STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065356	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Colorado Springs	2490 International Cir Colorado Springs, CO 80910

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#18) of three residents reviewed for accidents out of 44 sample residents received adequate supervision to prevent accidents. Resident #18 was admitted to the facility on [DATE] with diagnoses of traumatic subdural hemorrhage (bleeding near the brain) with loss of consciousness status unknown, seizures, generalized muscle weakness, cognitive communication deficit, unspecified dementia and history of falls. Resident #18 was identified as a high fall risk. On 11/26/25, Resident #18 sustained an unwitnessed fall. The facility recommended implementing care plan interventions which included a call light within reach, orienting Resident #18 to his room, assisting the resident with activities of daily living (ADL), keeping the resident's bed in the lowest position, floor mats to side of the resident's bed and offering Resident #18 frequent toileting. -However, observations during the survey revealed the resident's bed was not in the lowest position and the fall mats were not at the resident's bed side. Resident #18 sustained an additional unwitnessed fall on 12/9/25, where he hit his forehead and jaw. The resident was transferred to the hospital and received glue to his forehead laceration. Upon return from the hospital, the facility recommended implementing a personal urinal to be within reach of the resident at all times. -However, observations during the survey revealed the resident did not have his personal urinal within reach. Specifically, the facility failed to ensure person-centered fall interventions were consistently implemented for Resident #18, who sustained multiple falls, including a fall with injury that required transport to the hospital for treatment of a forehead laceration.Findings include: I. Facility policy and procedureThe Fall Management policy, revised 3/11/25, was provided by the director of nursing (DON) on 2/26/26 at 2:16 p.m. It revealed in pertinent part, The facility will assess the resident upon admission, readmission, quarterly, with change in condition, and with any fall event for any fall stocks and will identify appropriate interventions to minimize the risk of injury related to falls. Fall refers to unintentionally coming to rest on the ground, or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Risk refers to any external factor, facility characteristic (staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident. Supervision/Adequate Supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed This determination is based on the individual resident's assessed needs and identified hazards in the residents environment.II. Resident #18A. (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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident statusResident #18, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included traumatic subdural hemorrhage with loss of consciousness status unknown, seizures, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and a history of falling. The 1/14/26 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. He required partial/moderate assistance with most of his activities of daily living (ADL).The MDS assessment revealed the resident had difficulty with focusing his attention. The behavior was present but fluctuated during the assessment look-back period.The MDS assessment revealed the resident had two or more falls without injury and one fall with injury since his time of admission to the facility. B. Observations On 2/24/26 at 2:54 p.m. Resident #18 was sitting in his wheelchair in his bedroom. Resident #18 was leaning forward out of his wheelchair, reaching towards the ground. Resident #18 began resting his head on the tray table in front of him. Resident #18's body began to fall forward out of the wheelchair and his legs began to buckle. Registered nurse (RN) #4 was sitting directly across the hallway at the nurses' station from Resident #18's room, however, she was not paying attention to Resident #18.At 2:56 p.m., upon prompting, RN #4 entered Resident #18's room and asked Resident #18 what he was doing. Resident #18 said he was trying to throw something away. Resident #18 was still bent forward out of his wheelchair. RN #4 had to physically intervene to assist Resident #18 back to an upright and safe sitting position. RN #4 provided a verbal reminder and educated the resident on the importance of using his call light when he needed help in his room. Resident #18 said he wanted to lay down. RN #4 told Resident #18 she would go find some certified nurse aides (CNA) to help assist him back into bed. RN #4 placed the resident's oxygen back on him and pushed the call light, remaining with the resident. At 2:59 p.m. CNA #11 answered Resident #18's call light. RN #4 told CNA #11 Resident #18 wanted to lay down and instructed CNA #11 to stay with the resident while she went to get a sit-to-stand lift. CNA #12 was coming down the hall and RN #4 asked her to assist them with Resident #18's transfer from his wheelchair to his bed.On 2/26/26 at 2:06 p.m. Resident #18 was sleeping in his bed. Resident #18's bed was not in the lowest position, his floor mats were not in place by the bed and his personal urinal was not within reach. -However, Resident #18's care plan revealed his bed was to be in the lowest position, his personal urinal was to be within reach at all times and the floor mats were to be placed at the bed side to prevent Resident #18 from falling (see record review below). C. Record review1. Care plan The fall care plan, revised 12/10/25, identified Resident #18 was at risk for falls related to impaired mobility, history of falls, impaired vision, seizures and psychotropic medication use (medications that affect behavior, mood, thoughts, or perception). Pertinent interventions (revised 12/10/25), included ensuring the resident's call light was within reach, assisting the resident with ADLs as needed, providing adaptive equipment or devices as needed, completing a fall risk assessment and orienting the resident to his room. The actual fall care plan, revised 1/23/26, identified Resident #18 had multiple falls since his time of admission, with one fall resulting in an injury. Pertinent interventions (revised 1/23/26), included ensuring the resident' bed was in the lowest position at all times (initiated 11/28/25), clipping the call light onto the resident's clothing within his reach and vision, encouraging the resident to use the urinal for urgent episodes, ensuring the resident's personal urinal was within reach at all times, placing floor mats to the sides of the bed, providing a lipped mattress and moving the resident to a room directly across from the nurses station-However, observations revealed person-centered fall interventions were not consistently implemented for Resident #18 (see observations above). 2. Fall on 11/22/25 - unwitnessed The 11/22/25 nursing progress (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	note, documented at 1:45 p.m., revealed Resident #18 was found on the bathroom floor. Resident #18 was on the floor in the middle of the bathroom sitting upright. Resident #18 did not complain of pain and no apparent injuries were assessed by the RN. Root cause analysis was related to gait imbalance and a new intervention was implemented to offer Resident #18 frequent toileting. 3. Fall on 11/24/25 - witnessed The 11/24/25 nursing progress note, documented at 1:47 p.m., revealed Resident #18 was attempting to walk with his friend. The occupational therapist (OT) assisted the resident to the floor and notified the RN. Resident #18 was wearing his personal clothing with his shoes on. Resident #18 was educated by the RN and the OT about supervised walking with authorized personnel only and safe transferring. A CNA said she had also educated the resident on this prior to the witnessed fall. No injuries were assessed.-The progress note did not indicate what the root cause of the fall was or if the resident's fall interventions were reviewed to determine if the interventions were effective or if a new fall interventions were needed.4. Fall on 11/26/25 - unwitnessedThe 11/26/25 nursing progress note, documented at 8:09 p.m., revealed Resident #18 was seen by the nurse at 5:00 p.m. sitting in his wheelchair watching television. The director of nursing (DON) was walking past and saw Resident #18 had his call light on. The DON walked in to the resident's room and found Resident #18 sitting on the floor with his legs facing the sink and his wheelchair behind him. Resident #18 said he was trying to get his cell phone off the charger so he could put it away in the dresser drawer. Resident #18 was wearing non-skid socks at the time of the fall. The call light was pulled out of the wall socket and on the floor. The nurse completed the initial assessment with no obvious injuries and Resident #18 denied any pain. Resident #18 was assisted back into his wheelchair.-The progress note did not indicate what the root cause of the fall was or if the resident's fall interventions were reviewed to determine if the interventions were effective or if a new fall interventions were needed. 5. Fall on 12/1/25 - unwitnessedThe 12/1/25 nursing progress note, documented at 1:30 a.m., revealed Resident #18 was found on the floor in his room. Resident #18 said he rolled out of bed. Resident #18 said he did not hit his head and he landed on the fall mat. No pain was noted and the nurse completed an assessment before assisting the resident from the floor. Resident #18 was repositioned and changed in bed. The wedges and fall mats were put in place on both sides of the resident. The bed was placed in the lowest position and the resident's call light was within reach. -The progress note did not indicate what the root cause of the fall was or if the resident's fall interventions were reviewed to determine if the interventions were effective or if a new fall interventions were needed.6. Fall on 12/6/25 - unwitnessed The 12/6/25 nursing progress note, documented at 3:15 a.m., revealed Resident #18 was found sitting on the floor. The resident said he fell from the low bed. Resident #18 was assessed for injury and none were noted. Root cause analysis determined the cause of the resident's fall was toileting urgency due to a possible urinary tract infection (UTI). A urine sample was collected to verify a UTI and was sent out to validate. The 12/5/25 nursing progress note, documented at 7:09 p.m., revealed a stat (immediate) urinary analysis (UA) was collected from Resident #18 via clean catch. The urine sample was in the dirty utility refrigerator awaiting laboratory (lab) pickup. The lab was notified by the charge nurse on duty.7. Falls on 12/9/25 (two falls) - one witnessed fall and one unwitnessed fallThe 12/9/25 nursing progress note, documented at 2:17 p.m., revealed Resident #18 attempted to get out of his bed unassisted. Resident #18 was seen by the OT as he fell onto his right elbow without hitting his head. Resident #18 reported a 1 out 10 for pain to his right elbow. A head to toe assessment was performed and no injuries were noted. The nurse educated Resident #18 again, regarding the importance of calling for assistance. Resident #18 verbalized his understanding. Staff assisted the resident to the toilet before returning to bed. The 12/9/25 nursing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	progress note, documented at 7:24 p.m., revealed a loud thud was heard from Resident #18's room around 6:40 p.m. by surrounding staff. The CNA notified the nurse Resident #18 was bleeding. The RN walked over and saw the resident on the floor with his back towards the wall adjacent to the door with his feet towards the bathroom door. Resident #18 was attempting to sit up. Resident #18 was wearing his personal clothing and personal shoes. Blood was observed coming from the resident's right side of his face and top of his scalp. Resident #18 said he was attempting to empty his urinal and wanted to clean the mess up himself. No mess described by the resident was observed on the floor surrounding Resident #18. It was possible the resident mistook making a mess as he used a different urinal provided by his friend that evening and Resident #18 had impaired vision. Resident #18 did not utilize his call light for assistance. The resident was assessed by the nurse and then assisted by staff back into his wheelchair. Resident #18 was assessed for injuries after clearing away blood. The resident's right side of his forehead revealed a laceration, as well as a laceration to the right side of his jaw. Resident #18 said he had a 2 out of 10 for pain. Resident #18 was sent out to the hospital for evaluation and treatment. The resident required stitches and imaging for his head.8. Fall 12/10/25 - unwitnessed The 12/10/25 nursing progress note, documented at 10:17 p.m., revealed Resident #18 was found in bed but called the staff to alert them that he had slid from the bed and gotten himself back into bed. Resident #18 denied hitting his head, experiencing any new pain, or new injuries. The resident was assessed by the nurse. During the resident's neurological assessment, the nurse discovered Resident #18's heart rate and blood pressure were changing dramatically, and Resident #18 was having increased slurred speech. The nurse practitioner (NP) was present at the facility and evaluated the resident. An physician's order was placed to send Resident #18 to the hospital for further evaluation. Resident #18 was determined to be stable and sent back to the facility. 9. Fall 12/16/25 - unwitnessed The 12/16/25 nursing progress note, documented at 9:47 a.m., revealed Resident #18 sustained a fall while in the shower room. The nurse was alerted by a staff member and came to assess the resident. Resident #18 did not have any visible injuries and was alert and oriented. The resident said he was reaching to turn the water off and slid out of the shower chair onto the floor landing on his buttocks. Resident #18 was educated on the importance of asking for assistance and not to reach for objects out of his immediate reach. Resident #18 was also educated about this earlier in his room and the resident verbalized understanding at that time. Resident #18 was assisted back into the shower chair and taken back to his room. The CNA giving Resident #18 a shower had left the shower room, leaving the resident unattended for a few minutes during the incident. The CNA was educated on the facility's policy for leaving residents unattended during showers. The CNA verbalized understanding. -However during an interview with the DON (see interview below), it was revealed that Resident #18 should never be left alone in the shower room as he was a high fall risk and required high supervision to ensure the resident's safety. 10. Fall 12/31/25 - unwitnessedThe 12/31/25 nursing progress note, documented at 7:43 p.m., revealed Resident #18 was seen 10 minutes prior to his fall sitting in his wheelchair eating dinner. The resident had finished eating his dinner and wanted to get into bed. Resident #18 could not find his call light. The call light had fallen behind the left side of his wheelchair arm rest and was wrapped around the wheel. Resident #18 was wearing non-skid socks but the socks did not grip the floor to help with traction, and the resident fell to his buttocks. The bed was to the resident's left and the wheelchair was on his right. Resident #18 denied any injury or pain. Resident #18 said he was looking for the call light to call for help. The nurse assessed Resident #18 and determined no injuries were noted at this time. The resident was assisted to bed, ensuring the call light was clipped to the resident's shirt. Resident #18 was educated on safety (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	awareness and calling for assistance. 11. Fall 1/19/26 - unwitnessedThe 1/19/26 nursing progress note, documented at 6:36 p.m., revealed the nurse was notified by a CNA that Resident #18 was on the floor. The nurse went into the resident's room to assess the resident and Resident #18 was found in the bathroom with his back leaning against the wall. The resident was wearing long sleeves, a sweater, non-skid shoes, and his brief and sweatpants were around Resident #18's knee's. The resident said he was transferring from the toilet to the wheelchair without staff assistance and slipped when the wheelchair was not locked. A head to toe assessment was performed and no visible injuries were noted. The resident denied pain or injuries at the time of the assessment. Resident #18 was transferred back to his wheelchair. The call light was clipped to the resident. III. Staff interviews CNA #7 was interviewed on 2/26/26 at 9:08 a.m. CNA #7 said Resident #18 was very impulsive when he first arrived at the facility. CNA #7 said the resident was falling all the time; however, Resident #18 had not been falling as much lately. CNA #7 said Resident #18 had been declining recently and he was unable to stand on his own currently CNA #7 said some interventions for Resident #18 would be to keep close supervision on him. CNA #7 said if she saw Resident #18 trying to get up out of his wheelchair, she would ask the resident if he needed assistance with something. CNA #7 said up until recently, Resident #18 was good at communicating his needs. CNA #7 said if she saw Resident #18 put his feet out of the bed or if he put a leg out, that was a good indicator the resident needed to use the bathroom. CNA #7 said the resident was not on a toileting schedule, but said when she was working she toileted Resident #18 every two hours.The DON was interviewed on 2/26/26 at 2:16 p.m. The DON said accidents and hazards were defined by choking, falls with major injury, elopements, burns, leaving the facility against medical advice, and abuse and neglect. She said, depending on the incident, the procedure would be for the nurses to begin documentation by immediately completing a risk assessment. She said if the event was witnessed, then staff were to take statements from the resident and anybody else involved. The DON said making necessary notifications to the provider and family would be next as part of the investigation process. The DON said the root cause analysis of an incident was important because it helped to determine the cause of the incident and how to treat immediately to ensure the incident did not happen again. The DON said the facility put a lot of interventions in place to prevent Resident #18 from falling. The DON said Resident #18 was very impulsive due to his diagnoses. The DON said Resident #18 scored high on his BIMS assessment; however, his safety awareness was not present. The DON initially recalled the CNA was in the shower room with the resident at the time of the 12/16/25 fall. However, once she reviewed the 12/16/25 event progress note, the DON discovered that the CNA had left Resident #18 alone in the shower room. The DON confirmed the CNA was outside of the shower room for a few minutes. The DON said a resident was allowed, per the facility policy, to be left alone in the shower room only if a resident was alert and oriented. She said an alert and oriented resident did not have to be attended in the shower room, but staff was to check on the resident every five minutes. The DON said the CNA was educated on 12/16/25 by the RN. The DON said a resident with a diagnosis of high falls should not be unattended in the shower room. The DON said post-fall, the RN on duty should complete the head to toe assessment (skin, pain, fall, neuro's if the fall was unwitnessed) before doing anything else with the resident. The DON said the nurses should document this in a progress note. The DON said the licensed practical nurses (LPN) could complete the initial assessment of the fall, but the RN had to be the one who completed the head to toe assessment.The DON said on the days Resident #18 had multiple falls, there was nothing more the facility could do, and the DON said she started calling staff to come and provide one-to-one supervision with Resident #18. The DON said that was why there was a significant decrease in his falls after 12/10/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The DON said the resident's family also hired a private sitter to come in and sit with Resident #18 on the days the resident's wife could not make it or family and friends were not available. The DON said the facility attempted to offer Resident #18 a soft helmet and busy board, but his wife did not want either of those for dignity reasons. The DON said the facility arranged an appointment for the resident to see the neurological ophthalmologist. The DON said Resident #18 was complex and not appropriate for this setting. The DON said Resident #18's entire frontal lobe had been compromised and the resident was very impulsive as a result. The DON said residents had a right to fall and the facility had an obligation to try to keep the residents as safe as possible. The DON said the facility completed a high risk audit on all the residents that were high fall risks. She said the environmental audits were completed by the DON or unit manager. The DON said on grand rounds they asked staff who they thought was going to fall next, and any concerns about residents falling. The DON said CNAs could find a resident's fall interventions on the Kardex (comprehensive care tool. The DON said RNs would find interventions on the residents' care plans. The DON said CNAs did walking rounds, and fall huddles were done with all the staff. The DON said she created a fall binder back in December 2025 after the high volume of falls. The DON said the binder was placed at each nurses' station. She said the binder included a fall checklist which was a packet that each RN was to complete after a fall and give to the DON. The DON said the fall packet included a fall checklist, neurological assessment forms, resident and RN sign offs for interventions and education, and witness interview forms. The nursing home administrator (NHA) was interviewed on 2/26/26 at 6:45 p.m. The NHA said he was aware of Resident #18 being a high fall risk. The NHA said Resident #18 had a right to fall but he said he also knew the facility had a responsibility to ensure Resident #18's safety. The NHA said he was aware of Resident #18's impulsivity.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews the facility failed to ensure all drugs and biologics used in the facility were properly stored and labeled for one of four medications carts reviewed for storage and labeling. Specifically the facility failed to ensure over the counter (OTC) medications were discarded after the expiration date. Findings include:I. Facility policy and procedureThe House Stock Items policy, revised 9/15/24, was provided by the director of nursing (DON) on 2/25/26 at 4:05 p.m. It read in pertinent part, The facility should post the house stock medication list in an appropriate location such as medication rooms or a medication administration binder. The facility should ensure that house stock medications are stored in the original manufacturer's container. The medication name, strength, expiration date and lot number should be clearly visible.II. ObservationsOn 2/24/26 at 5:01 p.m. the medication cart on the 300 east hall was observed with licensed practical nurse (LPN) #4. The following items were found:A bottle of OTC CoQ10 100 milligrams (mg) supplement had a manufacturer's expiration date of 1/24/26.A bottle of OTC Calcium 500 mg had a manufacturer's expiration date of 1/30/26. A bottle of OTC Acetaminophen 500 mg had a manufacturer's expiration date of 12/30/25.III. Staff interviewsRegistered nurse (RN) #4 was interviewed on 2/24/26 at 4:50 p.m. RN #4 said she had worked at the facility for approximately two years. She said she was trained to write the date of when the OTC medications were opened. She said she was trained by the facility to discard the OTC medications three months after the open date that was written on the bottle. LPN #4 was interviewed on 2/24/26 at 5:01 p.m. LPN #4 said she was unsure of whether OTC medications expired 30 days after opening or according to the manufacturer's expiration date on the bottle. She said she did not know where to locate the OTC storage and expiration policy for the facility. She said she was unsure why nursing staff were writing the open date on the OTC medication bottles. She said if the expiration date on the manufacturer's bottle had passed then the medication should be discarded. The director of nursing (DON) was interviewed on 2/24/26 at 5:38 p.m. The DON said the nursing staff were expected to reference the manufacturer's date on the OTC medication bottles. She said all the nurses were trained by other bedside nursing staff. She said the facility did not provide any specific training on medication expiration dates of medications, whether the medications were from the pharmacy or OTC medications. The DON said all nursing staff should be properly trained and demonstrate competency for nursing medication tasks prior to performing medication administration. The DON said this was important to maintain resident safety. She said expired medications should not be administered to residents for safety reasons because expired medications could make a resident very sick.

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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 observations, record review and interviews, the facility failed to meet all requirements for the provision of hospice care for one (#41) of two residents reviewed for hospice services out of 44 sample residents.Specifically, the facility failed to ensure hospice notes were readily accessible, the comprehensive care plan was developed with delineation of care responsibilities established between the facility and hospice and the most current care plan from hospice was available for Resident #41.Findings include:I. Facility policy and procedureThe Facility and Hospice Agreement, signed 11/30/17, was provided by the nursing home administrator (NHA) on 2/23/26 at approximately 3:00 p.m. It read in pertinent part, Each party shall prepare and maintain complete and detailed clinical records concerning each hospice patient receiving hospice services under this agreement in accordance with its usual record-keeping procedures, and as required by applicable federal and state law and regulations and applicable Medicare and Medicaid program guidelines. Each party shall retain such records as required by applicable federal and state law. Each such record shall document that the specified services are furnished in accordance with this agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party, in accordance with federal and state patient privacy laws. Hospice will document that hospice services are furnished in accordance with this agreement.II. Resident #41A. Resident statusResident #41, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician's orders (CPO), diagnoses included hypertensive heart disease (heart disease resulting from uncontrolled high blood pressure) with heart failure, palliative care and protein-calorie malnutrition.The 12/2/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively intact with a brief interview for mental status (BIMS) score of nine out of 15. Resident #41 used a wheelchair to ambulate and needed partial assistance with bathing.The MDS assessment indicated the resident was receiving hospice services.B. Record reviewReview of Resident #41's February 2026 CPO revealed a physician's order for hospice services, ordered 3/22/24.A review of Resident #41's electronic medical record (EMR) revealed the most recent plan of care from the hospice services team was active from 9/19/25 to 11/17/25.-There was no current plan of care from the hospice services team in the resident's EMR.A review of Resident #41's hospice care plan, initiated 3/8/24, revealed the resident was receiving hospice services. Interventions included working cooperatively with the hospice team to meet Resident #41's needs (revised 7/19/24).-Review of Resident #41's EMR failed to reveal clinical documentation from the hospice service team's routine visits to the resident.III. Staff interviewsRegistered nurse (RN) #2 was interviewed on 2/25/26 at 5:05 p.m. RN #2 said neither Resident #41's physical chart nor the EMR had the most recent copy of the hospice services team's care plan for the certification period starting 1/17/26. RN #2 said she was not surprised the hospice notes were not updated or in chronological order in the physical chart. RN #2 said the facility's system for ensuring hospice was providing services was for the hospice staff to check in with the facility's nurses or physician if they had any concerns about Resident #41. RN #2 said the hospice staff did not have to sign into the facility, and there was no system in place to ensure hospice staff fulfilled their weekly visits. RN #2 said all hospice certified nurse aides (CNA) came to the facility on Tuesdays and Thursdays and usually helped their residents with bathing at that time, but there was no formal system for hospice staff to chart or report what care they had provided for the residents.Licensed practical nurse (LPN) #3 was interviewed on 2/26/26 at 2:46 p.m. LPN #3 said she had seen the CNA from the hospice services company earlier in the day (2/26/26). LPN #3 said the hospice CNA checked in with her before (continued on next page)

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	065356	A. Building B. Wing	02/26/2026

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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. Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection on three of three units.Specifically, the facility failed to: -Ensure appropriate personal protective equipment (PPE) was worn by staff while providing care for Resident #11, Resident #9 and Resident #109, who were all on enhanced barrier precautions (EBP); and,-Staff performed appropriate hand hygiene during wound care for Resident #9.Findings include: I. Professional reference According to the Centers For Disease Control And Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), (4/2/24), retrieved on 3/2/26 , from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high-contact resident care activities. EBP may be indicated for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO. II. Facility policy and procedure The Infection Prevention and Control Program and Plan (IPCP) policy, revised 6/2/25, was provided by the nursing home administrator (NHA) on 2/23/26 at approximately 3:00 p.m. It read in pertinent part, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. Ensure associates follow the IPCP's standards, policies and procedures (hand hygiene and appropriate use of PPE) while other needs are specific to particular roles, responsibilities, and situations. III. Resident #11 A. Observations On 2/25/26 at 9:41 a.m. a sign posted outside of Resident #11's room indicated Resident #11 was on EBP. According to the resident's electronic medical record (EMR), the resident had MDRO in her urine. A small bin containing isolation gowns was under the sign outside the resident's room. Certified nurse aide (CNA) #5 entered Resident #11's room to perform incontinence care for the resident. (continued on next page)

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