STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for three (#106, #37 and #10) of six residents reviewed for accident hazards out of 42 sample residents.Specifically, the facility failed to:-Ensure Resident #106 was transported appropriately in the facility transportation vehicle, which resulted in a fall from the resident's wheelchair causing fractures to both of her lower extremities;-Ensure Resident #37's care planned fall interventions were consistently implemented by staff in order to prevent multiple falls for the resident, including one with major injury; and,-Ensure the interdisciplinary team (IDT) reviewed Resident #37 and Resident #10's falls in a timely manner in order to determine if the residents' fall interventions were appropriate or if new fall interventions were needed.Resident #106, who was admitted to the facility on [DATE], had impairments to both lower extremities, used a wheelchair for mobility and was dependent on staff assistance for transfers. On 1/30/26 Resident #106 was being transported in her wheelchair, without the foot pedals attached, in a facility transportation vehicle to an outside appointment when her upper body began sliding forward in her wheelchair. When the facility transportation driver pulled over on the side of the road, Resident #106 slid further forward in her wheelchair and struck her lower legs on a structure in the transportation van, resulting in fractures to both of the resident's tibias (the larger of the two bones in the lower leg, connecting the knee to the ankle).The facility's failure to prevent an accident on a facility transportation vehicle resulted in serious harm for Resident #106 and continued to place residents at risk for serious harm or death if not corrected immediately. Additionally, Resident #37, who was admitted to the facility on [DATE], was determined by the facility to be at high risk for falls. Between 5/27/25 and 3/7/26, Resident #37 sustained 16 falls, with the fall on 3/7/26 resulting in a laceration to the resident's right cheek which required transport to the hospital's emergency department where the resident was diagnosed with a maxillary sinus fracture (involves broken bones in the upper jaw/cheek area).The facility implemented fall interventions for Resident #37's falls, however, the interventions were not consistently implemented in a timely manner and observations during the survey revealed care planned fall interventions were not being consistently implemented by staff.Additionally, the facility failed to identify and document fall interventions in a timely manner for Resident #10, who sustained five falls between 9/25/25 and 2/11/26. Findings include: I. Immediate Jeopardy A. Situation of immediate jeopardy On 1/30/26, Resident #106 was being transported in her wheelchair, without the foot pedals attached, in a facility transportation vehicle to an outside appointment when her upper body began sliding (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: 065361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	forward in her wheelchair. When the facility transportation driver pulled over on the side of the road, Resident #106 slid further forward in her wheelchair and struck her lower legs onto a structure in the transportation van, resulting in fractures to both of the resident's tibias. The facility failed to implement appropriate interventions to prevent further accidents for Resident #106 and other residents on the transportation van after Resident #106's accident on 1/30/26. The facility's failure to prevent an accident on a facility transportation vehicle resulted in serious harm for Resident #106 and the facility's failure to implement appropriate interventions following Resident #106's accident continued to place all residents at risk for serious harm or death if not corrected immediately. B. Imposition of immediate jeopardy On 3/11/26 at 5:00 p.m., the nursing home administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failures to prevent an accident for Resident #106 and implement appropriate interventions following the accident. C. Facility plan to remove immediate jeopardy On 3/12/26 at 2:56 p.m. the facility submitted a plan to remove the Immediate Jeopardy. The removal plan read: 1. Corrective action All resident transportation services were temporarily suspended by the facility on 3/11/26 and transferred to an outside company. This will continue until 3/16/26, once training and validation has been completed. All staff members assigned transportation responsibilities were immediately removed from transportation duties pending completion of retraining and competency validation. Competency validation started on 3/11/26 and will continue to be conducted and verified by the maintenance director (MTD) in collaboration with the nurse liaison or designated clinical representative as approved by the administrator. Residents requiring appointments during the review period were transported using medical transportation services through external transportation companies. 2. Identification of others The facility implemented a resident transportation risk assessment tool on 3/12/26 to identify residents who require special transportation precautions. All residents who utilize facility transportation will be assessed using this tool. The assessment identifies residents with conditions requiring additional safety considerations during transport, including those with ostomies, indwelling urinary catheters, suprapubic catheters, oxygen equipment, or other medical devices, and ensures appropriate precautions are implemented prior to transportation. 3. Systemic changes (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility implemented a comprehensive transportation safety program on 3/12/26 to include all of the following: -Transportation Safety Policy (updated March 2026); -Transportation Driver Job Description with defined safety duties (1/8/26); -Transportation Staff Competency Validation process; -Pre-Transport Safety Checklist (reviewed by the administrator or designee); -Transportation Special Circumstances Protocol; -Transportation Incident Investigation Template; -Transportation Safety Training Program; and, -Transportation Safety QAPI Monitoring Process. Wheelchairs must be secured using a four-point tie-down system. Residents must be secured with lap and shoulder seatbelts. Wheelchair brakes and foot pedals must be verified prior to transport by the administrator or designee. Resident stability must be confirmed before departure by the administrator or designee. Residents With Special Medical Circumstances: All medical devices for residents being transported will be evaluated on an individual basis, to include but not limited to, those with ostomies, indwelling urinary catheters, suprapubic catheters, oxygen equipment, or other medical devices, and ensures appropriate precautions are implemented prior to transportation if necessary. Staff Training and Competency Validation: All transportation staff will receive mandatory transportation safety training starting 3/12/26, including wheelchair securement procedures, restraint placement, medical device accommodations, and emergency response procedures. Attendance will be documented using a training sign-in sheet and competency validated using a transportation staff competency validation checklist. Validation will occur through the maintenance director and clinical liaison/designee as approved by the administrator (the maintenance director for securement and mechanical procedure and the clinical liaison for the special circumstance/medical items). Pre-Transport Safety Verification A Pre-Transport Safety Checklist will be completed starting 3/12/26 prior to each transport verifying wheelchair brakes engaged, foot pedals attached, four-point tie-down secured, lap and shoulder restraints applied, medical devices protected, and resident stability confirmed this will be completed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by (Maintenance Director and Clinical Liaison/Designee). 4. Monitoring A transportation incident adhoc quality assurance and performance improvement (QAPI) tool was completed to ensure structured review of any transportation-related incident including incident description, equipment review, root cause analysis, and corrective action planning. This adhoc was completed on 2/2/26. D. Removal of the immediate jeopardy The NHA was notified the immediate jeopardy was removed on 3/12/26 at 2:56 p.m. based on the facility's removal plan (see above). However, the deficient practice remained at a G level, actual harm that is not immediate jeopardy, isolated. II. Facility policy and procedure The Safety Responsibilities: Authorized (Facility Name) Drivers Operational policy and procedure, dated 2/4/13, was received from the NHA on 3/11/25. It read in pertinent part, The driver and all passengers are required to wear seatbelts and shoulder harnesses any time the vehicle is in motion. Wheelchairs must be made secure with the wheelchair straps located in the bus and van. The Fall Management policy and procedure, revised October 2025, was received from the NHA on 3/12/26 at 1:31 p.m. It read in pertinent part, A resident that is determined to be at an increased risk of falls may receive additional interventions, screening, monitoring or review as applicable and as determined by clinical leadership. Additional interventions may be implemented upon quarterly or annual review, significant change, or if actual falls occur. Falls will be reviewed by the interdisciplinary team (IDT) to ensure that appropriate interventions have been selected, implemented and are effective. Individualized care plan interventions will be implemented for residents after the fall risk assessment is completed. III. Failed to prevent an accident on a facility transportation vehicle resulting in serious harm A. Resident #106 1. Resident status Resident #106, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included vascular dementia, history of bowel perforation and unspecified fracture of the shaft of tibia. The 3/7/26 minimum data set (MDS) assessment documented the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. She had impairments to both lower extremities and was dependent on staff for transfers, bathing, dressing and bed mobility. The resident had a fracture and impaired range of motion. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Resident and representative interview Resident #106's representative was interviewed on 3/10/26 at 10:22 a.m. The representative said Resident #106 was being transported on the day of the accident (1/30/26) to a physician's appointment. The representative said Resident #106 told her that the facility' van driver hit the brakes hard and caused her to fall out of her wheelchair. She said the resident's body was swollen the next day when she came to visit her and the driver denied that the resident had fallen out of her wheelchair in the van. She said that the resident's other representative was waiting at the physician's appointment and saw the driver on the side of the road trying to adjust Resident #106 back into her wheelchair and the other resident had to come over and help the driver. The representative said after a few days, Resident #106's vital signs were unstable and the representative and the other representative requested that Resident #106 be sent out to the hospital. She said the facility said the resident's fractures were old fractures but the hospital indicated that they were new and related to the accident in the transportation van. The representative said since the accident, Resident #106 would no longer get out of bed, go to activities or visit with the family in the private dining room, and she had experienced increased depression. She said Resident #106 was put onto hospice care services after returning to the facility from the hospital due to her significant decline after the accident. Resident #106 was interviewed on 3/10/26 at 1:38 p.m. Resident #106 said the incident in the van was horrific and she was scared at the time but did not want to talk anymore about it. 3. Record review Resident #106's fall care plan, revised 10/7/25, revealed the resident was at risk for falls and injury from falls related to vascular dementia, anoxic brain injury (occurs when the brain is completely deprived of oxygen, leading to brain cell death within approximately four minutes), decreased mobility, weakness, chronic pain syndrome, hearing loss and pain medication use. Interventions, initiated 5/12/22, included anticipating her needs and ensuring the call light was within reach. -The care plan failed to reveal any updates to the resident's fall interventions after the accident on 1/30/26. -A review of Resident #106's electronic medical record (EMR) revealed no fall risk assessments were completed after the accident on 1/30/26 until after the resident had been sent out to the hospital on 2/4/26 (five days after the accident) and returned from the hospital (see hospital records below). A health status note, dated 1/30/26, revealed Resident #106 had returned to the facility from a physician's appointment and the nurse was notified by the transportation driver that the resident was transported without foot pedals. The resident had refused to wear foot pedals on her wheelchair, according to the van driver. Upon returning, the nurse noted purple and red bruising to the resident's right knee, an abrasion to her right second toe, a bruise to the bottom of her right heel, a blood blister to her left second toe, a bruise to her left heel, and a bruise to her left foot below the last toe. The nurse additionally noted moderate swelling to the resident's knees and legs. The physician was notified and the nurse provided pain management and an ice pack. An order administration note, dated 1/31/26 at 5:14 a.m., revealed Resident #106 was provided pain medication for a pain scale level of 9 out of 10 and the medication was ineffective. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An order administration note, dated 1/31/26 at 10:50 a.m., revealed the resident complained of a pain level of 10 out of 10 that was relieved intermittently by pain medication, topical pain gel, and ice packs. A health status note, dated 1/31/26 at 12:52 p.m., revealed Xray results obtained in the facility revealed age-indeterminate tibia fractures were noted. The family requested additional Xrays to determine if the fractures were acute or chronic. A health status note, dated 2/1/26 at 2:02 a.m., revealed similar Xray results after a second set of Xrays were obtained. An order administration note, dated 2/1/26 at 11:01 a.m., revealed Resident #106 refused three times to get out of bed to be weighed. A health status note, dated 2/1/26 at 7:40 p.m., revealed delayed generalized bruising to Resident #106's left leg, right knee, right great toe and right side of her right breast with a pain scale level of 7 out of 10. An order administration note, dated 2/2/26 at 8:37 a.m., revealed the resident was provided pain medication for a pain scale level of 7 out of 10 and the medication was ineffective. A health status note, dated 2/2/26 at 6:42 p.m., revealed Resident #106 was presenting with increased confusion, responding inappropriately to questions and not saying things that made sense to others. The resident had not had a bowel movement for three days. A physician follow up note, dated 2/3/26, revealed the resident had been getting out of bed less and eating less the last few days. A physician follow up note, dated 2/4/26 at 10:07 a.m., revealed Resident #106 had spent the weekend in bed with increased pain medications and intermediate hallucinations and confusion. The physician discussed with the family the resident's continued decline despite treatments in place and the family elected to have the resident sent to the hospital. A health status note, dated 2/4/26 at 10:17 a.m., revealed Resident #106 was sent out to the hospital. Hospital progress notes, dated 2/9/26, revealed Resident #106 had been admitted to the hospital with an increased need for oxygen (from 2 liters per minute (LPM) to 5 LPM), and an increased heart rate/respiration rate/leukocytosis (an immune response causing a high white blood cell count). She reported to the hospital staff that five days prior, she had been in the midst of a transport to an appointment, fell forward out of her wheelchair and landed on both of her knees. Since that time, she had an increase in bilateral lower extremity pain, decreased mobility and decreased oral intact. Xrays revealed a fracture in the bony attachment to the anterior ligament of the left tibia with soft tissue swelling and a fracture of the shin of the right tibia. Hospital progress notes, dated 2/16/26, revealed Resident #106 was admitted to the hospital on [DATE]. The records documented the resident was being treated for a recent fall several days prior to her hospital admission. The resident was wheelchair-bound and in the midst of a transport to an appointment, she fell forward out of her wheelchair and landed on both of her knees. The hospital Xrays revealed bilateral tibial fractures with recent trauma contributory. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A health status note, dated 2/19/26, revealed Resident #106 was readmitted to the facility. A health status note, dated 2/22/26, revealed the resident was admitted on hospice care services. The hospice pain screen admission notes, dated 2/22/26, revealed Resident #106 was admitted to hospice care services for heart failure, chronic obstructive pulmonary disease (COPD) and pain management. The resident reported to the hospice nurse that she was experiencing throbbing, intermittent pain in both bilateral lower extremities that interfered in her mobility and activity daily. The nurse documented the limited range of motion, pain and weakness related to bilateral lower extremity fractures affected the resident's quality of life. B. Staff interviews The facility's van driver was interviewed on 3/11/26 at 11:17 a.m. The van driver said he had been the transportation driver for a little over a month and was a certified nurse aide (CNA) prior to that. The van driver said that the training he received was from the previous van driver who was now the facility's central supply coordinator. The van driver said the central supply coordinator went over with him the basics of the van, safety features and how to connect the seat belts to the wheelchair and residents. The van driver said he had to do a return demonstration during the training as well. The van driver said that the only two people who drove the van were himself and the central supply coordinator. He said that when he went to pick up Resident #106 from her room on 1/30/26, she did not have foot pedals on her wheelchair and she told him that was her preference. He said he took her to the van and buckled her in with the four-point belts that attached the wheelchair base to the van. He said that the resident said she was comfortable, but once they started to get off the exit of the highway on the way to her physician's appointment, she said she was sliding down in her wheelchair. The van driver said she continued to slide down, but he was unable to pull over because he was exiting the highway and had to wait until he could pull over to a safe place on the road. He said when he was able to pull over, he could see that Resident #106 had slid down to where her knees and legs were resting on the step right behind the driver's seat. The van driver said that since the incident with Resident #106, every resident was expected to have foot pedals on their wheelchairs and he insisted that they have them on as part of transportation safety. He said he now left for residents' appointments a little earlier so he could ensure that he drove a little slower, and he made sure that he communicated with the CNAs as to what each resident's transfer status was. The van driver said if there was something that he was not comfortable with, he would have a transportation company take the resident on that appointment. The van driver said he believed several things caused the accident with Resident #106. He said that the resident was sitting on a blanket and her Hoyer lift (mechanical lift) sling, which made her slide more in her wheelchair. The van driver said he did not secure the seat belt the way he knew he should have, and it was not as tight as it could have been. The van driver said Resident #106 did not have foot pedals on her wheelchair so when she did start to slide, there was nothing to prevent her from continuing to slide. The van driver said that the facility had added foam padding to cushion the step where Resident #106 had hit her knees and legs to provide a buffer. The van driver demonstrated with a staff member in a wheelchair how he buckled Resident #106 into the van on the day of the accident. He took the shoulder part of the seat belt and buckled it around the back of the van seat instead of across the resident's shoulders, and the lap part of the seat belt went across her chest instead of her lap. He acknowledged that this was not the proper way to utilize the (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

seat belt, but he had been concerned that day on how to buckle her in without disrupting or damaging her ostomy bag.

The NHA was interviewed on 3/11/26 at 11:47 a.m. The NHA said the facility's process when they investigated Resident #106's accident on 1/30/26 included having the driver of the van role play the scenario, in addition to having the van driver receive retraining from the central supply coordinator and perform a return demonstration. The NHA said the facility also completed an audit of all the residents in wheelchairs to ensure that they had operational foot pedals so when they went out on appointments, there was no reason for them to go without foot pedals. The NHA said when Resident #106 came back to the facility on 1/30/26, a full assessment was done and no more transports were done for the rest of the day until the following Monday (2/5/26), after the van driver had received retraining. She said that she had been out of the building on the day of the accident, as well as the director of operation, who acted as the alternative NHA when she (the NHA) was out of the facility. The NHA said that there was no follow-up service inspection done on the van after the incident until 3/3/26.

The director of operations was interviewed on 3/11/26 at 12:10 p.m. The director of operations said even though he was not working on the day of Resident #106's accident, he was in communication with the director of nursing (DON) throughout the following day (1/31/26) to discuss the incident. The director of operations said the root cause analysis was that due to the resident not wearing her foot pedals, this prevented her from having a buffer from her sliding and hitting her legs.

The central supply coordinator was interviewed on 3/11/26 at 2:02 p.m. The central supply coordinator said she helped train the facility's current van driver when he was hired to take over the position. The central supply coordinator said she received her training from the previous van driver approximately six years ago (2020). The central supply coordinator said she received training on how to utilize the van and hook residents into the van from a different van driver who no longer worked at the facility. She said she had not received any other training or competencies since then. The central supply coordinator said her training consisted of being trained on locking the wheelchair into the van and utilizing the seat belt. She said that her trainer trained her by using an empty wheelchair and the central supply coordinator had to do a return demonstration of what the other driver had shown her.

The central supply coordinator said when she trained the current van driver, she had him ride with her and show her how to hook the residents into the van and get them out of the van. The central supply coordinator said her training with the van driver was not based on any worksheet or checklist, just her own knowledge of the transportation process. She said that she did not do a competency worksheet with him on his initial training and instead, did it with him on the follow-up training after the accident involving Resident #106. The central supply coordinator said she was unaware if there was an operations manual for the van itself. She said she did not know if there was a policy and procedure for driving emergencies. The central supply coordinator said that the van driver reports directly to the NHA, but she did not know who was responsible for servicing the van. She said if there was an emergency with the seat belt while the driver was driving the van and she was not available for him to call her, she was not aware of any other backup. The central supply coordinator said she did not know who the van driver was supposed to call if he was having a clinical or mechanical emergency while out on a transport.

The NHA was interviewed a second time on 3/11/26 at 2:37 p.m. The NHA said the MTD was in charge of the service and operations of the van. The NHA said she was not sure what competencies the central supply coordinator had when she initially trained the facility's current van driver or what
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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

he had been trained on, since the training had not been documented. She said that the van driver and the central supply coordinator were the only van drivers for the facility and if they had questions, they could contact the DON or the assistant director of nursing (ADON), however neither the DON or ADON had been trained on transportation. The NHA said she was unable to find any of the training that the central supply coordinator might have received prior to training the current van driver. The NHA said after the accident involving Resident #106, the van driver admitted he did not use the seatbelt as intended, but the NHA said she did not complete any investigation into the misuse of the seatbelt.

The MTD was interviewed on 3/11/26 at 3:12 p.m. The MTD said he had been working at the facility since January 2025 as a maintenance assistant and was promoted to the maintenance director in November 2025. He said that he completed the monthly checks of the van with a specific checklist but the checklist was not specific to the van itself, but only to a medical transport vehicle. The MTD said he did not get any training specific to the van and he said he was not sure if there was an operations manual in the van's glove box. He said he never received any competencies as far as training for the van. The MTD said if the van driver had an emergency related to simple mechanics of the van, such as oil changes or flat tires, he (the MTD) could assist with that, but he said things that were more complicated and specific to the van, he was not trained to assist with.

IV. Failed to ensure falls were reviewed by IDT timely and staff were consistently implementing care planned fall interventions to prevent a fall with major injury for Resident #37

A. Resident #37

1. Resident status

Resident #37, age greater than 85, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included vascular dementia, muscle wasting and atrophy, difficulty in walking, fracture of nasal bones and laceration of right cheek and temporomandibular area (area around the temple and cheek of the face).

The 3/10/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of five out of 15. The resident required partial to maximal assistance from staff for most activities of daily living (ADL).

2. Record review

The fall care plan, revised 12/10/25, revealed Resident #37 was at risk for falls due to his history of falls, diagnoses of vascular dementia, chronic respiratory failure, hearing loss, weakness, decreased mobility, psychotropic medication use and bowel and bladder incontinence. Pertinent interventions included assisting Resident #37 to the bathroom after each meal (initiated 8/29/25 and again on 12/20/25), assisting the resident to the bathroom before meals (initiated 2/21/26), using a non-recording video monitor in the resident's room (initiated 9/13/25), prompting the resident to void every two hours while awake (initiated 9/3/25), offering assistance with transfers to furniture in the common area (initiated 1/29/26), and using a fall mat at the resident's bedside for safety (initiated 3/9/26).

A fall risk evaluation, completed 4/26/25, revealed Resident #37 was at a high risk for falls.

A fall risk evaluation, completed 11/9/25, revealed Resident #37 was at a high risk for falls.
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NAME OF PROVIDER OR SUPPLIER: Brookside Inn		STREET ADDRESS, CITY, STATE, ZIP CODE: 1297 S Perry St Castle Rock, CO 80104	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An IDT note, dated 5/27/25 at 3:21 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 5/26/25. Resident #37 was attempting to self-transfer to the bathroom and fell due to gait imbalance, weakness and poor safety awareness. New interventions included a bedside floor mat while in bed, and prompted voiding before bed. An IDT note, dated 8/29/25 at 12:21 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 8/26/25. Resident #37 had a skin tear to his left inner thumb and first digit. Resident #37 had poor safety awareness, was often forgetful and did not utilize his call light, and attempted to ambulate independently to the bathroom. New interventions included staff assisting Resident #37 to the bathroom after meals and an occupational therapy evaluation. An IDT note, dated 9/9/25 at 10:28 a.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 9/5/25. Resident #37 had an abrasion to his right lateral leg. Predisposing factors included not utilizing his call light, weakness, impaired memory, poor safety awareness, confusion, and ambulating without assistance. New interventions included moving Resident #37's room closer to staff and an occupational therapy evaluation. -However, an occupational therapy evaluation was recommended as an intervention after the resident's previous fall on 8/26/25 (see above). An IDT note, dated 9/9/25 at 11:12 a.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 9/6/25. Resident #37 sustained a contusion to the back of his head with two puncture wounds. Resident #37 had poor safety awareness and did not comply with the occupational therapy recommendations or utilize his call light for assistance. Resident #37 believed he was safe to transfer himself and lost his balance, resulting in a ground-level fall. Resident #37 had been taken to the bathroom [ROOM NUMBER] minutes prior to the fall but said he was trying to go to the bathroom. An IDT note, dated 10/6/25 at 3:12 p.m., revealed Resident #37 was reviewed by the IDT team after a witnessed fall on 10/3/25. Resident #37 was in his room with a CNA who was placing a coffee cup on his table. Resident #37 wanted to be handed the coffee cup and attempted to stand, resulting in a ground-level fall. Resident #37 was impulsive and forgetful of his limitations. New interventions included ensuring Resident #37 was completely transferred into bed prior to finishing ADL tasks to prevent Resident #37 from standing up or transferring by himself. An IDT note, dated 11/10/25 at 12:03 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 11/9/25. Resident #37 had poor safety awareness and continued to try to get up without assistance from his wheelchair. Resident #37 had poor balance, gait and strength resulting in a ground-level fall. New interventions included a pharmacy review for Resident #37 as he was on multiple stool softeners which may have increased his need to use the bathroom. An IDT note, dated 12/19/25 at 1:58 p.m., revealed Resident #37 was reviewed by the IDT team after an unwitnessed fall on 12/15/25. Resident #37 was in the common area and had po

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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 prepared, distributed and served under sanitary conditions in the main kitchen.Specifically, the facility failed to ensure ready-to-eat foods were handled in a sanitary manner to prevent cross-contamination.Findings include:I. Professional referenceAccording to The Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 3/18/26, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301.11)II. ObservationsDuring a continuous observation of the lunch meal service on 3/11/26, beginning at 10:20 a.m. and ending at 12:40 p.m., the following was observed:At 10:52 a.m. cook (CK) #1 began preparing a peanut butter and jelly sandwich. Using gloved hands, CK #1 opened a plastic bread bag and retrieved two pieces of bread before putting them on the food preparation table. CK #1 walked into the dishwashing area and grabbed a knife and spoon. CK #1 then used his gloved hand to open the door to the walk-in refrigerator to retrieve a container of jelly. CK #1 returned to the food preparation area, picked up one piece of bread and held it in his gloved hand while he spread peanut butter on the bread. CK #1 then repeated this process while applying jelly to the other piece of bread. CK #1 closed the sandwich and held it in his hand as he walked into the dirty dish area to retrieve a clean plate. CK #1 then sent the sandwich out to the servers to be served to a resident.-CK #1 failed to change his gloves and perform hand hygiene after opening the door to the walk-in refrigerator to retrieve the jar of jelly and prior to picking up the pieces of bread and making the peanut butter and jelly sandwich.At 10:58 a.m. CK #1 was wearing gloves on each hand. CK #1 grabbed a small metal container and used a ladle to pour butter from a pot on the stove into the metal container. CK #1 used a brush to brush the butter from the metal container onto a baking sheet full of dinner rolls. CK #1 then used his same gloved hands to grab handfuls of the dinner rolls and place them into a steam table bin on the tray line.-CK #1 failed to change his gloves and perform hand hygiene after using the brush to brush butter on the baking sheet of rolls prior to handling the dinner rolls.At 11:06 a.m. the regional dietary supervisor began prepping ingredients for chef salads. The regional dietary supervisor donned gloves and used his gloved hands to unwrap plastic packaging containing pre-peeled boiled eggs. The regional dietary supervisor used his gloved hands to remove several handfuls of eggs and place them on a cutting board, and held the eggs to steady them as he cut them up. Using the same gloved hands, the regional dietary supervisor picked up the sliced egg pieces and put them into a metal container.-The regional dietary supervisor failed to change his gloves and perform hand hygiene after opening the packaging on the eggs and prior to handling the boiled eggs.At 11:08 a.m. CK #1 was wearing gloves on each hand. CK #1 put on oven mitts on both hands and removed a baking sheet full of dinner rolls from the oven. CK #1 removed the oven mitts and began using a brush to brush butter onto the dinner rolls. CK #1 opened the lid of one of the steam table bins and, using the same gloved hands, began to pick up handfuls of the dinner rolls and put them into the steam table bin.-CK #1 failed to change his gloves and perform hand hygiene after using oven mitts to remove the sheet of dinner rolls from the oven and prior to handling the dinner rolls with his hands.At 11:16 a.m. the regional dietary supervisor began putting together the chef salads. The regional dietary supervisor used his gloved hands to open a plastic bag of shredded lettuce, then used the same gloved hands to grab handfuls of the lettuce out of the bag and put them into two bowls. The regional dietary supervisor removed the lettuce and threw it in the trash can, opened the door to the walk-in refrigerator with his gloved hand and retrieved a new package of lettuce. The regional dietary supervisor then used the same gloved hands to open the new bag of lettuce and put handfuls of lettuce into two bowls. The regional dietary supervisor then used the same gloved hands to grab handfuls of the cut up boiled egg pieces and pieces of ham before adding them to the salad bowls.-The regional dietary supervisor failed to change his gloves and perform hand (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hygiene after handling the outside packaging of both packages of lettuce and prior to handling the lettuce, boiled eggs and ham while making the salads.At 11:30 a.m. CK #1 was prepping hamburgers. CK #1 used his gloved hands to grab a hamburger bun off of the grill and placed the hamburger patty on the bun using a spatula. CK #1 briefly held the hamburger and bun in his hand before placing it on a plate. CK #1 used his gloved hand to unwrap plastic wrap covering containers of hamburger toppings, then used the same gloved hands to grab a handful of lettuce and place it on top of the hamburger. CK #1 then used the same gloved hand to grab several pickle slices and put them on the hamburger patty.-CK #1 failed to change his gloves and perform hand hygiene after using the spatula and unwrapping the outer plastic wrap on the hamburger toppings and prior to handling the hamburger and bun, lettuce and pickle slices.At 11:45 a.m. CK #1 began assembling another hamburger. CK #1 grabbed a hamburger bun off of the grill using his gloved hand and put it on a plate. CK #1 used a spatula with his gloved hand and placed a hamburger patty on top of the bun. CK #1 then used the same gloved hand to retrieve the top hamburger bun from the grill before applying it to the hamburger. CK #1 repeated this process at 12:29 p.m. when preparing five more hamburgers. -CK #1 failed to change his gloves after touching serving utensils and prior to handling the hamburger buns and hamburgers.III. Staff interviewThe regional dietary supervisor was interviewed on 3/12/26 at 3:05 p.m. The regional dietary supervisor said ready-to-eat foods should be handled with single use/single task gloves. The dietary supervisor said the kitchen staff members should change their gloves when going from task to task.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review, and staff interviews, the facility failed to conduct and document a facility-wide assessment to determine and identify what resources are necessary to care for its residents appropriately during both day-to-day operations and emergencies.Specifically, the facility failed to develop a facility assessment that was facility specific to include, resources, training and specifics about the resident population.Findings include:I. Record reviewThe facility assessment was provided by the nursing home administrator (NHA) on 3/12/26 at 11:00 a.m. The facility assessment revealed it was last reviewed on 5/8/25 by the NHA. The facility assessment failed to:-Include staff competencies that were necessary to provide the level and types of care needed for the resident population.-Include a staff training program to ensure any training needs were met for all new and existing staff.-Identify all contracts, memoranda of understanding and other agreements to provide services or equipment to the facility during day to day operations and emergencies.-Identify facility resources needed to provide competent resident support during day-to-day operations and emergencies.-Identify how the facility evaluated what policies and procedures may be required in the provision of care, and how the facility would ensure policies and procedures meet current professional standards of practice.-Create a facility assessment that was accurate and unique to the facility. The assessment failed to include the secured unit was only for female residents. -Identify the areas of a facility-based and community-based risk assessment, utilizing an all-hazards approach.-Identify how a translator would be obtained for non-English speaking residents. II. Staff interviewsThe social services director (SSD) was interviewed on 3/12/26 at 9:30 a.m. The SSD said the secured unit had 19 residents and it was for female residents only.-However, the facility assessment failed to include that the secured unit was only for female residents (see above). The director of nursing (DON) was interviewed on 3/12/26 at 7:45 p.m. The DON said the facility had contracts with an oxygen company, laboratory company and also an Xray company. -However, the facility assessment failed to include the contracts with the oxygen, laboratory and Xray companies (see above). The DON said the facility admitted residents who were non-English speaking. She said the facility currently had a resident who understood some English, however it was not her primary language and that a translation line was available to be used by staff.-However, the facility assessment failed to identify how a translator would be obtained for non-English speaking residents (see above). The NHA was interviewed on 3/12/26 at 7:00 p.m. The NHA said the facility assessment was reviewed yearly. She said the interdisciplinary team (IDT) additionally reviewed and participated in the development. During the interview, the facility assessment was reviewed with the NHA. She acknowledged the assessment did not include any training, staffing plans, contracts held by the facility or the areas of emergency hazards which were identified by the facility. The NHA acknowledged the facility assessment additionally did not contain specific information in regards to the all-female resident secured unit.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety.Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care.Findings include:I. Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies and initiate a plan to correctF600 Abuse prevention During the recertification survey on 11/3/22, F600 was cited at a D level scope and severity, no actual harm with potential for more than minimal harm that is not immediate jeopardy, isolated.During the recertification survey on 2/8/24, F600 was cited at a D level scope and severity, no actual harm with potential for more than minimal harm that is not immediate jeopardy, isolated.During the abbreviated survey on 3/6/25, F600 was cited at a G level scope and severity, actual harm that is not immediate jeopardy, isolated. II. Cross-reference citationCross-reference F689: The facility failed to prevent an accident on a facility transportation vehicle resulting in major injuries for one resident.The facility failed to ensure Resident #106 was secured properly in a facility transportation vehicle on 1/30/26, resulting in the resident sustaining multiple fractures to her lower extremities. Additionally, the facility failed to address concerns regarding transportation staff training and proper fastening of restraints for residents during transportation. The facility's failure to safely transport residents created an immediate jeopardy (IJ) situation with actual serious harm. III. Staff interviewsThe medical director (MD) was interviewed on 3/12/126 at 4:00 p.m. The MD said he had been the MD for the facility for the last year. The MD said he attended the QAPI meetings regularly and came into the facility as needed. The MD said he was informed about the accident involving Resident #106 on 1/30/26 after it had occurred, and said the facility was good at communicating with him about any concerns. The MD said he provided guidance to the facility staff if there were any changes in standards of practice.The nursing home administrator (NHA) was interviewed on 3/12/26 at 7:24 p.m. The NHA said the QAPI committee included the MD, the director of nursing (DON), the interdisciplinary team (IDT) and herself. The NHA said the QAPI committee met monthly and followed a standard agenda each month with any QAPI plans or survey trends addressed as needed. The NHA said the QAPI committee used several methods to self-identify concerns, including morning meetings each morning, performing audits, investigating trends and reviewing resident council minutes. The NHA said concerns with abuse were previously identified due to findings from abbreviated surveys. The NHA said the facility consistently trained and educated the facility staff on abuse. The NHA said the QAPI team had also identified concerns regarding abuse reporting the year prior due to abbreviated surveys during that period. The NHA said the facility had investigated the verbal abuse incidents but had seen the incident with Resident #37 as a resident's behaviors rather than abuse. The NHA said the QAPI committee had identified and addressed the concerns regarding the incident with Resident #106 on 1/30/26 but thought the facility's failures stemmed from ensuring their documentation was in order.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to provide response, action and rationale to residents involved in group grievances. Specifically, the facility failed to effectively address, resolve and follow up with residents on the outcomes and resolutions of grievances expressed.Findings include:I. Facility policy and procedureThe Grievance and Concern policy, undated, was provided by the nursing home administrator (NHA) on 3/12/26 at 1:31p.m. It read in pertinent part, Residents have the right to receive a written decision on the grievance.The grievance coordinator, or designee, will confer with persons involved in the incident and other relevant persons. Within three days of receiving the grievance, the grievance coordinator shall provide an explanation of the finding and proposed remedies to the complainant and the aggrieved party. II. Resident group interviewSix residents (#23, #26, #41, #1, #53 and #70) who regularly attended the resident council meetings were interviewed on 3/11/26 at 10:00 a.m. The residents were identified as alert and oriented by the facility and assessment.The group of residents said the facility did not follow up on grievances brought up in the food council meetings. Resident #23 said when a grievance came up in the food council meeting, the department head tried to address it during the meeting, however, the same concerns continued to be brought up every month. She said the residents had started up their own separate committee to follow up amongst themselves if things in the food council meeting had been addressed or not. Resident #23 said the staff who used the ordering tablets did not know how to use them properly and this caused incorrect meal orders to be entered. Resident #41 said the staff did not offer healthy snacks to the residents, only sugary snacks. All the residents said that they were refused fresh fruit because it was seasonal and they continually did not get soup varieties or homemade soup. III. Record reviewA review of the food council meeting minutes, dated 1/13/26, revealed the residents brought up concerns regarding staff needing more training on communication. A review of the food council meeting minutes, dated 2/5/26, revealed the residents brought up concerns regarding wanting more fresh fruit and homemade (not canned) soups. A review of the food council meeting minutes, dated 3/5/26, revealed the residents brought up concerns regarding cold room trays, a lack of consistency in room tray delivery times, missing room tray meals, a desire for low sodium soup options and a request for fresh fruit. A review of the food council grievances provided by the NHA on 3/12/26 at 1:57 p.m., revealed a general concern form, dated 3/5/26, referencing resolutions to concerns had been addressed in meeting minutes. The NHA attached the 3/5/26 meeting minutes which revealed the following; Concerns regarding cold room trays would be looked into.Room tray delivery times had been posted.A QAPI (quality assurance and performance improvement) committee would review the missing meals and increased monitoring and staff education would occur. The kitchen needed time to adjust before the concern of low sodium soups not being provided could be addressed.The residents were reminded fresh fruit would have to wait on availability.-A review of the March 2026 grievances and the resident council meeting minutes failed to reveal the facility had followed up with any of the individual residents or the food council as a group regarding what had been done to resolve their concerns after the January 2026, February 2026 or March 2026 meetings. IV. Staff interviewsThe social services director (SSD) was interviewed on 3/12/26 at 11:30 a.m. The SSD said grievances and concerns brought up in the food council meetings were not written up as a grievance and resolutions were discussed with the residents at the time of the meeting. The regional dietary supervisor was interviewed on 3/12/26 at 2:27 p.m. The regional dietary supervisor said he recently took over the dietary services in the last two weeks and he had not attended a food council meeting yet. The regional dietary supervisor said if a concern or grievance was brought up in the food council meeting, a formal grievance form should be completed, addressed by his department, and a resolution should be brought back to the residents. He said he was not aware of some of the concerns the residents brought up in the food council meetings, but he said now that he was aware, he would begin to address the concerns and follow up with the residents to determine what resolutions would be satisfactory for them.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper storage of medications for one of one medication storage room and three of five medication storage carts.Specifically, the facility failed to:-Ensure eye drops, insulin vials, tuberculin (TB) serum vials and nebulizer medications were dated with the dates they were opened;-Ensure expired medications were discarded; and,-Ensure expired medical supplies were discarded.Findings include:I. Professional referenceAccording to the manufacturer [NAME] Lilly, Learn How to Use a Vial and Syringe for Lispro (Humalog), December, 2025, retrieved on 3/16/26 from https://insulins.lilly.com/humalog, Once opened, Humalog vials, prefilled pens, and cartridges should be thrown away after 28 days even if it still contains insulin.According to manufacturer Sanofi Pasteur Limited, beyond use date, December 2025, retrieved on 3/18/26 from https://www.fda.gov/2026, A vial of Tubersol which has been entered and in use for 30 days should be discarded. According to manufacturer [NAME] Laboratories, beyond use date, September 2025, retrieved on 3/18/26 from https://gentealtears.myalcon.com, It is good standard practice to date an ophthalmic (eye) medication upon opening, as the date should be tracked to reduce risk of using contaminated products. GenTeal eye drops should be discarded 90 days from opening.According to manufacturer Allergan, beyond use date, April 2024, retrieved on 3/18/26 from https://www.hdrxservices.com/Ophthalmic-Medication-Beyond-Use-Date-Guide-Apr-2024, Refresh Tears eye drops should be discarded 90 days from opening.According to manufacturer Teva, beyond use date, 2026, retrieved on 3/18/26 from https://www.tevausa.com. Open lidocaine patches that have not been used after 14 days should be discarded to avoid using a patch that is no longer effective.According to manufacturer Nephron Pharmaceuticals, beyond use date, 2026, retrieved on 3/18/26 from https://nephronpharm.com/products/ipratropium-bromide-05-mg-and-albuterol-sulfate-3-mg, Vials should be protected from light before use, therefore, keep unused vials in the foil pouch or carton. Vials should be used within two weeks once removed from the foil package. II. Facility policy and procedureThe Storage of Medications policy, undated, was provided by the nursing home administrator (NHA) on 3/12/26 at 1:00 p.m. It read in pertinent part, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.III. Observations and interviewsOn 3/10/26 at 4:16 p.m. the medication storage room was reviewed with licensed practical nurse (LPN) #1. The following items were found:-One vial of TB serum that was opened and was not dated.-Four 0.5 milliliter (ml) pre-filled syringes of Flucelvax that expired 6/30/25.-Two hydrocortisone acetate 25 milligram (mg) suppositories that expired October 2025.-One blood collection set with seven-inch tubing that expired 4/30/25.-28 Luer Lock caps (used to seal the connectors on an intravenous (IV) catheter) that expired 11/30/25.-27 Luer Lock caps that expired 3/1/26.-One Luer Lock cap that expired 7/28/25.-Nine Luer Lock caps that expired 2/28/26.-One Vacutainer blood collection needle that expired 2/28/25.-One enteral feeding tube clog remover that expired 4/30/25.-67 purple top Vacutainer blood collection vials that expired 2/28/26.-37 purple top Vacutainer blood collection vials that expired 6/30/25.-46 blue capped needles that expired 2/20/26.On 3/11/26 at 3:11 p.m. the medication cart on the secure unit was reviewed with registered nurse (RN) #4. The following items (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were found:-One bottle of Refresh Tears that was opened and was not dated.-A 16-ounce bottle of Drug Buster (activated charcoal-based disposal system designed to quickly deactivate and destroy unwanted pills, capsules, liquids, creams) was in the same drawer as liquid medications.-One foil package containing eight ampules of Ipratropium Bromide and Albuterol Sulfate (nebulizer medication) 0.5 mg/3 mg per 3 ml that was opened and was not dated. RN #4 said she was unaware the package should be dated once opened.On 3/11/26 at 3:20 p.m. the medication cart on A-Hall was reviewed with LPN #2. The following items were found:-One bottle of GenTeal tears that was opened and was not dated.-Two acetaminophen 650 mg suppositories that were lying loose in a small plastic container.-One vial of Lispro insulin that was opened and was not dated.-One single dose kit of naloxone hydrochloride nasal spray 4 mg that expired December 2025.On 3/12/26 at 11:00 a.m. the medication cart on B-Hall was reviewed with RN #3. The following items were found:-Two acetaminophen 650 mg suppositories that were lying loose in a small plastic container.-One foil package of a 4% Lidocaine patch that was opened.-One package containing a urinary drainage bag that was opened in the bottom drawer.-One foil package containing 19 ampules of Ipratropium Bromide/Albuteral Sulfate 0.5 mg/3 mg per 3 ml that was opened and was not dated. RN #3 said she was unaware the package should be dated once opened. -One half ounce tube of miconazole nitrate cream that expired February 2026.IV. Additional staff interviewsThe director of nursing (DON) was interviewed on 3/12/26 at 10:00 a.m. The DON said the night shift nurses were responsible for routinely reviewing the medication storage room and the medication carts to ensure any expired medications and supplies were removed from use. She said the pharmacist also completed routine medication cart reviews but she did not look for expired medications and supplies in the medication storage room. LPN #1 was interviewed on 3/12/26 at 10:15 a.m. LPN #1 said all nurses were to check expiration dates on medications during their shift throughout their medication pass, and the night shift nurses were to routinely review the medication room as well as the medication carts for any expired medications or supplies and remove them from use.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review and interviews, the facility failed to ensure meals were served according to the resident's preferences for residents on five of six units.Specifically, the facility failed to offer substantive menu alternatives and honor residents' food preferences. Findings include: I. Facility policy and procedure The Dining and Food Preferences policy and procedure, revised October 2022, was received from the nursing home administrator (NHA) on 3/12/26 at 1:31 p.m. It read in pertinent part, Upon meal service, any resident with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value. The alternate meal and/or beverage will be provided in a timely manner.II. Resident interviews and observationsResident #42 was interviewed on 3/9/26 at 10:45 a.m. Resident #42 said food had been her biggest problem with the facility. She said she sometimes got enough to eat. Resident #42 said the facility had gotten rid of their always-available menu when they had a management change. Resident #42 said she asked for fresh fruit all the time because the facility used to receive it in their shipments, but said the facility had stopped serving fresh fruit. Resident #42 said she would give anything for fresh fruit.Resident #69, Resident #70 and Resident #50 were interviewed together on 3/9/26 at 1:11 p.m. The residents said they often did not receive what they ordered on their meal trays. The residents said the nursing staff sometimes did not take their meal orders for the next day, so they would just receive the pre-set regular menu items.Resident #92 was interviewed on 3/9/26 at 12:36 p.m. Resident #92 said the facility changed their meal ordering process, so the staff would go around and get the residents' orders the day before. Resident #92 said the facility usually did not serve what was on the menu, and said it was frustrating. Resident #92 said she needed to request certain food items because her top dentures were broken.Resident #92 was interviewed a second time on 3/10/26 at 1:10 p.m. Resident #92 said her lunch was okay, but she was still hungry because she had not eaten much for breakfast that morning. Resident #92 said she had not been offered a snack between breakfast and lunch. Resident #92 activated her call light, and when certified nurse aide (CNA) #4 entered the room the resident requested a peanut butter and jelly sandwich. At 1:16 p.m. CNA #4 walked to the kitchen and spoke with the kitchen staff. CNA #4 asked the kitchen staff if they had any peanut butter and jelly sandwiches available. The kitchen staff's answer was inaudible. CNA #4 asked the kitchen staff if they could make a turkey sandwich instead. The kitchen staff's answer was inaudible. CNA #4 exited the dining room and returned to Resident #92's room, where she told Resident #92 the kitchen said they were out of sandwiches and the resident would have to wait until 2:00 p.m. to receive a snack.Resident #92 was interviewed a third time on 3/11/26 at 12:11 p.m. Resident #92 said the nursing staff had not woken her up to let her know her breakfast had been served that morning, so when she woke up her breakfast was cold. Resident #92 said she had ordered an omelet, sausage, toast and oatmeal, but received scrambled eggs, hashbrowns and oatmeal. Resident #92 said she could not eat hashbrowns. Resident #92 said she was offered a peanut butter and jelly sandwich by the nursing staff instead. Resident #92 said she did not think she was getting enough food to eat, and said she sometimes got a headache from not eating as much.Resident #11 was interviewed on 3/10/26 at 9:18 a.m. Resident #11 said the food served by the facility was getting better, but when the new company took over in the kitchen it was really bad. Resident #11 said residents did not have a choice in what they were served at meals, and the rules imposed by the kitchen kept changing. Resident #11 said sometimes her food was cold, and often the meat served at dinner was so tough she could not cut it. Resident #11 said the kitchen had a lot to work on. Resident #11 said the kitchen did not serve fresh fruit, as they said they could not order fresh fruit at that time of the year. Resident #11 said she only ever got fresh grapes, but was tired of grapes. Resident #11 was interviewed a second time on 3/11/26 at 5:48 p.m. Resident #11 said she only had two choices of what to eat at each meal, and if she did not like either of the choices there was nothing else available. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 said if she did not like the meal she received she was never offered other options like sandwiches or soups. Resident #11 said she had brought up her concerns with staff members and brought it up in the food council meetings, but the kitchen staff always answered by saying they did not carry those options in stock.III. Resident group interviewSix residents (#23, #26, #41, #1, #53 and #70) who frequently attended the monthly resident council meetings and were identified as alert and oriented by facility and assessment were interviewed on 3/11/26 at 10:00 a.m.Resident #41 and Resident #70 both said they wanted a variety of soups but the facility did not offer them.Resident #41 said the nursing staff took the residents' orders two to three days in advance, but if the nurse did not or was unable to take their order the nurse would just mark the resident for a regular meal tray.Resident #23 said the kitchen staff repeatedly told the residents they were not able to get fresh fruit, only canned. Resident #23 said there was not a resolution process for any food committee grievances. IV. Record reviewFood council meeting minutes, dated 1/13/26 at 10:00 a.m., revealed the residents in attendance requested more fresh fruit and vegetables, and more fresh soups. The minutes documented the facility responded by informing the residents they would buy fresh fruit and vegetables as they were available and in-season, and said their soups were made fresh and shipped frozen to the facility. The residents also requested the servers and new employees receive more training as the residents felt the staff members did not know what was expected of them. The facility responded by saying all dietary staff would receive training on the facility's new policies and procedures.Food council meeting minutes, dated 2/5/26 at 10:02 a.m., revealed the residents in attendance were requesting more fresh fruit and homemade soups. The meeting notes also documented that the alternate food menu would be condensed.-However, no documented facility response was provided to the residents' request for fresh fruit and soups.Resident council minutes, dated 3/4/26, revealed the director of operations spoke with the residents in attendance to inform them the dietary department was going through a lot of changes. The dietary manager spoke with the residents in attendance and said they were working on resident preferences and asked that all food concerns be addressed at the food council meeting the next day (3/5/26).Food council meeting minutes, dated 3/5/26 at 10:00 a.m., revealed the residents in attendance requested more fresh fruit and vegetables, and said the soup of the day was not to order on the new menu system. The minutes documented the facility responded by reminding the residents they would buy fresh fruit and vegetables as they were available and in-season, and said they would begin making soups from scratch once the new dietary company had established its systems. A grievance form, dated 3/5/26, revealed a grievance had been initiated from the resident food council on 3/5/26. The grievance form documented several concerns were brought up during the resident food council, and documented what was discussed by attaching the 3/5/26 food council minutes (see above). The grievance form documented the dietary company was to follow up with the concerned individual(s) within 48 hours of the complaint. The grievance form did not document any further follow-up or investigation.V. Staff interviews CNA #5 was interviewed on 3/11/26 at 6:07 p.m. CNA #5 said a lot of the processes involved with the kitchen had changed recently. CNA #5 said the nursing staff had to take residents' meal orders the day before the meal was served, which created issues as some of the residents did not remember what they ordered or no longer wanted what they had ordered the day before. CNA #5 said the facility used to have an always-available menu for the residents to order alternate items, but now residents just get what they are served. CNA #5 said if residents asked for alternatives from the kitchen their requests were denied, and the residents did not have as much freedom in their food choices as they used to. CNA #5 said several of the residents she worked with were often hungry, and some of the residents were not eating at all. CNA #5 said some of her coworkers had been going to the grocery store to purchase alternate snacks for the residents themselves.CNA #6 was interviewed on 3/12/26 at 9:18 a.m. CNA #6 said the recent changes implemented by the kitchen had affected how happy the residents were, as food was so important to their lives. CNA #6 said the kitchen no longer offered any menu items outside of their scheduled menu. CNA #6 said the kitchen previously used to (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	let residents order whatever they wanted at any time. CNA #6 said if a resident did not like what they were served, the kitchen staff would not serve any alternate items until they were finished serving the entire facility, so it could take 45 minutes to an hour to get any other food items for the residents. CNA #6 said the kitchen did have a menu with a few alternate entree items, but those items were only available during scheduled meal times. CNA #6 said if a resident refused their meal or did not eat much of their meal, she would go to the kitchen and just had to see what alternative the kitchen would give her. CNA #6 said she mostly received pantry snacks like crackers from the kitchen in those instances. CNA #6 said between meal times residents could have snacks like crackers, applesauce or yogurt. CNA #6 said she had not seen any of her residents lose weight but said she anticipated they would.CNA #7 was interviewed on 3/12/26 at 11:18 a.m. CNA #7 said the recent changes in the kitchen had annoyed the residents, as the new kitchen system had changed the residents' diets and cut out all of the menu items the residents used to like. CNA #7 said the kitchen no longer offered the same snacks or menu alternatives they used to offer, and said residents could no longer get fresh fruit. CNA #7 said if a resident did not want the meal they were served, the kitchen staff would not let the CNAs get alternate food items for the resident until the entire facility had been served, and if they ran out of what the resident wanted the resident would only get a sandwich. CNA #7 said the alternate menu items were a hamburger, cheeseburger, grilled cheese, hotdog or a salad. CNA #7 said the kitchen did not stock sandwiches for residents to have as snacks, and had only crackers or chocolate snacks. CNA #7 said she felt bad for the residents because of these changes. CNA #7 said her coworkers had gone to the grocery store to get snacks the residents would enjoy, and said she encouraged residents' families to supply the residents with snacks they would like. Licensed practical nurse (LPN) #1 was interviewed on 3/12/26 at 11:38 a.m. LPN #1 said the kitchen had made changes to the way meal tickets were filled out, so now the nursing staff had to collect residents' orders the day before. LPN #1 said a lot of the residents forgot what they had ordered the day prior and were agitated when they were served. LPN #1 said the kitchen used to stock a wider variety of menu items, but had recently cut their menu in half. LPN #1 said if a resident did not like what they were served or did not eat much, the nursing staff could offer the resident a sandwich or snack items. LPN #1 said if a resident was missing a menu item from their meal tray, it could take over 20 minutes to get the missing item from the kitchen, assuming it was still available. LPN #1 said the kitchen may have already thrown away the menu item if the resident waited too long, so LPN #1 said she could offer the resident a sandwich or snack instead, though LPN #1 said she thought most residents would not want a ham and cheese sandwich at 8:00 in the morning. LPN #1 said the kitchen did have grilled cheese sandwiches or soups available as alternate items, but said the resident could only order those items during scheduled meal time windows. LPN #1 said if a resident wanted soup or a grilled cheese sandwich outside of those windows, the kitchen would offer them snack items instead.The regional dietary supervisor was interviewed on 3/12/26 at 3:05 p.m. The regional dietary supervisor said the facility utilized a standard running menu for each meal time and had a bistro menu with alternative entrees as well. The regional dietary supervisor said the bistro menu items were not available between mealtimes, but were only available during the posted mealtimes. The regional dietary supervisor said if a resident requested a bistro item, such as a cheeseburger, outside of the posted meal times the kitchen would not be able to provide the resident with that item but they could offer snacks instead. The regional dietary supervisor said the kitchen staff were still trying to get new systems of operation in place, and did not have the staffing available to prepare bistro items between mealtimes while still ensuring the regular meals were served on time. The regional dietary supervisor said the fresh fruits the facility had available included grapes, apples, oranges and bananas. The regional dietary supervisor said they had previously offered kiwis and berries, but none of the residents wanted kiwis and they were no longer able to offer berries due to price increases. The regional dietary supervisor said the kitchen had stocked the same four fresh fruits for the last month, and when the seasons changed they would include different seasonal fruit varieties. The (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regional dietary supervisor said the facility had held its first food council with the new dietary company the Thursday prior, and said he had gotten the notes and grievance related to the meeting that day (3/12/26). The regional dietary supervisor said he had already addressed a lot of the residents' concerns with the NHA, but would review the food council notes and write a plan of action going forward. The dietary supervisor said he had not received any formal grievances regarding food prior to 3/12/26.The NHA was interviewed on 3/12/26 at 3:30 p.m. The NHA said the facility's previous dietary manager had left in November 2025. The NHA said she had tried hiring multiple other dietary managers between November 2025 and March 2026, but had not been able to fill the position. The NHA said she had been running the kitchen since November 2025 until the outside dietary company took over a few weeks ago. The NHA said she had a grievance from the food committee that she had received the week prior that she had just given to the dietary supervisor to address that day (3/12/26) but had been unable to do so prior due to the survey proce

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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 possible development and transmission of infectious diseases on two of three units.Specifically, the facility failed to:-Ensure housekeepers cleaned and disinfected the residents' rooms in a hygienic manner; -Ensure housekeepers cleaned high touch areas; -Ensure hand hygiene was completed during room cleaning; -Ensure dwell times for disinfectants were followed per manufacturer's recommendations:-Ensure staff followed appropriate hand hygiene practices;-Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing care for residents on enhanced barrier precautions (EBP); and,-Ensure appropriate infection control practices were followed during medication administration.Findings include: I. Housekeeping room cleaning failures AProfessional reference According to The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24), retrieved on 3/18/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. According to the Sani-Clean disinfectant directions, retrieved on 3/21/26 from https://www.pdqonline.com/wp-content/uploads/4481-SaniClean_tech.pdf Apply solution with a mop, cloth, sponge, hand pump trigger sprayer or low pressure coarse sprayer so as to wet all surfaces thoroughly. Allow to remain wet for 10 minutes, then remove excess liquid. B. Observations On 3/12/26 at 10:41 a.m. housekeeper (HK) #1 was observed cleaning resident room #A9, a double occupancy room. HK #1 performed hand hygiene with alcohol based hand rub (ABHR) and applied (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clean gloves. HK #1 collected two dry rags and a bottle of Sani-Clean 2 disinfectant spray. HK #1 entered the resident's room and went straight to the resident's area on the door side of the room and sprayed the chemical on the television (TV) console, and immediately wiped the disinfectant off with a rag. HK #1 then proceeded to the other resident's side of the room, sprayed the over bed table with the disinfectant and wiped the table immediately. HK #1 proceeded to the residents' bathroom where she began spraying the Sani-Clean solution on the seat of the toilet. After spraying the disinfectant, she immediately wiped the seat, then proceeded to put Comet cleaner into the toilet bowl. -HK #1 did not clean the high touch areas in the room, which included, the individual call lights, the bathroom call lights, the door knobs, the sink and the grab bars. -HK #1 failed to wait the allotted dwell time of 10 minutes for the disinfect before wiping the disinfectant from surfaces (see manufacturer's directions above). On 3/12/26 at 11:19 a.m. HK #2 was observed cleaning resident room #E7, a double occupancy room. HK #2 performed hand hygiene with ABHR and applied clean gloves. HK #2 collected two rags which were damp with the Sani-Clean cleaner. The cloths were not saturated all the way through. She went directly to the toilet and sprayed the toilet with disinfectant at 11:21 a.m. She lifted the toilet seat with her gloved hands and sprayed under the seat. Without changing her gloves or performing hand hygiene, HK #2 proceeded to go to the window bed and used the Sani-Clean dampened rag to clean the TV console and dresser as she touched a few of the resident's personal items to move them with the same gloved hands that had previously touched the toilet seat. She then went to the door side of the room and proceeded to clean the over bed table. She cleaned the call light with a damp towel. -HK #2 did not change her gloves when going from one side of the room to the other, or after touching the toilet seat and before touching the residents' personal items. At 11:25 a.m. HK #2 returned to the residents' bathroom and wiped the toilet from top down, four minutes after spraying the toilet with the disinfectant spray. -HK #2 did not clean the high touch areas in the room, which included, the individual call lights, the bathroom call lights, the door knobs, the sink, and the grab bars. -HK #2 failed to wait the allotted dwell time of 10 minutes for the disinfect before wiping the disinfectant from surfaces (see manufacturer's directions above). C. Staff interviews HK #1 was interviewed on 3/12/26 at 10:48 a.m. HK #1 said that the Sani-Clean disinfectant was a one second dwell time. She said she would clarify with the housekeeping supervisor (HKS). HK #2 was interviewed on 3/12/26 at 11:35 a.m. HK #2 said the cloths were damp and not completely saturated with the Sani-Clean. She said she dampened them so she did not have to spray the chemical near the residents or their personal items. She said the dwell time for the disinfectant chemical was two minutes. The HKS was interviewed on 3/12/26 at 2:30 p.m. The HKS said the housekeeping staff had been (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trained on proper handwashing. She said their hands needed to be cleaned with ABHR or soap and water prior to putting on gloves, between tasks and after touching the toilet. She said the Sani-Clean disinfectant had a 10 minute dwell time. She said the high touch areas, which included, the door knobs, call lights, grab rails needed to be cleaned each time the rooms were cleaned. D. Facility follow-up On 3/12/26 the HKS provided a document that indicated HK #1 and HK #2 had received training on how to clean the residents' rooms, including the use of the disinfectant chemicals with the appropriate dwell time and high touch areas. II. EBP and hand hygiene failures A. Professional reference According to the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 4/2/24, retrieved on 3/23/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), or wound care (any skin opening requiring a dressing). In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to standard precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because enhanced barrier precautions do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. According to the CDC's Hand Hygiene for Healthcare Workers, updated 2/27/24, retrieved on 3/4/26 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Know when to clean your hands: immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings, always clean your hands after removing gloves, remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil your hands. B. Observations On 3/11/26 at 10:20 a.m., a sign attached to the paper towel dispenser in Resident #91's room door indicated the resident was on EBP. The sign indicated a gown and gloves must be worn for high-contact resident care activities, including dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. Resident #91 had an open wound to his sacrum, an indwelling urinary catheter and a peripherally inserted central catheter (PICC - an a central intravenous (IV) line to administer fluids and medications). On 3/12/26 at 2:29 p.m., the restorative aide was observed performing active range of motion (AROM) exercises with Resident #91. Upon entering Resident #91's room, the restorative aide performed hand hygiene and donned gloves. Resident #91 was lying on his right side in bed and covered with a blanket. Using her gloved hands, the restorative aide used the bed controls to raise the resident's bed. The restorative aide uncovered Resident #91 to his waist, removed two different wedge pillows from behind his back, an approximately two to three foot long soft cylindrical cushion resting on top of the resident's chest, and placed them at the foot of the resident's bed. The restorative aide used her left hand to lift and support Resident #91's hand and her right hand to support the resident's elbow. The restorative aide performed AROM exercises with the resident's left arm, as he could tolerate, including elbow flexion/extension, wrist flexion/extension, front shoulder raises and lateral shoulder raises. The restorative aide unlocked Resident #91's bed and used her gloved hands to grab the resident's bed frame and pull the bed away from the wall. The restorative aide walked to the other side of Resident #91's bed, raised and supported his right arm, with her right hand supporting his hand and her left hand supporting his elbow. The restorative aide completed the same AROM exercises with the resident on his right side as tolerated. -The restorative aide failed to don a gown after entering Resident #91's room and before initiating restorative exercises. -The restorative aide failed to discard her gloves, perform hand hygiene, and don new gloves after she initially touched and relocated Resident #91's personal items and before she began restorative exercises. -The restorative aide failed to change her gloves and perform hand hygiene after touching and repositioning Resident #91's bed to access the resident's right side. The restorative aide moved back to Resident #91's left side and uncovered his legs. The restorative aide removed a pillow from between Resident #91's legs and removed the soft cushion boots that (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

were on his feet. The restorative aide observed that Resident #91 had had a bowel movement. The restorative aide covered Resident #91 with his blanket, repositioned and lowered his bed, then discarded her gloves and performed hand hygiene. The restorative aide exited Resident #91's room to find a certified nursing aide (CNA) to help with her with the resident's incontinence care.

On 3/12/26 at approximately 2:50 p.m. the restorative aide , CNA #1, and licensed practical nurse (LPN) #3 were observed performing incontinence care on Resident #91. Upon entering Resident #91's room, the restorative aide and CNA #1 performed hand hygiene and donned gloves. LPN #3 was wearing gloves upon entering Resident #91's room. The restorative aide, CNA #1 and LPN #3 moved to the left side of Resident #91's bed to begin incontinence care.

Upon prompting, CNA #1 said gowns should be worn during incontinence care for residents. CNA #1, LPN #3, and the restorative aide discarded their gloves, donned a gown and new gloves and returned to the resident's bedside.

CNA #1 used her gloved left hand to move the privacy curtain and walked around to the right side of Resident #91's bed. The restorative aide unlocked Resident #91's bed. The restorative aide, LPN #3 and CNA #1 all used their gloved hands to grab the bed frame and push/pull Resident #91's bed away from the wall. Using her gloved hands, the restorative aide grabbed a trash can by the sink and set it at the side of Resident #91's bed. The restorative aide obtained a package of wet cleansing wipes and placed them on Resident #91's bed. Resident #91 was positioned onto his left side.

LPN #3 placed her right hand on Resident #91's right upper arm and her left hand on his right hip to assist the resident staying on his left side. The restorative aide removed wipes from the package and handed them to CNA #1. CNA #1 used the wipes to cleanse Resident #91's perineum, rectal fold, and buttocks. CNA #1 handed the used wipes to the restorative aide to throw away in the trash bin next to Resident #91's bed. CNA #1 rolled up the dirty Chux pad (a disposable and absorbent pad) underneath Resident #91 and placed a new Chux pad on the bed.

LPN #3, CNA #1, and the restorative aide rolled Resident #91 onto his right side, removed and discarded the dirty Chux pad, and properly positioned the new one underneath the resident. Resident #91 was rolled onto his back. The restorative aide obtained wet wipes from the package, wiped in between Resident #91's legs and thigh folds, then discarded them. The restorative aide obtained more wipes and wiped around the resident's penis and pubic area, touching and wiping around the resident's suprapubic indwelling catheter line, then discarded the wipes. LPN #3, CNA #1 and the restorative aide used the fitted sheet underneath Resident #91 to boost him up in bed.

-CNA #1 failed to change her gloves and perform hand hygiene after touching the privacy curtain and moving Resident #91's bed before completing incontinence care.

-The restorative aide failed to change gloves and perform hand hygiene after moving the trash can and moving the resident's bed.

-LPN #3 failed to change her gloves and perform hand hygiene after moving the resident's bed and before assisting with repositioning during incontinence care.

-Additionally, LPN #3, CNA #1, and the restorative aide failed to don gowns before performing incontinence care until prompted.
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

CNA #1 and the restorative aide discarded their gloves, donned a new pair of gloves, and returned to the resident's bedside. Resident #91 was repositioned onto his right side, his soft boots were reapplied, two positioning wedges were placed behind his back, and a pillow was placed in between his knees. Resident #91 was covered with a blanket, his bed was moved next to the wall, and lowered.

LPN #3 and CNA #1 removed and discarded their gowns and gloves, then washed their hands at the sink, and exited the resident's room. The restorative aide discarded her gloves, donned a new pair of gloves, and removed/replaced the bag in the resident's trash can. The restorative aide discarded her gloves and gown and washed her hands. The restorative aide used a paper towel to pick up the tied trash bag, exited Resident #91's room and discarded the bag in a labeled bin for trash in the hallway.

-CNA #1 and the restorative aide failed to perform hand hygiene after discarding their gloves, and before repositioning the resident.

C. Staff interviews

The infection preventionist (IP) was interviewed on 3/12/26 at 4:06 p.m. The IP said for residents on EBP, staff only needed to wear gowns when performing high-contact activities specifically related to or involving the reason the resident was on EBP. The IP said for residents diagnosed with an MDRO, staff should wear gowns for all high-contact resident care. The IP said the use of gowns was important to prevent the spread of infection. The IP said it was not appropriate for staff to touch other items/surfaces, then proceed with incontinence care, without discarding and replacing gloves and performing hand hygiene between.

The IP said he was unaware that staff needed to wear a gown and gloves during all high-contact resident care for any resident on EBP. The IP said he felt requiring staff to wear EBP during ROM exercises could negatively impact the resident's dignity.

The director of nursing (DON) was interviewed on 3/12/26 at 6:35 p.m. The DON said EBP should be worn during all high-contact resident care activities. The DON said EBP helped prevent staff from transmitting potentially infectious organisms to residents from staff members' clothing or skin. The DON said her expectation was for staff to wear gowns when providing ROM exercises and during incontinence care. The DON said it was not appropriate for staff to touch multiple surfaces and then perform incontinence care wearing the same gloves. The DON said touching high-contact surfaces, around already immunocompromised residents, could potentially lead to poor outcomes and/or infections.

III. Failed to ensure appropriate infection control practices were followed during medication administration

A. Observation

On 3/10/26 at 9:47 a.m. registered nurse (RN) #2 was observed during medication pass dispensing medications from blister pack cards into her hand then placing them into a medication cup to administer to a resident.

When prompted, RN #2 acknowledged she dispensed the medications into her hand and said she knew she was not supposed to do that because it would be an infection control issue.
(continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Staff interview The DON was interviewed on 3/10/26 at 11:00 a.m. The DON said RN #2 should know that any medication should not be dispensed into a bare hand. She said medications should be dispensed directly into a medication cup. C. Facility follow up On 3/10/26 at 12:39 p.m. the director of rehabilitation (DOR) provided a copy of an employee education consultation titled Medication Handling Procedure that was provided to RN #2. The education included the correct procedures for dispensing oral medication tablets. On 3/12/26 at 10:00 a.m. the DON said she had requested the pharmacist complete a medication pass observation with RN #2. She said medication pass observations would be completed for all nurses.

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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 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 (#53) of four residents reviewed for abuse out of 42 sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #53 from verbal abuse by Resident #37.Findings include:I. Facility policy and procedureThe Abuse and Neglect policy and procedure, revised April 2008, was received from the nursing home administrator (NHA) on 3/12/26 at 3:12 p.m. It read in pertinent part, Abuse means to intentionally harm a resident. Verbal and emotional abuse occurs when someone threatens or humiliates a resident and makes them feel afraid. Examples may include yelling, screaming, unkind teasing, threatening, use of offensive language to a resident or in the presence of a resident or harsh tone of voice.II. Resident #37 (assailant)A. Resident statusResident #37, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included vascular dementia with mood disturbance, depression and cognitive communication deficits.The 3/10/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. The resident required partial to maximal assistance from staff for most activities of daily living (ADL).The MDS assessment documented the resident did not have physical behaviors directed towards others. The assessment documented the resident had verbal behaviors and other behavioral symptoms not directed towards others on one to three days during the seven-day assessment look back period.B. Record reviewThe behavior care plan, revised 2/16/26, revealed Resident #37 could be verbally aggressive towards staff at times. Resident #37 was easily irritated and verbalized dissatisfaction with trivial items, including someone being in his way or a chair being moved. Resident #37 had made racial comments towards residents of color. Resident #37 had exhibited physical aggression towards staff when attempting to provide care and had told staff he would rape them. Pertinent interventions included encouraging Resident #37 to take a break if he became escalated and reapproaching him later, administering medications as ordered, assisting the resident to develop more appropriate methods of coping and interacting and staff providing care in pairs.A progress note, dated 11/20/25 at 5:28 p.m., revealed Resident #37 attempted to stand from his wheelchair multiple times throughout his shift, yelled at staff members, and called people names. Resident #37 also attempted to toss his water pitcher at a certified nurse aide (CNA).A progress note, dated 12/19/25 at 2:02 p.m., revealed Resident #37 exhibited increased verbal and physical aggression. Resident #37 refused to eat at his assigned table in the dining room with other male residents. Resident #37 repeatedly yelled obscenities at the other male residents and was moved to a different table in the dining room on two occasions. Multiple attempts were made to redirect Resident #37 with minimal effect. Resident #37 also made inappropriate comments towards the female staff members and engaged in inappropriate touching with the staff members. Multiple redirection attempts were made for Resident #37 with minimal effect. Resident #37's physician was notified.A progress note, dated 1/13/26 at 9:48 a.m., revealed Resident #37 was found the day prior (1/12/26) on another hallway in the facility yelling racial slurs at a resident of color (Resident #53). Resident #37 was redirected back to his room when the incident occurred. No other concerns were noted afterwards.-There was no further follow-up documentation related to the 1/12/26 incident.-The facility investigation for the incident on 1/12/26 was requested from the NHA on 3/12/25 at 8:22 a.m., however the facility was unable to provide an investigation as they had determined the incident did not constitute abuse (see interviews below).A physician note, dated 2/25/26 at 10:41 a.m., revealed Resident #37 was seen by his physician per staff request due to an increase in the resident's behaviors, both sexual and verbal, and at times physical during cares. The note documented Resident #37 had been more difficult to redirect. The physician reviewed Resident #37's behaviors with his representatives and received consent to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	increase his psychotropic medication dose. The note documented given Resident #37's ongoing behavioral concerns, the physician may need to consider adding an antipsychotic medication as well.Review of Resident #37's behavior monitoring task from 2/11/26 through 3/12/26 revealed the resident was observed yelling or screaming at others on 2/16/26 and 3/7/26.III. Resident #53 (victim)A. Resident statusResident #53, age less than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included aphasia, hemiplegia and hemiparesis (paralysis and weakness on one side of the body), vascular dementia, major depressive disorder and cerebral infarction (stroke).The 2/9/26 MDS assessment revealed the resident had severe cognitive impairment when assessed by staff. The resident was independent for most ADLs.B. Record reviewA progress note, dated 1/13/26 at 9:51 a.m., revealed that on 1/12/26 Resident #53 was near his room when another resident (Resident #37) came up to him and began making racial slur comments. Resident #53 was laughing and the other resident was redirected away from the area. The nurse followed up with Resident #53 regarding the situation and asked if he was okay. Resident #53 said yes, shook his head, gave a thumbs up gesture and started laughing.A progress note, dated 1/14/26 at 2:07 p.m., revealed a facility social worker visited Resident #53 regarding another resident calling him a derogatory name on 1/12/26. Resident #53 chuckled and waved his hands when the social worker asked him if he was okay or upset. The social worker documented she provided Resident #53 with support.IV. Staff interviewsCNA #5 was interviewed on 3/11/26 at 6:07 p.m. CNA #5 said if she saw a resident having verbal or physical behaviors, she would remove the resident from the area and take the resident to their room. CNA #5 said most of the behaviors she had seen were between residents, so she would remove the residents from the area and give them space to calm down. CNA #5 said if she saw residents yelling at each other she would chart their behaviors in the resident's electronic medical record (EMR) and notify the nurse.CNA #5 said Resident #37 did have behaviors and he had good days and bad days. CNA #5 said Resident #37 became aggressive and tried to fight both staff members and other residents. CNA #5 said Resident #37 liked to hit, grab and bite, and could become triggered by anything. CNA #6 was interviewed on 3/12/26 at 9:18 a.m. CNA #6 said Resident #37 had verbal and physical behaviors. CNA #6 said Resident #37's behaviors were mostly directed toward staff members, and she had rarely heard of him lashing out at other residents. CNA #6 said if Resident #37 was starting to have behaviors, she would attempt to redirect him by seeing if he was hungry, tired or in pain. CNA #6 said generally when Resident #37 was becoming agitated, he needed to have a bowel movement, so the nursing staff would assist the resident to the bathroom. CNA #6 said if Resident #37 was having behaviors directed towards other residents, the staff would separate the residents, de-escalate them and try to monitor the residents to keep them separated. CNA #6 said the common areas could be overstimulating to the residents, so the staff would redirect the residents back to their room. CNA #6 said if she saw residents having behaviors directed at other residents, she would alert her nurse or the CNA of the other resident involved.The director of operations was interviewed on 3/12/26 at 10:37 a.m. The director of operations said the facility staff had followed up with Resident #37 and Resident #53 after the incident on 1/12/26 and found neither resident had any issues or concerns after the incident. The director of operations said the social services director (SSD) had been the staff member who had followed up with them. -However, Resident #53 suffered verbal abuse as Resident #37 called Resident #53 slurs targeting his race. -Additionally, there was no documentation of any psycho-social follow-up for Resident #37 (see record review above).The director of operations said the interdisciplinary team (IDT) reviewed all new progress notes every morning during their morning meeting to determine if the facility needed to take any follow-up actions. The director of operations said Resident #37 had not made physical contact with Resident #53 on 1/12/26, so the situation had not needed to be reported. The director of operations said the social services team had performed psychological follow-up assessments with both of the residents after the incident. The director of operations said he did not have any documentation in regards to an investigation of the incident, outside of the progress notes documented in Resident #37 and Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#53's EMRs regarding the incident 1/12/26.-However, there was no documentation in Resident #37's EMR to indicate the social services team had followed up with the resident after the incident with Resident #53 (see record review above). The SSD was interviewed on 3/12/26 at 2:51 p.m. The SSD said for any resident-to-resident altercations, the staff would separate the residents and call the NHA immediately so she could begin the facility's investigation. The SSD said the NHA would then determine if the incident was considered abuse, and if the facility needed to report the incident to the State Agency and begin staff interviews. The SSD said if the incident was determined to be abuse, they would educate the staff on abuse prevention, keep the residents separated and identify the residents' triggers. If the incident was not determined to be abuse, the SSD said the facility staff still kept the residents separated and began staff education. The SSD said the facility discussed any incidents with the IDT during their morning meeting and created physician's orders to monitor the residents after incidents as needed.The SSD said Resident #37's behaviors varied, and said he would get irritated if his hearing aide was not working. The SSD said Resident #37 tended to have some outbursts. The SSD said the staff had determined some of Resident #37's triggers included issues with his hearing aide, his oxygen settings or needing to use the bathroom. The SSD said Resident #37 was redirectable with food or watching movies.-However, the triggers and methods of redirection for Resident #37 were not documented in the resident's care plan (see record review above).The SSD said Resident #37 had one incident involving another resident on another hall, after which the social services staff had interviewed Resident #53 and he had just laughed and said it was fine, so the facility determined the situation was not abuse. The SSD said Resident #37 had another incident in which he had verbalized something in the dining room, and there was no reaction from any of the other residents around him.The director of nursing (DON) was interviewed on 3/12/26 at 3:54 p.m. The DON said Resident #37 was short-tempered. The DON said she did not know what Resident #37's triggers were, but said his direct caregivers were good about finding ways to interact with and redirect him. The DON said Resident #37 was able to be redirected with movies and sitting in the lobby with his daughter.The NHA was interviewed on 3/12/26 at 4:50 p.m. The NHA said the IDT discussed residents' behaviors during every morning meeting. The NHA said if a resident's behaviors involved any other residents, the IDT would send a member of the social services staff to talk with the residents involved and see if they were okay. The NHA said if there was physical contact between residents, the incident would be reportable.The NHA said after the incident with Resident #37 on 1/12/26, Resident #53 laughed the incident off and thought it was funny. The NHA said staff knew to check in on Resident #53 after the incident to see if he felt like he was harmed by the incident. The NHA said if Resident #53 felt he had been harmed, the staff would have alerted her right away.The NHA said for incidents of potential verbal abuse, the facility staff would interview the residents and see if the resident was upset or hurt by what the other resident had said, and if they were, that would constitute verbal abuse. The NHA said she determined if an incident was abuse evaluating criteria including threat or physical action, fear of imminent bodily injury, or if the resident was knowingly doing something. The NHA said if the incident on 1/12/26 had met even one of those criteria, she would have reported the incident between Resident #37 and Resident #53 to the State Agency. The NHA said Resident #37 had not knowingly called Resident #53 names or had intent behind what he was saying.-However, Resident #53 did suffer verbal abuse as Resident #37 called the other resident slurs directed towards Resident #53's race.Cross-reference F609 for failure to report an alleged violation.The NHA said for any abuse allegations, the facility staff spoke with other residents to see if they overheard anything from the incident, asked the residents what happened, and looked to see who may have overheard the incident or been offended by it. The NHA said the facility documented these notes in a file but did not keep the documents if they determined the incident was not abuse. The NHA said the facility staff had looked at Resident #37's incidents from a behavioral standpoint, and had arranged medication changes and physician evaluations for him as a result. The NHA said the staff knew about Resident #37's behaviors and knew to keep him away from other residents when he was agitated.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that residents were free from involuntary seclusion for two (#85 and #29) of three residents reviewed for proper placement out of 42 of sample residents.Specifically, the facility failed to accurately and timely re-evaluate the appropriateness of Resident #85 and Resident #29's placement in the secure unit.Findings include:I. Facility policy and procedureThe Special Care Unit and Pre-admission Assessment For Initial Placement/Evaluation For Continuing Placement policy was provided by the nursing home administrator (NHA) on 3/12/26 at 4:00 p.m. The policy read in pertinent part, The facility shall only place a resident into a secure unit that meets any of the following irreversible signs and symptoms:-The resident is in serious danger to self or others; or,-The resident habitually wanders or would wander out of the buildings and is unable to find the way back; or,-The resident has a significant behavior problem that seriously disrupts the rights of other residents; and, in all cases,-Less restrictive alternatives have been unsuccessful in preventing harm to self or others. A resident's placement in the secure unit shall terminate when the condition or behavior justifying the placement has diminished or they no longer meet the criteria, or when consent is terminated or withdrawn, or if the facility and physician determine that such continued placement would adversely affect resident health or safety.II. Resident #85A. Resident status Resident #85, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included cerebrovascular disease, hypertensive heart disease with heart failure, essential hypertension, history of falls, unspecific dementia and vascular dementia with mild mood disturbances. The 2/3/26 minimum data set (MDS) assessment revealed Resident #85 was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. The resident was dependent on staff for all activities of daily living (ADL), including dressing, showering, toileting, ambulating, set-up assistance for oral hygiene and assistance with eating. The assessment indicated Resident #85 had no physical behavioral symptoms directed towards others, such as hitting, kicking, grabbing, or hitting B. ObservationsDuring a continuous observation of the facility's secured unit on 3/10/26, beginning at 11:40 a.m. and ending at 3:37 p.m., the following was observed: At 11:40 a.m. Resident #85 was sitting in a Broda chair (specialized ergonomic wheelchair). At 11:45 a.m. staff provided feeding assistance to the resident at lunch time. After assisting the resident with eating, staff left Resident #85 sitting at the lunch table. The resident was falling asleep off and on and made no attempts to self-propel her wheelchair or wander.At 12:30 p.m. staff began distributing magazines to the residents. A magazine was put in front of Resident #85. The resident exhibited no wandering or aggressive behaviors and made no effort to self-propel her wheelchair.At 12:56 p.m. the hospice nurse visited Resident #85 at the same spot she had been sitting in the dining room. The hospice nurse checked the resident's vital signs, spoke to the staff and left the unit. Resident #85 remained in the same spot at the dining room table. The resident exhibited no wandering or aggressive behaviors and made no effort to self-propel her wheelchair.At 1:08 p.m. staff gave the resident a doll to hold. She continued sitting in the Broda wheelchair at the same spot at the table. The resident exhibited no wandering or aggressive behaviors and made no effort to self-propel her wheelchair.At 1:50 p.m. staff began passing out snacks to the residents. No snack was offered to Resident #85 and she continued sitting in the Broda wheelchair at the same spot and in the same position at the table. The resident exhibited no wandering or aggressive behaviors and made no effort to self-propel her wheelchair.At 2:42 p.m. during a group activity, staff arranged a fabric sensory/tactile apron on Resident #85's lap as she was not able to join the group activity. She did not attempt to touch the apron. The resident exhibited no wandering or aggressive behaviors and made no effort to self-propel her wheelchair.At 3:37 p.m staff wheeled Resident #85 to her room for incontinence care. The resident exhibited (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive behaviors.-Resident #85 had been sitting in the same position in her Broda wheelchair at the table from 11:40 a.m. until 3:37 p.m., almost four hours, without attempting to self-propel her wheelchair or exhibiting any wandering behaviors. The resident exhibited no aggressive behaviors.C. Record review The wandering risk assessment, dated 2/12/26, documented Resident #85 had no episodes of wandering in the past three months. The wandering risk assessment documented the resident was able to move herself in her wheelchair. -However, interviews with staff revealed the resident was not able to propel herself in her wheelchair (see interviews below). Review of Resident #85's electronic medical record (EMR) failed to reveal documentation from the resident's primary care physician which indicated the secured/locked unit was the least restrictive approach that was reasonable to protect the resident and assure her health and safety. D. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 3/11/26 at 3:22 p.m. CNA #10 said Resident #85 was unable to walk or propel herself in the Broda chair. The CNA said the resident never attempted to exit-seek. She said the resident could not communicate her needs.The social services director (SSD) was interviewed on 3/12/26 at 9:02 a.m. The SSD said each resident was reviewed for secure unit placement appropriateness every quarter. The SSD said Resident #85's last secure placement review was completed in February 2026. The SSD said the resident was not able to exit-seek and was on hospice services. She said the resident was on the unit in order for her to benefit from a smaller unit. The director of nursing (DON) was interviewed on 3/12/26 at 5:15 p.m. The DON said Resident #85 benefited from the smaller environment in the secure unit. She confirmed that a non-secure environment placement had not been tried for the resident. She said that the elopement risk evaluation completed on 2/17/26 for Resident #85 was not accurate as it documented the resident was able to walk. She said the incorrect documentation put Resident #85 resulted in the resident being calculated as a moderate risk for elopement with a score of 14; however, the DON said Resident #85 was wheelchair bound and was unable to move herself without staff's assistance.III. Resident #29A. Resident status Resident #29, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included non-Alzheimer's dementia without behavior disturbance, psychotic disturbance, mood disturbance and anxiety, hypertension, with history of fractures, transient cerebral ischemic attack and hypertension. The 1/6/26 MDS assessment revealed Resident #29 had moderate cognitive impairments with a BIMS score of nine out of 15. The resident was dependent on staff for ADLs. B. Resident interviewResident #29 was interviewed on 3/9/26 at 2:59 p.m. Resident #29 said she was aware she was in the secured unit. She said she did not like living in the secured unit and did not know the passcode for the secured unit door. She said she did not know why she was in the secured unit, but said it was probably because she answered a few questions wrong. C. ObservationsOn 3/9/26 at approximately 10:45 a.m., Resident #29 attended an activity outside of the secured unit. She was immediately assisted back from the unsecured area of the facility and was brought back to the secured unit. The resident had a book with her. During a continuous observation of the secured unit on 3/10/26, beginning at 11:40 a.m. and ending at 3:37 p.m., the following was observed:At 11:40 a.m. Resident #29 was sitting in her wheelchair and had finished eating lunch. She stayed at the dining table in the common area until 1:10 p.m. reading her book. At 1:10 p.m. staff assisted Resident #29 with pushing her in her wheelchair to join the group exercise activity outside of the secured unit. Staff assisted the resident back to the unit at 1:37 p.m. At 1:37 p.m. the resident continued sitting in her wheelchair in the common area, reading her book. At 2:10 p.m. Resident #29 was assisted to her room by two staff members for incontinence care. At 3:37 p.m. Resident #29 continued to be in her room. -During the observation above, Resident #29 exhibited no wandering, exit-seeking or aggressive behaviors.D. Record reviewThe wandering risk scale evaluation, dated 1/19/26, documented Resident #29 followed instructions and redirection at times and had no reported episodes of wandering in the past six months.The nurse practitioner note, dated 2/17/26, revealed Resident #29 was calm and cooperative. Review of Resident #29's EMR failed to reveal documentation from the resident's primary care physician which indicated the secured/locked (continued on next page)

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	065361	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit was the least restrictive approach that was reasonable to protect the resident and assure her health and safety. E. Staff interviews The SSD was interviewed on 3/12/26 at 9:02 a.m. The SSD said each resident was evaluated quarterly for placement on the secured unit. The SSD said Resident #29 was admitted nearly a year ago (2025), and she had exhibited some behaviors and had attempted to leave the facility a few days after her admission to the facility. She said the resident was then moved to the secured unit for safety. The SSD said Resident #29 did not exit-seek, but was benefiting from the smaller unit. She said the resident attended activities off the unit, and had been appropriate and had not exhibited any wandering or exit-seeking behaviors. She said the resident spent her time reading. The SSD said Resident #29 had not been trialed off of the unit for the three days to evaluate the appropriateness of transitioning the resident off of the secured unit. The SSD said the resident did not have the door code to be able to leave the secured unit when she wanted to. The DON was interviewed on 3/12/26 at 5:15 p.m. The DON said Resident #29 was transferred to the secured unit because she had some challenging behaviors and had attempted to leave the facility shortly after she was admitted to the facility. However, she said the resident had not exhibited any exit-seeking behavior. She said the resident had hallucinations, but could be redirected.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to adequately monitor residents for unnecessary psychotropic medications needed to provide effective and person-centered care for one (#85) of five residents reviewed for use of psychotropic medications out of 42 sample residents. Specifically, the facility failed to ensure the physician's order for Resident #85's as needed (PRN) lorazepam (antianxiety medication) was reevaluated and a rationale was provided by the physician to justify the continued use of the psychotropic medication beyond the 14-day limit.Findings include:I. Resident #85A. Resident statusResident #85, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included vascular dementia, restlessness and agitation.The 2/3/26 minimum data set (MDS) assessment revealed the resident was unable to complete the brief interview for mental status (BIMS) assessment. The resident had both short term and long term memory impairments, and had severely impaired decision making skills, per the staff assessment for mental status. The resident was dependent on one-person assistance from staff for all activities of daily living (ADL). The MDS assessment indicated the resident was receiving antianxiety medications.B. Record reviewReview of Resident #85's March 2026 CPO revealed the following physician's order:Lorazepam 0.5 milligrams (mg), give 0.5 mg by mouth every four hours as needed for dementia with behaviors, restlessness and agitation for 90 days, ordered 2/2/26. -The physician's order for the PRN lorazepam was prescribed for 90 days instead of for 14 days as required and did not include a rationale for extending the medication usage beyond 14 days. Review of Resident #85's psychotropic medication care plan, revised 1/27/26, revealed the resident received psychotropic medications for vascular dementia and behaviors. Interventions included giving medications as ordered by the physician and monitoring for side effects, reporting any increased agitation as evidenced by continual movement and restlessness to the point of putting herself to risk. The medication was to be reviewed quarterly and as needed in the psychotropic medication committee. Review of Resident #85's February 2026 and March 2026 medication administration records (MAR) revealed the resident received a dose of PRN lorazepam on 2/21/26 and 2/26/26. -However, the physician's order for the PRN lorazepam should have been reevaluated by the physician (on 2/16/26, 14 days after it was initially ordered on 2/2/26) and a new physician's order obtained for the medication or a rationale documented by the physician for the continued use of the medication beyond 14 days.A review of Resident #85's progress notes revealed no documentation to indicate the physician had reevaluated the resident's PRN lorazepam in order to justify the use of the medication beyond the 14-day limit for PRN psychotropic medications. II. Staff interviewsThe director of nursing (DON) was interviewed on 3/12/26 at 4:56 p.m. The DON said all psychotropic medications were reviewed quarterly in the psychotropic medication committee meeting. She said she was aware that PRN psychotropic medications should only be prescribed for 14 days and then reevaluated for continued use, unless the physician documented a rationale for ordering the medication for longer than 14 days. The DON said she would ensure a rationale was included in Resident #85's electronic medical record (EMR).

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of potentialabuse to the State Survey and Certification Agency in accordance with state law for one (#53) of four residents reviewed for abuse out of 42 sample residents.Specifically, the facility failed to report an incident of potential verbal abuse towards Resident #53 by Resident #37 to the State Agency.Findings include:I. Facility policy and procedureThe Abuse Reporting policy and procedure, dated March 2025, was received from the nursing home administrator (NHA) on 3/12/26 at 1:31 p.m. It read in pertinent part, If abuse happens or is suspected, the administrator will initiate an investigation by following guidelines set forth by the [State Agency] guidelines. If any type of abuse, neglect or misappropriation of property is confirmed by the NHA, the NHA will be responsible for notifying the State Agency within 24 hours from the time the incident occurred.II. Resident #37 (assailant)A. Resident statusResident #37, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included vascular dementia with mood disturbance, depression and cognitive communication deficits.The 3/10/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. The resident required partial to maximal assistance from staff for most activities of daily living (ADL).The MDS assessment documented the resident did not have physical behaviors directedtowards others. The assessment documented the resident had verbal behaviors and other behavioral symptoms not directed towards others on one to three days during the seven-day assessment look back period.B. Record reviewThe behavior care plan, revised 2/16/26, revealed Resident #37 could be verbally aggressive towards staff at times. Resident #37 was easily irritated and verbalized dissatisfaction with trivial items, including someone being in his way or a chair being moved. Resident #37 had made racial comments toward residents of color. Resident #37 had exhibited physical aggression towards staff when attempting to provide care and had told staff he would rape them. Pertinent interventions included encouraging Resident #37 to take a break if he became escalated and reapproaching him later, administering medications as ordered, assisting the resident to develop more appropriate methods of coping and interacting and staff providing care in pairs.A progress note, dated 11/20/25 at 5:28 p.m., revealed Resident #37 attempted to stand from his wheelchair multiple times throughout his shift, yelled at staff members, and called people names. Resident #37 also attempted to toss his water pitcher at a certified nurse aide (CNA).A progress note, dated 1/13/26 at 9:48 a.m., revealed Resident #37 was found the day prior (1/12/26) on another hallway in the facility yelling racial slurs at a resident of color (Resident #53). Resident #37 was redirected back to his room when the incident occurred. No other concerns were noted afterwards.-There was no further follow-up documentation related to the 1/12/26 incident.-The facility investigation for the incident on 1/12/26 was requested from the NHA on 3/12/25 at 8:22 a.m., however the facility was unable to provide an investigation as they had determined the incident did not constitute abuse (see interviews below).III. Resident #53 (victim)A. Resident statusResident #53, age less than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included aphasia, hemiplegia and hemiparesis (paralysis and weakness on one side of the body), vascular dementia, major depressive disorder and cerebral infarction (stroke).The 2/9/26 MDS assessment revealed the resident had severe cognitive impairment when assessed by staff. The resident was independent for most ADLs.B. Record reviewA progress note, dated 1/13/26 at 9:51 a.m., revealed that on 1/12/26 Resident #53 was near his room when another resident (Resident #37) came up to him and began making racial slur comments. Resident #53 was laughing and the other resident was redirected away from the area. The nurse followed up with Resident #53 regarding the situation and asked if he was okay. Resident #53 said yes, shook his head, gave a thumbs up gesture (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and started laughing.A progress note, dated 1/14/26 at 2:07 p.m., revealed a facility social worker visited Resident #53 regarding another resident calling him a derogatory name on 1/12/26. Resident #53 chuckled and waved his hands when the social worker asked him if he was okay or upset. The social worker documented she provided Resident #53 with support.IV. Staff interviewsThe director of operations was interviewed on 3/12/26 at 10:37 a.m. The director of operations said the facility staff had followed up with Resident #37 and Resident #53 after the incident on 1/12/26 and found neither resident had any issues or concerns after the incident. The director of operations said the social services director (SSD) had been the staff member who had followed up with them. -However, Resident #53 suffered verbal abuse as Resident #37 called him slurs targeting his race. -Additionally, there was no documentation of any psycho-social follow-up for Resident #37 (see record review above).The director of operations said the interdisciplinary team (IDT) reviewed all new progress notes every morning during their morning meeting to determine if the facility needed to take any follow-up actions. The director of operations said Resident #37 had not made physical contact with Resident #53 on 1/12/26, so the situation had not needed to be reported to the State Agency. The director of operations said the social services team had performed psychological follow-up assessments with the residents after each of the incidents. The director of operations said he did not have any documentation in regards to an investigation of the incident, outside of the progress notes documented in Resident #37 and Resident #53's electronic medical records (EMR) regarding the incident 1/12/26. The SSD was interviewed on 3/12/26 at 2:51 p.m. The SSD said for any resident-to-resident altercations, the staff would separate the residents and call the NHA immediately so she could begin the facility's investigation. The SSD said the NHA would then determine if the incident was considered abuse, and if the facility needed to report the incident to the State Agency and begin staff interviews. The SSD said Resident #37 had one incident involving another resident on another hall, after which the social services staff had interviewed Resident #53 and he had just laughed and said it was fine, so the facility determined the situation was not abuse. The SSD said Resident #37 had another incident in which he had verbalized something in the dining room, and there was no reaction from any of the other residents around him.The NHA was interviewed on 3/12/26 at 4:50 p.m. The NHA said the IDT discussed residents' behaviors during every morning meeting. The NHA said if a resident's behaviors involved any other residents, the IDT would send a member of the social services staff to talk with the residents involved and see if they were okay. The NHA said if there was physical contact between residents, the incident would be reportable to the State Agency.The NHA said after the incident on 1/12/26, Resident #53 laughed the incident off and thought it was funny. The NHA said staff knew to check in on Resident #53 after the incident to see if he felt like he was harmed by the incident. The NHA said if Resident #53 felt he had been harmed, the staff would have alerted her right away.The NHA said for incidents of potential verbal abuse, the facility staff would interview the residents and see if the resident was upset or hurt by what the other resident had said, and if they were, that would constitute verbal abuse. The NHA said she determined if an incident was abuse evaluating criteria including threat or physical action, fear of imminent bodily injury, or if the resident was knowingly doing something. The NHA said if the incident on 1/12/26 had met even one of those criteria she would have reported the incident between Resident #37 and Resident #53 to the State Agency. The NHA said Resident #37 had not knowingly called Resident #53 names or had intent behind what he was saying.-However, Resident #53 did suffer verbal abuse as Resident #37 called the other resident slurs directed towards Resident #53's race. The facility failed to report the incident to the State Agency.Cross-reference F600 for failure to keep residents free from abuse. The NHA said for any abuse allegations, the facility staff spoke with other residents to see if they overheard anything from the incident, asked the residents what happened, and looked to see who may have overheard the incident or been offended by it. The NHA said the facility documented these notes in a file but did not keep the documents if they determined the incident was not abuse.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide necessary services consistent with professional standards of practice to promote healing of pressure injuries and prevention of additional pressure injuries for two (#85 and #91) of three residents reviewed for pressure injuries out of 42 sample residents. Specifically, the facility failed to:-Ensure Resident #85, who was at high risk for skin break due to immobility was repositioned and provided incontinence care in a timely manner; and,-Ensure staff consistently implemented care planned pressure injury prevention interventions for Resident #85; and,-Ensure Resident #91, who had a stage 4 pressure injury, was repositioned in a timely manner.Findings include: I. Professional reference According to Basic Nursing third edition; [NAME] S. Treas, [NAME], [NAME] H. [NAME] (2022), page 1214-1215, Healthy people regularly shift position to maintain comfort. However, many patients are unable to move without assistance. They require a change of position at least every two hours to prevent skin breakdown, muscle discomfort. People who are immobile are more prone to pressure injury as a result of reduced circulation, impaired oxygen exchange to the tissues and edema. According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.p on 2/10/22, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and (continued on next page)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category/Stage 4: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected Deep Tissue Injury: Depth Unknown

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

II. Resident #85

A. Resident status

Resident #85, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included cerebrovascular disease, hypertensive heart disease with heart failure, essential hypertension, history of falls, unspecific dementia , vascular dementia with mild mood disturbances.

The 2/3/26 minimum data set (MDS) assessment review revealed Resident #85 was dependent on staff for activities of daily living (ADL), including dressing, showering, toileting, ambulating, set-up assistance for oral hygiene and assistance with eating.

B. Observations

During a continuous observation of the facility's secured unit on 3/10/26, beginning at 11:40 a.m. and ending at 3:37 p.m., the following was observed:

At 11:40 a.m. Resident #85 was sitting in a Broda chair.
(continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:45 a.m. staff provided feeding assistance to the resident at lunch time. After assisting the resident with eating, staff left Resident #85 sitting at the lunch table. The resident was falling asleep off and on. At 12:30 p.m. staff began distributing magazines to the residents. A magazine was put in front of Resident #85, however, staff did not attempt to take the resident to her room to check her for incontinence or reposition the resident. At 12:56 p.m. the hospice nurse visited Resident #85 at the same spot she had been sitting in the dining room. The hospice nurse checked the resident's vital signs, spoke to the staff and left the unit. Resident #85 remained in the same spot at the dining room table. At 1:08 p.m, staff gave the resident a doll to hold. She continued sitting in the Broda wheelchair at the same spot at the table. Staff did not reposition the resident or attempt to take her to her room to check her for incontinence. At 1:50 p.m. staff began passing out snacks to the residents. No snack was offered to Resident #85 and she continued sitting in the Broda wheelchair at the same spot and in the same position at the table. Staff did not attempt to reposition the resident or take her to her room to check her for incontinence. At 2:42 p.m. during a group activity, staff arranged a fabric sensory/tactile apron on Resident #85's lap as she was not able to join the group activity. She did not attempt to touch the apron and continued sitting at the same spot in the same position. At 3:37 p.m staff wheeled Resident #85 to her room for incontinence care. -Resident #85 had been sitting in the same position in her Broda wheelchair at the table from 11:40 a.m. until 3:37 p.m., almost four hours, without staff attempting to reposition her or check her for incontinence. During a continuous observation the facility's secured unit on 3/11/26, beginning at 8:45 a.m. and ending at 1:28 p.m., Resident #85 was again observed sitting in her Broda wheelchair in the same position. The resident remained in her wheelchair at the table for breakfast, an activity and lunch. No staff members attempted to reposition the resident or take her to her room to check her for incontinence. At 1:28 p.m. Resident #85 was taken to her room for incontinence care. -Resident #85 had been sitting in the same position in her Broda wheelchair at the table from 8:45 a.m. until 1:28 p.m., almost five hours, without staff attempting to reposition her or check her for incontinence. C. Record Review A review of Resident #85's skin care plan, initiated 1/27/26, revealed that she was at high risk for skin breakdown. Interventions included monitoring for repositioning and following facility protocols for the prevention/treatment of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interviews: Certified nurse aide (CNA) #10 was interviewed on 3/11/26 at 3:32 p.m. CNA #10 said the facility's incontinence care protocol for residents was every two hours for incontinent residents. She said Resident #85 was incontinent and needed two-person assistance for incontinence care. CNA #10 said the resident was able to pivot and hold the toilet bar while staff assisted her to sit on the toilet. She said she needed to check resident #85's tasks list in the electronic medical record (EMR) to know the resident's specific schedule for incontinence care. After checking the resident's incontinence schedule, CNA #10 said the resident should be checked for incontinence two to three times a day and as needed. She said sometimes it took longer if the staff were busy. CNA #10 said Resident #85's CNA task list did not say anything about repositioning the resident. Registered nurse (RN) #4 was interviewed on 3/12/26 at 4:05 p.m. RN #4 said Resident #85 was at high risk for skin breakdown. RN #4 said Resident #85's skin condition was good. She said the staff used barrier cream for the resident because her bottom was red. She said the redness came on and off. She said Resident #85 had had diarrhea for the last two days, and it had caused some skin redness. RN #4 said not providing incontinence care for long periods of four hours or more was a long time. RN #4 said Resident #85 should be repositioned in order to improve circulation and preserve her skin integrity. RN #4 said Resident #85 was at high risk for falls and so staff did not lay her down in bed during the day and kept her in the common area for supervision. She said Resident #85 wiggled around herself in the chair and did not need repositioning. RN #4 said if there were concerns about a resident's skin condition, the wound care nurse (WCN) would be verbally notified. The director of nursing (DON) was interviewed on 3/12/26 at 5:15 p.m. The DON said residents' skin integrity evaluations were performed upon admission, on a weekly basis, and as needed depending on the 24-hour communication log from the staff. The DON said for residents at high risk for skin breakdown, the interventions would be repositioning, hydration and barrier cream. The DON said Resident #85 was at high risk for skin breakdown. She said the frequency of repositioning or incontinence care depended on the resident's condition. The DON said incontinence care should happen before and after meals and as needed. She said it was the facility's approach not to put a specific time frame for the frequency. The DON said she did not know why the staff did not provide incontinence care and repositioning for Resident #85 for long periods of time (see observations above). She said it was even more necessary to provide frequent incontinence care for Resident #85 if the staff knew about her diarrhea and skin irritation. The DON said sitting long hours in the same position could increase the risk for pressure injuries for Resident #85. III. Resident #91 A. Resident status Resident #91, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2026 CPO, diagnoses included osteomyelitis of the sacral and sacrococcygeal vertebrae (a bone infection of the sacrum and/or coccyx), stage 4 pressure ulcer of sacral region, pilonidal cyst with abscess, profound intellectual disabilities, cerebral palsy, cognitive communication deficit and contractures of bilateral elbows and bilateral knees. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brookside Inn		STREET ADDRESS, CITY, STATE, ZIP CODE 1297 S Perry St Castle Rock, CO 80104	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/2/26 MDS assessment revealed the resident was cognitively impaired. He had short and long-term memory problems. His daily decision making ability was severely impaired. He had bilateral upper and lower extremity impairment. He used a wheelchair mobility device. He was dependent on staff for all ADLs. He had an indwelling urinary catheter. He was always incontinent of bowel. The assessment indicated he had an unhealed stage 4 pressure ulcer that was present on admission. He used a pressure-reducing mattress and a pressure reducing device for his wheelchair. He was on nutrition/hydration interventions and pressure ulcer wound treatments. B. Observations and interviews On 3/11/26 at 7:31 a.m. Resident #91 was sitting at an angle in his wheelchair in the common area. A ROHO cushion (air-filled cellular cushion) was visible underneath him. Resident #91 was holding a stuffed toy between his arms. On 3/11/26 at 8:00 a.m. Resident #91 was observed sitting in his wheelchair at a table in the dining room, eating breakfast. An unidentified staff member was providing meal assistance to the resident. Resident #91 was seated in the same position in his wheelchair as previously observed, sitting at an angle. During a continuous observation on 3/11/26, beginning at 8:32 a.m. and ending at 10:48 a.m., the following was observed: At 8:32 a.m., Resident #91 was observed sitting in the common area in his wheelchair. He continued to be sitting in the same angled position in his wheelchair as previously observed. At 9:00 a.m. an unidentified staff member wheeled the resident to a different location in the common area. She did not reposition or offer to reposition Resident #91. At 10:20 a.m. an unidentified staff member wheeled Resident #91 to his room and left the resident in the hallway outside of his room. CNA #4 wheeled the resident into his room and positioned his wheelchair next to his bed, facing the television. CNA #4 retrieved the resident's touch pad call light, placed it on his waist/lap, then exited the resident's room without repositioning the resident. At 10:48 a.m. CNA #3 entered the resident's room with a Hoyer lift (mechanical lift to transfer residents), followed by licensed practical nurse (LPN) #4. CNA #3 told LPN #4 that staff were going to put Resident #91 to bed because of how sleepy he was. CNA #4 re-entered the resident's room. CNA #3 and CNA #4 performed hand hygiene, donned a gown and gloves, transferred the resident to the bed with the lift, performed incontinence care and repositioned Resident #91 onto his right side in bed. CNA #4 was interviewed on 3/11/26 at 11:32 a.m. CNA #4 said Resident #91 was gotten up and dressed by the day shift that morning between 7:00 a.m. and 7:30 a.m, and had been sitting in his wheelchair since he was assisted out of bed. -Per CNA #4's interview and continuous observation (see above), Resident #91 had been sitting in the same position in his wheelchair for over four hours without repositioning assistance. C. Record review (continued on next page)

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Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #91's March 2026 CPO revealed the following physician's orders: Cleanse the sacral wound with wound cleanser. Use one full packet of collagen filler (dressing used to treat chronic, deep wounds) and apply to the wound bed, followed by calcium alginate with silver (a highly absorbent, antimicrobial wound dressing). Apply Skin-prep (a liquid barrier used to protect intact skin), then cover with a super absorbent dressing. Complete every night shift for wound healing, ordered 11/4/25. Check the function of the air mattress every shift for skin integrity, ordered 9/20/24. Check the ROHO cushion for proper inflation every Friday night shift for skin integrity, ordered 2/20/26. -Review of Resident #91's March 2026 CPO revealed no physician's orders specifying how often the resident should be repositioned to assist with wound healing. The skin integrity care plan, revised 8/8/24, documented Resident #91 had the potential for alteration in skin integrity due to decreased mobility related to developmental delays and contractures. Interventions included administering treatments as ordered (initiated 7/5/24), following facility policies/protocols for the prevention/treatment of skin breakdown (revised 10/23/24), monitoring/documenting/reporting signs and symptoms of infection (revised 10/23/24) and using a mechanical lift for transfers to prevent new/further injury (revised 10/23/24). The pressure injury care plan, revised 10/11/25, documented Resident #91 had a stage 4 pressure injury on his coccyx related to disease processes, developmental delay, a history of pressure injuries, immobility, and bowel and bladder incontinence. Interventions included administering treatments as ordered (initiated 7/24/24), applying an air mattress to promote wound healing and skin integrity (revised 4/18/25) and applying foam boots while in bed (revised 10/11/25). -Review of Resident #91's skin integrity and pressure ulcer care plan revealed no documented interventions addressing how often the resident should be repositioned to promote wound healing. -Additionally, there were no documented interventions addressing the resident's ROHO cushion and how to monitor/maintain it. The wound care physician follow-up note, dated 3/10/26 at 12:57 p.m., documented Resident #91 had an unavoidable stage 4 pressure injury to his sacrum. The note documented the wound appeared healthy, clean and stable. It documented Resident #91 was at increased risk of wound incidence due to impaired mobility, co-morbid conditions, impaired cognition, and scar tissue. It documented treatment recommendations included re-evaluating Resident #91 during the next visit, implementing pressure-relieving measures, offloading, and repositioning as tolerated. The wound care physician's note documented that residents with pressure injuries to their sacrum, coccyx, or ischium should be limited to sitting three times daily for periods of 60 minutes or less. D. Additional staff interviews CNA #8 was interviewed on 3/11/26 at 4:51 p.m. CNA #8 said dependent residents should be repositioned every two hours. CNA #8 said timely repositioning was important to offload skin and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent new/worsened skin issues. LPN #6 was interviewed on 3/11/26 at 5:09 p.m. LPN #6 said dependent residents, including Resident #91, should be repositioned every one to two hours. LPN #6 said it was important for skin integrity, to prevent skin breakdown, and maintain resident comfort. The wound care nurse (WCN) was interviewed on 3/12/26 at 5:00 p.m. The WCN said how often a resident was repositioned varied. The WCN said staff should attempt to change a resident's position every two hours. The WCN said residents could be resistant to position changes if the change prevented them from seeing the television or the door. The WCN said timely repositioning was important to maintain circulation, especially on bony prominences, and reduce the risk of pressure injury development. The DON was interviewed on 3/12/26 at 6:35 p.m. The DON said staff should offer and attempt to offload residents upon entering the resident's room for any care activities. The DON said many residents often complained about repositioning, so the facility hardly ever entered physician's orders to reposition every two hours. The DON said Resident #91 had pressure injury care interventions in place, to include applying an air mattress, using soft boots to float heels, positioning wedges, and offloading with incontinence care or meals. The DON said timely repositioning was important. The DON said offloading Resident #91's wound helped promote healing of his chronic wound, and prevent new skin issues from occurring.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure staff provided respiratory care consistent with professional standards of practice for two (#42 and #16) of three residents reviewed for oxygen services out of 42 sample residents. Specifically, the facility failed to:-Ensure staff adequately maintained and cleaned Resident #42's continuous positive airway pressure (CPAP) machine; and,-Ensure staff administered oxygen to Resident #42 and Resident #16 per physician's order.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 2021, accessed on 3/18/26 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 high flow oxymasks, CPAP, BiPAP, 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 CPAP/BiPAP (bilevel positive airway pressure) Cleaning policy and procedure, dated December 2024, was received from the nursing home administrator (NHA) 3/12/26 at 1:31 p.m. It read in pertinent part: It is the policy of (facility name) to clean CPAP/BiPAP equipment in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and manufacturer's recommendations to prevent the occurrence or spread of infection. CPAP, or continuous positive airway pressure, is a respiratory therapy intervention used to provide a patent airway during periods of sleep apnea. It uses air pressure generated by a machine, delivered through a tube into a mask that fits over the nose or mouth. Policy guidelines: Dust the machine when needed, and wipe clean with a damp cloth and mild detergent. If humidification is required, distilled or sterile water will be used to fill the humidifier chamber. Empty the chamber completely after each use and wipe dry. The facility will utilize the CPAP/BiPAP order set for instructions and timing of cleaning various aspects of the machine. Order set developed based on manufacturer's guidance, but may vary from resident to resident. III. Resident #42 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #42, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included congestive heart failure, type 2 diabetes mellitus, obstructive sleep apnea, depression and dependence on supplemental oxygen. The 2/2/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 13 out of 15. She had bilateral lower extremity impairment. She used a wheelchair mobility device. She required substantial assistance with bed mobility and transfers. She used oxygen therapy and a non-invasive mechanical ventilator. B. Observations and interviews On 3/10/26 at 9:14 a.m. Resident #42 was lying in bed watching television (TV). Resident #42 was receiving continuous oxygen therapy via an oxygen concentrator and nasal cannula (an oxygen delivery device). The oxygen concentrator was set at 4 liters per minute (LPM) and located between the resident's bed and dresser. Resident #42's CPAP machine was sitting on top of a dresser, approximately two to four feet from the head of her bed, with the humidifier chamber still connected. The humidifier chamber had an unmeasurable amount of water inside, and condensation was visible on the sides and top chamber walls. Resident #42 said the nursing staff were responsible for cleaning her CPAP machine. On 3/10/26 at 10:35 a.m. Resident #42 was lying in bed working on an activity. Her oxygen concentrator was set at 4 LPM, and oxygen was being administered through a nasal cannula. Resident #42 said she was supposed to be on 4 LPM of oxygen continuously. Resident #42's CPAP machine was in the same spot on the resident's dresser. The humidifier chamber was still connected to the resident's CPAP machine; there was an unmeasurable amount of water in the humidifier chamber, and condensation was visible on the chamber walls. On 3/10/26 at 1:05 p.m. Resident #42's CPAP machine was located in the same spot on her dresser. The humidifier chamber was still connected, water remained in the chamber and condensation was visible on the chamber walls. On 3/10/26 at 7:33 a.m. Resident #42 was asleep in bed. She was not wearing her CPAP mask. She was wearing a nasal cannula and receiving oxygen via her oxygen concentrator. The oxygen concentrator was set at 4 LPM. Resident #42's CPAP machine was on the counter next to her sink. The humidifier chamber was full of water, with the level slightly below the maximum fill line. Condensation was visible on the walls of the humidifier chamber. Resident #42 was interviewed on 3/11/26 at 12:07 p.m. Resident #42 said that she was unable to wear her CPAP last night (3/10/26) because the cord was frayed and staff could not find a replacement CPAP cord overnight. Resident #42 said a replacement cord was found this morning and already brought in. Resident #42 said she wore her oxygen overnight, set at 4 LPM, and denied feeling outside of her baseline since she did not wear her CPAP. -During the interview, Resident #42's roommate, Resident #92, was rinsing out Resident #42's CPAP humidifier chamber in their bedroom sink. Resident #92 said she was a former certified nursing aide (CNA) and she was cleaning Resident #42's CPAP because the nursing staff hardly ever did. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/26 at 11:27 a.m. Resident #42's CPAP machine was on top of her dresser. The humidifier chamber was connected to the resident's CPAP machine. There was an unmeasurable amount of water in the humidifier chamber and visible condensation on the walls of the humidifier chamber. Resident #42 was receiving continuous oxygen via nasal cannula. The oxygen concentrator was set at 4 LPM. C. Record review A review of Resident #42's March 2026 CPO revealed the following physician's orders: Wear CPAP at bedtime and throughout the day during nap times. Complete every shift for health maintenance, ordered 11/17/24. Disassemble CPAP mask into three parts, (headgear, cushion and frame). Clean all parts with warm soap and water, and completely rinse parts. Allow to air dry and avoid direct sunlight. Every day shift for respiratory hygiene, ordered 4/14/25. Disconnect air tubing/hose from mask and CPAP machine. In the sink, clean both the inside and outside of the tubing with warm water and mild soap. Rinse thoroughly with warm water. Allow to air dry on top of a clean towel. Avoid placng in direct sunlight. Complete every Saturday day shift for respiratory hygiene, ordered 4/14/25. Disconnect humidifier tub (chamber) from CPAP machine. Empty the tub and wipe thoroughly with disposable disinfectant wipe. Allow to dry out and store out of direct sunlight. The tub should always be clean, clear, and free of discoloration. Complete every day shift for respiratory hygiene, ordered 4/14/25. Oxygen at 3 LPM via nasal cannula for diagnosis of chronic obstructive pulmonary disease (COPD). Complete every shift for COPD. Record oxygen rate and saturation level on the medication administration record (MAR). Notify the physician if changes needed, ordered 5/3/24. -However, Resident #42's oxygen flow rate was observed to be set on 4 LPM during several observations (see observations above). The oxygen therapy care plan, revised 11/17/25, documented Resident #42 was on oxygen therapy related to congestive heart failure, COPD, obstructive sleep apnea, and chronic hypercapnic respiratory failure. Interventions included administering medications as ordered (initiated 5/4/24), using home CPAP settings (initiated 5/4/24), elevating the head of the bed to a level of comfortable breathing (initiated 5/4/24), and monitoring for signs and symptoms of respiratory distress (initiated 5/4/24). -Review of the oxygen therapy care plan revealed the facility failed to document any interventions specifically related to Resident #42's oxygen therapy, including the oxygen LPM. -Additionally, the facility failed to create a resident-specific care plan addressing Resident #42's CPAP use, settings and device cleaning and management. A review of Resident #42's March 2026 MAR revealed the following documented oxygen administrations: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42 was administered 4 LPM of oxygen on both the day and night shifts, on 3/1/26, 3/2/26, 3/3/26, 3/4/26 and 3/5/26. Resident #42 was administered 3 LPM of oxygen on both day and night shifts, on 3/6/26, 3/7/26, 3/8/26, 3/9/26, 3/10/26, and 3/11/26. -However, observations on 3/10/26, 3/11/26 and 3/12/26 revealed the resident's oxygen flow rate was set at 4 LPM (see observations above). -There was no documentation in the resident's electronic medical record (EMR) to indicate the resident's physician had been notified that the resident was receiving 4 LPM of oxygen. A review of Resident #42's March 2026 treatment administration record (TAR) revealed facility staff documented the resident's CPAP humidifier chamber was disconnected and cleaned, as ordered, on 3/1/26, 3/2/26, 3/3/26, 3/4/26, 3/5/26, 3/6/26, 3/7/26, 3/8/26, 3/9/26, 3/10/26, and 3/11/26. -However, observations of Resident #42's CPAP machine and humidifier chamber on 3/10/26, 3/11/26 and 3/12/26 (see see observations above) revealed multiple instances where the humidifier chamber was still connected to the resident's CPAP machine, contained residual water and had visible condensation on the walls. D. Additional staff interviews Licensed practical nurse (LPN) #3 was interviewed on 3/12/26 at 11:28 a.m. LPN #3 said staff had orders to disassemble and clean CPAP machines with CPAP cleansing wipes. LPN #3 said accurately cleaning a resident's CPAP machine was important for infection prevention. LPN #3 entered Resident #42's room at approximately 11:35 a.m. LPN #3 said CNAs helped take off CPAP masks when residents woke up, and the nurses were responsible for cleaning CPAP tubing and masks. LPN #3 confirmed the humidifier chamber was still connected to Resident #42's CPAP machine. LPN #3 said she always noticed the humidifier chamber was connected to Resident #42's CPAP machine. LPN #3 said Resident #42 required between 4 LPM to 5 LPM of oxygen. LPN #3 confirmed Resident #42's oxygen concentrator was set at 4 LPM. LPN #3 exited Resident #42's room and returned to the medication cart to pull up Resident #42's physician's orders. LPN #3 said the current physician's order for Resident #42's CPAP indicated to disconnect the CPAP humidifier chamber, cleanse it, and leave it to dry (see physician's orders above). LPN #3 said the humidifier chamber should have been disconnected from Resident #42's CPAP machine. LPN #3 said Resident #42 had been on 4 LPM of oxygen for as long as she had cared for the resident. LPN #3 said Resident #42's oxygen order was for 3 LPM of oxygen. LPN #3 said Resident #42 was not being administered oxygen per the physician's order. LPN #3 said she would contact Resident #42's physician to obtain an updated order. The infection preventionist (IP) was interviewed on 3/12/26 at 4:06 p.m. The IP said he would have to refer to the manufacturer's instructions or resident orders for CPAP cleaning and maintenance. The IP said Resident #42 had a physician's order to disconnect, empty, and clean the resident's CPAP humidifier chamber daily. The IP said properly cleaning and maintaining a resident's CPAP was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to prevent the spread of infection. The IP said it was not appropriate for a resident's roommate to clean their CPAP machine due to the roommate not knowing current instructions or orders. The director of nursing (DON) was interviewed on 3/12/26 at 6:35 p.m. The DON reviewed Resident #42's March 2026 CPO and MAR. The DON confirmed staff documented the resident received 3 LPM to 4 LPM of oxygen (see record review above) the week of 3/8/26 to 3/11/26. The DON said administering 4 LPM of oxygen was against the physician's order. The DON said staff should have notified the physician and updated Resident #42's oxygen order to reflect the increase in the resident's oxygen flow rate. The DON reviewed Resident #42's CPAP physician's orders and confirmed there was a physician's order to disconnect and clean the humidifier chamber daily (see physician's orders above). The DON said properly cleaning CPAP machines was important for infection control purposes. The DON said it was not appropriate for Resident #42's roommate to clean her CPAP machine for multiple reasons, including infection control and resident dignity. The DON said the MDS coordinator was responsible for updating a resident's care plan for oxygen therapy and CPAP use. The DON said Resident #42's care plan did not reflect interventions addressing the use, cleaning, and maintenance of the resident's CPAP machine. The DON said the information should have been documented as it instructed staff on how to care for residents, and what care/treatments were to be provided. IV. Resident #16 A. Resident status Resident #16, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included chronic right heart failure, history of pulmonary embolism, and dependence on supplemental oxygen. The 2/26/26 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. Resident #16 required maximum assistance for activities of daily living (ADL), including bed mobility and was dependent on staff for transfers. Resident #16 had impairment on one side of the upper and lower extremities and required oxygen therapy. B. Resident observations and interview On 3/9/26 at 11:00 a.m. Resident #16 was observed lying in bed wearing oxygen via a nasal cannula. An oxygen concentrator was on the floor beside his bed and the oxygen concentrator's flow rate was set between 3 and 3.5 LPM The cannula tubing was not dated. Resident #16 said she was not aware what the oxygen flow rate was to be set on. On 3/10/26 at 9:39 a.m. Resident #16 was observed lying in bed wearing oxygen via a nasal cannula and the oxygen concentrator's flow rate was set between 3 and 3.5 LPM. The cannula tubing was not dated On 3/11/26 at 7:26 a.m. Resident #16 was observed lying in bed wearing oxygen via a nasal cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the oxygen concentrator's flow rate was set between 3 and 3.5 LPM. The cannula tubing was not dated. On 3/11/26 at 1:30 p.m. Resident #16 was observed lying in bed wearing oxygen via a nasal cannula and the oxygen concentrator's flow rate continued to be set between 3 and 3.5 LPM. The cannula tubing was not dated. On 3/12/26 at 7:45 a.m. Resident #16 was observed lying in bed wearing oxygen via a nasal cannula and the oxygen concentrator's flow rate remained set between 3 and 3.5 LPM. The cannula tubing was not dated. C. Record Review Review of Resident #16's March 2026 CPO revealed the following physician's order: Oxygen at 2 liters/minute via nasal cannula for diagnosis of hypoxia, ordered 8/7/21. Resident #16's comprehensive care plan, initiated 8/8/21, indicated the resident had oxygen therapy related to heart failure. Pertinent interventions included oxygen via nasal cannula per physician orders for diagnosis of heart failure, monitoring for signs/symptoms of respiratory distress and report to physician as needed (PRN): respirations, pulse oximetry (measures oxygen saturation, increased heart rate (tachycardia), restlessness, diaphoresis (sweating), headaches, lethargy, confusion, atelectasis (lung collapse), hemoptysis (coughing up blood), cough, pleuritic (inflammation of lung lining) pain, accessory muscle usage, and skin color. Review of the March 2026 medication administration record (MAR) revealed nursing staff were documenting and signing off that Resident #16 was receiving oxygen at 2 LPM. -However, on 3/9/26, 3/10/26, 3/11/26, and 3/12/26 the resident's oxygen flow rate was observed to be set between 3 and 3.5 LPM (see observations above). D. Staff interviews Review of Resident #16's oxygen concentrator LPM setting was completed with LPN #1 on 3/12/26 at 11:19 a.m. LPN #1 acknowledged the resident's oxygen flow rate was set at a little above 3 LPM. She said she thought the flow rate was supposed to be set on 3 LPM but she would need to check. After LPN #1 reviewed Resident #16's oxygen order, she confirmed the oxygen flow rate was supposed to be set on 2 LPM. She said she would normally check a resident's oxygen flow rate setting and their oxygen saturation during her shift and if there was a discrepancy noted, she would investigate the reason the oxygen flow rate was different from what the physician's order indicated and adjust it if needed. She said nurses should not document the incorrect oxygen flow rate on the MAR. The DON was interviewed on 3/12/26 at 6:35 p.m. The DON confirmed Resident #16's oxygen order was for 2 LPM. She confirmed the oxygen set at 3 to 3.5 LPM was not following the physician's order. She said nursing staff were able to titrate up oxygen flow rates to keep residents' saturations greater than 88% but there would have to be a physician's order in place to titrate the oxygen. She said nursing staff were to notify the physician and update physician's orders immediately if there was a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Inn	1297 S Perry St Castle Rock, CO 80104

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 - Few	change in a resident's oxygen needs. She said it was important for nursing staff to follow physician's orders because residents were placed on different oxygen flow rates for various medical conditions and an increase in oxygen needs would indicate a change in condition. The DON confirmed Resident #16's March 2026 MAR indicated nursing staff were documenting the resident was receiving oxygen at 2 LPM. She said it was not appropriate for nursing staff to document an incorrect oxygen liter flow rate.