident's name and the date the medication was opened. -One inhaler of Incruse Ellipta Inhalation Aerosol Powder (a medication used to treat chronic obstructive pulmonary disease) was stored inside an appropriately labeled pharmacy medication box.-However, the individual bottle of medication inside the box was not labeled with the resident's name and the date the medication was opened. On 4/9/26 at approximately 5:30 p.m. the second floor [NAME] medication storage room was observed with RN #5. The following was observed: -There were individual boxes of Ozempic pens (a weekly injectable medication used to improve blood sugar in adults with type 2 diabetes and often aiding weight loss) stored in the refrigerator in appropriately labeled pharmacy medication boxes. The pharmacy boxes were opened.-However, the Ozempic pens in each box were not individually labeled with the specific resident name and the date the medications were opened.RN #5 said the Ozempic pens were used once every week and did not need to be individually labeled since the pharmacy labeled box was labeled with the resident's name. II. Additional staff interviewsThe director of nursing (DON) was interviewed on 4/9/26 at approximately 6:30 p.m. The DON said Ozempic pens administered weekly did not need to be labeled with a resident's name, because the pens were used only once and discarded.The DON said that medications inside the Latanoprost and the Ellipta inhaler pharmacy boxes should be labeled with the resident's name so staff would know who the medication belonged to if the medication got separated from the box.

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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 two (#4 and #80) of four residents reviewed for ancillary services, such as dental services, out of 49 sample residents received routine dental care obtaining routine and 24-hour emergency dental care.Specifically, the facility failed to:-Provide dental services for Resident #4 who had broken and missing teeth; and,-Provide dental services for Resident #80 who had identified dental decay.Findings include: I. Facility policy and procedure The Dental Services policy and procedure, revised 9/3/25, was provided by the regional support team member on 4/9/26 at 6:26 p.m. It read in pertinent part, The facility is responsible for obtaining needed dental services, including routine dental services. Upon admission, the facility will obtain the name of the resident's dentist and if none is provided, will select a dentist to provide dental services as needed. Arrangements will be made promptly for routine and emergency dental services. Residents will be assisted with making appointments and arranging transportation to and from the dentist's office if necessary. II. Resident #4 A. Resident status Resident #4, age [AGE], was admitted on [DATE], discharged to the hospital on 1/29/26 and readmitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included acute respiratory failure, protein-calorie malnutrition, chronic obstructive pulmonary disease and heart failure. According to the 2/11/26 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required setup or cleanup assistance from staff for oral hygiene and was independent for personal hygiene and eating. The assessment did not document the resident had any broken or missing teeth. B. Resident observation and interview Resident #4 was interviewed on 4/6/26 at 3:19 p.m. Resident #4 said she had fallen and broken her teeth two years prior after she fell and hit her mouth on her sink. Resident #4 said she had been without her teeth for two years, and said she would be interested in getting dentures. During the interview, Resident #4 was observed to be missing most of her upper teeth and had some broken or damaged teeth. Resident #4 was interviewed a second time, in the presence of the MDS nurse and the MDS coordinator on 4/9/26 at 4:36 p.m. Resident #4 said she wanted to get permanent dentures. Resident (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#4 said no one from the facility had talked to her about dentistry or offered to have her see the dentist since she was admitted to the facility. During the interview, the MDS nurse performed an oral exam on Resident #4 which revealed multiple missing teeth and one broken tooth on her upper palate (see record review and interviews below). C. Record review The comprehensive care plan, revised 4/3/26, revealed Resident #4 was at risk for oral/dental health problems as a result of her aging process. Pertinent interventions included providing mouth care daily, observing and reporting any signs or symptoms of oral or dental problems which needed attention, including pain or teeth observed to be missing, broken, loose, eroded or decayed. An admission assessment tool, dated 12/27/25 at 3:00 p.m., revealed Resident #4 was assessed by a member of the facility's nursing staff on admission. Resident #4's oral health status was able to be examined at the time, and it was documented the resident did not have any broken or missing teeth. -However, observations revealed the resident was missing multiple teeth and had some damaged teeth (see observations above). The admission MDS assessment, dated 12/29/25, documented Resident #4's oral status was able to be assessed. The assessment documented Resident #4 did not have any broken or loose teeth. -However, observations revealed the resident was missing multiple teeth and had some damaged teeth (see observations above). An MDS note, dated 12/29/25 at 8:53 p.m., revealed Resident #4 received a mini nutritional assessment and a pain assessment by a member of the facility's MDS staff. Resident #4 had some bottom teeth and had no upper teeth. The note documented Resident #4 had previously fallen and broken her upper teeth. -However, these missing and broken teeth were not correctly documented on the 12/29/25 MDS assessment (see assessment above). Review of Resident #4's April 2026 CPO revealed the following physician's order: Resident may have dental, podiatry, audiology and optometry care as needed, ordered 2/9/26. An MDS note, dated 4/9/26 at 5:11 p.m., revealed Resident #4 had an oral exam completed by the MDS nurse. The exam identified Resident #4 had dental caries (cavities) and a broken/chipped tooth in the upper left palate, and revealed the resident's upper palate was otherwise edentulous (toothless). After a conversation with Resident #4, it was established the resident would like to proceed with seeing the facility's dental services to discuss getting dentures. The note documented the MDS department would notify the social services department to schedule Resident #4 with the facility's dentist so the resident could be seen the next time the dentist visited the building. -However, the exam and discussion with Resident #4 occurred during the survey process and 59 days after Resident #4 was readmitted to the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's electronic medical record (EMR) did not reveal any care conference documentation or any documentation pertaining to dentistry referrals prior to the 4/9/26 MDS note. D. Staff interviews The regional nurse consultant and the social services assistant were interviewed together on 4/9/26 at 2:23 p.m. The social services assistant said the social services department scheduled residents' ancillary appointments, including dentistry. The social services assistant said the social services department was informed of which residents needed ancillary services by the nursing staff or the residents' families, and asked the residents about ancillary services during their care conferences. The regional nurse consultant said the facility had experienced issues with their prior social services director scheduling ancillary services. The social services assistant said she was not sure when Resident #4's last care conference was. The social services assistant reviewed Resident #4's EMR and said she could not find any care conference notes. The social services assistant said the facility's dentist came in each week to examine whichever residents were on the list to be seen. The director of nursing (DON) was interviewed on 4/9/26 at 4:15 p.m. The DON said the facility used an as-needed dentistry program and had a dentist who visited the facility weekly. The DON said if a resident had any broken teeth, it would trigger the nursing staff to put the resident on the list to be seen by the facility dentist. The DON said he would want Resident #4 to be seen by the dentist if she had any broken teeth in order to determine if there was any tooth decay as a result. The MDS coordinator and the MDS nurse were interviewed together on 4/9/26 at 4:36 p.m. The MDS coordinator and the MDS nurse both said they had not spoken with Resident #4. The MDS nurse said Resident #4 had an MDS assessment completed on 2/11/26 which did not reveal any dental problems at the time. The MDS nurse said MDS staff completed the oral evaluation portion of the MDS assessment by examining the resident, looking at nurse admission assessments, and conducting a mini nutritional assessment where they discussed any oral or dentition problems with the resident. The MDS nurse said if a resident had missing or broken teeth, she would want to have the resident be evaluated by the dentist. The MDS nurse said the MDS department would refer the resident to the social services department to have the resident's name added to the facility's dentist's list to be seen. The MDS nurse said when the MDS department referred a resident to the dentist, they added the referral information to the resident's progress notes, emailed the social services department and spoke directly with the social services department. The MDS nurse said the facility also discussed residents with dental needs in the facility administration's residents-at-risk meetings. The MDS nurse and the MDS coordinator entered Resident #4's room and completed an oral examination on the resident (see observations above). The MDS nurse said Resident #4 had one broken tooth on her upper palate along with several missing teeth. The MDS nurse said she would add Resident #4 to the list of residents who needed to be seen by the facility's dental services. III. Resident #80 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #80, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included Parkinson' s disease, anxiety and diabetes type 2. The 1/24/26 MDS assessment revealed the resident was unable to complete the BIMS assessment. Per the staff assessment for mental status, the resident had short and long term memory loss with severely impaired decision making. The resident was dependent on staff to assist with toileting, bathing, and transfers. The resident required moderate staff assistance (staff must complete half of the task) with oral hygiene and personal hygiene. The assessment revealed the resident complained of difficulty or pain when swallowing with no natural teeth. B. Resident observation and interview On 4/8/26 at 12:56 p.m. Resident #80 was sitting in the common area watching television. Upon observation, he had lower natural teeth and no natural upper teeth. The resident's teeth revealed one area on the lower teeth with a blacked area on the side, food debris in between several teeth, and red and swollen lower gums. Resident #80 was interviewed, using a Spanish translator, on 4/8/26 at 1:00 p.m. When he was asked if he had pain, Resident #80 pointed to his mouth and one of his arms. The MDS nurse was interviewed on 4/9/26 at 4:00 p.m. The MDS nurse acknowledged that she marked cavities in Resident #80's admission MDS assessment and conducted an observation as well as a resident interview when she completed the oral status section for him. Upon the MDS nurse's observation of Resident #80's teeth on 4/9/26, she identified two distinct black spots on the resident's lower center teeth, with one of the black spot taking up 40% of the resident's tooth. The MDS nurse said Resident #80 had obvious cavities, based on her observations, and she should have marked that in his 1/24/26 MDS assessment and reported it to social services to schedule him a dental exam. C. Resident's representative interview Resident #80's representative was interviewed on 4/8/26 at 1:08 p.m. The resident's representative said Resident #80 was able to express himself in Spanish. The resident's representative said that Resident #80 had told her that he had pain in his mouth and lower teeth. She said his oral pain has worsened since he came to the facility and she had told the nursing staff he needed to see a dentist, but no one ever followed up with her on making him a dental appointment. D. Record review The activities of daily care plan, revised 1/17/26, revealed Resident #80 had deficits in self care related to a diagnosis of Parkinson's disease. Interventions, initiated 12/26/25, revealed the resident required one-on-one staff assistance with feeding, was completely dependent on staff for oral hygiene, and had natural lower teeth. The dental care plan, initiated 12/26/25, revealed Resident #80 was at risk for oral/dental health (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems related to natural lower teeth and no upper teeth with self care deficits due to Parkinson's disease. Interventions, initiated 12/26/25, included coordinating arrangements for dental care, transportation as needed/as ordered, observing and reporting any signs or symptoms of oral/dental problems needing attention (such as pain, debris in mouth, eroded or decayed teeth) and providing oral care daily. Review of Resident #80's April 2026 CPO revealed the following physician orders: May have dental, podiatry, audiology, optometry care as needed, ordered 12/24/25. Provide oral care with toothbrush and toothpaste, three times a day after meals, ordered 1/1/26. A review of Resident #80's EMR revealed the following: An admission note, dated 12/24/25, revealed Resident #80 would be seen by all ancillary services. The 12/30/25 MDS assessment indicated the resident had no natural teeth, however, it additionally identified the resident as having obvious or likely cavities during the oral status interview and observation. A health status note, dated 1/3/26, revealed that oral care was provided to Resident #80 and built-up plague was noted. The 1/24/26 MDS assessment indicated during the oral status interview and observation that the resident had no natural teeth and no obvious or likely cavities. -Review of Resident #80's EMR failed to reveal any progress notes from a dentist to indicate that the resident had been seen and treated by a dentist during his stay at the facility. A review of pain assessments from 12/24/25 to 4/3/26 failed to document any assessment of Resident #80's oral pain. E. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 4/9/26 at 9:57 a.m. CNA #3 said the CNAs completed oral care and sometimes the nurses would do it. She said Resident #80 did not refuse oral care and she said she had not noticed any dental decay for the resident. The second floor unit manager was interviewed on 4/9/26 at 10:10 a.m. The unit manager said the CNAs completed residents' oral care and if there was a dental concern, the CNAs reported it to her and she let the social services department know the resident needed to see the dentist. The unit manager said that no one had reported to her that Resident #80 needed to see the dentist. The regional nurse consultant and the social services assistant were interviewed together on 4/9/26 at 2:23 p.m. The social services assistant said she was not sure when Resident #80's last care conference was. The social services assistant reviewed Resident #80's EMR and said she could not find any care conference notes. The social services assistant said the facility's dentist came in each week to (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	examine whichever residents were on the list to be seen. She said she would add Resident #80 to the list to be seen the following week.