STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Care Center	885 S Hwy 50 Business Loop Olathe, CO 81425

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions in the main kitchen.Specifically, the facility failed to ensure staff followed appropriate hand hygiene practices during the meal service. Findings include:I. Professional referenceAccording to the Colorado Retail Food Regulations (3/16/24), chapter 2-301.12, retrieved on 5/5/26, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.14)II. Facility policy and procedureThe Handwashing/ Hand Hygiene policy, revised December 2025, was provided by the nursing home administrator in training on 4/30/26. Hand hygiene is the primary means for preventing healthcare-associated infections (HAIs) and the transmission of multidrug-resistant organisms (MDROs). This facility requires strict adherence to evidence-based hand hygiene practices for all personnel, including licensed, unlicensed, contracted, therapy, dining, housekeeping, volunteers, and students. Perform hand hygiene before applying non-sterile gloves. The use of gloves does not substitute for hand hygiene. Always perform hand hygiene after gloves are removed.According to the policy, hand hygiene should be completed after touching contaminated surfaces. The Food Preparation and Service policy, revised January 2024, was provided by the nursing home administrator (NHA) on 4/30/26 at 11:38 p.m. The policy read in pertinent part, Food is handled properly with frequent hand washing and proper sanitation guidelines per local, state and federal guidelines and codes. Hand washing is done regularly after using the restroom, after breaks and after handling raw foods, bare hands do not touch ready to eat foods. Handwashing signs are posted above hand washing sinks and employees have hand washing techniques reviewed regularly and at orientation. III. Observations During a continuous observation of the lunch meal service in the kitchen on 4/29/26,, beginning at 11:00 a.m. and ending at 12:33 p.m., the following was observed:At 11:36 a.m the dietary manager (DM) was going in and out of the walk-in refrigerator, retrieving items for a chef salad. She donned gloves on her hands and proceeded to assemble the salads. -The DM did not perform hand hygiene prior to donning her gloves.At 11:39 a.m. the DM completed the salads, removed her gloves from her hands and dropped a glove on the floor. She picked up the glove, threw it away and washed her hands.At 11:41 the DM dropped a second glove on the floor, picked it up right hand, tossed the glove in the trash, sealed an onion in a plastic baggie and placed the bag in the walk-in refrigerator. She wiped down her work station counter and washed her hands.-The DM did not perform hand hygiene prior to sealing the onion in the bagging and touching the refrigerator door handle with her right hand. At 11:57 a.m. dietary aide (DA) #1 placed a glove on her right hand without performing hand hygiene. She pulled up the back of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	her pants with the gloved hand and placed her hands in and out of the front pockets of her apron.At 12:00 p.m. DA #1 placed a glove on her left hand without performing hand hygiene and used the thermometer to check the temperature of the egg rolls. At 12:06 p.m. cook (CK) #1 placed her left thumb on the eating surfaces of the plates as she dished the ready-to-eat food. At 12:09 p.m. a resident's diet card fell to the floor. CK #1 picked up the diet card with her left hand and placed it on a meal tray next to the plated food. The DM handed the tray with the meal and the diet card to a staff member for delivery. CK #1 continued to plate resident's food for the remainder of the meal service, frequently placing her thumb on the eating surface and without performing hand hygiene.-The laminated diet card was not wiped down after it fell to the floor. -CK #1 did not wash her hands after she picked up the diet card off the floor.At 12:13 p.m. DA #1 placed her hands in her apron pocket, pushed up glasses with fingers and took the temperature of a corn dog without performing hand hygiene.At 12:15 p.m. DA #1 pushed up glasses with fingers, held a plate with her thumb on the eating surface of the plate and then placed the corn dog on the plate without performing hand hygiene.At 12:17 p.m. without performing hand hygiene, DA #1 took the temperature of the hamburger patties and placed the patties on a plate, touching the edge of one of the slices of lettuce with her thumb.At 12:18 p.m. DA #1 touched her nose with her left hand, without performing hand hygiene she took the temperature of chicken nuggets and placed her right thumb on the plate with the chicken nuggets. She touched her glasses with the back of her right hand and donned gloves on both of her hands. At 12:20 p.m. DA #2 sniffed with her nose and placed the back of her left hand to her nose. Without performing hand hygiene, she then retrieved several adaptive equipment plates and placed them next to the steam table. She moved a clean large cook sheet and retrieved a small bag of potato chips from the storage room and handed the chips to the DM. The DM placed the bag of chips on a meal tray next to a resident's plated food and the tray was sent out for delivery. At 12:24 p.m. DA #1 was preparing a grilled cheese sandwich. She touched the sandwich with her left hand as she flipped the sandwich with a spatula.At 12:25 p.m. without performing hand hygiene or removing her gloves, DA #1 removed the grilled cheese from the pan, placed it on a plate and cut the grilled cheese in half, holding the grilled cheese steady with her gloved fingers and she cut it. DA #1 removed her gloves and washed her hands.At 12:29 p.m. DA #1 pulled the back of her pants up with hands, scratched her face near her mouth with her index finger, wiped down a thermometer, touched the microwave handle and buttons and used the thermometer multiple times to warm up and temperature the collard greens while pushing her glasses with the back of her hand and touching her nose twice with her left index knuckle. -DA #1 did not perform hand hygiene after touching her pants, her glasses and her face before touching the thermometer and the microwave to prepare the vegetables.IV. Record reviewA 2/4/26 dietary staff in-service participation log was provided by the administrator in training on 4/30/26 at 12:48 p.m. The participation log documented eight dietary staff received hand hygiene education, conducted by the DM on 2/4/26. The participation log documented CK #1 and DA #2 attended the hand hygiene training. The log did not indicate DA #1 attended the in-service on hand hygiene. V. Staff interviewsDA #2 was interviewed on 4/30/26 at 10:16 p.m. DA #2 said she should wash when she was working in the kitchen and after touching her face, trash or after touching anything that was potentially contaminated. CK #1 was interviewed on 4/30/26 at 10:18 p.m. CK #1 said she should wash hands any time she changed tasks or any time there was a risk of cross-contamination. She said if something dropped on the floor, she should pick it up, toss it away and wash her hands. She said not washing hands could contaminate the food.The DM was interviewed on 4/30/26 at 11:12 p.m. The DM said hand hygiene should be conducted after every task change and before putting gloves on. She said if something drops to the floor. Staff should wash their hands after picking the item off the floor. The DM said she saw CK #1 pick the diet card off the floor and place it on the tray. The DM said the floor was a contaminated surface. She said she would re-educate CK #1 to wash her hands after picking anything off the floor and not to place something on a resident's meal tray that was cross-contaminated.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents grievances were resolved in an acceptable and timely manner for four (#67, #26, #39 and #62) of five residents reviewed for grievances of 35 sample residents.Specifically, the facility failed to:-Resolve grievances concerning long call wait times for Resident #67 and Resident #26; and, -Resolve grievances concerning missing personal belongings for Resident #39 and Resident #62.Findings include I. Facility policy and procedure The Grievance policy, dated 5/8/23, was received from the nursing home administrator in training on 4/30/26 at 6:34 p.m. It read in pertinent part, To provide residents and responsible parties with information on the facility grievance procedure. To ensure that residents are afforded their right to file a grievance without discrimination or reprisal and that such grievance shall be responded to promptly and in written form. Upon receipt of a Grievance and Complaint Report or Complaint Concern form, the social services director or designee will explore the allegations/concerns. The appropriate department director will be notified of the nature of the complaint and that follow-up is necessary. The Grievance and Complaint Investigation Report (resolution) must be filed with the administrator within five (5) working days of receipt of the grievance or complaint form. II. Call light grievances A. Resident #67 1. Resident status Resident #67, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, diabetes with diabetic neuropathy, congestive heart failure and chronic respiratory failure. The 2/4/26 minimum data set (MDS) assessment revealed the resident was moderately impaired with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required substantial or maximal assistance from staff for transfers. The resident did not walk and used a wheelchair to get around. 2. Resident interview Resident #67 was interviewed on 4/27/26 at 2:52 p.m. Resident #67 said the facility's administration told the resident council that staffing and the long call wait times would change but it had not. He said the resident council brought up the concern about long call light wait times four months ago and nothing had changed. Resident #67 was interviewed again on 4/29/26 at 2:00 p.m. Resident #67 said that the east hallway had three good, certified nurse aides (CNA), but the East hall was staffed with one CNA per shift and they needed more than one staff member to help residents. He said there were several residents (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needing two staff members to assist them with transfers. He said there was a CNA who floated from unit to unit, but that CNA rarely responded to provide assistance on the East hall and the nurse was busy performing nursing duties, which made the wait time long when care assistance was needed. He said the other problem with getting the nurse to help the CNAs was that the nurses on the east hallway were older and not physically able to help with a resident's transfer/lift. Resident #67 said all of this contributed to the long waiting times for call lights. Resident #67 said when he brought the call light wait time concern to the facility's leadership, he was told they could not schedule more staff because the current resident census numbers did not support scheduling additional staffing. Resident #67 said that the facility had a staff member float to help on hallways, but it was not enough. 3. Record review A grievance form, dated 1/13/26, revealed Resident #67 reported call lights were not getting answered in a timely manner. He said long call lights were occurring after 6:00 p.m. and during shift change at 2:00 p.m. Resident #67 said no one showed up for work. The activities director (AD) documented a response and action taken on 1/14/26. The AD documented said she spoke with Resident #67 about the call light time complaint and he reported that he continued to make the complaint because he wanted two CNAs on the East hall. The director of nursing (DON) spoke with the resident and explained that two CNAs on the East hall was not possible with the facility's staffing allowances. The follow-up action to the grievance, documented by the facility, revealed call light times were pulled from 1/1/26 to 1/16/26. The follow-up documented there was only one call light time longer than 30 minutes during that timeframe and the average call light wait time was 6.2 minutes. The call light times were pulled to identify trends in high call light times. The follow-up documented the nurse management team used a pager to assist with answering call lights and call light trends were addressed with each shift. There was no signature from Resident #67 on the form, but the form documented the resolution was discussed with Resident #67 who verbally agreed the grievance was resolved. The resolution date was documented as 1/19/26. The nursing home administrator (NHA) signed the grievance form on 1/19/26. -However, per the interview with Resident #67 during the survey, the resident said call light times were long and nothing had changed (see Resident #67's interview above). B. Resident #26 1. Resident status Resident #26, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included diabetes with other circulatory complications, morbid obesity, congestive heart failure and depression. The 4/6/26 MDSassessment revealed the resident was cognitively intact with a BIMS score of 15 out (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 15. The resident required substantial assistance from staff for transfers, as the resident used a wheelchair for mobility and could not walk on her own. 2. Resident interview Resident #26 was interviewed on 4/29/26 at 2:00 p.m. Resident #26 said that the facility had older nurses that worked the floor and they were unable to lift residents, or use the Hoyer lift (mechanical lift), and this created longer call light wait times, especially on the evening and night shifts. 3. Record review A grievance form, dated 4/13/26, was written by the social services director (SSD) on behalf of Resident #26. The grievance form revealed Resident #26 said she was throwing up last night (4/12/26)and there was only one registered nurse (RN) in the hall. The resident said she was changed at 11:00 p.m. and did not get changed again until 6:00 a.m. (seven hours later). The resident said she was soaked by 3:00 a.m. and did not get assistance to get changed, even though she had activated her call light for help. The grievance response documented that the NHA checked the call light system records to determine how long it took staff to respond to Resident #26's call light. Additionally, the nursing schedule was checked and two nurses and three CNAs were on shift the night of 4/12/26. The call light times for 4/12/26 were reviewed and revealed the resident's call light was on for longer than 48 minutes during the night. The follow-up action for the grievance revealed that staff were educated on the expectations to check in on Resident #26 when her call light was on, even when her eyes were closed. -The grievance investigation completion date was documented as 4/17/26 and signed by Resident #26; however, the grievance was not signed by the NHA or the designee completing the investigation. -Additionally, there was no response or resolution to the resident's allegation that she was left soaking wet from urine for three hours, despite activating her call light for assistance to get cleaned up. C. Resident council grievance A grievance form, dated 3/10/26, revealed the resident council group complained that call light wait times at night, between 10:00 p.m. and 6:00 a.m., were too long. The facility's response to the grievance was that nursing staff were educated to carry radios and pagers at all times and to respond to call lights promptly. Call light report times were now being pulled for residents' rooms throughout the building. The grievance form was signed by the DON on 3/13/26. -However, no was circled, indicating that the concern was not resolved for the resident council. D. Staff interviews (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #3 was interviewed on 4/30/26 at 2:50 p.m. CNA #3 said when answering call lights, it was based on which resident called first and, depending on what the resident may need, depending on the resident's needs of that day. She said typically she would work her way down the residents' call lights and call for help if she needed assistance. CNA #3 said she had heard of long call light wait times and that it was unfortunate, but when providing the same level of care to all residents, call light wait times might be a little longer. She said her response time typically took less than five minutes. She said that she had not been made aware of any call lights being longer than five minutes. CNA #3 said call light times had been a topic of discussion at staff meetings since December 2025, as that was when she started working at the facility. CNA #4 was interviewed on 4/30/26 at 2:59 p.m. CNA #4 said he could manage answering call lights effectively with the pager that he had. He said if things got busy, he would call for help as well. He said when it was busy, he took care of the residents, in the order they called for assistance. He said when it came to mechanical lifts, he would coordinate with other staff members to make sure the lift transfer with the resident was completed quickly and safely. CNA #4 said that he had not noticed long call light wait times, and the facility had implemented systems in place to track and manage the call light wait times, such as the pagers, and a monitor near the administration offices to track call light times. CNA #4 said when he answered a call light, he would stay there until the task was completed and the resident did not need anything else. He said that he would not answer the call light and leave. CNA #5 was interviewed on 4/30/26 at 3:05 p.m. CNA #5 said that he responded to call lights as they came in. He said that he prioritized call lights as needed. He said if he knew a resident was a fall risk, he may go there first if they had their call light on, but it was based on urgency and safety. CNA #5 said he had not witnessed the long call wait times, but he had heard residents complaining about the wait times. He said that typically long call light wait times did not happen, but if there was an emergency, it could happen. He said he did not rush the residents or the care that he provided. He said when providing care to the residents, it could take a while and residents understood this. CNA #5 said he felt like staffing was good but he thought the overnight staff might need more CNAs. He said that as needed nurses (PRN) and CNAs were not available all the time and this put a strain on the staff. The SSD was interviewed on 04/30/26 at 5:06 p.m. The SSD said that grievances started with social services and once she took the grievances, she would give the grievances to the proper department, such as nursing, maintenance or environmental cleaning for follow-up to the concern. She said generally, the turnaround time for responses was about a day for the department to respond to the grievance, unless it was urgent and it would occur the same day. She said that the grievance, once it was resolved, would go to the NHA. The SSD said the NHA would look over each grievance and the response and sign the form. The SSD said that when it came to call lights, the facility had been putting out education for CNAs and other staff members as needed. She said everyone had been trying to resolve the call light (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative said he had concerns about missing money for Resident #39 that he reported a week ago to the DON. He said he did not want to fill out a grievance form because he wanted to handle the matter with the DON. He said he was told by the DON that he would have answers within the week but he had not heard anything yet. B. Resident #62 1. Resident status Resident #62, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included adult failure to thrive, chronic respiratory failure and cerebral infarction. The 2/13/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. The resident required substantial maximal assistance from staff for all ADLs. 2. Resident interview Resident #62 was interviewed on 4/27/26 at 10:05 a.m. Resident #62 said she had moved rooms three or four times and she was upset about this because she had missing items after the room changes. She said she was missing clothes, a blanket, a microphone and checks. 3. Record review The facility's grievance reports from January 2026, February 2026 and March 2026 were provided by the NHA on 4/29/26 at 6:09 p.m. The grievance forms revealed the following: -On 1/9/26 Resident #62 reported a missing blanket and microphone; -On 2/18/26 Resident #62 reported missing clothes and room move concerns; and, -On 2/27/26 Resident #62 reported missing checks. C. Staff interviews CNA #2 was interviewed on 4/30/26 at 9:20 a.m. CNA #2 said when an item was reported missing, she would notify the nurse. She said she assisted the resident to find the missing item, such as clothes, and looked in the laundry department. She said there was a form the resident could fill out for missing items and then the form would be given to the nurse or the social services department. CNA #1 was interviewed on 4/30/26 at 9:40 a.m. CNA #1 said he helped residents look for missing items when needed. He said Resident #62 reported things missing often. He said he reported the missing items to the nurse and social services when the resident reported them to him. The SSD was interviewed on 4/30/26 at 10:45 a.m. The SSD said residents filled out grievance forms when they wanted to report missing items and the form was given to the appropriate staff members to investigate. The SSD said concerns for missing clothes went to the laundry department and everything else went to social services. She said, If needed, the facility would replace the missing items after the investigation. She said she was not familiar with the missing checks for Resident #62 or the missing money for Resident #39. She said she was not aware of the follow-up for those (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to follow infection control measures with hand hygiene when performing housekeeping duties and medication administration. Specifically, the facility failed to:-Ensure housekeeping staff cleaned residents' rooms from a cleaner area to a dirtier area;-Ensure housekeeping staff performed appropriate hand hygiene when cleaning residents' rooms;-Ensure registered nurse (RN) #1 performed appropriate hand hygiene after picking up a medication off the floor;-Maintain a water program to prevent pathogens from building up in the sink drains in the satellite kitchen, the hand washing sink in the common area and the residents' room sinks; and, -Clean the facility sinks to prevent build-up and keep the drains of the sinks in the common areas of the kitchen, hallways and public restrooms free of food waste and other buildup which promotes the development of pathogens and biofilm.Findings include: I. Housekeeping failures A. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy, dated February 2026, was provided by the nursing home administrator in training on 4/30/26 at 1:02 p.m. The policy read in pertinent part, The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. Supplies and equipment appropriate for the task (for example), disinfectant solution, cleaning cloths, mop, bucket and personal protective equipment (gowns, gloves and mask). Steps in the procedure for resident room cleaning: If the resident is in their room, request permission to enter and clean the room. Gather supplies and equipment. Apply gloves and other personal protective equipment (PPE) when applicable. Clean all high-touch items with disinfectant solution: bedside tables, overbed tables, chairs, beds, lights, call bells, bedrails, mop the floors, discard mop solution, remove gloves and perform hand hygiene. The Handwashing and Hand Hygiene policy, dated December 2025, was provided by the nursing home administrator in training on 4/30/26 at 1:03 p.m. The policy read in pertinent part, Hand hygiene is the primary means for preventing healthcare-associated infections (HAIs) and the transmission of multidrug-resistant organisms (MDROs). This facility requires strict adherence to evidence-based hand hygiene practices (as described in this policy) for all personnel, including licensed, unlicensed, contracted, therapy, dining, housekeeping, volunteers, and students. All personnel are provided with hand hygiene training upon hire and annually thereafter. Hand hygiene competency of staff is measured, including through return demonstrations to verify technique. All personnel are required to adhere to hand hygiene policies and practices. Staff adherence to hand hygiene is incorporated into infection prevention and control process surveillance and monitored by the infection preventionist as part of the facility infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hand hygiene is indicated: Before touching a resident, before preparing or handling food, medications, or parenteral solutions, after exposure to blood, body fluids, excretions, or contaminated surfaces, after touching the resident's environment or belongings, after glove removal and whenever hands are visibly soiled. Use an alcohol-based hand rub (ABHR) containing at least 60% alcohol for most clinical situations. Unless hands are visibly soiled, ABHR is the preferred method of hand hygiene in clinical situations because it is more effective at killing germs, faster to use, and less irritating to the skin than soap and water. The use of gloves does not substitute for hand hygiene. Always perform hand hygiene after gloves are removed. B. Housekeeping observations On 4/29/26 at 10:20 a.m. housekeeper (HK) #1 was mopping the floor in resident room [ROOM NUMBER]. HK #1 left room [ROOM NUMBER], dropped the mop into the bucket outside the room and went directly into resident room [ROOM NUMBER] to remove the trash inside the bathroom. -HK #1 failed to perform hand hygiene after exiting room [ROOM NUMBER] and prior to entering room [ROOM NUMBER]. HK #1 proceeded to put the trash from room [ROOM NUMBER]'s bathroom in the bin outside the room and then donned (put on) gloves. -HK #1 did not perform hand hygiene after handling the trash from the resident's bathroom prior to putting on gloves. After putting on the gloves, HK #1 returned to resident room [ROOM NUMBER]. HK #1 sprayed the toilet in room [ROOM NUMBER] and immediately wiped down the toilet with a wet sponge from top to bottom, then the toilet seat and inside the rim of the toilet bowl. After wiping everything down with the wet sponge, he repeated the process with a rag. He flipped the rag inside out to wipe around the outside of the toilet. -HK #1 did not allow the disinfectant to remain on the surface of the toilet for any period of time, prior to wiping it off with the wet sponge. -HK #1 failed to clean the toilet in room [ROOM NUMBER] from a cleaner area to a dirtier area. HK #1 proceeded to put the rag and the sponge in a bag that hung on the housekeeping cart outside the room, but he did not perform hand hygiene. He doffed (took off) his gloves and proceeded to sweep the floor of the resident's room and the bathroom and then switched out the broom for the mop to complete cleaning the floors. He put the mop back in the bucket outside the room, and again did not perform hand hygiene. -HK #1 failed to perform hand hygiene after cleaning the resident's toilet and prior sweeping and mopping the floors in room [ROOM NUMBER]. Without performing hand hygiene, HK #1 proceeded to don gloves and returned to resident room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[ROOM NUMBER]. He blew his nose with his gloved hands, touched the door handle in room [ROOM NUMBER] to throw the tissue away and walked out of room [ROOM NUMBER] -HK #1 failed to perform hand hygiene prior to putting on gloves and returning to room [ROOM NUMBER] after cleaning the toilet in room [ROOM NUMBER]. -HK #1 failed to perform hand hygiene after blowing his nose and prior to touching the door handle in room [ROOM NUMBER]. After throwing his tissue away in room [ROOM NUMBER] and exiting the room, HK #1 took off his gloves and without performing hand hygiene, put on a new pair of gloves. He proceeded to go into resident room [ROOM NUMBER]'s bathroom with disinfectant spray, a sponge and a rag to clean the toilet. HK #1 proceeded to clean the toilet in room [ROOM NUMBER] in the same manner he had just cleaned the toilet in room [ROOM NUMBER] (see above). -HK #1 failed to perform hand hygiene after cleaning the toilet in room [ROOM NUMBER]. -HK #1 failed to clean the toilet in room [ROOM NUMBER] from a cleaner area to a dirtier area. -HK #1 did not allow the disinfectant to remain on the surface of the toilet for any period of time, prior to wiping it off with the wet sponge. C. Staff interviews HK #1 was interviewed on 4/29/26 at 10:38 a.m. HK #1 said the process for cleaning residents' rooms was to clean the residents' room and then sweep and mop. He said he cleaned the rooms with a sponge soaked in a floor cleaner solution and the mop water came from a dispensing machine in the housekeeping closet. He said he sprayed the toilets, sinks, handles and faucets and wiped them down with the sponge first and then a rag to dry the areas. He said he knew how to clean toilets from his previous job and he received in-person training when he started working at the facility a few months ago. HK #1 said he changed his gloves in between residents' rooms and used hand sanitizer when he finished cleaning residents' rooms. HK #2 was interviewed on 4/30/26 at 11:35 a.m. HK #2 said residents' rooms were cleaned with a bleach solution. She said housekeeping staff were supposed to spray the residents' mirrors, sinks and high touch areas, such as the call lights and door handles of the resident's rooms and let the solution sit on the surfaces before wiping the surfaces down with a sponge and a dry rag. She said the toilets in the resident's rooms should be cleaned last. She said hand hygiene was performed before entering the resident's room, before donning gloves and after doffing gloves. She said each housekeeping cart had hand sanitizer to use. The maintenance director (MTD) was interviewed on 4/30/26 at 11:40 a.m. The MTD said housekeepers were educated on how to clean residents' rooms and to perform hand hygiene in between glove use and entering or exiting the residents' rooms. He said housekeeping education was completed upon hire and annually. He said he would expect the housekeepers to follow the appropriate cleaning procedures for the safety of residents and staff. II. Failed to ensure RN #1 performed appropriate hand hygiene after picking up a medication off the floor (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Observation On 4/29/26 at 4:41 p.m. RN #1 was observed during medication administration. RN #1 dropped one medication tablet onto the floor. She picked up the tablet with her bare hands and put the medication tablet in the medication destruction solution. Without performing hand hygiene, RN #1 proceeded to remove another medication tablet from the medication package -RN #1 failed to perform hand hygiene after picking up the medication from the floor and prior to dispensing another medication tablet from the medication package. B. Staff interview The director of nursing (DON) was interviewed on 4/30/26 at 12:15 p.m. The DON said hand hygiene was completed before and after each resident medication administration. She said RN #1 should have performed hand hygiene after picking up the medication tablet from the floor, prior to dispensing another medication. She said staff were educated to perform hand hygiene during medication administration and she would be completing spot checks for competencies. III. Sink drain failures A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Project Firstline: Drains and Biofilms: Hiding Places for Germs, undated, retrieved on 5/5/26 form https://www.cdc.gov/project-firstline/media/pdfs/microlearn-drains-508.pdf, Germs can live and grow in drain biofilms and can spread to patients and cause infections, but they don't have to. You can stop the spread by being aware of the risks of water in healthcare settings and taking action to prevent infections. Germs in the sewer, including drug-resistant germs, can be found in the plumbing all the way up to the drain. These germs can buildup in the plumbing to form slimy layers called biofilms. Germs in biofilms can spread to patients and cause infections that are difficult and sometimes impossible to treat. When water splashes out of a drain, it can spread germs from the biofilm to your skin and nearby surfaces and equipment. According to the CDC's Considerations for Reducing Risk: Water in Healthcare Facilities (2/6/26), retrieved on 5/5/26 from https://www.cdc.gov/healthcare-associated-infections/php/toolkit/water-management.html, Opportunistic pathogens of premise plumbing (OPPP) microorganisms in building water systems that are more likely to cause disease in at-risk or immunocompromised individuals. Tap water meets stringent safety standards in the United States, but it is not sterile. Germs may be present when water leaves the tap. For typical household uses, these germs rarely pose a serious health risk. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other opportunistic pathogens within the water system. C. Observations Observations of the common area sinks and residents' room sinks were conducted on 4/28/26 at approximately 1:15 p.m. and again on 4/30/26 at approximately 3:30 p.m. The condition of the sink drains as described below did not change throughout the survey (4/27/26 to 4/30/26). The north hall common area double basin sink in the dining room area was heavily soiled. The drain on the garbage disposal side had a heavy buildup of chunky solid debris stuck on to the rubber insert splash guard. The rubber guard had degraded in areas and exposed the inner disposal blades clearly. The inside blades had built up brown debris. The drain on the other side of the skin basin had a heavy buildup of brown debris on and around the rim of the drain flange and there was a buildup of sludge inside the drain on the piping. The sink in the staff bathroom on the north hall had a heavy buildup of black sludge inside the drain and down into the piping. When the pipe was wiped with a clean white paper towel the paper towel had a heavy layer of black sludge from the drain; however, the drain remained soiled with the black sludge. The west hall common area double basin and handwash sink in the food preparation area was heavily soiled with a heavy buildup of black sludge in the drain. The double basin sink had a heavy film of brown buildup around the outer rim of the drain flange and a buildup of blackened sludge in the sink drain. The handwashing sink had a heavy tarry buildup of black matter inside the white drain pipe. The hand washing sink outside of the south staff bathroom had a moderate amount of brown buildup in the drain around the sink drain flange. The sink in the rehabilitation therapy room had a thickened layer of black buildup in the drain and a heavy buildup of green chalky buildup on the skin faucet where the water comes out. The hand washing sink in the east hall nurses cart area had a buildup of brown staining and sludge on the sink drain stopper and blackened buildup inside of the drain. In addition the drain was extremely slow to drain. Sink drains in the residents' rooms had a mild buildup of brown sludge in the drains under the drain flange. D. Resident group interview A group of four alert and oriented residents (#22, #26, #67 and #68), deemed interviewable by assessment and the facility, were interviewed on 4/29/26 at 3:10 p.m. The residents said the facility had problems with sewage back up about six to seven months ago, in the winter months, and had to make repairs to improve drain flow. E. Staff interviews HK #1 was interviewed on 4/29/26 at 10:38 a.m. HK #1 said each resident's room was cleaned daily, including the resident's sink. He said the sinks were to be sprayed with a cleaning solution and then (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide written notification of room changes and roommate changes for one (#62) of two residents reviewed for notifications out of 35 sample residents.Specifically, the facility failed to provide timely written and/or verbal notification of room and/or roommate changes to Resident #62 and/or the resident's representatives.Findings include:I. Facility policy and procedureThe Room Change and Roommate Assignment policy, dated November 2025, was provided by the nursing home administrator (NHA) on 4/30/26 at approximately 12:32 p.m. The policy read in pertinent part, Resident room or roommate assignments may change if the facility deems it necessary. Resident preferences are considered when roommate changes are necessary. Prior to changing a room or roommate assignment, all parties involved in the change/assignment (residents and their representatives) are given at least a 24-hour advance written notice of the change. Documentation of a room change is recorded in the resident's medical record.II. Resident #62A. Resident statusResident #62, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included adult failure to thrive, chronic respiratory failure and cerebral infarction (stroke). The 2/13/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The resident required substantial maximal assistance from staff for all activities of daily living (ADL).B. Resident interviewResident #62 was interviewed on 4/27/26 at 10:05 a.m. Resident #62 said she had moved rooms three or four times and she was upset about this because she had missing items after the room changes. She said she was not provided anything in writing or provided with any verbal notice prior to her room changes.Cross-reference F585 for failure to resolve grievances. C. Record review-Review of Residents #62's electronic medical record (EMR) revealed documentation to indicate the resident or the resident's representative was verbally informed the resident was changing rooms.The alert note, dated 3/28/26 at 12:16 a.m., documented Resident #62 was on alert charting for a room change and had adjusted well. She was pleasant with her roommate at that time and no verbal outbursts were noted. All of the resident's needs were met.The alert note, dated 3/28/26 at 1:52 p.m., documented Resident #62 was on alert charting for a room change and had adjusted well. She was pleasant with her roommate at that time.The alert note, dated 3/28/26 at 9:36 p.m., documented Resident #62 was possibly not doing well with the room change. The resident's roommate had complaints of Resident #62 yelling at her and being belligerent. Staff would continue to monitor.The Room and/or Roommate Change Authorization Notification form, dated 5/14/25, revealed a verbal okay was obtained from the resident's representatives to move Resident #62 from her room on the 100 hall to a room on the 400 hall for maintenance concerns. The form documented consent was given verbally and was signed by the social services director (SSD).-However, there was no documentation in Resident #62's EMR to indicate the facility provided the resident or the resident's representative with a copy of the room change form.The Room and/or Roommate Change Authorization Notification form, dated 2/17/26, revealed a verbal okay was obtained from the resident's representatives to move Resident #62 from the room on the 400 hall back to her room on the 100 hall or maintenance concerns. The form documented consent was given verbally and was signed by the social services director (SSD).-However, there was no documentation in Resident #62's EMR to indicate the facility provided the resident or the resident's representative with a copy of the room change form. The Room and/or Roommate Change Authorization Notification form, dated 3/27/26, revealed a verbal okay was obtained from the resident's representative to move Resident #62 from her room on the 100 hall to a different room on the 100 hall for maintenance concerns. The form documented consent was given verbally and was signed by the social services director (SSD).-However, there was no documentation (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in Resident #62's EMR to indicate the facility provided the resident or the resident's representative with a copy of the room change form.III. Staff interviewsThe SSD was interviewed on 4/30/24 at 10:45 a.m. The SSD said a room change authorization form should be filled out for each resident room change or when a resident got a new roommate. She said the form included a verbal consent from the family to move the residents. She said residents were informed of the move. She said she was responsible for completing room change forms. The SSD said that there were written room changes or new roommate authorization forms completed for Resident #62. She said she had no other documentation to show Resident #62 was informed of the moves.-However, the room change forms indicated by the SSD did not reveal documentation that Resident #62 or her representative had received a copy of the room change forms. The NHA was interviewed on 4/30/26 at 6:10 p.m. The NHA said residents and their representatives were provided a copy of the room change form and agreed upon the move. The NHA said residents' representatives received a copy of the room change form when the residents were not cognitive enough to make decisions. The NHA said the facility received verbal consents from representatives when the decision was made by the representative. The NHA said Resident #62's representatives were notified of the resident's room changes. She said she had no documentation to show the resident was informed of the room changes.-However, the room change forms indicated by the SSD did not reveal documentation that Resident #62 or her representative had received a copy of the room change forms.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#38) of five residents out of 35 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #38 from physical abuse by Resident #3.Findings include: Record review, observations and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/27/26 to 4/30/26, resulting in the deficiency being cited as past non-compliance with a correction date of 2/5/26.I. Incident between Resident #38 and Resident #3 on 1/31/26On 1/31/26 at approximately 1:30 p.m. registered nurse (RN) #2 heard a commotion in the hallway, outside the room of Resident #3. RN #2 witnessed Resident #3 hit Resident #38, causing Resident #38's lip to bleed. The two residents were immediately separated from each other and placed on frequent checks. Resident #38 had a small laceration to the middle of her upper lip and a small bruise below her lower lip. II. Facility plan of correctionThe plan of correction the facility put in place in response to the physical abuse incident between Resident #38 and Resident #3 was provided by the NHA on 4/29/26 at approximately 3:00 p.m.The plan read: A. Immediate action to correct the deficient practice The plan of correction, dated 1/31/26, identified the facility's noncompliance concern was related to staffing levels. The plan documented corrective actions taken to correct the noncompliance included education to nurse management on appropriate staffing levels on the memory care unit and medication changes for pain reviewed care planned and updated for Resident #3 and Resident #38. B. Systematic changesEducation was provided to all nurse management and the staffing coordinator on 2/5/26 to ensure appropriate staffing levels included two licensed certified nurse aides (CNA) on the memory care unit on the day shift and the evening shifts and the availability of the on-call nurse until appropriate coverage was met.C. MonitoringThe staffing team, which included the nursing home administrator (NHA), the director of nursing (DON), the assistant director of nursing (ADON), the staff development coordinator , the memory care director, the human resource director and the staffing coordinator, met and reviewed the staffing needs for each day, week and weekend. A daily audit (Monday through Friday) addressing any staffing needs was implemented. A monthly review of staffing levels and needs would be reviewed in the facility's quality assurance and performance improvement (QAPI) meeting every one to three months.III. Facility policy and procedureThe Abuse policy, dated 5/3/23, was provided by the nursing home administrator in training on 4/28/26 at 11:24 a.m. The policy read in pertinent part, (The facility) does not condone resident abuse and will take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident symptoms. Providing a safe environment for the resident is one of the most basic and essential duties of our facility.IV. Incident of physical abuse of Resident #38 by Resident #3 on 1/31/26A. Facility investigationThe facility investigation provided by the nursing home administrator (NHA) on 4/29/26 at approximately 3:00 p.m. The investigation documented RN #2 heard a commotion in the hallway, outside the room of Resident #3 on 1/31/26 at approximately 1:30 p.m. The nurse witnessed Resident #3 hit Resident #38, causing Resident #38's lip to bleed. The residents were immediately separated from each other and placed on frequent checks. According to the investigation, Resident #38 had a small laceration to the middle of her upper lip and a small bruise below her lower lip. The investigation documented 15-minute checks for Resident #3 and Resident #38 were initiated on 1/31/26 after the incident. The 15-minute checks continued through 2/2/26. The investigation included statements (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from staff members working on the memory care unit on 1/31/26. RN #2's statement identified that she was near her medication cart when she saw Resident #38 standing outside Residents #3's room. She went to the residents in an attempt to separate them but could not get there in enough time before Resident #3 hit Resident #38. According to the statement, RN #2 saw both residents near her cart a few minutes prior to the incident and there was no concern at that time. Activity assistant (AA) #1's statement identified that AA #1 was at lunch at the time of the incident and did not witness the altercation. According to the statement, she felt resident pain could have caused increased agitation, contributing to the altercation. CNA #3's statement identified that CNA #3 was charting in the dining area and did not witness the incident. The statement indicated that CNA #3 felt there were no concerns with either Resident #38 or Resident #3 prior to the incident as CNA #3 had seen both residents five minutes earlier. The statement documented CNA #3 stated it was hard when there were not two CNAs on the memory care unit.The investigation summary identified both Resident #38 and Resident #3 could have been experiencing an increase in pain leading up to the altercation. The residents were frequently monitored and residents were redirected from Resident #3's room. According to the summary, Resident #3 was very protective of her room. Resident #3 was care planned to have a velcro stop sign across her doorway or her door closed to help deter other residents from going into her room. However, Resident #3 would often not allow the sign up or the door closed. The investigation summary addressed the need for the medication cart and the charting area to be closer to Resident #3's room for increased monitoring of the resident. The medications were reviewed and adjusted for both residents related to pain/discomfort as potential contributing factors to the incident. The investigation documented that the memory care unit staff were educated on 2/3/26 regarding person-centered care, after the altercation. Pertinent members of the interdisciplinary team (IDT) were provided education on 2/5/26 related to ensuring two CNAs were present/scheduled on the memory care unit during the day and evening shifts. According to the education, the on-call nurse would be utilized as necessary until coverage was found. Review of the investigation identified the facility substantiated the abuse. B. Resident #38 (victim)1. Resident statusResident #38, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included vascular dementia, severe, with agitation, Alzheimer's disease unspecified, neurological disorder with Lewy bodies disease, bipolar disorder and chronic pain. The 4/16/26 minimum data set (MDS) assessment identified Resident #38 exhibited short and long term memory problems, inattention and disorganized thinking. She had hallucinations, delusions and physical and verbal behaviors directed towards others.The staff assessment for mental status indicated the resident's cognition was moderately impaired with impaired decision making. The resident required supervision and cues. The MDS assessment indicated Resident #38 was independent with her mobility.2. Record reviewThe wandering and elopement care plan, revised 3/31/26, identified Resident #38 was at risk for wandering related to Alzheimer's disease, but was pleasantly confused and could be easily redirected. Interventions, initiated 1/9/24, directed staff to identify patterns and purpose of wandering, offer pleasant diversions, structured activities, food, and reorientation strategies. The dementia care plan, revised 3/31/26, documented Resident #38 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Interventions included directing staff to offer toileting or assessing the resident for pain if she appeared agitated and providing pain medication as ordered (initiated 2/3/26). The interventions indicated staff should offer toileting and fluids frequently due to her history of constipation that contributed to her urinary retention (revised 2/5/26). According to the interventions, Resident #38 became agitated when she was retaining urine or constipated, causing pain/discomfort with cystocele/prolapse (dropping of the bladder) requiring staff to monitor for the signs and symptoms (initiated 3/5/26). The dementia care plan further identified that Resident #38 would become agitated; she could become loud, disrupting the environment. Interventions included offering to take her to her room to sit in her recliner to calm and reset her mood, if she continued to escalate, staff should offer (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to calmly sit with her (initiated 3/13/26). The 1/31/26 nurse progress note documented Resident #38 was involved in a resident-to-resident altercation with another resident (Resident #3). The residents were separated and Resident #38 was placed on frequent checks. The physician and the resident's representative were notified and an investigation was initiated.The 2/1/26 nurse progress note documented Resident #38 was on alert charting to monitor related to a resident-to-resident altercation on 1/31/26. The note documented the resident had a small bruise to her mid-lower lip and her skin was intact. According to the note, 15-minute checks were in place and non-interviewable charting was completed. The note indicated staff monitored her whereabouts and assisted in keeping her away from the other resident's (Resident #3) bedroom to avoid confrontations. C. Resident #3 (assailant) 1. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included vascular dementia, severe with agitation, memory deficit following other non-traumatic intracranial hemorrhage, and depressive disorder recurrent, moderate. The 4/30/26 MDS assessment documented Resident #3 exhibited short and long term memory problems, and fluctuating disorganized thinking. The staff assessment for mental status indicated the resident was moderately impaired in cognition, poor decision making and required supervision and cues. According to the MDS assessment, the resident had verbal behaviors directed toward others, could significantly intrude on the privacy or activity of others and disrupt care or living environment.2. ObservationsObservations during the survey period identified Resident #3's velcro stop sign was frequently across her doorway, staff were redirecting residents away from Resident #3's room. Additionally, staff were requesting, and receiving, other staff members on the memory care unit to assist in the supervision of residents whereabouts when both memory care unit CNAs were providing care in residents' rooms. 3. Record reviewThe behavior/dementia care plan, revised 3/11/25, documented Resident #3 had impaired cognitive function/impaired thought processes related to dementia. She had verbal aggression of yelling/screaming and physical aggression, including hitting. Additional behaviors included refusal of care, being withdrawn, tearfulness/crying and negative statements. Interventions included assessing for pain (initiated 2/5/26) and keeping the resident's door closed when she refused to have her stop sign up in her doorway (revised 2/5/26). However, according to the care plan, Resident #3 would often decline for her door to be closed so staff should help redirect other residents away from her room (revised 2/5/26). The care plan identified Resident #3 was protective of her room and would become upset if others entered or tried to enter the room.The 1/31/26 alert note documented Resident #3 was on alert charting due to a resident-to-resident altercation. According to the note, the resident was pleasantly confused with no noted injury.The 2/2/26 nursing note documented Resident #3 continued on alert charting related to the altercation on 1/31/26. According to the note, Resident #3 had decreased agitation on 2/2/26. The staff monitored her for signs of pain and offered activities and personal care when she was distressed. The note identified Resident #3 was refusing to allow staff to replace the stop sign to the doorway of her room and would not allow the nurse to apply analgesic gel to her contracted hand. However, 15-minute checks were continued and the other resident involved in the altercation (Resident #38) was removed from areas near Resident #3.V. Staff interviewsThe NHA was interviewed on 4/30/26 at 12:57 p.m. The NHA said Resident #3 hit Resident #38 (on 1/31/26) and the investigation determined physical abuse was substantiated. She said RN #2 witnessed the incident, but was not able to separate the residents before Resident #38 was hit. The NHA said Resident #3 did not like people in her room but she would often take down the stop sign that helped deter other residents from entering her room. The NHA said pain was a factor for both residents. The NHA said Resident #38 had difficulty communicating her needs and time and the staff determining her needs related pain, constipation, and urinary retention. The NHA said staff should assess the resident for pain related to constipation and urinary retention. She said the pain medication ordered for Resident #38 increased her constipation. The NHA said Resident #3 had pain related to her hand contracture but would often refuse interventions. She said pain could have contributed to Resident #3's agitation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 1/31/26. She said the nurse practitioner reviewed the residents' medication management with new treatment orders implemented following the incident. The NHA said staff were educated on person-centered care after the incident between Resident #3 and Resident #38, to include behaviors and contributing factors.The NHA said the facility investigation identified there was one CNA and one nurse on the memory care unit at the time of the altercation. She said there were usually two CNAs scheduled on the memory care unit and she felt that the staffing levels in the unit on 1/31/26 was an isolated incident. She said there was a CNA who called in that day and the CNA had not been replaced in coverage. She said there should have been two CNAs scheduled on 1/31/26 so the facility implemented past non-compliance correction actions to include education with staff management to ensure appropriate staffing coverage daily for the memory care unit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure nursing staff followed physician's orders in accordance with professional standards of practice for one (#61) of two residents out of 35 sample residents.Specifically, the facility failed to ensure physician's orders for the settings on Resident #61's alternating air mattress was monitored and set properly for effective pressure relief.Findings include:I. Facility policy and procedureThe Medication and Treatment Orders policy, undated, was provided by the nursing home administrator in training on 4/30/26 at 6:34 p.m. The policy read in pertinent part, Orders for medications and treatments will be consistent with principles of safe and effective order writing.II. Resident #61A. Resident statusResident #61, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included paraplegia, west nile infection, muscle weakness, acute respiratory failure and chronic pain syndrome. The 2/5/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment indicated the resident was dependent on staff assistance for completing all care. B. Resident observations and interviewsOn 4/27/26 at 10:18 a.m. was lying in bed. Resident #61's air mattress was observed to be set to 350 pounds of pressure. -However, per the physician's orders, the resident's air mattress was to be set to 150 pounds of pressure (see physician's orders below).Resident #61 said she was comfortable lying in her bed, but her mattress pinched her when the head of the bed was in an upright position and made her uncomfortable. She said it was important to have a nurse reposition her approximately every hour before pain set in or the pain could become excruciating and intolerable. Resident #61 said the facility gave her the mattress to prevent pressure sores; however the mattress recently failed and deflated and she was left lying on the metal frame, which was very uncomfortable. She said it took a long time for the maintenance director (MTD) to fix and reinflate the mattress. On 4/28/26 at 9:01 a.m. Resident #61's air mattress was observed to be set at 350 pounds of pressure.On 4/29/26 at 4:17 p.m. Resident #61's air mattress was again observed to be set at 350 pounds of pressure.On 4/30/26 at 10:05 a.m. Resident #61's air mattress was observed to be set at 150 pounds of pressure. The resident said her bed was more comfortable now that the mattress and air pump had been replaced (see staff interviews below).On 4/30/26 at approximately 3:53 p.m. Resident #61's air mattress pump was observed to be labeled with the physician-ordered settings and directions to not change the settings from 150 pounds of pressure.C. Record reviewReview of Resident #61's April 2026 CPO revealed the following physician's order: Alternating pressure mattress to bed. Set at 150 pounds of pressure. Check the mattress every shift for proper setting and function. Air mattress to improve circulation and help with skin itchiness, ordered 1/20/26.Review of Resident #61's April 2026 treatment administration record (TAR), from 4/1/26 to 4/29/26 revealed that nurses were signing off each shift that the resident's air mattress was on the proper settings and functioning properly. -However, observations during the survey revealed the air mattress settings were incorrect and the nurses were not able to accurately explain the settings and process for monitoring of the mattress (see observations above and interviews below). III. Staff interviewsRegistered nurse (RN) #3 was interviewed on 4/29/26 at 4:33 p.m. RN #3 said she was not sure of the correct mattress settings for Resident #61's air mattress. She said the maintenance director (MTD) set the controls on the residents' air mattresses and she would find out the answer.The MTD and the director of nursing (DON) were interviewed together n 4/29/26 at 4:41 p.m. The MTD said that an outside durable medical equipment (DME) vendor installed and set up the residents' air mattresses and ensured the beds were set at the proper settings. The MTD said he was not sure how the facility could tell what the air flow on the mattresses was supposed to be set to and he did not know if there were physician's orders for guidance. He said the air mattress settings should be set based on the resident's weight and after the resident was on the air mattress, the staff (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could increase the pressure setting to make sure the mattress stayed inflated.The DON said that she would have to look into Resident #61's physician's orders to see if they included setting orders for the air mattress. The MTD said he was having problems keeping some of the air mattresses inflated. He said he just took one out of a room today (4/29/26) that was not working properly. He said that he was not aware of any issues with Residents #61's air mattress until he was alerted of the problem today (4/29/26).The MTD said he understood a properly inflated air mattress was necessary to prevent bed sores. RN #4 was interviewed on 4/30/26 at 10:27 a.m. RN #4 said Resident #61's air mattress was to be set based on her weight. She said that currently, the mattress was set to 150 pounds of pressure, which was equal to the resident's current weight. She said that if the resident weighed more, she would just change the air flow based on her weight. RN #4 said she was unsure if Resident #61 had physician's orders for the mattress settings. She said she knew there was something in the TAR about the resident's air mattress, but she did not know exactly what the orders were. She said that having the mattress at the proper setting for the resident's weight was important to prevent skin break down. She said she would have to refer back to the TAR for more information.The MTD was interviewed again on 4/30/26 at 10:33 a.m. The MTD said on 4/29/26, he discovered that the electric pump for Resident #61's mattress was not working properly. He said he replaced the pump and the resident's air mattress seemed to be working better. He said he was not sure how long the mattress had not been working properly and could not guess. The nursing home administrator (NHA) was interviewed on 4/30/26 at 10:35 a.m. The NHA said she was educating nursing staff to monitor the settings of each resident's air mattress and to report functional failures and changes in the mattresses. She said that the facility was looking at other mattress options as they continued to fix existing problems with the air mattress in the facility. The DON was interviewed again on 4/30/26 at 5:17 p.m. The DON said Resident #61's air mattress had continued to malfunction, so a new air mattress was ordered and was being installed today (4/30/26).