STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 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 and interviews, the facility failed to store, distribute, and serve food in a sanitary manner in two of two kitchen refrigerators.Specifically, the facility failed to ensure nutritional beverages were labeled and dated when opened in the kitchen nourishment refrigerator and the walk-in refrigerator. Findings include:I. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 4/22/26 read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter 3-29).II. Facility policy and procedureThe Food Receiving and Storage policy and procedure, revised November 2022, was provided by the nursing home administrator (NHA) on 4/15/26 at 12:16 p.m. It read in pertinent part, All food stored in the refrigerators or freezers shall be covered, labeled and dated with used by date. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Beverages are dated when opened and discarded after twenty-four hours. III. ObservationsOn 4/13/26 at 8:50 a.m. the following was observed at the main kitchen nourishment fridge and the walk-in refrigerator during the initial kitchen tour and the follow-up observation.In the nourishment refrigerator the following was observed:One opened container of thickened apple juice that was not dated;One container of thickened orange juice that was not dated;One opened container of lemon-flavored thickened water that was not labeled;-One opened container of tomato juice that was not dated; and,-One opened container of unsweetened black tea that had a use-by date of 8/21/25.In the walk-in refrigerator, there was one opened sweet baby barbecue container that was undated.On 4/14/26 at 1:00 p.m. the following was observed at the main kitchen nourishment fridge and the walk-in refrigerator during the initial kitchen tour and the follow-up observation.In the nourishment refrigerator the following was observed:One opened container of thickened apple juice that was not dated;One container of thickened orange juice that was not dated;One opened container of lemon-flavored thickened water that was not labeled;-One opened container of tomato juice that was not dated; and,-One opened container of unsweetened black tea that had a use-by date of 8/21/25.In the walk-in refrigerator, there was one opened sweet baby barbecue container that was undated.On 4/15/26 at 12:21 p.m. the following was observed in the main dining room during lunch observation.During the lunch service, there was a container full of ice that had a gallon of milk, tomato juice and apple juice. The staff were serving these drinks to residents. The beverage containers were opened, but were undated.III. Staff interviewsDietary aide (DA) #2 was interviewed on 4/15/26 at 1:10 p.m. DA #2 said (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	all opened beverages should be dated and labeled, however did not know why they should be dated and labeled. She said she looks for the expiration date on the carton.The dietary manager (DM) was interviewed on 4/15/26 at 1:30 p.m. The DM said the kitchen staff should have all opened juice cartons dated and labeled to be aware of how long it has been opened to avoid distributing contaminated beverages to any resident. She said all kitchen staff and dietary aides were trained to understand the importance of labeling. She said the staff might have forgotten to label those beverages in the nourishment refrigerators. The DM said she would immediately provide education to the kitchen staff and dietary aides to ensure open beverages were labeled and dated properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for four (#4, #7, #22 and #2) of six residents reviewed for respiratory care out of 29 sample residents.Specifically, the facility failed to ensure that Resident #4, Resident #7, Resident #22 and Resident #2 received oxygen therapy in accordance with their physician's orders.Findings include: I. Professional reference According to Nursing Skills, Open Resources for Nursing (Open RN), Ernstmeyer K, [NAME] E, editors. Eau [NAME] (WI): [NAME] Valley Technical College; published 11/11/21, accessed on 4/20/26 from https://www.ncbi.nlm.nih.gov/books/NBK593208/, Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. (Chapter 11) Devices such as high flow oximetry masks, CPAP (continuous positive airway pressure), BiPAP (bilevel positive airway pressure), or mechanical ventilation may be initiated by the respiratory therapist or provider to deliver higher amounts of inspired oxygen. (Chapter 11) Manage oxygen therapy and equipment: If the patient is already on supplemental oxygen, ensure the equipment is turned on, set at the required flow rate, correctly positioned on the patient, and properly connected to an oxygen supply source. If a portable tank is being used, check the oxygen level in the tank. Ensure the connecting oxygen tubing is not kinked, which could obstruct the flow of oxygen. Feel for the flow of oxygen from the exit ports on the oxygen equipment. II. Facility policy and procedure The Oxygen Administration policy, revised October 2010, was provided by the nursing home administrator (NHA) on 4/15/26 at 11:41 a.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for safe oxygen administration. The general guidelines require verifying that there is a physician's order, reviewing the physician's orders, or the facility protocol for oxygen administration. Preparing appropriate equipment, ensuring safety by removing flammable items and posting warning signs, selecting and applying the correct oxygen delivery device, monitoring the resident for tolerance and complications, documenting all relevant details, and educating the resident and others about oxygen safety precautions. III. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included interstitial pulmonary disease (disorders causing progressive inflammation and irreversible scarring of the lung tissue), muscle weakness, depressive episodes, acute cystitis without hematuria (inflammation of the bladder), and hypo-osmolality (a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition characterized by an abnormal low concentration of solutes in the blood or other body fluid) and hyponatremia (a condition characterized by low sodium levels in the blood). The 1/20/26 minimum data set (MDS) assessment revealed that the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She required maximum assistance with transfers, set-up assistance with eating and moderate assistance with personal hygiene and toileting. The assessment revealed the resident was receiving oxygen therapy. B. Observation and resident interview On 4/13/26 at 3:28 p.m. was in her room. There was a nasal cannula (a tubing device that delivers oxygen through the nose) in her nose and connected to a room oxygen concentrator. The oxygen concentrator was set to 2 liters per minute (LPM) of oxygen. Resident #4 said she used oxygen at all times during the day and at night. She said the staff members set the oxygen liter flow. Resident #4 said the staff switched her to the portable oxygen tank when she left her room and put her back on the oxygen concentrator when she returned to her room. On 4/14/26 at 11:04 a.m. Resident #4 was lying down on her bed with a nasal cannula in her nose. The nasal cannula was connected to the oxygen concentrator, which was set at 2 LPM. On 4/15/26 at 9:15 a.m. Resident #4 was sitting in her recliner in her room with a nasal cannula in her nose. The nasal cannula was connected to the oxygen concentrator, which was set at 2 LPM. Resident #4 said she did not know how many liters of oxygen she was receiving. She said a staff member assisted her into her recliner and applied the nasal cannula to her nose. C. Record review The respiratory/oxygen care plan, initiated 4/29/24 and revised 4/8/26, revealed that Resident #4 was at risk for respiratory distress related to interstitial lung disease. Interventions included administering oxygen per the medical director's (MP) order. A review of Resident #4's April 2026 CPO revealed the following physician's order: Oxygen via nasal cannula at 1 LPM at bedtime, ordered 4/9/25. -However, observations on 4/13/26, 4/14/26 and 4/15/26 revealed Resident #4 was receiving 2 LPM of oxygen during the day, not 1 LPM at night as ordered by the physician (see observation above). D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 4/15/26 at 9:15 a.m. CNA #4 said she was able to verify the residents' oxygen orders in the residents' electronic medical records (EMR) and adjust their oxygen flow rates per the physician's orders. CNA #4 said she did not verify the physician's order for Resident #4's oxygen at the beginning of her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift. She said Resident #4 was receiving 2 LPM of oxygen -However, the physician's order for Resident #4 indicated the resident should be on 1 LPM of oxygen at night (see physician's order above). Registered nurse (RN) #2 was interviewed on 4/15/26 at 9:20 a.m. RN #2 said Resident #4 was on continuous oxygen related to a respiratory illness. He said Resident #4 received oxygen at all times. RN #2 said it was necessary to follow the physician's order because oxygen was considered a medication. RN #2 said several medical complications, such as hypoxia (low blood oxygen levels) and hyperoxia (too much oxygen levels), could develop when residents' oxygen orders were not followed accurately as prescribed. RN #2 said he did not know why Resident #4's physician's order for oxygen indicated the resident only wore oxygen at bedtime because the resident had been on continuous oxygen for a long time. RN #2 said he would call the physician to clarify the resident's oxygen order. IV. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included anemia, chronic systolic congestive heart failure, chronic atrial fibrillation, chronic obstructive pulmonary disease (COPD), and muscle weakness. The 2/17/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required supervision and assistance with eating, personal hygiene and transfers and set-up assistance with toileting. The assessment indicated the resident required oxygen therapy B. Observations and resident interview Resident #7 was interviewed on 4/13/26 at 1:38 p.m. Resident #7 said she always used oxygen continuously. Resident #7 said the facility staff regulated her oxygen liter flow rate and she believed she had a physician's order for 2 LPM. Observation of the oxygen concentrator connected to Resident #7's nasal cannula revealed the oxygen concentrator was set at a flow rate of 3 LPM. On 4/14/26 at 9:28 a.m. Resident #7's oxygen concentrator was set at a flow rate of 3 LPM. On 4/15/26 at 9:25 a.m. the resident's oxygen concentrator was set at a flow rate of 2 LPM. C. Record review The respiratory care plan, initiated 5/31/24 and revised 10/23/25, revealed that Resident #7 required oxygen therapy at night related to chronic respiratory failure with hypoxia. Interventions included administering oxygen and medications as ordered by the physician, observing oxygen precautions and reporting any abnormalities to the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #7's April 2026 CPO revealed the following physician's order: Oxygen at 1 LPM at bedtime via nasal cannula, ordered 4/9/25. -However, observations on 4/13/26, 4/14/26 and 4/15/26 revealed Resident #7 was receiving 3 LPM and 2 LPM of oxygen continuously, not 1 LPM at bedtime as ordered by the physician. D. Staff interviews RN #2 was interviewed a second time on 4/15/26 at 9:34 a.m. RN #2 said Resident #7 was receiving continuous oxygen and confirmed that the resident's room concentrator was set to 2 LPM. RN #2 verified the physician's order and confirmed that the order read 1 LPM of oxygen at bedtime. RN #2 said he would immediately clarify the resident's oxygen orders with the physician. RN #2 said he did not verify the oxygen liter flow rate that Resident #7 was receiving at the beginning of his shift. The director of nursing (DON) and the chief nursing officer were interviewed together on 4/15/26 at 9:50 a.m. The DON said residents had their initials written on a label that was attached to their portable oxygen tanks with an indication of how many LPM of oxygen each resident was on. The DON said staff were required to check the residents' oxygen liter flow rates at the beginning of their shift. The DON said CNAs were not trained to alter or change the oxygen liter flow rates. The DON said nurses were able to change the liter flow rates of oxygen orders when necessary, document the changes and inform the physician if a change was needed. The DON said she did not know why Resident #4 and Resident #7's oxygen orders indicated they were only on oxygen at bedtime because they were receiving continuous supplementary oxygen. The DON said insufficient or excessive oxygenation could result in medical complications for residents with respiratory diseases. The chief nursing officer said oxygen was a form of medication and required a physician's order to administer. She said the facility would conduct a full-house audit of all residents receiving supplementary oxygen and ensure they were receiving the correct oxygen liter flow rates. V. Resident #22 A. Resident status Resident #22, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included heart disease, kidney failure, diabetes and asthma. -The MDS assessment had not been completed at the time of the survey. B. Observation and resident interview On 4/15/26 at 8:29 a.m. Resident #22 was sitting in her room wearing a nasal cannula attached to a portable oxygen tank. The portable oxygen tank was observed with RN #2 and was set to an oxygen flow rate of 4 LPM. Resident #22 was interviewed on 4/15/26 at 8:46 a.m. Resident #22 said she had been receiving 4 LPM of oxygen continuously since she was admitted to the facility from the hospital two weeks prior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review A review of Resident #22's comprehensive care plan, initiated 4/7/26, revealed no care plan related to the resident's use of oxygen. A review of Resident #22's April 2026 CPO revealed the following physician's order: Oxygen 2 liters per nasal cannula, continuous day/night, ordered 4/1/26. D. Staff interviews RN #3 was interviewed on 4/15/26 at 9:15 a.m. RN #3 said there was no need to check Resident #22's oxygen setting every shift if her oxygen saturation level (amount of oxygen in the blood) was normal. RN #3 said Resident #22's physician's order was for 2 LPM of oxygen. RN #3 said Resident #22 might have changed the oxygen setting on her portable oxygen tank herself. RN #3 said she was going to contact the physician to confirm the correct order for the resident's oxygen flow rate. RN #3 was interviewed a second time on 4/15/26 at 9:25 a.m. RN #3 said she contacted the physician regarding Resident #22's oxygen flow rate. She said the physician's order for 2 LPM of oxygen was correct. The DON and the chief nursing officer were interviewed together on 4/15/26 at 9:50 a.m. The chief nursing officer said the nurses should check the residents' oxygen settings each shift to ensure the oxygen flow rates matched the physician's orders. The DON said the nurses should document in the residents' progress notes if there was a discrepancy. The DON said it was important to follow the physician's order for oxygen administration as too much oxygen administration could be harmful to the resident. The DON said Resident #22 had a previous oxygen order for 4 LPM and the primary physician had changed the order to 2 LPM when she was readmitted to the facility on [DATE]. The DON said there should have been a care plan for Resident #22's oxygen administration. The DON said if Resident #22 had changed the settings for oxygen administration, this should have been addressed in the resident's care plan. VI. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included hypertension, gastric reflux (acid flows into the esophagus), hypothyroidism (underactive thyroid), peripheral vascular disease (narrowed or blocked blood vessels), sleep apnea (breathing stops and starts during sleep), hyperlipidemia (elevated cholesterol levels in the blood), dementia and diabetes The 3/11/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. The resident required maximum assistance with activities of daily living (ADL). The resident required a wheelchair for mobility. The MDS assessment indicated that the resident required oxygen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations On 4/13/26 at 10:00 a.m. Resident #2 was seated in a recliner in her room. The resident had a nasal cannula in her nose which was attached to an oxygen concentrator. The oxygen concentrator was set to an oxygen flow rate of 3 LPM. On 4/14/26 at 11:00 a.m. Resident #2 was seated in her recliner watching television (TV). The resident had a nasal cannula in her nose which was attached to an oxygen concentrator. The oxygen concentrator was set to an oxygen flow rate of 3 LPM. On 4/15/26 at 9:15 a.m. Resident #2 was in her recliner watching a game show on TV. The resident had a nasal cannula in her nose which was attached to an oxygen concentrator. The oxygen concentrator was set to an oxygen flow rate of 3 LPM. C. Record review A review of Resident #2's April 2026 CPO revealed the following physician's order: Oxygen at 3 LPM via nasal cannula at bedtime, ordered 4/9/25. D. Staff interviews RN #3 was interviewed on 4/15/26 at 4:00 p.m. RN #3 said Resident #2 had a physician's order for oxygen at night for sleep apnea. She said the resident should only be on oxygen at bedtime, per the physician's order. RN #3 said the CNA caring for the resident must have put her oxygen on during the day. RN #3 said she would educate the CNA on what the resident's oxygen needs were. The DON was interviewed on 4/15/26 at 4:15 p.m. The DON said Resident #2 had a physician's order for oxygen at bedtime. The DON said Resident #2 should only have oxygen on at bedtime, per the physician's orders. The DON said it was important for staff to follow the physician's orders. The DON said she would be doing education to the staff regarding following the physician's orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain hearing abilities for one (#3) of two residents reviewed for hearing out of 29 sample residents.Specifically, the facility failed to follow up on a post-eligibility treatment of income (PETI) request in order to obtain a hearing aid in a timely manner for Resident #3.Findings include:I. Facility policy and procedureThe Audiology and Ancillary Services policy and procedure, undated, was provided by the nursing home administrator (NHA) on 4/15/26 at 12:07 p.m. It read in pertinent part, The purpose of this policy is to provide a process for identifying, arranging, and documenting audiology services for residents who need hearing-related care. The facility will provide or arrange audiology services for residents as needed and as ordered by a physician or other authorized provider, when required. Services may be provided by a licensed audiologist or through a contracted provider. Audiology services may include hearing evaluations, hearing aid recommendations, hearing aid checks, communication recommendations, and follow-up related to hearing concerns. A resident may be referred for audiology services when hearing concerns are identified by nursing, therapy, the provider, the resident, or the resident's representative. A provider order will be obtained when required. The facility will coordinate audiology services based on the resident's needs and provider availability. Audiology recommendations will be shared with the care team and added to the resident's care plan as appropriate. All services, recommendations, and follow-up will be documented in the medical record.II. Resident #3A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included unspecified hearing loss, supraventricular tachycardia (a cardiovascular condition characterized by a fast heart rate), muscle wasting and atrophy, unspecified dementia and major depressive disorder.The 1/7/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He was independent with eating and required moderate assistance with toileting and personal hygiene, and maximum assistance with transfers. He used a wheelchair or a walker for locomotion.The MDS assessment documented that he had minimal hearing difficulty.B. Observation and resident interviewResident #3 was interviewed in his room on 4/13/26 at 12:29 p.m.The resident said he developed a hearing deficit upon his admission to the hospital from the facility. He said that after returning to the facility, he reported the issue to the social services director (SSD). Resident #3 said he had been waiting for assistance with obtaining a hearing aid for several months. Resident #3 said he had completed an audiology appointment several months ago, during which a hearing aid was recommended by the audiologist. Resident #3 said he got frustrated and angry when he could not hear. He said it had become difficult to hold a conversation with others unless they spoke louder. Resident #3 said he was not offered any accessories to facilitate better communication with others while he waited for his hearing aid.C. Record reviewThe speech and communication care plan, initiated 10/3/25 and revised 1/9/26, revealed that Resident #3 usually understood but may miss some parts or the intent of a message due to significant hearing loss in the left ear. Interventions included speaking distinctly and rephrasing or simplifying language, repeating information or adjusting tones if the resident was not able to understand, providing a quiet, non-hurried environment, free of background noise and distractions and audiology consults and evaluations as needed.The 2/19/26 audiology patient visit note revealed Resident #3's pure-tone testing bilateral (a hearing assessment that measures the softest sounds a person can hear) suggested mild sloping to moderate sensorineural hearing loss (a permanent inner ear damage) and recommended a hearing aid and retesting if concerns changes.-There was no documentation in Resident #3's electronic medical record (EMR) to indicate that the facility had obtained a physician's order for a hearing aid after the 2/19/26 audiology visit.III. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 4/14/26 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 2:50 p.m. CNA #5 said Resident #3 had a hearing impairment. CNA #5 said staff had to speak louder for Resident #3 to hear them when they were communicating with him. CNA #5 said Resident #3 often became agitated due to his inability to hear during care.The SSD was interviewed on 4/14/26 at 3:56 p.m. The SSD said Resident #3 attended an audiology appointment on 2/19/26. She said a post-eligibility treatment of income (PETI) cash request was filed on 2/24/26, but the resident had not yet received a formal letter indicating whether the request was approved. The SSD said that if a formal letter was not received within a couple of weeks, the standard procedure was to follow up with the office. However, the SSD said she had not followed up on the request and acknowledged that she should have done so. The director of nursing (DON) was interviewed on 4/15/26 at 10:14 a.m. The DON said Resident #3 had a hearing impairment and had been seen by an audiologist. She said Resident #3 did not have a physician's order for a hearing aid. The DON said staff had to speak clearly and louder for the resident to hear. The DON said Resident #3 had not been provided with any accessories while he waited for a hearing aid.The SSD was interviewed a second time on 4/15/26 at 5:02 p.m. The SSD said she had not documented her action at the time the PETI was filed. The SSD said her understanding of the PETI cash process was that the amount was based on the monthly resident portion and the money must accumulate over time. The SSD said the resident's portion of the cost of the hearing aid was $1,100.00 and estimated that it would take three months for the required funds to be available for Resident #3. The SSD said the delay in the PETI cash funding should not serve as a barrier to the resident obtaining his hearing aid.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065360	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Health Care	221 2nd St Fowler, CO 81039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease. Specifically, the facility failed to: -Ensure staff performed appropriate hand hygiene in the dining room while assisting residents with eating; -Ensure housekeeping staff used appropriate hand hygiene practices while cleaning the residents' rooms; and, -Ensure housekeeping staff cleaned high-touch surfaces in residents' rooms.Findings include: I. Failed to ensure staff performed appropriate hand hygiene while assisting residents in the dining roomA. Facility policy and procedureThe Handwashing policy, revised October 2025, was received from the nursing home administrator (NHA) on 4/15/26 at 4:00 p.m. The policy read, All personnel are trained on the importance of handwashing. Wash your hands after contact with the resident or in the resident's environment. The use of gloves does not replace handwashing or hand hygiene.B. ObservationsOn 4/13/26 at 11:15 a.m. certified nurse aide (CNA) #1 was observed assisting three residents with eating in the dining room.-CNA #1 failed to perform appropriate hand hygiene between any residents.II. Housekeeping failuresA. Facility policy and procedureThe Cleaning And Disinfection Of Environmental Services policy, revised August 2019, was received from the NHA on 4/15/26 at 4:00 p.m. The policy read, Non-critical contaminated areas can be decontaminated where they are used. Housekeeping surfaces such as desk tops will be cleaned regularly. Non-critical surfaces will be disinfected with an Environmental Protection Agency (EPA)-registered intermediate hospital disinfectant with the dwell time as follows on the label.B. ObservationsOn 4/15/26 at 10:00 a.m., the housekeeping director was cleaning room [ROOM NUMBER].The housekeeping director sprayed the bathroom with Virex diversity disinfectant spray and proceeded to clean the resident's bathroom. When the housekeeping director finished cleaning the bathroom, she took off her gloves. Without performing hand hygiene, the housekeeping director began cleaning the resident's room. -The housekeeping director failed to perform hand hygiene after cleaning the bathroom and removing her gloves prior to beginning cleaning in the resident's room.The housekeeping director made the resident's bed, gathered the trash and swept and mopped the floor. The housekeeping director did not perform hand hygiene after exiting room [ROOM NUMBER]. -The housekeeping director failed to clean the high touch surface areas in the room, including the resident's bedside table, the residents' call light, the bed control and the door knobs.-Additionally, the housekeeping director failed to perform appropriate hand hygiene after cleaning the resident's room.III. Staff interviewsCNA #1 was interviewed on 4/13/26 at 2:15 p.m. CNA #1 said she should have washed her hands in between helping each of the three residents she was assisting with eating in the dining room. She said she should have washed her hands before assisting another resident.The housekeeping director was interviewed on 4/15/26 at 10:20 a.m. The housekeeping director said that the CNAs would clean the residents' bedside tables. She said she cleaned the residents' call lights once a week, along with the bed controls. She said she realized that the high contact areas should be cleaned daily. She said she would change her cleaning to include the bedside table, call light, bed controls, and door knobs to a daily disinfection cleaning.The director of nursing (DON) was interviewed on 4/15/26 at 5:04 p.m. She said that the staff assisting residents with eating should regularly perform hand hygiene. The DON said if staff were assisting more than one resident with eating, they should perform hand hygiene in between residents. The DON said the housekeepers should perform hand hygiene after removing gloves and sanitize high-contact areas in residents' rooms daily.The NHA was interviewed on 4/15/26 at 5:15 p.m. The NHA said that the housekeeping staff should disinfect the high-contact surfaces in the residents' rooms on a daily basis.