STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065345	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were informed of the treatment, including the risks and benefits, of proposed care and to choose the alternative option if they preferred for three (#4, #9 and #76) of six residents reviewed out of 51 sample residents.Specifically, the facility failed to: -Ensure Resident #4's consent explained the risks versus benefits for psychotropic medications; -Ensure Resident #9 and/or Resident #9's representative were informed and agreed to an increase in the dose of the resident's psychotropic medication; and, -Ensure Resident #76 and/or the resident's representative consented to antibiotic therapy prior to the administration of antibiotics.Findings include: I. Facility policy and procedure The Psychotropic Medication Management policy and procedure, dated [DATE], was provided by the vice president of clinical services on [DATE] at 12:32 p.m. It read in pertinent part, Residents and or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments and non-pharmacological interventions. Consent will be obtained, as indicated. It is recommended that the community use the psychotropic medication management Consent and Disclosure form. The Resident Rights policy and procedure, revised [DATE], was provided by the vice president of clinical services on [DATE] at 12:32 p.m. It read in pertinent part, You have the right to request, refuse and or discontinue medications and treatments (but this could be harmful to your health), and to know the consequences of such actions. II. Failed to ensure Resident #4's consent explained the risks versus benefits for psychotropic medications A. Resident status Resident #4, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included displaced fracture of left femur, hypertension, history of falling, aortic stenosis, dementia, osteoarthritis, anxiety and depression. According to the [DATE] minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He used a walker. He required set up assistance with eating. He required substantial assistance with oral hygiene, toileting, showering, dressing and personal hygiene. The assessment revealed he had an anxiety disorder and depression. He took an antipsychotic and an (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antidepressant medication with an indication noted. B. Record review Review of Resident #4's [DATE] CPO revealed the following physician's orders: Risperidone (an antipsychotic medication) 0.5 milligrams (mg). Take one tablet by mouth at bedtime for dementia with behaviors, ordered [DATE]. Sertaline (an antidepressant medication) 50 mg. Take one tablet by mouth a day for depression, ordered [DATE]. Review of Resident #4's [DATE] medication administration record (MAR) revealed the resident's first dose of risperidone was given on [DATE]. Review of Resident #4's [DATE] MAR revealed the resident's first dose of sertraline was given on [DATE]. -A review of the consent for risperidone and sertraline failed to reveal if the facility had explained the risks versus benefits of risperidone and sertraline to the resident or the resident's representative. C. Staff interviews Registered nurse (RN) #1 and RN #3 were interviewed together on [DATE] at 2:26 p.m. RN #1 and RN #3 said nursing staff was responsible for obtaining consent at the time of a resident's admission to the facility for medications with black box warnings (when clinical data shows a medication carries a severe risk of death or life threatening adverse reactions, serious physical injury or permanent disability or high addiction or dependence potential). RN #1 said the nurses should explain the side effects, what symptoms the facility was monitoring the resident for and inform the resident or the resident's representative to report back to staff if they observed symptoms or behaviors so nursing staff could inform the physician. RN #1 and RN #3 said risks versus benefits were covered to let the resident know what to look out for. RN #1 and RN #3 said they used a consent form so nursing staff could provide the resident something in writing for them to reference if they had any questions. RN #1 said consent needed to be obtained before the medication was administered. RN #1 said risperidone was an antipsychotic medication and sertraline was an antidepressant medication. RN #1 said Resident #4 took both medications. RN #1 looked at Resident #4's electronic medical record (EMR) and looked at Resident #4's consent form for psychotropic medications. She said she did not know why the consent form did not document the risks versus benefits of the resident's psychotropic medications. Social services assistant #1, Social services assistant #2, unit manager #1, and unit manager #2 were interviewed together on [DATE] at 4:48 p.m. Social services assistant #1 said the unit manager was responsible for obtaining consent for medications with black box warnings. Social services assistant #1 said consent was obtained because the facility needed to explain the side effects of medications (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with black box warnings and so the residents or their representatives knew the risks versus benefits of the medication. Social services assistant #1 said the consent covered the benefits, the adverse reactions and concerns. She said consent should be obtained before the medication was administered Unit manager #2 said she explained the risks versus benefits of the psychotropic medications and she documented that consent was obtained on a consent form. Unit manager #2 said she completed a progress note as well Social services assistant #1 said she was familiar with Resident #4. Social services assistant #1 said risperidone was a psychotropic medication and sertraline was an antidepressant medication. Social services assistant #1 said Resident #4 took both medications. Social services assistant #1 said she did not know where Resident #4's consent form was and said the consent should document the risks versus benefits of the medications. Social services assistant #1 said she did not know Resident #4's consent form for the psychotropic medications did not have the risks versus benefits documented on it. The director of nursing (DON) and the vice president of clinical services were interviewed together on [DATE] at 4:43 p.m. The DON said nursing staff was responsible for obtaining consent at time of a resident's admission to the facility for medications with black box warnings. The DON said the nurses should explain the side effects, what symptoms the facility was monitoring for and inform the resident or the resident's representative to report back to staff if they observed symptoms or behaviors so nursing could inform the physician. The DON said risks versus benefits were covered to let the resident or the resident's representative know what to look out for. The DON said the facility used a consent form so nursing staff could provide the resident something in writing for them to reference if they had any questions. The DON said consent needed to be obtained before the medication was administered. The DON and the vice president of clinical services said risperidone was a psychotropic medication and sertraline was an antidepressant medication. The DON said Resident #4 took both medications. The vice president of clinical services said the consent form used for Resident #4's psychotropic medications did not indicate the risks versus benefits of the medications, so it was unknown if it was explained to the resident and or the resident's representative. The vice president of clinical services said there were two consent forms the facility used and she needed to change the process so the consent form that included risks versus benefits was consistently used. III. Failed to ensure Resident #9 and/or Resident #9's representative were informed and agreed to an increase in the dose of the resident's psychotropic medication A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included senile degeneration of the brain, unspecified dementia with other behavioral disturbance, encephalopathy and hypertension. The [DATE] MDS assessment revealed the resident had severe impairment with making decisions regarding tasks of daily life, per the staff assessment for mental status. She was dependent on staff to assist with oral hygiene, toileting hygiene, bathing and dressing. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment indicated Resident #9 received antipsychotic medications. B. Record review Review of Resident #9's [DATE] CPO revealed the following physician's order: Seroquel (antipsychotic medication) oral tablet 50 mg) (Quetiapine Fumarate), give one tablet by mouth two times a day, ordered [DATE]. A review of the resident's psychotropic medication informed consent form, dated [DATE], revealed Resident #9 consented to Seroquel 12.5 mg twice daily. A review of the psychotropic medication review, dated [DATE], revealed Resident #9 continued on Seroquel 12.5 mg twice daily. Additional recommendations included increasing the resident's Seroquel dose to 25 mg twice daily and adding behavior and side effect monitoring. -However, there was no documentation in the resident's EMR to indicate the resident's representative had been informed of the recommendation and subsequent increase in the dosage increase of Seroquel. A review of the psychotropic medication review, dated [DATE], revealed Resident #9's Seroquel dosage was 50 mg twice daily for dementia with behaviors. The psychotropic committee recommendations included consolidating the medication to 50 mg tablets. A review of the psychotropic medication review, dated [DATE], revealed Resident #9 remained on Seroquel 50 mg twice daily. -However, a review of Resident #9's EMR revealed no updated psychotropic medication informed consent forms for the resident's increased Seroquel dosage from 12.5 mg twice daily to 50 mg twice daily. Review of Resident #9's [DATE] medication administration record (MAR) revealed Seroquel oral tablet 25 mg (Quetiapine Fumarate), give one tablet by mouth two times a day for encephalopathy, was started on [DATE]. Review of Resident #9's [DATE] MAR revealed Seroquel oral tablet 25 mg (Quetiapine Fumarate), give two tablets by mouth two times a day for encephalopathy, was started on [DATE]. (Seroquel 25 mg one tablet two times per day was discontinued.) A review of Resident #9's [DATE] MAR revealed Seroquel oral tablet 50 mg (Quetiapine Fumarate), give one tablet by mouth two times a day for dementia with behaviors, was started on [DATE]. (Seroquel 25 mg two tablets two times per day was discontinued.) A review of Resident #9's [DATE], [DATE], February 2026, [DATE], [DATE] and [DATE] (from [DATE] to [DATE]) MARs revealed Resident #9 received Seroquel 50 mg one tablet twice daily for dementia with behaviors. C. Staff interviews (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The executive director was interviewed on [DATE] at 6:23 p.m. The executive director said every time there was an increase in dosage for a resident's psychotropic medications, a consent should have been obtained. The executive director said he could not find the consent form for Resident #9's dosage increase of Seroquel from 25 mg to 50 mg. The executive director said the social services department or unit managers were responsible for obtaining consents. Unit manager #1 was interviewed on [DATE] at 6:28 p.m. Unit manager #1 said the interdisciplinary team (IDT) reviewed residents' behaviors and nursing notes to determine whether a psychotropic medication dosage increase was needed after the resident's first month of stay in the facility. Unit manager #1 said social services staff obtained consents in the past, however, the unit managers now participated in IDT meetings and were responsible for obtaining updated consents. Unit manager #1 said it was important to obtain consent for psychotropic medication increases because higher dosages increased the risk for side effects and adverse reactions. The staff development coordinator was interviewed on [DATE] at 6:41 p.m. The staff development coordinator said Resident #9 went to the hospital in [DATE] for an eye infection and the Seroquel dose may have been increased while she was in the hospital. -However, according to the resident's MARs, the resident's Seroquel was increased in [DATE] (see record review above). The DON and the vice president of clinical services were interviewed together on [DATE] at 7:15 p.m. The DON said a new consent for Resident #9 should have been obtained when the dosage of her psychotropic medication increased. The DON said the social services department was responsible for obtaining consent forms and it was a team effort to get updated consent forms. The DON said she could not find an updated consent form for when Resident #9's dosage of Seroquel increased. The DON said the facility had health information management issues and staff were trying to get caught up and may have lost the updated consent form for the resident. IV. Failed to ensure ensure Resident #76 and/or the resident's representative consented to antibiotic therapy prior to the administration of antibiotics A. Resident status Resident #76, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included senile degeneration of the brain (progressive loss of brain cells and cognitive function associated with advanced age), major depressive disorder, motor neuron disease, dementia and peripheral vascular disease. The [DATE] MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of seven out of 15. B. Resident's representative interview Resident #76's representative was interviewed on [DATE] at 1:49 p.m. Resident #76's representative said she was so upset that Resident #76 was treated with antibiotics for a urinary tract infection (UTI) and that he was not allowed to die with dignity. She said the resident had begged herself and their children to let him die. Resident #76's representative said when she was notified of a suspected UTI, she said she did not want the resident to begin antibiotic therapy. She said she wanted hospice (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to evaluate her husband to re-establish hospice services. However, she said the facility treated Resident #76 with antibiotics two of the three days the antibiotic therapy was ordered for. Resident #76's representative said she spoke to the physician about not starting antibiotic therapy and he said he would talk to the nurse about their choice. She said the facility told her there was a note in the EMR that the physician was going to call the nurse, but for some unexplained reason, the nurse did not get the information from the physician. Resident #76's representative said the facility told her they worked hard to communicate but they had had problems with their phone system and could not provide documentation of the physician notifying the nurse not to administer the antibiotic therapy. C. Record review Review of Resident #76's EMR revealed the resident appointed his wife to be his general durable power of attorney, signed [DATE]. Resident #76's EMR revealed the medical orders for scope of treatment (MOST) form documented the resident did not want cardiopulmonary resuscitation (CPR) and wanted comfort-focused treatment only, signed [DATE]. Review of Resident #76's CPO revealed the following physician's order: Ceftriaxone sodium (antibiotic) injection solution reconstituted 1 gram (gm). Inject one gm intramuscularly (IM) one time per day for three days for a pending urine culture, ordered [DATE]. Review of Resident #76's February 2026 medication administration record (MAR) revealed the following: Ceftriaxone sodium (Rocephin)1 gm IM injection was administered on [DATE] and [DATE]. Review of Resident #76's progress notes revealed the following documentation: On [DATE] at 4:17 p.m. an alert note documented Resident #76 was lethargic, had dysuria (pain with urination), altered mental status (AMS) and had pus-like urine noted with a brief change at 3:30 p.m. The nurse practitioner (NP) was notified and she gave orders for a culture and sensitivity (C&S - a urine test used to identify the specific germ causing an infection and to find the most effective medication to treat it), complete metabolic panel (CMP) and a complete blood count (CBC) stat (immediately). The staff were awaiting a laboratory (lab) draw and urine collection, the resident's representative was notified and the nurse would notify the incoming shift for monitoring. On [DATE] at 5:33 a.m. a nursing note documented that the nurse received a call back from the facility's on-call physician and received new orders to administer Rocephin one gm daily for three days, pending the urine culture after obtaining the urine sample. On [DATE] at 4:29 a.m. a nursing note documented Resident #76 was on monitoring for antibiotic use. The resident was on Rocephin one gm IM daily for three days post-urinalysis and pending a urine culture. On [DATE] at 1:10 p.m. a nursing note documented that the nurse spoke to Resident #76 and the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's representative about treatment for UTI, and they requested that treatment be held until hospice re-evaluated the resident on [DATE]. On [DATE] at 12:00 a.m. a physician encounter note documented Resident #76 was seen for UTI follow-up and a goals of care discussion with the resident's representative. The resident recently graduated from hospice care because he no longer met hospice requirements. He had labs and a urine culture obtained over the weekend due to increased confusion and abnormal vital signs. The on-call team was notified of the results and gave an order for Rocephin for three days while awaiting the final urine culture. The resident's representative discussed with the bedside nurse and the on-call physician to hold the Rocephin. However, the Saturday [DATE] dose had already been given at that point. -The facility failed to ensure Resident #76 and the resident's representative consented to antibiotic therapy before Rocephin was administered. The [DATE] at 12:00 a.m. physician's encounter note documented the resident's wife reiterated that Resident #76 made his wishes very clear to her early on in his diagnosis, prior to increased cognitive impairment, that he did not want to live in his current condition, and she knew he would not want to be treated for something acute to prolong his life. Per documentation, the on-call team was calling the nurses' station to put a hold on the Rocephin dose on Sunday, [DATE]. -However, the facility failed to provide documentation that the on-call physician attempted to notify the bedside nurse not to administer the Rocephin. The [DATE] at 12:00 a.m. physician's encounter note documented the physician's order had since been cancelled and Resident #76 did not receive Rocephin on [DATE], nor would he receive any further antibiotics for the UTI with greater than (>) 100,000 colony-forming units (cfu) per milliliter (ml) proteus mirabilis (a gram-negative, anaerobic bacterium - typically indicates a significant UTI). However, the resident received two doses of Rocephin prior to this. The resident recently graduated off hospice and hospice would re-evaluate to see if he met criteria for readmission to hospice services. Discussion of goals of care with the resident's representative and staff today included no treatments of any kind - comfort goals of care with no life sustaining measures or treatments. Created alerts in the facility's EMR that the resident was not to receive antibiotics of any kind for future infections. On [DATE] at 12:16 p.m. a nursing note documented the nurse spoke with the resident's wife regarding Resident #76 receiving two doses of antibiotics to treat a UTI, which was opposite of her wishes. She directly told the nurse and the facility's on-call physician to not treat based on the resident's wishes. The care profile was updated to reflect no labs or hospital transfer was to happen without the resident representative's permission. Review of the [DATE] grievance form and investigation revealed Resident #76's representative was notified of a change of condition by the bedside nurse, but the representative approved laboratory tests and not antibiotic therapy. Review of the [DATE] ethics committee consultation revealed the resident's representative's wish was to allow the UTI to lead to sepsis and, ultimately death, as in her mind this would be her way of honoring Resident #76 to die once his quality of life was gone. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to ensure a response, action, and rationale to residents involved in group grievances. Specifically, the facility failed to effectively address, resolve, and demonstrate the facility's response to group grievances regarding long call light wait times.Findings include:I. Facility policy and procedureThe Grievance Management policy, dated September 2025, was provided by the executive director on 5/8/26 at 12:32 p.m. It read in pertinent part, A complaint or issue brought to the attention of the facility by a resident or resident representative that is not resolved more informally and in a very timely manner, generally within three days, will be referred to the formal problem-resolution procedure outlined in this policy. The nursing home administrator (NHA), or designee, is the designated facility associate responsible for receiving grievances. Any resident, resident representative or resident council that wishes to complain about treatment, conditions, or violations of rights, shall present such grievance to the facility NHA orally or in writing within 14 calendar days of the alleged incident giving rise to the grievance. The NHA or designee shall investigate and confer with persons involved in the alleged incident and other relevant persons and, within three calendar days of receiving the grievance, shall provide a written explanation of findings and proposed remedies to the complainant. The final written outcome will be provided within a reasonable time, not to exceed thirty (30) days following receipt of the grievance. The written report shall include at a minimum, the date the grievance was received, the date the report is written, a summary statement of the grievance, steps taken to address the grievance, a summary of the findings or conclusions of the investigation, a statement as to whether the grievance was confirmed or not confirmed, and any corrective action taken to be taken by the facility because of the grievance.II. Resident group interviewA group interview was conducted on 5/6/26 at 10:30 a.m. with four residents (#24, #54, #55, and #87) who were identified as interviewable through facility and assessment. The residents said call light wait times were long and were usually worse during the night shift. The residents said there were not enough certified nurse aides (CNA) on the floor during the night shift to help residents in a timely manner. The residents said their needs were not always met in a timely manner due to low staffing. They said it could take up to two hours for staff to help them. The residents said they did not like waiting that long because a lot of things could go wrong. They said some residents activated neighboring residents' call lights in an effort to get a staff member's attention so assistance could be provided. Resident #87 said she waited one hour that morning (5/6/26) for staff to answer her bathroom call light. Resident #87 said there were times she got up without assistance because staff did not respond timely to call lights. She said she was concerned about falls because she was not supposed to get up on her own.The residents said concerns regarding call light response times and staffing had been brought up during resident council meetings for several months. The residents said the issues continued and were not resolved.III. Additional resident interviewResident #79 was interviewed on 5/4/26 at 12:43 p.m. Resident #79 said she waited one hour the previous day for staff to respond to her call light. She said she usually waited for assistance to go to the bathroom because she had fallen a few times. Resident #79 said even when she pulled the bathroom call light cord five times, staff rarely responded.IV. Resident council meeting minutesResident council meeting minutes from November 2025, December 2025, January 2026, February 2026, March 2026 and April 2026 were provided by the NHA on 5/5/26 at 2:38 p.m.The 1/14/26 resident council meeting minutes revealed concerns that CNAs and nurses needed to be more aware of bathroom call lights. The assistant executive director told residents that the management team planned to complete call light audits to ensure call lights were working and that CNAs and nursing staff answered call lights in a timely manner.The 2/18/26 resident council meeting minutes revealed concerns that call light times were getting very long. Residents said call light wait times sometimes were 30 minutes and sometimes could be two hours due to insufficient staffing.The 3/11/26 resident council meeting minutes revealed that the assistant director of nursing (ADON) (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked whether the call light times had improved and the general consensus from the residents was that they had improved a little bit. The management team implemented a new process to ensure call lights were answered more quickly.The 4/8/26 resident council meeting minutes revealed concerns regarding staffing and requests for more CNAs. The ADON told the residents that staffing numbers were based on census and said she would follow up with the management team regarding the residents' staffing concerns.-However, the resident council meeting minutes failed to reveal that the facility resolved the ongoing concerns related to long call light wait times and staffing concerns identified during the January 2026, February 2026, March 2026 and April 2026 resident council meetings.V. Staff interviewsThe executive director and the vice president of clinical services were interviewed together on 5/6/26 at 1:46 p.m. The executive director said the facility installed a new call light system in July 2025 because the previous system was outdated and difficult to replace. The executive director said staff received training from the company that installed the system and the nurse managers continued to train staff. The executive director said nurses and CNAs received the call light notifications through an application on their phones and staff could accept and cancel call lights through the application. The executive director said call lights were expected to be answered within 10 minutes. The executive director said if a call light was not answered within 10 minutes, the alert escalated to a nurse and after another 10 minutes, it escalated to the management team. The executive director said the NHA, the director of nursing (DON) and the nurse managers reviewed call light reports weekly and reviewed timing concerns to identify trends related to delayed responses.CNA #4 was interviewed on 5/6/26 at 4:38 p.m. CNA #4 said one CNA was responsible for approximately 11 to 12 residents on the Ponderosa unit and it was difficult to get residents up, toileted and showered before breakfast. CNA #4 said morning care responsibilities were nonstop and staff did not always have enough time to complete resident care timely. CNA #4 said residents sometimes waited 30 minutes to one hour for assistance during busy shifts. CNA #4 said residents complained about waiting for assistance and some residents toileted themselves because they could not wait for staff assistance.Social services assistant #1 was interviewed on 5/7/26 at 7:21 p.m. Social services assistant #1 said the facility documented resident concerns on a grievance form. Social services assistant #1 said grievances related to nursing were forwarded to the DON and grievances related to dining services were forwarded to the appropriate department. Social services assistant #1 said concerns related to call lights were reported to the DON and the NHA.The executive director was interviewed again on 5/7/26 at 7:26 p.m. The executive director said the facility had received complaints about call lights from residents. The executive director said the facility began discussing call lights in April 2026 through a Performance Improvement Plan (PIP), discussed the issue during an all-staff meeting and completed an in-service with staff. The executive director said delayed call light responses occurred more often during meal times and when staff were getting residents up or back to bed.-However, residents continued to experience long call wait times, including on the morning of 5/6/26 (see resident group interviews above).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report allegations of abuse to the State Survey and Certification Agency in accordance with state law for three of six allegations of abuse.Specifically, the facility failed to:-Report an allegation of verbal abuse between Resident #46 and Resident #56 on 2/18/26 within two hours of the incident;-Report an allegation of sexual abuse between Resident #82 and certified nurse aide (CNA) #6 on 12/19/25 within two hours of the incident; and,-Report an allegation of sexual abuse between Resident #79 and CNA #6 on 1/3/26 within two hours of the incident.Findings include:I. Facility policy and procedureThe Abuse policy, dated March 2024, was provided by the nursing home administrator (NHA) on 5/4/26 at 4:35 p.m. It read in pertinent part, The (facility) will strive to prevent abuse and report, investigate and respond to actual and suspected abuse, as well as care for and treat those who may be victims of abuse. The facility will meet the requirements of Federal, State, and local law in its response to actual or suspected abuse. Occurrence reporting policies and procedures must be similarly followed. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include but are not limited to, threats of harm and saying things to frighten a resident. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. Reporting suspected abuse occurrences: after trying to intervene to stop the abuse, neglect, exploitation or other mistreatment, associates and volunteers must report suspected or actual abuse to the executive director; the community will ensure the resident(s) are protected from potential future abuse, neglect and/or exploitation while the investigation is being conducted; the executive director, on behalf of the community, will ensure that law enforcement and all other applicable regulatory agencies are notified within 24 hours of becoming aware of the allegation of abuse, neglect or exploitation; the executive director must also notify the resident's family or other legal representative about the allegation within 24 hours of becoming aware of the allegation; Colorado law also requires that personnel engaged in the admission, care of treatment of at-risk elders to report suspected physical or sexual abuse, mistreatment, exploitation and neglect to law enforcement within 24 hours of observation or discovery; any suspected or witnessed abuse, neglect, involuntary seclusion or misappropriation of resident property may result in immediate suspension of the associate(s) pending further investigation; and, refusal to report abuse or suspected abuse in violation of this policy in a timely manner is grounds for immediate disciplinary action up to and including termination.II. Record reviewThe facility investigations for three verbal and sexual abuse allegations were provided by the NHA on 5/5/26 at 2:00 p.m. The investigations documented the following:The alleged sexual abuse between Resident #82 and CNA #6 occurred on 12/19/25 at 3:45 p.m.Cross-reference F550 for failure to treat residents with dignity and respect.-However, the facility failed to report the allegation of potential sexual abuse until 12/20/25 at 11:51 a.m., 20 hours after the incident occurred.The alleged sexual abuse between Resident #79 and CNA #6 occurred on 1/3/26 at 7:00 p.m.Cross-reference F550 for failure to treat residents with dignity and respect.-However, the facility failed to report the allegation of potential sexual abuse until 1/7/26 at 1:49 p.m., 90 hours after the incident occurred.The alleged verbal abuse between Resident #46 and Resident #56 occurred on 2/18/26 at 4:00 p.m. -However, the facility failed to report the allegation of potential verbal abuse until 2/19/26 at 12:15 p.m., 20 hours after the incident occurred.III. Staff interviewsThe NHA was interviewed on 5/5/26 at 3:07 p.m. The NHA said staff should report potential abuse immediately to the director of nursing (DON) or herself, as the abuse coordinator. She said the first step with an abuse allegation was to ensure the resident was safe and removed from the situation, then a registered nurse (RN) should complete an assessment of the resident. The NHA said she would then report the allegation of abuse to the ombudsman, corporate (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the human resources (HR) department before she involved the police, nursing board and adult protective services (APS). She said she would get the initial incident report submitted to the State Agency before immediately and quickly investigating the incident to determine if the allegation of potential abuse was actual abuse. The NHA said the initial incident report would be submitted to the State Agency within two hours if the resident experienced an injury or harm.Social services assistant #2 was interviewed on 5/6/26 at 3:37 p.m. Social services assistant #2 said the NHA was the abuse coordinator for the facility. She said staff should report potential abuse immediately if there was harm, but the facility had two hours to report abuse to the State Agency after it was discovered. Social services assistant #2 said facility staff were to report abuse to their supervisor, who would then report the allegation directly to the NHA.The executive director and the DON were interviewed together on 5/8/26 at 11:46 a.m. The DON said abuse should be reported to the State Agency within two hours of the incident. She said investigations should be completed within five days of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for three out of six allegations reviewed for abuse.Specifically, the facility failed to:-Thoroughly investigate a sexual abuse allegation by certified nurse aide (CNA) #6 towards Resident #82 on 12/19/25;-Thoroughly investigate a sexual abuse allegation by CNA #6 towards Resident #79 on 1/3/26; and,-Thoroughly investigate a neglect allegation involving CNA #5 on 4/1/26.Findings include: I. Facility policy and procedure The Abuse policy and procedure, dated March 2024, was provided by the nursing home administrator (NHA) on 5/4/26 at 4:03 p.m. It read in pertinent part, Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Examples of neglect include but are not limited to, failing to provide needed care such as not responding to a call light, failing to nourish, toilet, or hydrate a resident. The community will strive to prevent abuse from occurring by doing the following: education, staffing levels, communicating and reporting concerns and resident rights. A detailed investigation will be completed. The senior staff member on duty will initiate an investigation immediately and notify the executive director. Applicable assessments will be completed. The investigation will determine if the allegation was verified, not verified or inconclusive. All potential relevant physical evidence will be saved, and the circumstances thoroughly documented. Care planning and corrective action will be taken to prevent future occurrences. In situations where an associate is the alleged perpetrator, action taken will depend on the severity of the incident and information provided during the investigation. II. Failed to thoroughly investigate an allegation of sexual abuse between Resident #82 and CNA #6 A. Facility investigation The facility's investigation of the 12/19/25 allegation of sexual abuse was provided by the NHA on 5/5/26 at 2:00 p.m. The facility's investigation report revealed an interview with Resident #82 was conducted on 12/22/25 (three days after the allegation was made) by the social services director (SSD). The interview revealed Resident #82 felt like the male care giver (CNA #6) had his hands where they should not be. When the resident was asked to clarify, she stated she was referring to her breasts. The SSD asked Resident #82 if she would feel more comfortable during cares if the male care giver asked her to move her own breasts out of the way and Resident #82 said yes. Resident #82 stated that she felt safe and did not like being touched by male care givers when possible. -The investigation failed to reveal documentation to indicate that an interview was conducted with the assailant, the date the interview with the alleged assailant took place, or what questions were asked of the alleged assailant, CNA #6. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Facility investigation The facility's investigation was provided by the NHA on 5/5/26 at 2:00 p.m. The investigation, dated 1/7/26 at 1:49 p.m., documented Resident #79 said CNA #6 patted the area of her leg right below her bottom during a transfer. The investigation revealed the social services director (SSD) interviewed Resident #79 about the incident. The investigation documented Resident #79 said she was sitting on the edge of her bed and needed her feet to be put up onto the bed. Resident #79 said she was clothed and in her brief when CNA #6 tapped her bottom. The investigation documented Resident #79 said she felt safe at the facility, but she felt the interaction was sexual in nature. The SSD asked Resident #79 if she asked CNA #6 to stop or if she told the CNA she was uncomfortable. Resident #79 said she did not. The investigation revealed the NHA and the interim director of nursing (DON) conducted a follow-up interview with Resident #79. The investigation documented Resident #79 said CNA #6 patted the back of her leg right below her bottom during a transfer, and she thought it might have been sexual in nature. CNA #6 was suspended during the investigation. The facility's investigation documented the facility was unable to substantiate the allegation of sexual abuse because the incident did not meet the criteria of: knowingly; consent not given; and/or, sexual intrusion/penetration, touching intimate parts or the clothing covering the intimate parts or, examiners or treats resident/patient for other than [NAME] fide medical purposes or, observes or photographs another person's intimate parts or, physical force/threat. The investigation documented CNA #6 and Resident #79 both said the CNA put his hands on the resident's leg for the purpose of the bed transfer. -However, the investigation documented that Resident #79 told the SSD, the NHA and the interim DON that she felt the contact by CNA #6 was sexual in nature. The facility's investigation failed to reveal documentation of the following: -The facility's investigation failed to document CNA #6's interview. -The facility's investigation failed to document education provided to CNA #6 following the incident. -The facility's investigation failed to document any training CNA #6 received related to abuse and transfers. -The facility's investigation failed to include documentation to indicate attempts were made to observe and assess CNA #6's performance while the CNA provided transfer assistance to ensure his understanding of safe and appropriate transfers. B. Resident #79 (alleged victim) 1. Resident status Resident #79, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses included Parkinson's disease (a progressive neurodegenerative disorder of the central nervous system which leads to movement issues), gastro-esophageal reflux disease (GERD), anxiety disorder and depression. The 4/7/26 MDS assessment revealed the resident was moderately cognitively intact with a BIMS score of 12 out of 15. The MDS assessment revealed the resident required set-up assistance with ADLs including eating, oral hygiene and personal hygiene. She required partial/moderate assistance with toileting, dressing and mobilizing from sitting to lying. 2. Resident interview Resident #79 was interviewed on 5/4/26 at 12:00 p.m. Resident #79 said she had been touched by a staff member in a way that made her feel uncomfortable. She said CNA #6 put her to bed and assisted her from a sitting to a lying position. Resident #79 said CNA #6 patted her on the bottom and she thought that was why he did not work there anymore. Resident #79 was interviewed again on 5/7/26 at 8:20 a.m. Resident #79 said she thought CNA #6 intentionally touched her inappropriately when he laid her in bed. She said she felt safe at the facility and was not fearful of abuse. 3. Record review Review of Resident #79's comprehensive care plan, initiated 12/22/25, revealed the resident had a personal preference to have female caregivers when possible, and for female caregivers to accompany male caregivers if any were present, including outside vendors. Pertinent interventions, initiated 2/20/26, included to give the resident the option to wait for a female caregiver and ensure a female caregiver was present when male vendors or caregivers were present; and, provide female caregivers as frequently as possible. Review of Resident #79's Kardex (tool utilized by staff to provide consistent care for residents) report revealed the following intervention: Give the resident the option to wait for a female caregiver and ensure a female caregiver is present when male vendors or caregivers are present. C. Staff interviews The NHA was interviewed on 5/5/26 at 5:04 p.m. The NHA said CNA #6 was interviewed during the investigation of the incident involving Resident #79. She said CNA #6's interview and education were not in the facility's investigation because she had moved offices and was unable to locate the documentation. The NHA said she would try to locate the documentation. CNA #2 was interviewed on 5/6/26 at 11:02 a.m. CNA #2 said she was familiar with Resident #82 and Resident #79. She said Resident #79 had never complained about being touched inappropriately. CNA #6 was interviewed on 5/7/26 at 8:43 a.m. CNA #6 said there were many ways to assist a resident from sitting to lying and it depended on the resident's ability. CNA #6 said during the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nightshift on 1/3/26, Resident #79 activated her call light every two to three minutes, even though he tried to ensure she had everything she needed within reach and asked if there was anything else he could do before he left her room. He said at some point during the shift, Resident #79 started to change her stance to him, but he was not sure what happened. CNA #6 said he spent his shift going into her room every five to 15 minutes to provide her with assistance. CNA #6 said he did not recall patting Resident #79 on or near the bottom. He said 1/3/26 was the last nightshift he worked at the facility and during his dayshift on 1/6/26, he received a call and was told that he abused a resident and was being suspended. CNA #6 said the facility spoke to him about taps but he did not know why he would ever tap a resident on the bottom. He said he was told he was cleared to work at other facilities, but not this one IV. Failed to thoroughly investigate an allegation of potential neglect involving CNA #5 A. Facility investigation The investigation of the alleged neglect between involving CNA #5 was provided by the executive director on 5/5/26 at 2:30 p.m. The facility's investigation revealed CNA #4 worked on the rehabilitation unit and she observed CNA #5 working in the same unit, sleeping while working the overnight shift on 4/1/26. The neighborhood had a maximum of 18 residents with one registered nurse (RN) and two CNAs assigned for the night shift. All residents were cared for by the RN and CNA #4 during the time when CNA #5 was allegedly sleeping. The investigation started on 4/2/26 and consisted of interviewing residents and other staff members. The investigation included a review of CNA #5's employee personnel file and a review of the residents' call lights report. CNA #5 was suspended pending the investigation. The investigation documented that the residents were not assessed because all residents were cared for during the time the staff member was allegedly sleeping. CNA #5 was interviewed and did not deny sleeping at work. Int The staff interviews revealed a pattern of CNA #5 sleeping on shift. Interviews with staff revealed a lack of knowledge amongst staff regarding company's policies regarding sleeping while at work. All staff were educated on the employee handbook that indicated sleeping on the job was prohibited. Staff were educated on neglect standards which stated sleeping was against the standard of practice and a reportable event. The investigation documented staff understood the expectations and that sleeping on the job would result in official disciplinary action, up to and including termination. As a result of the facility's investigation, CNA #5 was terminated on 4/7/26. It was verified CNA #5 was sleeping during his shifts. It could not be verified whether CNA #5 was on lunch break or not. CNA #5 was terminated as sleeping was a violation of the employee handbook. The investigation documented that all residents were cared for by RN #9 and CNA #4 on 4/1/26, so no resident was at risk at any time during the shift. -The investigation failed to reveal documentation of CNA #4's (the staff member who reported the alleged neglect) statement or interview. -A request for documentation to indicate CNA #5 was not allowed to work during the facility's (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigation was made on 5/7/26, however the facility was unable to provide documentation. B. CNA #4's interview (reporter of potential neglect allegation) CNA #4 was interviewed on 5/6/26 at 4:38 p.m. CNA #4 said she had worked at the facility for almost a year and she started in June 2025. She said she worked per diem (as needed) for the facility and worked in all of the units. She said the abuse coordinator for the facility was the NHA and she reported abuse to the director of nursing (DON) or the NHA. She said she reported abuse when staff were not doing their job, such as sleeping on the job. She said she documented everything on an application on her phone so she did not forget anything and so if the NHA or the DON had any questions, she had something to reference. CNA #4 said she emailed the NHA regarding what she saw with CNA #5 on 4/1/26. CNA #4 said she reported the instance of potential neglect from CNA #5 on 4/2/26. She said she was working a night shift on 4/1/26 in the rehabilitation unit. She said she was working with a RN #9 and CNA #5. She said CNA # 5 did not have his phone while he was working that night. CNA #4 said it was important for him to have his phone because it was the facility issued phone that had the call light application on it, which CNAs if a resident used their call light. CNA #4 said CNA #5's phone ran out of battery power. CNA#4 said CNA #5 was asleep on the couch in the unit. CNA #4 said RN #9 said CNA #5 sleeping happened all the time. CNA #4 said she wrote everything down that CNA #5 was not doing. She said at 12:00 a.m., CNA did not do one round and at 3:50 a.m., he did not do any additional rounds. CNA #4 said he was sleeping from at least 12:00 a.m. to 3:00 a.m CNA#4 said RN#9 woke up CNA #5 by telling him his call lights were going off. She said he jumped and he appeared not to care. CNA #4 said she and RN #9 completed the nursing responsibilities that CNA #5 should have done so residents did not go without care. CNA #4 said the NHA interviewed her last week (week of 4/26/26). CNA #4 said before the interview last week, the administration's response was that they were going to investigate. CNA #4 said she noticed in the semi-secure unit that once or twice a different CNA, who was a woman, slept during her shift. CNA #4 said she had checked on that CNA's residents while the CNA was asleep too. CNA #4 said she told the unit nurse and the nurse's response was that the female CNA slept often. CNA #4 said it was important to report because if the two-hour rounding was not done, residents who required incontinence care could sit in their own feces and urine for a long period. C. Record review The email sent by CNA #4 to the NHA was provided by CNA #4 on 5/8/26 at 10:17 a.m. The email was sent on 4/2/26 at 6:31 a.m. It read in pertinent part, On 4/1/26 CNA #5 was sleeping and multiple call lights were going off. After being woken by RN #9, he went to the nurses' station to ask which call light was going off. His phone was dead and he did not have one nearby. The only rounds CNA #5 did were at 6:00 p.m. when he arrived on shift to do vital signs and breakfast orders and at 5:00 a.m. before the shift was up. At 12:00 a.m. CNA #5 did not do a single round. At 3:50 a.m., CNA #5 still did not do a single round. CNA #5 made my nurse and me extremely uncomfortable with the lack of care he gave to these residents. Here is a photo of CNA #5 sleeping while on shift. He did not communicate to my nurse or me that he was taking a break and again, multiple call lights were going off. A picture was attached to the email which revealed a male lying on a couch in the rehabilitation unit. D. Staff interviews (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #9 was interviewed on 5/5/26 at 5:25 p.m. RN #9 said she had worked at the facility for seven months. She said she reported abuse based on the chain of command. She said she reported abuse to her unit manager who reported it to the DON who reported it to the NHA. She said the only time neglect was suspected, it was because CNA #5 was asleep. RN #9 said she rounded consistently throughout her shift to ensure the two CNAs scheduled in her unit met the residents' needs, such as wanting water and incontinence care. RN #9 said she had some CNAs who were really good at rounding and responding to call lights and she had other CNAs she had to police more. RN #9 said CNA #5 slept and was on his phone throughout his shift. RN #9 said she knew residents on her shift were not neglected because if the CNA did not provide care, she provided the care herself. RN #9 said she reported CNA #5 to the facility's previous DON who worked at the facility for a couple of weeks, but she did not know the outcome from that report. -However record review revealed no documentation related to allegations previous night, CNA #5 slept during his shift. The NHA, the DON and the executive director were interviewed together on 5/5/26 at 3:07 p.m. The NHA said she was the abuse coordinator for the facility and she started working at the facility in June 2025. She said staff should report abuse immediately to the DON or to her. She said when there was suspected abuse, she first determined the residents involved were safe and then she reported to the police, adult protective services (APS), the State Agency, corporate human resource and the nursing board. She said she reported to the different agencies depending on the type of abuse and who was involved. She said corporate human resources would be involved if staff were involved in the allegation and the nursing board was involved if staff were involved and she wanted to ensure the community was kept safe. The NHA said she divided the work between the DON, SSD and herself. She said the SSD interviewed the victim, additional residents and family members. The NHA said the DON interviewed the staff members and the NHA helped where needed. The NHA said the SSD interviewed the victim to determine if the resident was safe. The NHA said the facility did not use cameras or recordings when investigating because there were no cameras in the building. The NHA said if a resident was unable to communicate, they used non-verbal observations for signs of distress. The NHA said the SSD and the DON also checked in with the family and the floor staff to see if they noticed a change in a resident after an allegation. The NHA said they monitored the residents to see if they were okay. The NHA said she was not sure how the SSD monitored residents but she would find out. The NHA said she determined which residents to interview based on the type of abuse. The NHA said most of the time, it was based on the unit because it was a good sample of the residents involved. The NHA said she interviewed staff who worked in the unit the alleged abuse took place in because the staff would have good insight. The DON said she interviewed CNA #5 regarding the incident on 4/1/26. The DON said she used open-ended questions and said the allegation was that other staff members had to wake him up, answer his call lights and had to make sure his residents were safe. The NHA said CNA #4 called the NHA on 4/2/26 early in the morning and said she was not sure if it was okay that CNA #5 slept on their shift. The NHA said it was the first time she heard about CNA #5 sleeping while working. The NHA said she talked to RN #9 who confirmed what CNA #4 said. The NHA said she did not substantiate the allegation of potential neglect because RN #9 and CNA #4 said they addressed the residents' needs while CNA #5 was sleeping. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The executive director and the DON were interviewed together on 5/8/26 at 11:46 a.m. The executive director said on 4/2/26 at 3:30 a.m. CNA #4 and RN #9 reported to the NHA that CNA #5 was sleeping during their shift. The DON said staff were trained on 4/2/26 and staff in all units were trained that sleeping on the job was prohibited and was considered neglect of resident care. The DON said an abuse investigation would be started. The executive director said interviews with staff and residents were conducted on 4/6/26. He said the DON and the NHA interviewed the staff and the social services staff interviewed the residents. The executive director said he was not sure who specifically interviewed the residents and the interview forms did not have a section to indicate who completed the resident interviews for the 4/1/26 neglect allegation. The executive director said CNA #5's personnel file was reviewed on 4/6/26 and the CNA was terminated on 4/7/26. The executive director and the DON said they did not know CNA #4 reported that she was not interviewed until last week. The executive director said there was not a statement from CNA #4 in the investigation and he was not aware CNA #4 reported that she saw other staff sleeping in other units. The executive director and the DON said they did not know RN #9 reported she knew CNA #5 slept on other shifts. The executive director said based on that information, it was hard to substantiate or unsubstantiate the allegation of neglect since there was a pattern of CNA #5 sleeping on his shift.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#82 and #79) of four residents out of 51 sample residents were treated with respect, dignity and care in a manner that promoted quality of life or recognized the residents' individuality. Specifically, the facility failed to ensure Resident #82 and Resident #79 were treated with dignity and respect during transfers.Findings include: I. Resident #82 A. Facility investigation The facility's investigation of the 12/19/25 allegation of sexual abuse was provided by the NHA on 5/5/26 at 2:00 p.m. The facility's investigation report revealed an interview with Resident #82 was conducted on 12/22/25 (three days after the allegation was made) by the social services director (SSD). The interview revealed Resident #82 felt like the male care giver (CNA #6) had his hands where they should not be. When the resident was asked to clarify, she stated she was referring to her breasts. The SSD asked Resident #82 if she would feel more comfortable during cares if the male care giver asked her to move her own breasts out of the way and Resident #82 said yes. Resident #82 stated that she felt safe and did not like being touched by male care givers when possible. The facility's investigation revealed education was given to CNA #6. The topics that were discussed included residents' rights, abuse nontolerance and avoiding abuse allegations. The education was provided to the CNA over the phone. A note on the back of the education, dated 12/29/25 at 11:56 a.m. (10 days after the allegation was made), documented that a registered nurse (RN) had spoken to CNA #6 over the phone and CNA #6 verbalized understanding and he would utilize the techniques that were discussed. Cross-reference F609 for failure to report allegations of abuse within two hours of the incident. B. Resident status Resident #82, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), depression, muscle weakness, difficulty in walking and overactive bladder. The 4/30/26 minimum data set (MDS) assessment revealed Resident #82 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. She needed substantial to maximal assistance for most of her activities of daily living (ADL) and was dependent on staff for toileting. C. Resident interview Resident #82 was interviewed on 5/4/26 at 11:12 a.m. Resident #82 said an employee had touched her inappropriately. She said that the employee no longer worked at the facility. She said she told her pastor and that he went with her to report it to the facility staff. She said she did not want to talk (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about it. D. Record review Resident #82's ADL care plan, revised 4/4/23, revealed she had an ADL self-care deficit due to her muscle weakness and COPD. Pertinent interventions included transferring her with stand-pivot (assisting the resident to a standing position, having them pivot on their feet, and then sitting down) with one-person assist. On days that she was weak, staff were to use the Hoyer lift (mechanical lift). On 12/22/25 the intervention of cares in pairs and the resident preferred female care workers was added to the care plan. Resident #82's unmet needs care plan, initiated 8/13/25, revealed she would periodically become tearful and would not be able to explain why and would become very anxious when waiting for care, which would sometimes result with her making allegations about staff. Pertinent interventions included acknowledging the resident's emotions without judgment and reminding her that she did not do anything wrong, informing social services if frequency or intensity of episodes increased, providing reassurance when she appeared tearful or anxious, and using a calming tone and validating statements. E. Staff interviews The nursing home administrator (NHA) was interviewed on 5/5/26 at 5:05 p.m. The NHA said she was at the facility on 12/19/25 when the assistant director of nursing (ADON) contacted her and told her about the allegation of Resident #82's breasts being touched inappropriately. She said she checked in with Resident #82 and the nurse who was on duty. She said she had found out that certified nurse aide (CNA) #6 was trying to move the resident's breasts out of the way as Resident #82 was transferring from the toilet back to her wheelchair because Resident #82's breasts hung down to her waistline. The NHA said the facility determined the incident was more of a dignity issue related to not informing the resident what was going to happen during the transfer. She said education was done with CNA #6 and that it was done over the phone because he was suspended during the investigation. She said CNA #6 was educated on methods to use to avoid abuse allegations, resident rights and the abuse policy. CNA #2 was interviewed on 5/6/26 at 11:02 a.m. CNA #2 said that when she was helping a female resident in the bathroom and her breasts hung low, she said she would use the resident's shirt to help hold her breasts up and out of the way. She said when she was helping a resident go from sitting to a lying position, she would not touch the resident's buttocks area or upper thigh area. CNA #7 was interviewed on 5/6/26 at 11:59 a.m. CNA #7 said he had only been employed at the facility for a month. He said when he transferred a resident from the sitting position to a lying position, he never touched the resident's buttocks area or upper thigh area. He said he would support their back and hold their legs around the knee area. He said when he would help a resident in the bathroom, he would always ask them for permission before he touched them. He said there were times when a female resident would accept his help with care one day and then decline his help on a different day, which was why he would ask them for permission first. He said he was informed of residents who preferred female CNAs from the report sheets. He said he would also let the nurse know if a resident expressed feeling uncomfortable when he offered care. Licensed practical nurse (LPN) #3 was interviewed on 5/6/26 at 1:35 p.m. LPN #3 said when she (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted a resident with going from sitting to lying, she supported the resident's shoulders or lower back and if she had to help with their legs, she would be touching their lower leg area, not around the buttocks area. She said if she was helping a resident in the bathroom and the resident's breasts were in the way of pulling up their pants, she would ask the resident permission to move her breasts or see if the resident could move her breasts herself. LPN #1 was interviewed on 5/6/26 at 2:13 p.m. LPN #1 said when assisting a resident from sitting to lying, she would touch their back and under their knees or calves, but not their buttocks area. She said when assisting a resident in the bathroom, she would communicate everything that she was doing. She said if the resident's breasts were in the way, she would ask the resident to move them. The director of nursing (DON) and the executive director were interviewed together on 5/8/26 at 11:46 a.m. The DON said she would expect her staff, when assisting a resident from sitting to lying, to support the resident's side and their legs. She said they should not be touching the buttocks area. She said when her staff was assisting a female resident in the bathroom and their breasts were in the way, she would expect her staff to talk to the resident and explain everything that they were doing. She said she would expect her staff to communicate to the resident that they would have to touch them. The DON said she was not employed at the facility when the incident with Resident #82 and CNA #6 occurred. She said she would have conducted CNA #6's training in person and that she would have had a second manager with her to offer assistance and more training. She said she would have followed up with Resident #82 and Resident #79 (see Resident #79 investigation below) and would have let the physicians know what had happened and also have the nurses monitor the resident's behaviors for any adverse reactions to the incidents. She said she would then follow up with the residents again to make sure they felt like they were being treated with respect and dignity. II. Resident #79 A. Facility investigation The facility's investigation was provided by the NHA on 5/5/26 at 2:00 p.m. The investigation, dated 1/7/26 at 1:49 p.m., documented Resident #79 said CNA #6 patted the area of her leg right below her bottom during a transfer on 1/3/26. The investigation revealed the social services director (SSD) interviewed Resident #79 about the incident. The investigation documented Resident #79 said she was sitting on the edge of her bed and needed her feet to be put up onto the bed. Resident #79 said she was clothed and in her brief when CNA #6 tapped her bottom. The investigation documented Resident #79 said she felt safe at the facility, but she felt the interaction was sexual in nature. The SSD asked Resident #79 if she asked CNA #6 to stop or if she told the CNA she was uncomfortable. Resident #79 said she did not. The investigation revealed the NHA and the interim director of nursing (DON) conducted a follow-up interview with Resident #79. The investigation documented Resident #79 said CNA #6 patted the back of her leg right below her bottom during a transfer, and she thought it might have been sexual in nature. CNA #6 was suspended during the investigation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation documented the facility was unable to substantiate the allegation of sexual abuse because the incident did not meet the criteria of: knowingly; consent not given; and/or, sexual intrusion/penetration, touching intimate parts or the clothing covering the intimate parts or, examiners or treats resident/patient for other than [NAME] fide medical purposes or, observes or photographs another person's intimate parts or, physical force/threat. The investigation documented CNA #6 and Resident #79 both said the CNA put his hands on the resident's leg for the purpose of the bed transfer. -However, the investigation documented that Resident #79 told the SSD, the NHA and the interim DON that she felt the contact by CNA #6 was sexual in nature. Cross-reference F609 for failure to report allegations of abuse within two hours of the incident. B. Resident status Resident #79, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included Parkinson's disease (a progressive neurodegenerative disorder of the central nervous system which leads to movement issues), gastro-esophageal reflux disease (GERD), anxiety disorder and depression. The 4/7/26 MDS assessment revealed the resident was moderately cognitively intact with a BIMS score of 12 out of 15. The MDS assessment revealed the resident required set-up assistance with ADLs including eating, oral hygiene and personal hygiene. She required partial/moderate assistance with toileting, dressing and mobilizing from sitting to lying. C. Resident interview Resident #79 was interviewed on 5/4/26 at 12:00 p.m. Resident #79 said she had been touched by a staff member in a way that made her feel uncomfortable. She said CNA #6 put her to bed and assisted her from a sitting position to a lying position. Resident #79 said CNA #6 patted her on the bottom and she thought that was why he did not work there anymore. Resident #79 was interviewed again on 5/7/26 at 8:20 a.m. Resident #79 said she thought CNA #6 intentionally touched her inappropriately when he laid her in bed. She said she felt safe at the facility and was not fearful of abuse. D. Record review Review of Resident #79's comprehensive care plan, initiated 12/22/25, revealed the resident had a personal preference to have female caregivers when possible, and for female caregivers to accompany male caregivers if any were present, including outside vendors. Pertinent interventions, initiated 2/20/26, included to give the resident the option to wait for a female caregiver and ensure a female caregiver was present when male vendors or caregivers were present and provide female caregivers as frequently as possible. Review of Resident #79's Kardex (tool utilized by staff to provide consistent care for residents) report revealed the following intervention: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident the option to wait for a female caregiver and ensure a female caregiver was present when male vendors or caregivers were present. E. Staff interviews The NHA was interviewed on 5/5/26 at 5:04 p.m. The NHA said she thought the SSD notified her about the incident involving Resident #79 and CNA #6, but she did not fully remember. She said CNA #6 was interviewed during the investigation of the incident involving Resident #79, and he said the resident did not like how he transferred the resident from an upright seated position to a flat lying position. The NHA said CNA #6 said that he put his hand on the back of her leg to help support her lower back. She said CNA #6's phone interview and education were not in the facility's investigation because she had moved offices and was unable to locate the documentation. The NHA said the facility suspended CNA #6 pending the investigation, performed an assessment on Resident #79, contacted the resident's representative and all of the parties, including the police department and the ombudsman in effort to protect Resident #79 and other residents from future occurrences. She said the facility interviewed other residents to ensure their safety and interviewed staff to see if they had seen any behaviors from CNA #6. She said CNA #6 was very well loved by staff and residents alike and the whole team raved about him. The NHA said CNA #6 no longer worked at the facility, due in part to the allegations of Resident #79 and Resident #82 (see Resident #82 investigation above). However, the NHA said she would not have allowed CNA #6 to continue working with his CNA license if she thought he was an unsafe caregiver.The NHA said CNA #6 remained a part of the as needed (PRN) pool with the company, not at the facility specifically, because he did not show signs of abusive behavior and the residents seemed to really like him and felt safe with him. The NHA said Resident #79 was high anxiety and if her call lights were not answered immediately, her anxiety went way up and she continued to press her call light. She said Resident #79 averaged 27 to 30 call light activations per shift and the interdisciplinary team (IDT) met daily in an effort to decrease her anxiety. The NHA said the facility tried to ease Resident #79's transition to the facility by having care conferences with the resident's representative. CNA #2 was interviewed on 5/6/26 at 11:02 a.m. CNA #2 said she was familiar with Resident #79. She said Resident #79 had never complained about being touched inappropriately. CNA #6 was interviewed on 5/7/26 at 8:43 a.m. CNA #6 said there were many ways to assist a resident from sitting to lying and it depended on the resident's ability. CNA #6 said during the nightshift on 1/3/26, Resident #79 activated her call light every two to three minutes, even though he tried to ensure she had everything she needed within reach and asked if there was anything else he could do before he left her room. He said at some point during the shift, Resident #79 started to change her stance to him, but he was not sure what happened. CNA #6 said he spent his shift going into her room every five to 15 minutes to provide her with assistance. CNA #6 said he did not recall patting Resident #79 on or near the bottom. He said 1/3/26 was the last nightshift he worked at the facility and during his dayshift on 1/6/26, he received a call and was told that he abused a resident and was being suspended. CNA #6 said the facility spoke to him about taps but he did not know why he would ever tap a resident on the bottom. He said he was told he was cleared to work at other facilities, but not this one.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for two (#53 and #79) of five residents out of 51 sample residents. Specifically, the facility failed to ensure assessments were conducted to determine whether the self-administration of medications was clinically appropriate for Resident #53 and Resident #79.Findings include: I. Facility policy and procedure The Medication Administration: Self-Administration by Resident policy, dated January 2026, was provided by the executive director on 5/8/26 at 12:34 p.m. It read in pertinent part, Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Facilities must adhere to state specific laws and regulations. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical and visual ability to carry out this responsibility during the care planning process. The results of the interdisciplinary team assessment are recorded on the medication self-administration assessment, which is placed in the resident's medical record. II. Resident #53 A. Resident status Resident #53, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic atrial fibrillation (rapid irregular heartbeat), chronic obstructive pulmonary disease (emphysema and difficulty breathing), peripheral vascular disease (progressive circulation disorder, narrowing blood vessels), prediabetes, chronic kidney disease stage three, obesity, and left artificial knee joint. According to the 4/16/26 MDS assessment, Resident #53 was moderately cognitively impaired with a BIMS score of 12 out of 15. Resident #53 required set-up assistance with eating, oral hygiene, and personal hygiene. He required substantial assistance with toileting and showering. B. Observation and resident/resident's representative interviews On 5/4/26 at 12:13 p.m., during an interview with Resident #53 and his representative, there were three containers sitting on top of the bedside table next to the resident's telephone. One container was a four-ounce tube labeled Remedy clinical prevent silicone cream. The second container was a jar labeled with Resident #53's name and nystatin (a prescription antifungal medicine used to treat yeast infections), zinc (treats skin irritation) and lidocaine (an anesthetic for numbing) cream. The third container was labeled with Resident #53's name and Nystop (a prescription antifungal to treat skin infections). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53 and his representative said they did not know what the medications were for and when they were last used. Resident #53's representative said she thought the medications might have come from the hospital. C. Record review Review of Resident #53's May 2026 CPO revealed the following physician's orders: Nystop external powder 100,0000 units/gram (gm). Apply to the urethral opening topically three times a day for candidiasis, ordered 5/1/26. Nystatin, zinc, and lidocaine cream. Apply to the buttocks topically three times a day for fungal infection, ordered 5/2/26. -A review of Resident #53's May 2026 CPO did not reveal a physician's order for the use of silicone cream. -A review of Resident #53's EMR did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #53 was able to safely administer her own medications. D. Staff interviews Registered nurse (RN) #1 was interviewed on 5/7/26 at 2:26 p.m. RN #1 said medications should never be left at a resident's bedside. RN #1 said the only time a medication could be left with the resident was if the resident had an assessment indicating the resident was able to self-administer medications. RN #1 said she always worked in the rehabilitation unit and said there were no residents in the rehabilitation unit who could self-administer medications. RN #1 said she was familiar with Resident #53 and said she saw the medicated creams left on top of the resident's bedside table on 5/4/26. RN #1 said she thought the night nurse may have left the medications on top of the resident's bedside table because the treatment creams were locked in the bedside table drawer for any residents who required treatment in the rehabilitation unit. RN #1 said Resident #53 could not self-administer the treatment medications. RN #1 said the medication cart nurse had one key and the unit manager had the other key for the residents' treatment medication drawers on the bedside tables. RN #1 said it was important to not leave medications unattended because sometimes they had residents with dementia who may try to take the medication and the unit had a lot of family and friends who visited who may take the medication. RN #1 said it was important to not leave the medications at a resident's bedside to avoid accidents. The DON and the vice president of clinical services were interviewed together on 5/7/26 at 4:43 p.m. The DON said medications could be left at a resident's bedside if a resident had an assessment indicating the resident could self-administer medications. The DON said all residents' rooms in the rehabilitation unit had a drawer in the bedside table to store treatment supplies, including creams. The DON said the drawers were locked. The DON and the vice president of clinical services said RN #1 did not notify them the treatment medications were left on top of Resident ##53's bedside table by the night nurse. The DON said Resident #53 could not self-administer the treatment medications and the creams (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not have been left unattended with the resident. III. Resident #79 A. Resident status Resident #79, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included Parkinson's disease (a progressive neurodegenerative disorder of the central nervous system which leads to movement issues), gastro-esophageal reflux disease (GERD), anxiety disorder and depression. The 4/3/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 12 out of 15. She required set-up assistance with activities of daily living (ADL) including eating, oral hygiene and personal hygiene. B. Observations On 5/4/26 at 12:00 p.m. Resident #79 had one bottle of circulation and vein support supplements and one bottle of glucosamine chondroitin supplements sitting on her bedside table. On 5/6/26 at 11:16 a.m. Resident #79 had one bottle of circulation and vein support supplements and one bottle of glucosamine chondroitin supplements sitting on her bedside table. On 5/7/26 at 8:25 a.m. Resident #79 had one bottle of circulation and vein support supplements and one bottle of glucosamine chondroitin supplements sitting on her bedside table. C. Record review Review of Resident #79's May 2026 CPO revealed the following physician's order: The resident may self-administer lion's mane, circulation and vein support and glucosamine chondroitin, ordered 3/2/26. -However, review of Resident #79's electronic medical record (EMR) did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #79 was able to safely administer her own medications. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/6/26 at 11:58 a.m. LPN #1 said some of the residents at the facility had assessments completed to evaluate if the resident was able to self-administer medications at the bedside. She said she was not sure if Resident #79 had a completed self-administration assessment. LPN #1 said it was important to never leave medications at the bedside unless there was a self-administration assessment because the resident could administer the wrong dose of medication. The director of nursing (DON) and the MDS coordinator were interviewed together on 5/7/26 at 4:43 p.m. The DON said medications should never be left at a resident's bedside unless there was an evaluation for the resident to self-administer the medications, because the resident could confuse the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications, a visiting family member might assist the resident to take the medication unknowingly and to avoid dementia related accidents. The DON and the MDS coordinator were interviewed together a second time on 5/7/26 at 6:20 p.m. The DON said there should have been an assessment to evaluate the appropriateness of Resident #79 storing and self-administering supplements independently at her bedside. She said it was important to ensure the self-administration evaluation was completed so the staff could confidently say the resident was able to identify what they were taking, that they could read the label and that they could remember which medications they took and when.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure one (#80) of one resident reviewed out of 51 sample residents was provided personal privacy in his room. Specifically, the facility staff failed to knock before entering Resident #80's room to protect the resident's right to personal privacy.Findings include:I. Facility policy and procedure The Know Your Rights policy, revised October 2023, was provided by the executive director on 5/8/26 at 12:32 p.m. It read in pertinent part, You have the right to be treated with respect and dignity and in a manner that promotes maintenance and enhancement of your quality of life. You have the right to use a phone, including your own personal cell phone, and talk privately. You have the right to privacy in treatment and caring for your personal needs. II. Resident #80A. Resident statusResident #80, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia without behavioral disturbance and type 2 diabetes. The 2/23/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required set-up assistance with oral hygiene, toileting hygiene and dressing.The assessment documented Resident #80 had no behaviors.B. Resident interview and observations Resident #80 was interviewed on 5/4/26 at 4:01 p.m. Resident #80 said staff sometimes entered his room without knocking. Resident #80 said it occurred across all shifts and was not related to a specific staff member. Resident #80 said he preferred staff to knock before entering because he frequently used the phone or watched television and preferred privacy. Resident #80 said it had happened a few times and he would wave his phone at staff when they entered without knocking to let them know he was on the phone, and staff would then leave the room.During the interview, at 4:03 p.m., two unidentified staff members entered Resident #80's room without knocking and said they were checking on his roommate. Resident #80 said it was annoying when staff did not knock before entering his room. Resident #80 said he had not reported the issue to anyone. Resident #80 said if the issue became worse, he would place a sign on his door reminding staff to knock before entering.III. Staff interviewsCertified nurse aide (CNA) #2 was interviewed on 5/7/26 at 12:15 p.m. CNA #2 said the facility expected staff to knock and wait for a response before entering a resident's room. CNA #2 said staff should still knock before entering a resident's room, even if the resident could not respond or if the call light was activated. CNA #2 said she was aware Resident #80 preferred staff to knock before entering his room because Resident #80 would ask staff to knock before entering his room. CNA #2 said the staff protected Resident #80's privacy by pulling the privacy curtain when checking on the resident's roommate. CNA #2 said she did not know why staff entered Resident #80's room without knocking across different shifts.Registered nurse (RN) #4 was interviewed on 5/7/26 at 12:25 p.m. RN #4 said the expectation for facility staff was to always knock before entering a resident's room, even if the resident's door was closed. RN #4 said staff were educated during orientation to knock and provide privacy before entering resident's rooms. RN #4 said Resident #80 preferred his door to remain closed and preferred staff to knock before entering his room. RN #4 said Resident #80 did not want anyone entering his room without knocking. RN #4 said staff understood residents' privacy should be protected, regardless of whether a resident specifically requested staff to knock before entering. RN #4 said staff who failed to knock before entering a resident's room were first provided education regarding the expectations for resident privacy. RN #4 said repeated concerns were reported to the supervisor for follow-up.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from chemical restraints for two (#4 and #79) of five residents out of 51 sample residents.Specifically, the facility failed to -Ensure Resident #4's use of an antipsychotic medication was appropriately monitored and reviewed by the interdisciplinary (IDT) for continued medical necessity; -Ensure Resident #4 and Resident #79's behaviors related to the use of psychotropic medications were identified and monitored; and, -Ensure Resident #4 and Resident #79's care plans included resident-specific non-pharmacological care approaches for the residents' behaviors.Findings include: I. Facility policy and procedure The Psychotropic Medication Management policy and procedure, revised December 2024, was provided by the vice president of clinical services on 5/8/26 at 12:32 p.m. It read in pertinent part, The IDT (interdisciplinary team) will first identify and address any medical, physical, psychological causes and or social and environmental triggers. If antipsychotic medications are prescribed, documentation must show ongoing evaluation of the effectiveness of the interventions with a rationale for decisions. A regular psychotropic IDT committee will evaluate the effects of the medications on a resident's physical, mental, and psychosocial well-being and to consider whether the medication should be continued, reduced, discontinued, or otherwise modified. Antipsychotic medications and care plans will be reevaluated during quarterly care plan reviews or more often if indicated. II. Resident #4 A. Resident status Resident #4, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included displaced fracture of left femur, hypertension, history of falling, aortic stenosis, dementia, osteoarthritis, anxiety and depression. According to the 4/24/26 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He used a walker. He required set up assistance with eating. He required substantial assistance with oral hygiene, toileting, showering, dressing and personal hygiene. The assessment revealed he had an anxiety disorder and depression. He took an antipsychotic medication and an antidepressant medication with an indication noted. The assessment revealed antipsychotic medications were rec The assessment revealed the resident did not have hallucinations, delusions, physical behavioral symptoms or verbal behavioral symptoms directed towards others. The resident did not wander during the assessment look-back period. The patient health questionnaire-9 (PHQ-9 - a tool utilized to determine depression levels) revealed the resident scored a one out of 27, which indicated the resident had minimal depression. The resident reported he felt down depressed or hopeless on two to six days over the last two-week assessment (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	look-back period. B. Record review The depression and dementia with behavior care plan, initiated and revised on 4/20/26, revealed Resident #4 lived with depression and dementia. Interventions included monitoring for drowsiness, dizziness, vertigo, headache, tremor, weakness, fatigue, insomnia, postural hypotension, edema, dry mouth, anorexia, weight gain and urine retention, monitoring for dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, extrapyramidal (EPS) symptoms, assisting in developing a program of activities that were meaningful and of interest, assisting to identify strengths and coping skills, administering medications per physician order, monitoring and recording the resident's mood to determine if problems seemed to be related to external causes and monitoring, recording and reporting to the physician as needed any acute episodes or feelings of sadness. The elopement care plan, initiated and revised on 4/22/26, revealed Resident #4 was at risk for harm or injury to himself due to the family expressing concerns about him wandering. Interventions included distracting the resident from wandering by offering pleasant diversions, following facility protocols for elopement risk and facility procedures for missing persons, personalizing his environment with familiar objects and providing structured activities. The sleep cycle disturbance care plan, initiated and revised on 4/22/26, revealed Resident #4 had reported insomnia. Interventions included discussing and helping the resident to reduce any physical symptoms affecting sleep, ensuring decreased stimuli two hours before bedtime, increasing activity during the day time, medicating per physician order, reducing unnecessary interruptions in his sleep cycles and talking about suggestions about sleep comfort. -Review of Resident #4's depression, dementia, elopement, and sleep cycle care plans revealed there were no person-centered non-pharmacological interventions identified on the care plans. Review of Resident #4's May 2026 CPO revealed the following physician orders: Melatonin (a medication used for treating sleep issues) 5 milligrams (mg). Take one tablet by mouth one time a day for insomnia, ordered 4/17/26. Quetiapine fumarate 25 mg (an antipsychotic medication). Take one tablet by mouth one time a day for anxiety with behavioral disturbances, ordered 4/12/26 and discontinued 4/15/26. Risperidone 0.5 mg (an antipsychotic medication). Take one tablet by mouth at bedtime for dementia with behaviors, ordered 4/15/26. Sertraline 50 mg (an antidepressant medication). Take one tablet by mouth one time a day for depression, ordered 4/13/26. Antidepressant medication. Monitor for drowsiness, dizziness, vertigo, headache, tremor, weakness, fatigue, insomnia, postural hypotension, edema, dry mouth, anorexia, weight gain, urine retention every day and night shift, ordered 4/13/26. Antipsychotic medication. Monitor for dry mouth, constipation, blurred vision, disorientation, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, EPS symptoms, every day and night shift, ordered 4/13/26. -However, there was no physician's order for what resident-specific behaviors to monitor for each psychotropic medication in order to justify the medications. -Review of Resident #4's electronic medical record (EMR) revealed there was no documentation to indicate what resident-specific behaviors were being monitored, what interventions were offered and if the interventions were effective, in order to justify the continuation or addition of the resident's psychotropic medications. C. Staff interviews Registered nurse (RN) #1 and RN #3 were interviewed together on 5/7/26 at 2:26 p.m. RN #1 and RN #3 said they monitored sleep when a resident took melatonin or trazodone or if the resident reported they could not sleep. They both said they monitored sleep based on a physician's order that indicated to document the resident's hours of sleep per shift. RN #1 said she knew what behaviors to monitor based on monitoring the resident when they were first admitted to the facility and having frequent checks. RN #1 said when the resident was first admitted , the facility's admissions team would know the resident had a behavior. RN #1 said she also received a report from the hospital regarding a resident's behaviors. RN #1 and RN #3 said they both worked the day shift and they did not see a lot of resident behaviors. They both said most of the behaviors occurred during the night shift and they were told about the behaviors during the shift report. RN #1 said there was a physician's order for the night shift to document when they observed the behavior and they could also document behaviors as a progress note. RN #1 and RN #3 said they were both familiar with Resident #4. RN #1 said when he was first admitted to the facility, he was agitated and wanted to get out of bed and the antipsychotic medication helped him. RN #1 said they were concerned for him getting out of bed because he had limitations due to his fractured femur. They both said he did not exhibit any behaviors. RN #1 said she knew if the melatonin was effective because there was a three-day monitoring period at admission, and then the physician determined if the melatonin should be continued. Social services assistant #1, social services assistant #2, unit manager #1, and unit manager #2 were interviewed together on 5/7/26 at 4:48 p.m. Social services assistant #1 said the IDT reviewed residents who were on psychotropic medications monthly. Social services assistant #1 said the IDT should document the meetings, but she said she did not know how they documented the meetings because she did not attend the meetings. Social services assistant #1 said she did not know what was covered in the meeting because she did not attend the meetings. Social services assistant #1 said she did not know who (from social services) was part of the psychotropic meetings. Unit manager #1 said if a medication was used for sleep, they wanted to make sure it was effective by tracking it during the day and the night. Unit manager #1 said they made adjustments if the resident was drowsy during the day. Unit manager #1 said the nurse documented the amount of sleep in the medication administration record (MAR) because it would be a physician's order to monitor (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleep. Unit manager #1 said she knew what behaviors to monitor for because there would be a physician's order based on the medication. Unit manager #1 said they knew what interventions were effective for the resident by talking to the resident and the resident's family. -However, Resident #4's physician's orders did not include resident-specific behaviors to monitor for each medication. -Additionally, the physician's orders did not include an order to monitor for hours of sleep for Resident #4. Unit manager #1 and social services assistant #1 said they were familiar with Resident #4. Unit manager #1 and social services assistant #1 said they did not know if there were any behaviors to monitor. Social services assistant #1 said Resident #4 was very confused when he was first admitted to the facility but she had not see any behaviors from the resident recently. Unit manager #1 said Resident #4 did not have any behaviors and his sleeping was fine. Unit manager #1 said the resident was more engaged, more alert and more mobile. Unit manager #1 said since Resident #4 did not have any behaviors there were no interventions for him. The director of nursing (DON) and the vice president of clinical services were interviewed together on 5/7/26 at 4:43 p.m. The DON said she monitored sleep when a resident took melatonin, trazodone or if the resident reported they could not sleep. The DON said the facility monitored a resident's sleep based on a physician's order that indicated to document hours of sleep per shift. The DON said she knew what behaviors to monitor each resident for based on monitoring the resident when they were first admitted to the facility and conducting frequent checks on the resident. The DON said when a resident was first admitted to the facility, the facility's admissions team would know the resident had a behavior. The DON said the unit nurses received a report from the hospital. The vice president of clinical services said there should be a physician's order for behavior monitoring that had a list of generic interventions for nursing to use during their shift. The vice president of clinical services said the list was modified as the unit staff learned what worked and what did not work for each resident. The vice president of clinical services said the IDT met monthly and as needed to review residents who were on psychotropic medications. The DON said she was familiar with Resident #4. The DON said the IDT had not met to review Resident #4's psychotropic medications. The vice president of clinical services said she reviewed Resident #4's EMR and did not see a physician's order to monitor his behaviors or a physician's order to offer interventions and to document if the interventions were effective. III. Resident #79 A. Resident status Resident #79, age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included Parkinson's disease (a progressive neurodegenerative disorder of the central (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nervous system which leads to movement issues), anxiety disorder and depression. The 4/7/26 MDS assessment revealed the resident was moderately cognitively intact with a BIMS score of 12 out of 15. The MDS assessment revealed the resident required set-up assistance with activities of daily living (ADL), including eating, oral hygiene and personal hygiene. She required partial/moderate assistance with toileting, dressing and ambulation. The MDS assessment indicated Resident #79 did not demonstrate verbal or physical behavioral symptoms toward others, reject care or wandered during the assessment look-back period. The MDS assessment revealed the resident was mildly depressed with a PHQ-9 (patient health questionnaire - a diagnostic tool designed to screen, monitor, and measure the severity of depression in adult patients) score of five out of 27. B. Record review Review of Resident #79's May 2026 CPO revealed the following physician's orders: Venlafaxine hydrochloride (HCl) 24-hour extended release (ER) (antidepressant medication) oral tablet, 37.5 mg. Give three tablets by mouth one time per day for depression, for a total of 112.5 mg, ordered 4/17/26. Antidepressant medication - Monitor for drowsiness, dizziness, vertigo (the sensation of movement), headache, tremor, weakness, fatigue, insomnia, postural hypotension (a sudden drop in blood pressure occurring when standing up from a seated or lying position), edema, dry mouth, anorexia, weight gain and urine retention. Every day and night shift, document: 'Y' if monitored and none of the above observed and document: 'N' if monitored and any of the above was observed and also select chart code 'Other/See Nurses Notes' and document findings in a progress note, ordered 12/23/25. Clonazepam (anti-anxiety medication) oral tablet, 0.5 mg. Give one tablet by mouth one time per day for generalized anxiety, ordered 12/23/25. Anti-anxiety medication (clonazepam) - Monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. Every day and night shift, document: 'Y' if monitored and none of the above observed and document: 'N' if monitored and any of the above was observed and also select chart code 'Other/ See Nurses Notes' and document findings in a progress note, ordered 12/23/25. Monitor for the following behaviors: (0) No behavior noted. (1) Biting/hitting/striking out. (2) Continuous crying. (3) Continuous screaming/yelling. (4) Continuous pacing/wandering/elopement. (5) Danger to self. (6) Danger to others. (7) Extreme fear. (8) Hallucinations. (9) Delusions. (10) Paranoia. (11) Repetitive anxious verbalizations. (12) Verbal abuse. (13) Refusing to do independent tasks, every day and night shift. Record the behavior code(s) and the number of episodes in supplemental documentation. Use C for continuous number of episodes, ordered 1/14/26. -However, the behaviors the physician's order indicated were to be monitored were not resident-specific to Resident #79. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Non-pharmacological interventions: (1) Dim lights. (2) Warm blanket. (3) Aromatherapy. (4) Music. (5) Repositioning. (6) Heat. (7) Ice. (8) Other. Every day and night shift record each intervention attempted, ordered 12/22/25. -However, the non-pharmacological interventions were not resident-specific to Resident #79 and did not indicate which intervention should be used for which behaviors. Review of Resident #79's comprehensive care plan, initiated 12/23/25, revealed the resident's anxiety and moderately impaired cognition sometimes resulted in the resident pressing her call light repeatedly and not remembering what she needed assistance with. Additionally, if someone assisted the resident, the resident may not ask for everything she needed at that time, resulting in her pressing the call light again after someone had assisted her. The care plan revealed Resident #79 often stated that her needs had not been met after they had been met. Pertinent interventions, initiated 1/9/26, included anticipating and meeting the resident's needs and making sure she felt heard by using rephrasing and feedback, encouraging the resident to express her feelings appropriately, using active listening and responding to the resident's feelings and tone and explaining all procedures to the resident before starting care and allowing the resident time to adjust to changes. Resident #79's anxiety care plan, initiated 12/23/25, revealed the resident used anti-anxiety medications related to anxiety disorder. Pertinent interventions, initiated 12/23/25, included administering anti-anxiety medications as ordered by the physician and monitoring for side effects and effectiveness every shift, monitoring for drowsiness, slurred speech, nausea and aggressive/impulsive behavior, monitoring the resident for safety - anti-anxiety medications were associated with an increased risk of confusion, amnesia, loss of balance, cognitive impairment that looked like dementia and increased risk of falls, broken hips and legs and monitoring/recording the occurrences of target behavior symptoms, such as pacing, wandering, disrobing, inappropriate response to verbal communication and violence/aggression towards staff or others. Resident #79's depression care plan, initiated 12/23/25, revealed the resident used antidepressant medication for depression and sleep. Pertinent interventions, initiated 12/23/25, included administering antidepressant medications as ordered by the physician and documenting side effects and effectiveness every shift, monitoring for drowsiness, dizziness, vertigo, headache, tremor, weakness, fatigue, insomnia, postural hypotension, edema, dry mouth, anorexia, weight gain and urine retention and monitoring/documenting/reporting as needed any adverse reactions to antidepressant therapy, such as changes in behavior/mood/cognition, hallucinations/delusions, social isolation and suicidal thoughts. -A review of Resident #79's EMR revealed there was no documentation of what specific interventions were offered to the resident and if the interventions were effective when the resident was exhibiting behaviors. -A review of Resident #79's EMR revealed there was no documentation on what individualized behaviors the facility was specifically monitoring for Resident #79 and what interventions were identified to help Resident #79 if she exhibited any behaviors. C. Staff interviews The nursing home administrator (NHA) was interviewed on 5/5/26 at 5:04 p.m. The NHA said Resident #79 had high anxiety and if her call lights were not answered immediately, her anxiety went way up (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she continued to press her call light. She said Resident #79 averaged 27 to 30 call light activations per shift and the IDT met daily in an effort to decrease her anxiety. The NHA said the facility tried to ease Resident #79's transition to the facility by having care conferences with the resident's representative. CNA #6 was interviewed on 5/7/26 at 8:43 a.m. CNA #6 said Resident #79 activated her call light every two to three minutes, even though he tried to ensure everything was in reach and asked her if there was anything else he could do for her before he left her room. He said he spent his shift on 1/3/26 going to her room every five to 15 minutes to answer her call light for basic things. The DON and the MDS coordinator were interviewed together on 5/7/26 at 6:20 p.m. The DON said depending on the medication, there were template orders in the MAR that the facility used as a guide and modified based on each resident's behaviors. She said the psychopharmacological committee discussed each resident's use of psychotropic medications with the physician, the pharmacist, the behavioral health provider, the bedside nurses and herself. The DON said the committee discussed resident updates, any new or changed behaviors and determined if it was reasonable to wean or discontinue a resident from a psychotropic medication. She said if the committee was concerned about a particular resident, they might continue to monitor the resident the following month or they might complete the quarterly regulatory reviews if no behaviors were demonstrated. The DON said progress notes, documentation, care plans and consents were reviewed at that time. She said the psychopharmacological committee utilized the residents progress notes for documentation rather than specific psychiatric pharmacology documentation. The MDS coordinator said the non-pharmacological interventions in Resident #79's MAR were not resident specific and were not effective interventions. She said the effectiveness of interventions implemented should be documented. The MDS coordinator searched Resident #79's EMR and said the nursing staff did not document the effectiveness of behavioral or non-pharmacological interventions for the resident. She said an E for effectiveness should be documented in the MAR. The MDS coordinator said Resident #79's care plan should have included specific interventions and identified triggers to help manage the resident's anxiety.

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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 and documentation for one (#93) of one resident reviewed for a safe and orderly discharge out of 51 sample residents. Specifically, the facility failed to ensure a discharge summary was completed at the time of Resident #93's hospital transfer.Findings include:I. Facility policy and procedureThe Discharge and Transfer policy, dated May 2025, was provided by the executive director on 5/8/26 at 12:34 p.m. It read in pertinent part, For a transfer to another provider, for any reason, the following information will be provided to the receiving physician: contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive information; and, all other information necessary to meet the resident's needs. Anticipated transfers or discharges - resident initiated discharges. Obtain physician orders for transfer or discharge and instructions or precautions for ongoing care; provide transfer/discharge notice to the resident/representative and ombudsman as indicated; complete discharge summary; the facility will educate the resident about transfer or discharge; assist with transportation arrangements as needed; and, supporting documentation shall include evidence of the resident's or representative's verbal or written notice of intent to leave the facility, a discharge plan and documented discussions with the resident and/or resident representative.II. Resident #93A. Resident statusResident #93, age greater than 65, was admitted on [DATE] and discharged to the hospital on 3/17/26. According to the May 2026 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), atrial fibrillation (a rapid, chaotic, and irregular heartbeat originating in the heart's upper chambers), hyperlipidemia and long term use of anticoagulants (blood thinner medication).The 3/21/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. The resident required partial/moderate assistance with activities of daily living (ADL), including dressing and showering. She required set-up assistance with toileting and oral hygiene and was independent with eating.The MDS assessment documented the resident was discharged with an anticipated return to the facility.B. Record reviewReview of Resident #93's progress notes revealed the resident was admitted to the facility on [DATE] following hospitalization for a fecal impaction. The resident was admitted to the facility with some confusion.The following was documented in Resident #93's progress notes on 3/17/26:At 1:00 a.m. a physician documented that since Resident #93's arrival to the facility, there had been concern that she now seemed to be exhibiting more right-sided clumsiness/weakness that was not present before arriving at the facility. Previous providers documented a discussion with the family about needing to go back to the hospital due to new changes, but after a discussion with the family, it appeared that observation was not pursued. However, she continued to exhibit right-sided weakness despite the most recent stroke that caused left-sided weakness. Her left side appeared to be doing better than her right. The physician discussed this with physical therapy (PT)/occupational therapy (OT) and her bedside nurse, who all agreed that her right side seemed to be now the problematic side. The physician reviewed her imaging, which did show some findings of chronic old left-sided infarcts (strokes) - but again, the right-sided weakness/clumsiness was more pronounced over the past week. -However, the progress note documentation should have a documentation time of 1:00 p.m. (see interview below).At 4:00 p.m. nursing staff documented that Resident #93 was taken to the local hospital via ambulance on a stretcher accompanied by two emergency medical technicians (EMT). The resident's son followed in his own car. The family requested the emergency department (ED) visit as the resident had new increased right-sided weakness. The resident was in stable condition upon exit from the facility.Resident #93's electronic medical record (EMR) revealed the resident was discharged to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	local hospital on 3/17/26.-However, review of the EMR did not indicate that documentation of transfer information was provided to the hospital on 3/17/26 when Resident #93 was transferred to the hospital.III. Staff interviewsThe director of nursing (DON) and the MDS coordinator were interviewed together on 5/7/26 at 6:20 p.m. The DON said when a resident was being transferred out of the facility to the hospital, the nurse should first get an order from the physician, call the family and print the transfer move out record. She said the resident's facesheet and medical orders for scope of treatment (MOST) form were sent with the resident when she left the building. The DON said sometimes the nurses at the facility did not use the same version of the hospital transfer form, but the hospital transfer form did not get completed for Resident #93. She said the nurse probably printed the hospital transfer document and sent it to the hospital with the resident, but ideally they would have made two copies so that the facility would have a record of the documentation provided to the hospital. The DON said she searched Resident #93's EMR for documentation that the physician was notified of the resident's discharge from the facility. She said she would have to call the physician, but the facility's process would be to ensure the physician was notified. The DON said she was pretty confident the facility notified the physician and she could find the documentation.The DON was interviewed again on 5/7/26 at 8:35 p.m. The DON said she spoke to the physician to confirm an assessment was performed on Resident #93 at 1:00 p.m. on 3/17/26, not 1:00 a.m. She said there was a note at the bottom of the assessment that said the physician would contact the family about possibly sending the resident out of the facility, so both the physician and the family were aware of the resident's discharge.Registered nurse (RN) #6 was interviewed on 5/8/26 at 9:24 a.m. RN #6 said when a resident was transferred out of the facility, there was a transfer document in the computer that needed to be completed by the nurse. She said the resident's representative, physician and any other staff pertinent to the resident's care should be notified of the transfer and it should be documented on the hospital transfer documentation. RN #6 said the hospital transfer form, along with the resident's vital signs history, medical history, MOST form, medications, lab work and any other relevant history, such as ultrasounds, were sent with the resident once the ambulance arrived. She said the nurse gave a report to the receiving facility once the ambulance arrived. RN #6 said it was important that the required documentation was provided to the receiving facility so that the facility would know the resident. She said there was no reason the hospital transfer form would not be completed - because it was an online document.RN #6 said she was not familiar with Resident #93 because she was a float nurse, and the resident was admitted to the facility for a short period of time. She said a hospital transfer form and required documentation should always be completed when a resident left the facility.

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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 observations, record review and interviews, the facility failed to develop and implement a comprehensive care plan for two (#12 and #53) of two residents out of 51 sample residents.Specifically, the facility failed to:-Ensure Resident #12's care planned intervention for a positioning pillow was consistently implemented to support and elevate her right arm while seated in her wheelchair;-Ensure Resident #12's care plan was updated when the resident refused the wrist-hand-finger orthosis (WHFO) brace intervention for her right hand contractures;-Develop and implement a care plan focus for Resident #53's knee contracture, including identifying interventions to prevent worsening of the resident's contractures; and,-Include the interventions for physician-ordered heel booties on Resident #53's skin integrity care plan.Findings include: I. Facility policy and procedure The Care Plan policy, dated January 2026, was provided by the executive director on 5/8/26 at 12:32 p.m. It read in pertinent part, The comprehensive care plan will describe, at a minimum, the following:-The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and,Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor resident's progress. Alternative interventions will be documented as needed. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, with significant change of condition, when desired outcome has not been achieved, readmission from hospital or other community and as needed. The facility will attempt alternative methods for refusal of treatment and services and document such attempts and discussions in the medical record. Qualified associates/staff/ancillary providers responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out interventions, initially and when changes are made as well as their responsibility of communicating to the appropriate staff any change in condition. II. Resident #12 A. Resident status Resident #12, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke caused by blocked blood flow), hemiplegia (paralysis on one side of the body) and major depressive disorder. According to the 3/13/26 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. She required (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantial assistance with personal hygiene, upper body dressing and transfers. She was dependent on staff for toileting hygiene and bathing. The MDS assessment documented the resident did not reject care. B. Resident observations On 5/4/26 at 11:45 a.m. Resident #12 was sitting in her wheelchair in the dining room. The resident's contracted right hand rested on her lap without a pillow for support. The resident did not have an orthotic device on her right hand. On 5/5/26 at 10:11 a.m. Resident #12 was assisted from her room to the dining room in her wheelchair. The resident's right hand rested on her lap without a pillow for support. The resident did not have an orthotic device on her right hand. On 5/6/26 at 12:54 p.m. Resident #12 was sitting in the dining room in her wheelchair holding her contracted right arm against her chest without a pillow for support. The resident did not have an orthotic device on her right hand. On 5/6/26 at 5:25 p.m. Resident #12 was sitting in the dining room eating with her left hand while holding her contracted right hand against her chest without a pillow for support. The resident did not have an orthotic device on her right hand. On 5/7/26 at 9:01 a.m. Resident #12 was sitting in the dining room holding her contracted right hand against her chest without a pillow for support. The resident did not have an orthotic device on her right hand. On 5/7/26 at 9:15 a.m. Resident #12 used her left hand on the hallway handrail to propel herself to her room in her wheelchair. The resident's right hand rested on her lap without pillow support. The resident did not have an orthotic device on her right hand. C. Record review The activities of daily living (ADL) care plan, initiated 12/9/2020 and revised 4/30/25, revealed Resident #12 had an ADL self-care performance deficit related to a history of cerebrovascular accident with right-sided hemiplegia, cognitive deficit, limited mobility and impaired balance. The care plan revealed the resident's right side was affected and she had a contracture to the right hand. Interventions included placing a small pillow on the right side of the resident's wheelchair to keep her arm elevated every day and night shift. Additional interventions included applying a wrist-hand-finger orthosis (WHFO) brace to the resident's right hand and arm, either during the day or at night in bed as tolerated and monitoring comfort and skin twice daily for the resident's right hand contracture. -However, Resident #12 was not observed with a support pillow under her right hand or wearing the WHFO brace during the survey process (see observations above). A 11/28/24 restorative progress note revealed Resident #12 used her left side to assist with wheelchair propulsion. The note revealed increased stiffness through the resident's right upper extremity was observed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/17/24 physician progress note revealed Resident #12 had stiffness of her right hand, chronic, worsening contracture with worsening pain when the orthotic brace was applied. A 3/26/25 nursing progress note revealed Resident #12 had arthritis pain in her right hand during the orthotic brace placement. The Kardex (a tool utilized by staff to provide consistent resident care) revealed Resident #12 required extensive assistance from staff with dressing and was dependent on extensive assistance from staff with transfers and bed mobility. Interventions included placing a small pillow on the right side of the resident's wheelchair to keep her arm elevated every day and night shift. -However, Resident #12 was not observed with a support pillow under her right hand during the survey process (see observations above). D. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 5/7/26 at 9:22 a.m. CNA #8 said staff reviewed the residents' electronic medical records (EMR) and the Kardex to identify care plan interventions for residents. CNA #8 said Resident #12 previously used a hand sling (orthotic device) but refused to wear it because it was uncomfortable. CNA #8 said Resident #12 required a pillow under her right arm while seated in the wheelchair to keep the arm elevated because the resident leaned to the right side. CNA #8 said staff were supposed to place the pillow under the resident's right arm when the resident got up in the morning and whenever she sat in the wheelchair. CNA #8 said the resident sometimes refused the pillow in the morning but later accepted it during the day. CNA #8 said staff documented any resident refusals in the EMR and notified the nurse. Registered nurse (RN) #10 was interviewed on 5/7/26 at 9:42 a.m. RN #10 said interventions for Resident #12's right arm included placing a pillow under the resident's right arm for support. RN #10 said CNAs were expected to notify nurses of resident refusals. RN #10 said no CNA had notified her of any refusals from Resident #12 for the right arm pillow during the time she had worked with the resident. RN #10 said it was important for CNAs to notify nurses of refusals to ensure continuity of care. RN #10 said if the resident refused care, she would wait a while, speak with the resident, ensure the resident's hearing aids were in place and attempt the intervention again. RN #10 said if the resident continued to refuse, she would document the refusal in a progress note. RN #10 said nurses ensured CNAs followed positioning interventions by reminding staff to follow the residents' care plan interventions and ensure residents were positioned safely and comfortably. The director of nursing (DON) and unit manager (UM) #2 were interviewed together on 5/7/26 at 10:03 a.m. The DON said staff were expected to be familiar with residents' care plans and follow the Kardex. The DON said resident interventions appeared in the resident's EMR dashboard. The DON said Resident #12's right hand contracture required monitoring to ensure there was no skin breakdown. The DON said nurses were expected to complete skin assessments, evaluate residents for pain and discomfort and notify the physician of concerns. The DON said staff were expected to follow interventions directing the use of a pillow to support the resident's arm. The DON said the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions on the care plan for Resident #12's right hand contractures were from 2020 and should have been updated to reflect the resident's refusals and current needs. The DON said nurse managers and the therapy team updated residents' care plans. The DON was interviewed again on 5/7/26 at 12:10 p.m. The DON said she did not have documentation to indicate Resident #12 refused the right arm support pillow intervention. The DON said the CNAs task documentation included a yes or no option for placement of the pillow. The DON said she provided education to staff regarding documenting resident tasks accurately. III. Resident #53 A. Resident status Resident #53, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic atrial fibrillation (rapid irregular heartbeat), chronic obstructive pulmonary disease (emphysema and difficulty breathing), peripheral vascular disease (progressive circulation disorder, narrowing blood vessels), prediabetes, chronic kidney disease stage three, obesity and left artificial knee joint. According to the 4/16/26 MDS assessment, Resident #53 was moderately cognitively impaired with a BIMS score of 12 out of 15. Resident #53 required set-up assistance with eating, oral hygiene and personal hygiene. He required substantial assistance with toileting and showering. The assessment revealed he had one unstageable pressure injury as a deep tissue injury at admission. B. Resident and resident's representative interview Resident #53 and Resident #53's representative were interviewed together on 5/4/26 at 12:07 p.m. in his room. Resident #53's representative said Resident #53 had been in and out of the hospital and the facility for multiple reasons, including a knee surgery that had complications. During the interview, Resident #53 was observed sitting in his recliner with a blanket covering him from his chest to his feet. The resident's bed had a wooden footboard at the bottom of it and two blue booties were observed under the resident's desk. Resident #53's representative said before Resident #53 was admitted to the facility, he had callouses on the heels of both feet that resolved before he was admitted to the facility. She said the facility put the booties on the resident at night when he was in bed. Resident #53 said the facility did not always put the booties on when he was in bed. Resident #53 was observed to be a tall man. Resident #53 said he was six feet two inches tall and the bed was too small for him because the foot board hit the heels of his feet. C. Observations On 5/5/26 at 8:14 a.m. Resident #53 was lying in his bed awake with no blanket covering his legs. Both feet were observed touching the footboard at the bottom of the bed. The blue booties were observed underneath the desk in his room. The head of the resident's bed was elevated to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately 60 degrees and the knee section of the bed was raised to approximately 30 to 45 degrees. On 5/6/26 at 5:40 a.m. Resident #53 was lying in his bed sleeping with a blanket covering his legs. The blue booties were again observed underneath the desk in his room. The head of the resident's bed was elevated to approximately 60 degrees and the knee section of the bed was raised approximately 30 to 45 degrees. Both feet were observed touching the footboard at the bottom of the bed. D. Record review Review of Resident #53's 4/30/26 hospital discharge instructions, prior to his readmission to the facility following a hospital stay for sepsis, revealed the following wound care recommendations: Left heel and left second toe. Cleanse with normal saline and gauze, remove old drainage, pat dry. Apply Anasept gel (hydrogel used to treat and prevent infections in various wounds) to wounds, cover with bordered foam, and change every other day. Keep heel boots in place at all times. -However, review of Resident #53's electronic medical record (EMR) did not identify heel boots as a physician's order or as a care plan intervention to prevent pressure injuries or worsening of the resident's knee contractures. Review of Resident #53's 5/1/26 facility admission assessment revealed the care planning section on the assessment, including the focus area, goal and interventions was not completed. The skin integrity care plan, no revision date, revealed Resident #53 had an actual impairment to his skin integrity, including a wound on his toe, heel and left knee, one skin tear and a rash. Interventions included following the facility's protocol for treatment of injuries, identifying and documenting potential causative factors and eliminating when possible, monitoring and documenting skin injuries, using caution during transfers, weekly documentation, including measurement of each skin breakdown and wound monitoring and treatment per physician's order. -However, the care plan interventions did not include the use of booties. -Review of Resident #53's care plan did not identify his risk for knee contractures. E. Staff interviews RN #1 was interviewed on 5/7/26 at 2:26 p.m. RN #1 said typical interventions to prevent pressure injuries included frequent elevation, boots and a dressing-like cushion. RN #1 said she was responsible for implementing the care plan interventions. RN #1 said she knew the interventions because it was a physician's order. RN #1 said if it was an intervention CNAs carried out, the nurses told the CNAs about the intervention. RN #1 said if a resident refused an intervention, she documented the refusal and notified the physician. RN #1 said she was familiar with Resident #53. She said he had the booties because he was supposed to wear them when he was in bed. She said she did not see him wear them while in bed and said he was not in bed when she worked her shifts. RN #1 said she would talk to the physician to get an order for the booties. RN #1 said Resident #53 needed to wear the booties because he had knee surgery which caused his knee to not straighten completely and he was at risk for knee contractures. She (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the booties helped prevent knee contractures. The DON and the vice president of clinical services were interviewed together on 5/7/26 at 4:43 p.m. The DON said typical interventions to prevent pressure injuries included frequent elevation, boots and dressings that acted as a cushion. The DON said the nurses were responsible for implementing the interventions. The DON said the nurses knew the interventions for resident's skin integrity based on physician's orders. The DON said the nurses told the CNAs if it was an intervention for the CNA to carry out. The DON said if the resident refused interventions, nurses were to chart the refusal and follow up with the wound care physician or primary care physician. The DON said she was familiar with Resident #53. The DON said Resident #53 had the booties for both feet because he was at risk for his knee contractures worsening. The DON said she was not aware the booties were not being worn while he was in bed. The vice president of clinical services said the facility should reassess how Resident #53 was positioned while in bed. She said the facility could look into a bed extender or remove the board at the foot of the resident's bed. The DON and the vice president of clinical services said they did not know the heel booties not included as a physician's order and were care planned as an intervention on Resident #53's comprehensive care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#40) of five residents out of 51 sample residents were provided services that maintained professional standards of quality. Specifically, the facility failed to: -Ensure staff obtained a physician's order specifying personalized settings for air mattresses for Resident #40; and, -Ensure staff maintained air mattresses according to the manufacturer's recommendations for Resident #40.Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel (NPIAP), Prevention and Treatment of Pressure Ulcers and Injuries(3/17/26), retrieved on 5/14/26 from https://www.guidelinecentral.com/guideline/23835, It is good practice for organizations to maintain an inventory of, or access to, a range of full body support surfaces appropriate to the clinical context. The inventory should be maintained, stored and used in accordance with manufacturer recommendations. It is good practice to use a full body support surface or integrated bed system that appropriately accommodates the weight, height, size and body mass distribution of the individual.II. Manufacturer's instructionsAccording to Pressure Guard's Alternating Pressure Mattresses (APM) Bariatric owner's manual, provided by the vice president of clinical services on 5/8/26 at 12:32 p.m. The system consists of a foam shell with a high-density foam topper serving as the support surface underneath the patient. The foam shell also includes contoured foam bolsters at the sides and ends of the mattress, providing added patient stability and positioning. The system also includes the unique Heel Slope feature, designed to further reduce pressure for the sensitive heel area. Within the foam shell is housed the inflation system, consisting of air cylinders which run lengthwise within the mattress. The Air Control Unit connects to the mattress at the patient's foot-end. The product is intended to be operated by personnel who are qualified to perform general nursing procedures and have received adequate training in the treatment and prevention of pressure injuries.III. Resident #40 A. Resident statusResident #40, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders, diagnoses included osteoporosis, hypertension, prediabetes, open wound on left knee, osteoarthritis and anxiety.According to the 4/30/26 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 had an impairment on one side of her lower extremity and used a walker. She required set up assistance with eating, supervision with oral hygiene and with personal hygiene. She required substantial assistance with toileting and partial assistance with dressing. B. ObservationsOn 5/5/26 at 8:45 a.m. Resident #40 was sitting in her recliner on the left side of her bed. There was an air mattress attached to her bed. On 5/6/26 at 10:57 a.m. Resident #40 was sitting in her recliner. There was an air mattress attached to her bed.On 5/6/26 at 12:28 p.m. Resident #40 was sitting in her recliner. There was an air mattress attached to her bed. C. Record review -Review of Resident #40's May 2026 CPO failed to reveal a physician's order for an air mattress. -There was no documentation in the resident's electronic medical record (EMR) to indicate the resident's mattress was being monitored and maintained on a routine basis and documentation of what the air mattress setting should be on and if an assessment was completed. IV. Staff interviews Registered nurse (RN) #1 was interviewed on 5/7/26 at 2:26 p.m. RN #1 said the admissions staff determined who required an air mattress and they placed an order with the durable medical equipment (DME) company for the mattress to be delivered. RN #1 said there should be a physician's order for an air mattress to monitor the function of the mattress every shift. RN #1 said nursing staff was responsible for routine maintenance checks of air mattresses and if there was anything faulty, they notified maintenance. RN #1 said she did not know who was responsible for setting the mattress function parameters for residents' air mattresses RN #1 said she was familiar with Resident #40. She said Resident #40 had a special air mattress because she rarely moved and the mattress helped prevent pressure injuries. RN #1 said Resident #40 also had a surgical procedure on her left leg and she did (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not like the original mattress. At 4:08 p.m. RN #1 went into Resident #40's room and the air mattress was turned on. RN #1 said she did not know if the air mattress settings were correct for the resident. RN #1 said she would ask the physician for an order. The director of nursing (DON) and the vice president of clinical services were interviewed together on 5/7/26 at 4:43 p.m. The vice president of clinical services said all residents had the same mattress and the residents' regular mattress setting was set to stage 2. If a resident had a condition that required a low air loss, then a special mattress was ordered. The vice president of clinical services said an assessment was not completed prior to a mattress being utilized. The vice president of clinical services said the facility's wound care physician may recommend a special mattress and that would be reflected in a physician's order. The DON said she was familiar with Resident #40. The DON said the resident had a special mattress because she complained about the original mattress. The vice president of clinical services said they would look into the resident's air mattress.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interviews, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for two (#48 and #82) of four residents reviewed for accident hazards out of 51 sample residents.Specifically, the facility failed to:-Ensure staff provided adequate assistance when transferring Resident #48 with a sit-to-stand lift (a mobility device designed to help individuals with partial weight-bearing capability transition from a seated to a standing position), which resulted in a fall for the resident; -Ensure staff notified the appropriate individuals when Resident #48 sustained a fall when staff were transferring her with the sit-to-stand lift; and,-Ensure staff transported Resident #82 in her wheelchair in a safe manner, which resulted in a skin tear to the resident's left forearm.Findings include: I. Failures for Resident #48's sit-to-stand lift transfer and fall from the sit-to-stand A. Facility policy and procedure The Mechanical Lifts to Transfer Residents policy, dated August 2025, was provided by the executive director on 5/8/26 at 12:34 p.m. It read in pertinent part, Mechanical lifts must be used in a dignified, respectful manner, and with discretion when transferring a resident. The operation of any mechanical lift for resident transfers will be consistent with state regulations. Evaluation of the resident's need for assistance with transferring from one surface to another is to be completed upon move-in, significant change in condition and on return to the community from hospitalization or other treatment centers. If a resident requires use of a mechanical lift, then the community will provide information to the resident on the appropriateness of a mechanical lift to meet his/her transfer needs. Types of mechanical lifts may include: sit-to-stand; and, Hoyer. Safety issues for both the resident and associates will be evaluated. Once a resident is evaluated and clinically approved for the use of a mechanical lift, the following steps will be taken: notify the practitioner as appropriate and obtain an order for evaluation by physical therapist (PT) or physical therapist assistant (PTA) to determine specific transfer needs; PT/PTA will evaluate the resident and will be reviewed regularly; and, associates are responsible for reporting to a supervisor any problems or concerns with a resident's ability to participate in a sit-to-stand transfer or whole body transfer immediately. If concerns occur, the resident will be re-evaluated to determine whether the resident is capable of transfers. B. Resident status Resident #48, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included Parkinson's disease (a progressive neurodegenerative disorder of the central nervous system which leads to movement issues), acute kidney failure and obstructive sleep apnea (the muscles of the throat relax and block the airway during sleep, pausing breath during sleep). The 4/22/26 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment revealed the resident was dependent or required substantial/maximal assistance from staff with activities of daily living (ADL), including dressing, showering, toileting and mobilizing from sitting to standing. C. Resident interview Resident #48 was interviewed on 5/4/26 at 2:40 p.m. Resident #48 said she fell from a mechanical lift a few months back and she still had a bruise on her right leg. She said one staff member operated the lift and told her not to hang on to the machine, so she fell. Resident #48 was unable to recall the staff member's name who told her not to hang onto the lift. Resident #48 was interviewed again on 5/6/26 at 4:55 p.m. Resident #48 said her fall from the mechanical lift happened a long time ago. She said the staff educated her on how to use the sit-to-stand lift when she first started using it. Resident #48 said she felt safe with how the nursing staff had been using the sit-to-stand lift and transferring her between surfaces since the fall. D. Record review Review of Resident #48's Kardex (tool utilized by staff to provide consistent care for residents) report revealed the resident was dependent on the sit-to-stand mechanical lift for transfers, and the resident required assistance from one to two staff members to move between surfaces. Review of Resident #48's fall care plan, initiated 11/9/23, revealed the resident was at risk for falls related to Parkinson's disease, history of falls, cognitive deficit, difficulty walking, lack of coordination, muscle weakness, limited mobility, poor safety awareness, use of psychotropic medication, chronic knee pain, functional incontinence of the bladder and bowel and unsteady gait and balance. A pertinent intervention, initiated 8/22/25, included providing the resident education regarding her role in using the sit-to-stand lift. Review of Resident #48's ADL care plan revealed the resident needed assistance with ADLs and had a self-care performance deficit related to muscle weakness from Parkinson's disease, cognitive deficit, limited mobility, poor safety awareness, use of psychotropic medication, chronic knee pain, functional incontinence of the bladder and bowel and unsteady gait and balance. Pertinent interventions included utilizing the sit-to-stand lift for transfers (revised 8/22/25) and providing the resident with extensive assistance from one to two staff members to move between surfaces using the sit-to-stand (revised 1/3/25). Review of Resident #48's electronic medical record (EMR) revealed the following progress notes: A progress note, dated 2/20/26 at 12:03 a.m., revealed a certified nurse aide (CNA) was assisting Resident #48 to and from the bathroom and while being lowered to the bed, the resident released her hands from the sit-to-stand lift. The CNA lowered the resident to the floor for her safety. The nurse was alerted and found the resident sitting on the floor crying. The resident was helped back to bed by two CNAs and did not complain of pain or discomfort. An advanced practice provider note, dated 3/5/26 at 9:30 a.m., revealed that Resident #48 expressed concern about an incident that occurred approximately two weeks ago when a new CNA with only one week of experience operated the mechanical lift without supervision. The resident reported that during the transfer, another CNA she had previously declined to work with took over the lift and told (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her not to hang on, which resulted in her falling a short distance and sustaining a small bump. -However, review of the resident's EMR did not reveal documentation of an assessment by a registered nurse (RN) or report/notification of a fall to the physician or resident's representative following the fall from the mechanical lift. -Review of Resident #48's EMR failed to reveal documentation that indicated the resident was re-evaluated by physical therapy (PT)/occupational therapy (OT) for mechanical lift use after she sustained the fall from the sit-to-stand lift on 2/20/26. E. Staff interviews CNA #1 was interviewed on 5/6/26 at 5:00 p.m. CNA #1 said when a resident started to use a mechanical lift for the first time, she would check their medical record to see what kind of assistance the resident required. She said because she would be assigned rehabilitation residents in the Ponderosa unit, she would go one step further and get a report from the rehabilitation nurse upstairs. CNA #1 said she would never transfer a resident without first knowing their transfer status. She said she would educate the resident on how to use the device, where to hold on to and where to place their feet to feel secure. The executive director was interviewed on 5/6/26 at 6:00 p.m. The executive director said he and the regional director of clinical services searched but could not find an incident report for Resident #48's fall from the sit-to-stand lift on 2/20/26. He said the CNA who transferred the resident was working tonight (5/6/26) and he interviewed her. The executive director said the CNA believed that because Resident #48's fall had been witnessed and another staff member was there, the event did not need to be reported and the resident did not need to be assessed. He said there was no incident report or investigation for the incident, but there should have been one. The executive director said staff would be educated on reporting falls and completing incident reports and investigations. CNA #2 was interviewed on 5/7/26 at 10:55 a.m. CNA #2 said if she noticed a resident fell, she would call the nurse or push the call light so as never to leave the resident. She said the resident should be assessed by the nurse and the assessment should be documented in the facility's electronic medical system. CNA #2 said she used the sit-to-stand lift with Resident #48 often, and the resident was supposed to be a one-person assist but sometimes the resident lets go of the lift. She said if staff did not really know the resident, the resident should be a two-person assist for transfers using the sit-to-stand lift. CNA #2 said this was communicated to newer staff members in shift-to-shift report. Licensed practical nurse (LPN) #2 was interviewed on 5/7/26 at 11:12 a.m. LPN #2 said if she noticed a resident fell, she would first ensure the resident was safe. She said since she was an LPN, it was not within her scope of practice to thoroughly assess the resident, so she would call the RN to do the assessment together with her. LPN #2 said the assessment should be documented and the unit manager, the physician and the resident's representative should be notified. LPN #2 said Resident #48 was a one-person assist to transfer with the sit-to-stand lift, but she knew there were times when the resident needed a two-person assist because her legs and arms were not that strong. She said Resident #48's Parkinson's disease had progressed and the resident was not always able to hold on to the mechanical lift that well. LPN #2 said she did not think it was normal for the resident to let go of the sit-to-stand lift, but she said she thought Resident #48 was not able to hold on because of her Parkinson's disease. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 said PT/OT and restorative nursing were responsible for determining the resident's mechanical lift use. She said PT would re-evaluate the resident for mechanical lift use if there was a significant change in the resident. She said it was documented on the medication administration record (MAR) for the nurses, and she believed the CNA report sheets said what type of transfer the resident required. LPN #2 was interviewed again on 5/7/26 at 2:45 p.m. LPN #2 said she was not sure if anyone had reported Resident #48's mechanical lift transfer change of condition. The director of rehabilitation was interviewed on 5/7/26 at 3:19 p.m. The director of rehabilitation said residents were re-evaluated based on condition changes, such as a fall. She said the facility held biweekly meetings involving the therapy, nursing and restorative teams and they discussed change of conditions and determined if therapy services were appropriate. The director of rehabilitation said she would determine if a mechanical lift was appropriate for a resident by observing the nursing staff perform the sit-to-stand lift transfer with the resident. She said the PT team would look at the resident's upper extremity (arms and core) strength and determine if the resident was able to bear their own weight to hold on to the lift. The director of rehabilitation said if the resident was unable to meet those requirements, the PT would have recommended a Hoyer lift (full-body mechanical lift). The director of rehabilitation said Resident #48 was initiated with restorative therapy at the end of 2024, and the resident's last PT evaluation was in 2024. The director of rehabilitation said Resident #48 required maximal assistance for transfers and she knew Resident #48 had some knee pain. She said Resident #48 was a one-person assist to transfer unless she used a Hoyer lift, which required a two-person assist. The director of rehabilitation said she did not believe she had been notified about a change of condition related to transfer status for Resident #48. She said she could not recall that she was notified or aware of Resident #48's sit-to-stand fall on 2/20/26. The director of rehabilitation said after becoming aware of Resident #48's fall, she would still say a sit-to-stand transfer would be the safest option for Resident #48. She said therapy could definitely re-evaluate Resident #48's mechanical lift use. II. Failed to ensure staff transported Resident #82 in her wheelchair in a safe manner, which resulted in a skin tear to the resident's left forearm A. Resident status Resident #82 age greater than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), depression, muscle weakness, difficulty in walking and overactive bladder. The 4/30/26 MDS assessment revealed Resident #82 had moderate cognitive impairment with a BIMS score of 10 out of 15. She needed substantial to maximal assistance for most of her ADL and was dependent on staff assistance for toileting. B. Resident interview and observation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #82 was interviewed on 5/4/26 at 11:38 a.m. Resident #82 said one of the CNAs was taking her down to the dining room in her wheelchair for breakfast. She said the CNA was probably going too fast and her (Resident #82) arm hit the dining room table. She said the nursing staff changed her bandage on a regular basis. She said she was supposed to have it changed that day (5/4/26). During the interview, Resident #82 was observed with a large bandage on her left forearm with the date of 5/2/26 written on it. C. Record review The skin integrity care plan, revised 4/28/25, revealed Resident #82 was at risk for skin impairment due to decreased mobility. Pertinent interventions included applying Eucerin cream twice daily to dry areas as requested by the resident (initiated 5/24/23), following the facility's protocol for treatment of injuries (6/29/22) and using caution during transfers and bed mobility to prevent striking the resident's arms, legs and hands against any sharp or hard surface (6/29/22). A nursing progress note, dated 4/25/26 at 9:49 a.m., revealed a CNA reported that she was taking Resident #82 to the dining room for breakfast and while wheeling her to the table, the resident's left outer arm accidentally got hit on the dining room table and the resident sustained a skin tear. The CNA immediately brought the resident to the nurse. The skin tear was located on the resident's left outer arm near the elbow. The skin tear measured 6.5 centimeters (cm) by 3.5 cm. The note documented that the wound was cleansed with normal saline and steristrips and Xerofoam (wound dressing) were applied and covered with bordered gauze. Resident #82 denied any pain and the unit manager and the resident's son were notified. Review of Resident #82's May 2026 CPO revealed the following physician's order: Remove optifoam dressing carefully. Keep steristrips intact. Cleanse/pat dry. Recover with optifoam every three days and as needed, ordered 4/29/26. D. Staff interviews CNA #9 and CNA #10 were interviewed together on 5/7/26 at 11:01 a.m. CNA #9 said she had only been working at the facility for one month and CNA #10 said she had worked at the facility for a year and a half. CNA #9 and CNA #10 said that if they saw any new skin issues on a resident, they would let their nurse know immediately. CNA #9 said she did not know how Resident #82 got her skin tear on her arm. She said she only knew that the resident had a bandage on her forearm. CNA #10 said she had heard that Resident #82's arm had gotten scraped on a dining room table because a CNA was going too fast when pushing the resident's wheelchair. CNA #9 and CNA #10 said they said they had not received any recent training on preventing skin tears. Registered nurse (RN) #11 was interviewed on 5/7/26 at 11:15 a.m. She said when she was notified of a new skin issue or skin tear for a resident, she would do an assessment. She said she would measure the wound and then report it to the unit manager. She said she would document a skin issue note and get orders from the physician. She said she was the nurse that was on duty the day that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #82 got the skin tear (4/25/26). She said the CNA was taking her down to the dining room in her wheelchair and Resident #82's left forearm hit the corner of the dining room table. RN #11 said the CNA immediately brought Resident ##82 back to her (RN #11) so she could assess her. She said she treated the wound and dressed it. She said the physician's assistant saw the resident's skin tear the next day and told the staff to change the dressing every other day. RN #11 said there were not any interventions that were put in place to prevent the injury from happening again. She said she was unsure if education was given to the CNA. She said she had told the CNA to be careful. The director of nursing (DON) and the regional director of clinical services were interviewed together on 5/7/26 at 1:27 p.m. The regional director of clinical services said she did not see an interdisciplinary (IDT) note regarding Resident #82's skin tear so she was not sure if any education was given to the CNAs about preventing skin tears. The DON said she had not given any education to the CNAs regarding how to prevent further skin tears.

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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 staff provided respiratory care consistent with professional standards of practice for one (#4) of two residents reviewed for oxygen services out of 51 sample residents. Specifically, the facility failed to ensure there was a physician's order in place for Resident #4's oxygen.Findings include: I. Professional referenceAccording to Nursing Skills, Open Resources for Nursing (Open RN); Ernstmeyer K, [NAME] E, editors. Eau [NAME] (WI): [NAME] Valley Technical College; published 2021, accessed on 5/14/26 from https://www.ncbi.nlm.nih.gov/books/NBK593208/, Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. (Chapter 11)II. Facility policy and procedureThe Oxygen Use policy and procedure, revised December 2024, was provided by the vice president of clinical services on 5/8/26 at 12:32 p.m. It read in pertinent part, Prescriber orders will be obtained for residents requiring assistance with oxygen. Orders shall include liter flow, frequency, and route.III. Resident #4A. Resident status Resident #4, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included displaced fracture of left femur, hypertension, history of falling, aortic stenosis, dementia, osteoarthritis, anxiety and depression. According to the 4/24/26 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He used a walker. He required set up assistance with eating. He required substantial assistance with oral hygiene, toileting, showering, dressing, and personal hygiene. The 4/24/26 MDS assessment indicated Resident #4 was not receiving oxygen therapy. B. Resident interview and observation Resident #4 was interviewed in his room on 5/4/26 at 3:37 p.m. Resident #4 was lying in bed and had a nasal cannula in his nose. An oxygen concentrator was observed next to the head of the resident's bed with the power turned on. Resident #4 said his oxygen was great. Resident #4 said he did not know how long he had used oxygen or what it was used for. C. Record review-Review of Resident #4's May 2026 CPO revealed no physician's orders for oxygen. The oxygen therapy care plan, initiated 4/22/26, revealed Resident #4 had oxygen therapy. Interventions included for residents who were ambulatory, providing extension tubing or portable oxygen apparatus, monitoring for signs and symptoms of respiratory distress and reporting to the physician as needed, and oxygen settings were to be oxygen via nasal cannula per physician's order. IV. Staff interviews Registered nurse (RN) #1 and RN #3 were interviewed together on 5/7/26 at 2:26 p.m. RN #1 and RN #3 said they knew which residents needed to be on oxygen based on the hospital report and discharge orders. RN #1 and RN #3 said nurses were responsible for the oxygen settings and placing oxygen on residents. RN #3 said the certified nurse aides (CNA) did vital signs but they could not adjust oxygen settings. RN #1 and RN #3 said there needed to be a physician's order for a resident to receive oxygen therapy. RN #1 said she was familiar with Resident #4. She said the resident was not on oxygen. RN #1 said there might have been an oxygen concentrator in the resident's room because therapy sometimes left concentrators in the residents' rooms when therapy was determining if the resident needed oxygen when discharging from the facility. RN #1 said she did not see Resident #4 sleep much and RN #3 said she did not see Resident #4 with oxygen on while asleep. RN #1 went to Resident #4's room, after the interview, at 3:43 p.m. observed Resident #4 with a nasal cannula in his nose and the oxygen concentrator next to his bed was on. RN #1 said she did not know why he had oxygen on while he was resting and she thought maybe a CNA placed oxygen on him when they transferred him to bed. RN #1 said she would follow up because if he required oxygen, there should be a physician's order. The director of nursing (DON) and the vice president of clinical services were interviewed together on 5/7/26 at 4:43 p.m. The DON said nurses were responsible for oxygen therapy. The DON said there needed to be a physician's order for any resident who used oxygen. The DON said she was familiar with Resident #4 and said he was admitted to the facility with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen therapy. The DON said there should either be a physician's order for Resident #4 to receive oxygen as needed or the oxygen concentrator needed to be removed from Resident #4's room.

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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, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in one of three medication carts and two of two medication rooms.Specifically, the facility failed to ensure residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened.Findings include:I. Professional referencesAccording to Sanofi Pasteur's Tubersol: Tuberculin (Tb) purified protein derivative (PPD), (2022), retrieved on 5/12/26 from https://www.sanofi.com/assets/countries/canada/docs/products/vaccines/tubersol-en.pdf, Storage, stability and disposal: a vial of Tubersol which has been opened and in use for 30 days should be discarded.According to GlaxoSmithKline (GSK) Biologicals' Arexvy: Respiratory syncytial virus (RSV) vaccine, (2026), retrieved on 5/12/26 from https://www.fda.gov/files/vaccines%2C%20blood%20%26%20biologics/published/Package-Insert-AREXVY.pd Storage after reconstitution (adding a liquid to a powdered medication to create a liquid solution for administration): discard the reconstituted vaccine if it is not used within four hours or if the vaccine has been frozen.B. Facility policy and procedureThe Medication Storage policy, dated January 2026, was provided by the executive director on 5/8/26 at 12:34 p.m. It read in pertinent part, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from the stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists. Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken.II. ObservationsOn 5/7/26 at 11:59 a.m. the transitional care unit's medication storage room was observed with registered nurse (RN) #3. The following item was found: One bottle of bisacodyl 5 milligram (mg) tablets, with an expiration date of April 2026.-However, the expired medication should have been removed from the medication supply upon its expiration.On 5/7/26 at 1:50 p.m. the Aspen medication cart was observed with licensed practical nurse (LPN) #2. The following item was found:One opened Spiriva Respimat (tiotropium bromide) 2.5 microgram (mcg) inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the date the medication was opened for Resident #63.On 5/7/26 at 2:00 p.m. the Aspen medication storage room refrigerator was observed with LPN #2. The following items were found:One Arexvy respiratory syncytial virus (RSV) vaccine vial kit stored in an appropriately labeled medication box for Resident #107.-However, Resident #107 was discharged from the facility on 4/3/26 and the vaccine should have been removed from the medication supply.One opened multi-use vial of Tubersol Tb PPD, 5 tuberculin units (TU) per 0.1 milliliter (ml), opened 2/1/26.One used multi-use vial of Tubersol Tb PPD, 5 TU/0.1ml, opened 2/19/26.-However, both vials of Tubersol had been open for more than 30 days and should have been removed from the medication supply (see professional reference above).III. Staff interviewsRN #3 was interviewed on 5/7/26 at 11:59 a.m. RN #3 said the bottle of bisacodyl tablets were expired and she would remove it from the supply.LPN #2 was interviewed on 5/7/26 at 1:50 p.m. LPN #2 said the individual Spiriva inhaler inside the medication box should have been labeled with the date the inhaler was opened.LPN #2 was interviewed again on 5/7/26 at 2:00 p.m. LPN #2 said the RSV vaccine should have been removed from the medication room after Resident #107's discharge from the facility. She said the pharmacist checked the medication carts regularly, but she did not know if they also checked the refrigerators. LPN #2 read the side of the Tubersol (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	boxes and said the vials should have been discarded 30 days after they were opened. The director of nursing (DON) and the minimum data set (MDS) coordinator were interviewed together on 5/7/26 at 6:20 p.m. The DON said she would not have expected the expired bisacodyl tablets to be in the transitional care unit's medication room. She said the central supply person should have been managing the stock medication supply to ensure there were no expired medications that could have accidentally been grabbed for use.The DON said Resident #63's individual Spiriva inhalation device should have been labeled with the date the medication was opened. She said it was important for the staff to know the expiration date of the medication so they could make sure it was still effective. The DON said she would provide nursing staff with additional education on medication labeling and storage.The DON said she would not have expected to find a discharged resident's medications in the medication room. She said the nurses should have moved any medications belonging to discharged residents to the expired stock as they were noticed.The DON said the Tubersol multi-use vials were good for 30 days after opening, then should have been moved to expired stock by nursing staff. She said it was important to monitor the medication supply for expired vaccines because the facility would never want to give a resident an expired vaccine. She said the vials of Tubersol might have been given accidentally after the expiration date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain accurately documented medical records for one (#106) of four residents reviewed out of 51 sample residents. Specifically, the facility failed to ensure Resident #106's electronic medical record (EMR) was amended to ensure the events that occurred at the time of the resident's death in the facility were accurately documented.Findings include: I. Resident #106A. Resident statusResident #106, age [AGE], was admitted on [DATE] and passed away in the facility on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included acute systolic (congestive) heart failure (left ventricle loses ability to pump), chronic kidney disease, metabolic encephalopathy (brain dysfunction) and dementia. The [DATE] 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. The assessment revealed the resident needed substantial to maximal assistance with most of his activities of daily living (ADL). B. Record reviewReview of Resident #106's final wishes care plan, initiated [DATE], revealed the resident's code status (dictates the exact medical interventions a patient wants, or does not want, if their breathing or heart stops) was no cardiopulmonary resuscitation (CPR). Pertinent interventions included informing staff of the resident's code status, monitoring and reporting changes in condition to the physician and the resident's responsible party, ensuring the resident or the resident's responsible party signed the code status sheet and the sheet was in the medical record and reviewing code status at least quarterly. A nursing note, dated [DATE] at 1:15 p.m., documented the nurse found Resident #106 taking his last breath when the nurse went to give him his medication at 11:50 a.m. The note documented all attempts to rouse Resident #106 failed; the resident's vital signs were checked with no readings. The note documented Resident #106's lips were purple and he had cold fingers and was unresponsive. The note documented the nurse called a code and called 911. The emergency staff arrived around 12:00 p.m. and the resident's death was confirmed at 12:15 p.m.-However, there was no documentation in the resident's EMR to indicate that CPR was not actually conducted due to the resident's code status of no CPR, despite the fact that the nurse called a code and 911 (see interviews below). II. Staff interviewsLicensed practical nurse (LPN) #4 was interviewed on [DATE] at 7:25 p.m. LPN #4 said Resident #106's medical orders for the scope of treatment (MOST) form was found in a binder at the nurses' station on the rehabilitation unit. He said Resident #106 was fine in the morning (on [DATE]), he said he took his medication and there were no signs or symptoms of a decline. He said Resident #106 was a do-not-resuscitate (DNR) code status. He said CPR was not conducted on the resident, but he did call a code blue (emergency announcement indicating a life-threatening medical emergency). LPN #4 said he did call 911 which he said he thought was the facility protocol. He said when emergency services first got to the facility, they asked what the resident's code status was. He said he had notified the assistant director of nursing (ADON) at the time of the event. He said the event was very traumatic because Resident #106's death was not expected. He said he did get training on how to handle death and who to notify at the debriefing after the death. The ADON was interviewed on [DATE] at 8:05 p.m.The ADON said Resident #106 was at the facility for therapy, but he was planning on discharging because was not improving during therapy. She said the day that he passed away, speech therapy was working with him and he had been complaining of pain. She said the speech therapist rearranged some pillows to help him feel more comfortable and then she left and let the nurse know so he could get the resident some Tylenol. She said by the time the nurse got to his room, Resident #106 was already unresponsive. She said the nurse called 911 and then called her. The ADON said CPR was not performed on Resident #106 at all, even though LPN #4 did call a code and 911. She said LPN #4 called the code and 911 because the resident was unresponsive and it was unexpected, but she said CPR was not performed. She said the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's MOST form was reviewed and the coroner was called but did not come out but did release the body. She said Resident #106's representative was present at the facility at the time the resident's death certificate was signed. She said within a couple of hours after the resident's death, the funeral home came and got his body. She said when a death occurred in the facility, the documentation should be narrative progress notes that document everything that happened.-However, the facility failed to document in Resident #106's EMR that CPR was not conducted on the resident (see record review above). The director of nursing (DON) and the minimum data set (MDS) coordinator were interviewed together on [DATE] at 10:25 a.m. The DON and the MDS coordinator said if a resident was found unresponsive, they would check the resident's vital signs. They said if the resident was a DNR then they would not call 911, they would respect the resident's wishes. They said they would call the physician and the family. The DON and the MDS coordinator said the terminology call a code or coded was not normally used in their facility. They said it insinuated that CPR was performed and respiratory therapy came, which was not what happened with Resident #106.-However, the facility failed to document in Resident #106's EMR that CPR was not conducted on the resident (see record review above).

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Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to meet all the requirements for the provisions of hospice care for two (#75 and #38) of two residents reviewed for hospice care services out of 51 sample residents. Specifically, the facility failed to:-Ensure hospice notes were readily available in Resident #75 and Resident #38's electronic medical records (EMR);-Ensure Resident #75 and Resident #38's comprehensive care plans were developed with a delineation of care responsibilities between the facility staff and the hospice care services team; and, -Ensure there was a designated hospice care services coordinator.Findings include: I. Facility policy and procedure The Hospice/Palliative Care Coordination policy and procedure, dated December 2024, was provided by the executive director on 5/8/26 at 12:32 p.m. It read in pertinent part: How the community and hospice/palliative care will communicate with each other and coordinate services: The provision that is the responsibility of the hospice and/or palliative care to determine the appropriate course of care and the responsibility of the community to provide room and board and follow the regulations. The director of nursing (DON)/health wellness director/ assisted living director or designee is responsible for coordinating care that is ordered by the practitioner/healthcare provider and documenting this in the resident's service plan/care plan. The hospice and/or palliative care provider sign and shall adhere to standards set forth in the agreement. Which include but are not limited to the following: Provide documentation for the resident record as soon as practicable.II. Resident #75A. Resident statusResident #75, age greater than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders, diagnoses included anxiety disorder, chronic kidney disorder, and cerebral arteriosclerosis (hardening, thickening, or narrowing of the arteries within the brain). The 4/13/26 minimum data set (MDS) assessment revealed Resident #75 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The assessment indicated Resident #75 needed substantial to maximal assistance with most of her activities of daily living (ADL). The assessment revealed the was receiving hospice care services. B. Resident's representative interviewResident #75's representative was interviewed on 5/6/26 at 3:52 p.m. The representative said the hospice nurse that had been taking care of Resident #75 had not been around for three weeks and the facility nurses told her that the resident was running low on some supplies. She said the unit nurse did not know who to reach out to. She said that the hospice certified nurse aide (CNA) had also been out for a few weeks due to school and she had not seen anyone from the hospice care team recently. C. Record reviewThe May 2026 CPO revealed Resident #75 was admitted to hospice care services on 4/1/26 with the diagnosis of cerebral atherosclerosis. -A review of the comprehensive care plan, initiated 4/2/26, revealed Resident #72 was receiving hospice care services, however, it failed to include interventions and a delineation of care services between the facility and hospice care services team. A review of Resident #75's EMR revealed a hospice plan of care from when she was living at the assisted living community. -A review of Resident #75's EMR revealed the resident's routine hospice care service notes not uploaded into the system until 5/5/26 (during the survey process).III. Resident #38A. Resident statusResident #38, age [AGE], was admitted on [DATE]. According to the May 2026 CPO, diagnoses included acute kidney failure, chronic obstructive pulmonary disease (COPD), and hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the right dominant side. The 4/1/26 MDS assessment revealed Resident #38 was cognitively intact with a BIMS score of 13 out 15. The assessment revealed Resident #38 needed substantial to maximal assistance with most of his ADL. The assessment indicated that Resident #38 was receiving hospice care services. B. Record reviewThe May 2026 CPO documented Resident #38 was admitted to hospice care services on 12/8/25. -A review of the comprehensive care plan, initiated 10/28/25, revealed Resident #38's hospice care plan was initiated on 4/1/26, four months after he was first admitted to (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice care services. -Resident #38's hospice care plan failed to include a delineation of care responsibilities between the facility and the hospice care services team. Review of Resident #38's EMR revealed the resident's routine hospice care service notes were not uploaded into the system until 5/5/26 (during the survey process). IV. Staff interviewsRegistered nurse (RN) #5 was interviewed on 5/5/26 at 3:35 p.m. RN #5 said the hospice team communicated with the facility staff using binders. She said she could not find the binders for any of the facility's current residents who were receiving hospice care services. CNA #2 was interviewed on 5/6/26 at 11:30 a.m. CNA #2 said she knew who was on hospice because it was written on her report sheet. She said the nurses would let her know when the hospice CNA would be coming. She said the nurses would look in a book to see the days that hospice was coming. She said she did not know where that book was. CNA #7 was interviewed on 5/6/26 at 11:59 a.m. CNA #7 said he had only been employed with the facility for a month. He said he knew who was on hospice because the nurse would let him know and it was also on his report sheet. He said the nurse would tell him when the hospice CNAs were going to be coming. Licensed practical nurse (LPN) #3 was interviewed on 5/6/26 at 1:35 p.m. LPN #3 said the facility did not utilize a communication binder for the hospice residents. She said the hospice team was good at verbally communicating with the facility staff. She said she did not know the scheduled days that hospice staff would come and see their residents. She said she knew who was on hospice by looking at the hospice order. She said she did not formally know what care hospice was in charge of providing for each resident, she just knew because she had worked as a nurse for so long. LPN #1 was interviewed on 5/6/26 at 2:13 p.m. LPN #1 said when a resident first was accepted on hospice care services and when they had picked which hospice provider they wanted, there would be an initial care meeting. She said when a hospice CNA came into the facility, they would verbally let the facility staff know what cares they had done. She said the hospice nurses would do the same and they communicated verbally. LPN #1 said the hospice CNAs would also write on a whiteboard in the residents' rooms to indicate which days they came to the facility. She said there used to be a binder that hospice staff would sign off in, but the binder was no longer there. She said the facility might have changed the process. The hospice CNA was interviewed on 5/7/26 at 8:25 a.m. The hospice CNA said she had been out for three weeks due to an injury. She said she was the CNA for Resident #38 and Resident #75. She said someone from the hospice team should have been filling in for her while she was out. She said she was not sure who it was. She said she only charted in the hospice charting system. She said she did not document anywhere at the facility. She said she did verbally check in with the facility nurses. The director of nursing (DON) and the regional director of clinical services were interviewed together on 5/7/26 at approximately 2:15 p.m. The regional director of clinical services said there was not a specific hospice coordinator. She said there were multiple layers and different people involved. She said nursing staff knew when hospice staff visited because the hospice staff would check in with them and the nurses were in charge of coordinating care. She said preferred providers were able to chart directly into the facility's EMR. She said the hospice nurses should be able to chart directly in the EMR. She said she hoped that the hospice team would communicate if one of their caregivers was going to be out for an extended period of time. She said there did not have to be a specific care plan for hospice, as long as there was a delineation of care within the care plan. She said that the medical records staff member had just started working at the facility in February 2026, so the facility was playing catch up on getting records scanned into the electronic medical system. The executive director and the regional director of clinical services were interviewed together on 5/7/26 at 3:20 p.m. The executive director said he would think that the unit managers would be the hospice coordinators because they knew the residents best. He said nursing should know when the hospice team visited because it should be in the residents' EMRs. He said if hospice was unable to chart in the EMR, then they could handwrite a note and the facility could upload it for them into the EMR. He said hospice notes should be readily available to the staff, but he said he was unsure of how quickly the documentation should be uploaded. He said the unit managers (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be the ones who ensured the hospice notes were readily available. He said the hospice care plans should be integrated into the facility's care plans. He said the interdisciplinary team (IDT) developed the care plan. He said there should be a delineation of care in the care plan. He said the hospice care plan should be initiated when the resident first was accepted on hospice care services. He said the nursing team and people from their sister community were helping upload documentation when the facility did not have a medical records person.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.Specifically, the facility failed to:-Ensure housekeeping staff followed proper cleaning procedures for cleaning and disinfecting resident rooms and high-frequency touched areas; -Ensure housekeeping staff performed hand hygiene and glove changes appropriately; and,-Ensure staff followed chemical dwell times and appropriately disinfected the blood pressure device between residents. Findings include: I. Housekeeping failures A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Environment Cleaning Procedures (3/19/24), retrieved on 5/11/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=h High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bedrails; IV (intravenous) poles; sink handles; bedside tables; counters where medications and supplies are prepared; edges of privacy curtains; patient monitoring equipment (keyboards, control panels); call bells; door knobs and light switches. According to the CDC's Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 5/11/26 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, To protect yourself and your patients from deadly germs, all healthcare personnel should understand how to care for and clean their hands. Hand hygiene, which protects both healthcare personnel and patients, involves cleaning hands by washing with soap and water, using antiseptic hand rubs (such as alcohol-based foams or gels), or performing surgical hand antisepsis. Cleaning your hands reduces the potential spread of deadly germs, including those resistant to antibiotics. It also lowers the risk of healthcare personnel becoming colonized or infected by germs acquired from patients. Because some healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep everyone safe, maintaining healthy skin is a common challenge. According to the CDC's Hand Sanitizer Guidelines and Recommendations (3/12/24), retrieved on 5/11/26 from https://www.cdc.gov/clean-hands/about/hand-sanitizer.html, Germs are everywhere. They can get onto hands and items we touch during daily activities and make us sick. Cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There are important differences between washing hands with soap and water and using hand sanitizer. Apply the gel product to the palm of one hand (read the label to learn the correct amount). Cover all surfaces of hands. Rub your hands and fingers together until they are dry. This should take around 20 seconds. B. Facility policy and procedures The Infection Control and Prevention policy, dated July 2025, was provided by the executive director on 5/4/26 at 1:35 p.m. It read in pertinent part, Residents and associates of the facility will follow comprehensive infection control standards based on preventing, identifying, reporting, investigating, and controlling infections and communicable diseases, and complying with regulation, including mandatory reporting guidelines. Standard precautions, including hand hygiene are taught and monitored. All associates and volunteers are expected to follow proper hand hygiene techniques, per the Hand Hygiene policy. C. Observations During a continuous observation on 5/6/26, beginning at 1:07 p.m. and ending at 1:13 p.m., the following was observed: At 1:07 p.m., housekeeper (HK) #1 entered resident room [ROOM NUMBER] on the Evergreen unit with a bottle containing a clear solution labeled bleach and began cleaning the room. HK #1 used the bleach solution to clean the toilet. HK #1 wiped the counter and sink area and removed trash from the room. -HK #1 failed to clean the sink prior to cleaning the toilet. -HK #1 did not clean the resident's call light. During a continuous observation on 5/6/26, beginning at 1:42 p.m. and ending at 2:02 p.m., the following was observed: At 1:42 p.m. HK #2 entered resident room [ROOM NUMBER] on the Ponderosa unit. At 1:43 p.m. HK #2 cleaned the sink and toilet using acid free restroom cleaner (AFRC). HK #2 returned to his cart, and without changing his gloves, picked up a mop pad and mop stick and began mopping the floor with an unlabeled spray bottle of cleaner. -HK #2 failed to perform hand hygiene after cleaning the bathroom and prior to mopping the resident's floor. At 1:46 p.m. HK #2 returned to his cart, retrieved a rag and began cleaning the bedside table, window and window sills without changing his gloves. At 1:48 p.m. HK #2 vacuumed the floor and then adjusted the trash bag beside the resident's bed without changing his gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-HK #2 failed to change his gloves and perform hand hygiene during the entire cleaning of room [ROOM NUMBER]. D. Staff interviews HK #1 was interviewed on 5/6/26 at 1:14 p.m. using Spanish interpreter services. HK #1 said she used bleach to clean the residents' toilets and would use acid free restroom cleaner (AFRC) to deodorize the rooms. HK #1 said she would also use Victoria's Secret spray to deodorize the room. HK #1 said she did not sanitize the residents' call lights because certified nurse aides (CNA) were responsible for sanitizing call lights. CNA #3 was interviewed on 5/6/26 at 2:10 p.m. CNA #3 said CNAs cleaned the resident's call buttons two times per day. CNA #3 said she wiped the call buttons with bleach wipes and staff were supposed to clean them two times during their shift. HK #2 was interviewed on 5/6/26 at 2:03 p.m. HK #2 said he identified the cleaning solutions by the color of the bottles. HK #2 said he should have changed his gloves, performed hand hygiene and donned a new pair of gloves after completing one task and before moving on to a new task when cleaning room [ROOM NUMBER]. The housekeeping supervisor was interviewed on 5/6/26 at 3:08 p.m. The housekeeping supervisor said housekeeping staff identified the cleaning products by the color of the liquid, however, the bottle used by HK #2 to mop the floor in room [ROOM NUMBER] should have had a label on it. The housekeeping supervisor said housekeeping staff should start cleaning the toilet areas first, then remove their gloves, perform hand hygiene and don a new pair of gloves before moving to the sink area. The housekeeping supervisor said staff should remove gloves before cleaning high touch areas. The housekeeping supervisor said housekeeping staff should clean the floor last using a microfiber mop. The housekeeping supervisor said these steps were important for infection control to prevent the spread of germs. The housekeeping supervisor said housekeeping staff were responsible for cleaning and sanitizing residents' remotes and call lights; however, CNAs were also expected to sanitize those items. The housekeeping supervisor said housekeeping staff used acid free restroom cleaner (AFRC) to clean the toilets and did not use it to deodorize residents' rooms. The housekeeping supervisor said housekeeping staff did not use bleach to clean toilets. The housekeeping supervisor said HK #1 was confused because housekeeping staff used bleach to remove odors from the floor. The housekeeping supervisor said he would provide education to the housekeeping staff regarding the proper cleaners to use. The infection preventionist (IP) was interviewed on 5/7/26 at 11:30 a.m. The IP said the facility provided infection prevention education to housekeeping staff and supervisors to ensure staff understood infection prevention concerns. The IP said cleaning and sanitizing residents' call lights was part of the housekeeping staffs' daily tasks; however, CNAs also sanitized the residents' call lights. The IP said HK #2 should have changed gloves and performed hand hygiene and donned new gloves between cleaning tasks to prevent bringing bacteria from one area to another area, which increased the potential for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Failed to follow chemical dwell times and appropriately disinfect the blood pressure device between residents A. Professional reference According to Diversey's Oxivir Tuberculin (Tb) Wipes manufacturer instructions, dated 2023, retrieved on 5/12/26 from https://s3.amazonaws.com/imperialdade.com/apps/catalog/digital-assets/24241/product-documentation/cca87 Effective against key pathogens – Tb, Methicillin-resistant Staphylococcus aureus (MRSA), Norovirus (gastrointestinal - GI virus), Vancomycin-resistant enterococci (VRE) and Candida auris (a fungus that can cause multidrug-resistant infections). Kills Hepatitis B virus (HBV), Hepatitis C virus (HCV) and human immunodeficiency virus (HIV) in one minute. Tuberculocidal in five minutes. Fungicidal in three minutes and kills Candida auris in five minutes. Use instructions: pre-clean heavily soiled areas; apply product by coarse trigger spray or disposable wipe to hard, non-porous inanimate surfaces; all surfaces must remain visibly wet for one minute; use a five minute contact time for Tb, a three minute contact for fungi and a five minute contact time for Candida auris; and, air dry, wipe surfaces to dry and remove any residue, or rinse with potable water as necessary. B. Observations On 5/6/26 licensed practical nurse (LPN) #1 was observed during medication administration. The following was observed: At 11:16 a.m. LPN #1 was preparing to administer medications, including a blood pressure medication with specific parameters for administration, to Resident #79. LPN #1 removed a basket of vital signs equipment, including a thermometer, automated blood pressure device and pulse oximetry device (measures the oxygen saturation in the blood), from the medication cart. She then donned (put on) clean gloves and removed one Diversey Oxivir Tb wipe from its container. The Oxivir Tb's chemical dwell time (time that a surface area should remain wet to ensure proper disinfection) was printed and visible on the container's label. The chemical dwell time was one minute. LPN #1 wiped the front and back surfaces of the blood pressure cuff in 15 seconds. The blood pressure cuff did not look shiny or wet. She then returned the blood pressure cuff to the basket of vital signs equipment. -LPN #1 failed to allow the disinfectant to remain on the surfaces of the blood pressure cuff for the recommended one-minute dwell time (see professional reference above). After she measured Resident #79's blood pressure, LPN #1 removed the blood pressure cuff from the resident's left upper arm and placed it back into the basket of vital signs equipment without disinfecting it again. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:39 a.m. LPN #1 was preparing to administer medications, including a blood pressure medication with specific parameters for administration, to Resident #62. LPN #1 collected the basket of vital signs equipment and the resident's crushed medications in applesauce before she entered Resident #62's room. Without disinfecting the blood pressure cuff, LPN #1 measured Resident #62's blood pressure on his left upper arm over a long sleeve shirt. After she measured Resident #62's blood pressure, LPN #1 removed the blood pressure cuff from the resident's left upper arm and placed it in the basket of vital signs equipment without disinfecting the blood pressure cuff. -LPN #1 failed to disinfect the blood pressure cuff between obtaining blood pressures for Resident #79 and Resident #62. C. Staff interviews LPN #1 was interviewed on 5/6/26 at 11:58 a.m. LPN #1 said she did not disinfect the blood pressure cuff before she used it on Resident #62. She said the Oxivir wipe dwell time was one minute, but she said she was not sure whether the one-minute dwell time meant the product should be allowed to dry for one minute or if the product should remain wet with chemicals for one minute. LPN #1 said the blood pressure cuff was not wet or shiny looking when she wiped it before using it to obtain Resident #79's blood pressure. She said it was important to appropriately disinfect the blood pressure cuff and to follow chemical dwell times in order to prevent the contamination of pathogens between residents. The IP was interviewed on 5/7/26 at 12:30 p.m. The IP said the nursing staff should wipe the vital signs equipment with an Oxivir wipe between residents and after each use. She said she did not know the chemical dwell time for the Oxivir wipes off the top of her head, but she educated the staff that the dwell time was printed on the back of the Oxivir container. The IP said the blood pressure cuff should have been disinfected between using it to obtain blood pressures for Resident #79 and Resident #62. She said it was important to disinfect the vital signs equipment appropriately between residents because the facility did not want to transfer bacteria between residents. The DON and the minimum data set (MDS) coordinator were interviewed together on 5/7/26 at 6:20 p.m. The DON said vital signs equipment should be cleaned between each resident. She said the facility used Oxivir wipes, and the chemical dwell time was one minute. The DON said it was important to follow chemical dwell times so that the facility did not share any potential infections amongst residents. She said this was an opportunity for education.