STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065376	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Greenwood Village	6450 S Boston St Greenwood Village, CO 80111

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#2) of three residents received the highest practicable treatment and care in accordance with professional standards of practice of seven sample residents.Specifically, the facility failed to ensure all prescribed medications including medications to treat cirrhosis of the liver (scarred and damaged liver that prevents it from working properly), high blood pressure, and a chronic mental health disorder were ordered and obtained from the pharmacy to administer to the resident upon admission. Findings include:I. Facility policy and procedureThe admission Process policy and procedure, revised April 2025, was provided by the nursing home administrator (NHA) on 9/22/25 at 11:31 a.m. The policy read in pertinent part, Admissions will follow a process so that the community can appropriately meet the clinical and financial needs of residents. Once the community gives verbal acceptance of a resident, the admission Department will notify the appropriate department managers to ensure necessary clinical services and room arrangements are anticipated. The Admission/Nursing Department will obtain the state-specific transfer form so that proper discharge orders from the previous community were obtained.The admission Data Collection and Orders policy and procedure, revised September 2025, was provided by the NHA on 9/22/25 at 11:31 a.m. The policy read in pertinent part, The nursing department is responsible for recording specific clinical data in the medical record upon a resident's admission to the community. The designated pharmacy should be notified of the new admission and order confirmation of pharmacy supplied items.The Medication Management Overview policy and procedure, revised April 2025, was provided by the NHA on 9/22/25 at 10:30 a.m. It read in pertinent part, Medicine shall be administered as prescribed by the health care provider. Medication management services include but are not limited to:-Delivering medications to residents within acceptable time parameters.-Maintaining written or electronic records of medication orders and administration.II. Resident #2A. Resident statusResident #2, age [AGE], was admitted to the facility on [DATE] and discharged on 6/4/25. According to the June 2025 computerized physician orders (CPO), diagnoses included cirrhosis of the liver, hypertension, bipolar disorder (mental illness) and diabetes mellitus.The 6/3/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15 and no behavioral issues. B. Record reviewReview of the June 2025 CPO revealed the following physician's orders:-Rifaximin oral tablet 550 milligrams (mg) with instructions to give one tablet by mouth two times a day, for cirrhosis of the liver, ordered 5/29/25.-Risperidone oral tablet 4 mg with orders to give one tablet by mouth at bedtime for bipolar disorder, ordered 5/29/25.-Midodrine oral tablet 10 mg with instructions to give one tablet by mouth three times a day for hypotension, ordered 5/29/25.Review of May 2025 and June 2025 medication administration records (MAR) revealed the facility did not have all medications on hand to administer them to the resident, as ordered by the resident's physician.Resident #2 was not administered the following ordered medications:-Rifaximin on 5/29/25 or 5/30/25 because the medication was not available. -Risperidone on 5/29/25 at bedtime because it was not available.-Midodrine on 5/29/25 because it was not available.Review of Resident #2's progress notes confirmed that the medications as listed above were not provided (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because they were unavailable. A physician assistant's note, dated 6/9/25, documented the resident had multiple comorbidities requiring medication management that required frequent clinical evaluations. The note documented without regular monitoring and management, the resident was at moderate to high risk of symptom exacerbation and complications resulting in hospitalization or death. The resident required multiple medications (polypharmacy), which required close monitoring to avoid any drug related adverse events.C. Resident representative interviewResident #2's representative was interviewed on 9/23/25 at 12:52 p.m. The representative said she visited the resident at the facility daily with a few exceptions, and met regularly with staff. She said the staff did not notify her about changes in Resident #2's care, instead they informed her only after the facts occurred. She said an unidentified registered nurse (RN) on the third floor told her the facility decided to discontinue Rifaximin, a medication Resident #2 had been prescribed for liver disease. She said Rifaximin was prescribed to remove toxins from the resident's body. She said if he did not take it the toxins could go to his brain. The representative said the facility told her they were discontinuing the medication because they were not able to obtain it from the pharmacy. Resident #2's representative said she brought in Resident #2's medications from home to the facility including the Rifaximin because she suspected the resident missed prescribed medications. The representative said the facility nurse would not accept and administer the medications to the resident.E. Staff interviewsRN #1 was interviewed on 9/23/25 at 11:20 a.m. RN #1 said the admitting nurse received the admission paperwork from the hospital and verified all ordered medications were on the MAR as ordered and in stock from the pharmacy. RN #1 said their pharmacy provided all medications per the physician's orders. RN #1 said when there were delays in medications from the pharmacy, the nurses could access the emergency backup medication kit to obtain a one time dose of prescribed medication to give to the resident. She said if a specific medication was not available, the physician might provide a medication order for a comparable one. RN #1 said medications brought in by family would not be used. She said instead the pharmacy was required to provide the medications. She said sometimes they could use a medication supplied from the family if there was an urgent need for the medication to be administered, like an inhaler to treat asthma. The consultant pharmacist was interviewed on 9/23/25 at 1:54 p.m. The consultant pharmacist said the order for Rifaximin was received on 5/29/25 at 7:00 p.m. and delivered on 5/31/25 at 12:07 a.m. She said the order for Trizepatide was received on 5/29/25 at 7:30 p.m., but she did know the reason for the delay in providing the medications. She said she would speak with the pharmacy operation director and call back with more information. She said she could not comment on potential risks or consequences of not administering Resident #2's Rifaximin for two days without first reviewing Resident #2's clinical records.The pharmacy operation director was interviewed on 9/23/25 at 2:20 p.m. The pharmacy operation director said the delivery of Rifaximin was delayed because the order was rejected by the resident's insurance provider and required the facility to agree to submit a written agreement to cover the cost of the medication before the order could be processed. The pharmacy operation director said it took two days for the facility to provide the agreement. The pharmacy operation director said he could not comment on what could happen to Resident #2 if he missed Rifaximin for two days. The pharmacy operation director said not administering Rifaximin for two days might not cause major adverse events, but it could cause some cognitive issues. The pharmacy operation director said the Trizepatide was not delivered because the provider had placed the order on hold per a note provided by the facility, but there was no documentation of why the order was placed on hold. The director of nursing (DON) was interviewed on 9/23/25 at 3:17 p.m. The DON said when a resident was admitted , the nurse on duty would fill the role of the admission nurse and would review the hospital orders with the on-call physician and the resident's medical provider. He said all the medications would be verified. He said the orders were then sent to the pharmacy to be filled.The DON said he was not sure how long medication delivery would take but he estimated the ordered medications would be filled and delivered to the facility within a couple hours. He said the facility would not administer medications brought in by family (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because they could not verify the accuracy of the medications. The DON said he did not know why Resident #2's missed several medications after admission or why the delivery was delayed. The DON said he would look into the medication delays. The DON said Resident #2 was administered Trizepatide at the hospital on 5/29/25 prior to his admission to the facility. The DON said the next dose was scheduled for 6/5/25, however Resident #2 was transferred to the hospital on 6/4/25. He said that was the reason the medication was not administered at the facility.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#2) of three residents reviewed for accident hazards/ falls out of seven sample residents.Specifically, the facility failed to:-Ensure Resident #2, who had a history of falls, was appropriately assessed at admission to determine needed interventions to prevent ongoing falls; -Ensure appropriate fall prevention interventions were in place; and,-Ensure all clinical staff were educated on Resident #2's orthostatic hypotension diagnosis (a sudden drop in blood pressure that happens when a resident changes position from lying or seated position to a standing position causes dizziness and/or fainting) which puts the resident at a high risk for falls. Findings include:I. Professional referenceAccording to [NAME] M, [NAME] A, Taraborrelli P, Panagopolous D, Torocastro M, [NAME] R, Lim PB. Orthostatic Hypotension in Older People: Considerations, Diagnosis and Management, 3/21/21. Retrieved on line 11/17/25 from https://pmc.ncbi.nlm.nih.gov/articles/PMC8140709/ Orthostatic hypotension is very common in older people and is encountered daily in emergency departments and medical admissions units. It is associated with a higher risk of falls, fractures, dementia and death, so prompt recognition and treatment are essential. Orthostatic hypotension is defined by a drop of greater than 20 mmHg (millimeters of mercury, a unit of measurement for pressure, to measure blood pressure) in systolic blood pressure (BP) or greater than 10 mmHg diastolic BP after standing for three minutes. Immobility and associated deconditioning, cognitive decline, and dementia are major causes of orthostatic hypotension. It is thus essential that it is identified, and that the consequences are anticipated and managed. Non-pharmacological measures (include but not limited to): -Fluid repletion (hydration); -Physical exercise, leg exercises; -Compressing the venous beds in the abdomen and legs is also effective. Evidence is strongest for abdominal compression. Conclusion: Orthostatic hypotension is a common, persistent and disabling condition which is encountered daily in general medical practice. It drastically impairs quality of life and results in rapid and progressive deconditioning and functional deterioration, often resulting in institutionalization. When orthostatic hypotension co-exists with supine hypertension (high blood pressure when lying down), careful consideration of short- and medium-term risks should be balanced and discussed with the patient. Using simple, effective, practical measures to diagnose, monitor and alleviate it can have a major impact in maintaining independence in older people.II. Facility policy and procedureThe Falls Management policy and procedure, revised August 2025, was provided by the nursing home administrator (NHA) on 9/22/25 at 11:31 a.m. The policy read in pertinent part: Residents should be evaluated for the risk of falling so that interventions may be considered in order to: Promote resident safety, Promote appropriate clinical and interdisciplinary assessment of falls and fall risk factors and coordinate management of acute and recurrent falls. Early identification of risk for falls and reduction of multiple falls may enable residents to maintain their dignity and maximize their level of independence. Fall Risk Data Collection should be completed upon admission, quarterly, and after a significant change of condition. Resident Centered Approaches:1. The IDT (interdisciplinary team) should implement a fall prevention plan to assist with reducing falls related to risk factors and history of falls.2. If the fall risk evaluation identifies several possible risk factors, the IDT may choose to prioritize interventions. (try one or a few at a time, rather than many at once.)3. Initial interventions may include, but are not limited to, room setup, reviewing the resident's balance, footwear review, lighting, call system orientation, personal items within reach, etc.4. If a fall occurs with interventions in place, IDT should review the resident to determine if additional or different interventions should be implemented.III. Resident #2A. Resident statusResident #2, age [AGE], was admitted to the facility on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included orthostatic hypotension, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repeated falls, and unsteadiness on the feet.The 6/3/25 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 13 out of 15 and no behavioral issues. The assessment documented the resident was dependent on staff to complete toileting and showering tasks and required maximal assistance where staff completed more than half the effort to complete personal hygiene tasks and lower body dressing.The resident had repeated falls before admission and one fall while a resident of the facility. B. Resident's representative interviewResident #2's representative was interviewed on 9/23/25 at 12:52 p.m. The resident's representative said she visited the facility daily with few exceptions, and met regularly with staff to discuss the resident's care needs. She said staff did not notify her about changes in Resident #2's care. The resident's representative said the resident had sudden drops in blood pressure causing him to be unsteady on his feet; she asked nursing staff to make sure he wore his physician prescribed abdominal binder to aid his body prevent his blood pressure from dropping and making him unsteady with an increased risk of falling. Nursing staff assured her the abdominal binder would be applied, but it was not. The resident representative said she frequently observed Resident #2 without the prescribed abdominal binder.The resident representative said Resident #2 fell in the facility's care on 6/2/25. Resident #2 was in the bathroom without the abdominal binder in place, and no staff were present to assist him. As a result, Resident #2 fell. The representative said one of the facility's registered nurse (RN) called her and told her Resident #2 fell but was uninjured. Resident #2's representative said when she arrived at the facility she found that Resident #2's glasses were broken and he had blood coming from his nose. She said she immediately questioned nursing staff about his fall, injuries and why he was not wearing his prescribed abdominal binder. C. Record review1. Resident's preadmission historyThe 5/22/25 hospital progress notes revealed Resident #2, with a history of recurrent falls with a direct connection to orthostatic hypotension and low blood pressure. The note documented that the resident presented at the hospital after a fall at home. Emergency medical response services (EMS) responded to the resident medical alert and found him on the floor of his apartment bathroom in front of the toilet. EMS assessment revealed the resident was confused and hypotensive (having extremely low blood pressure) Later at the hospital, after initial treatment, Resident #2 said he fell twice before EMS arrived. He said he fell from his bed before he fell in the bathroom. The 5/27/25 hospital assessment revealed Resident #2 had several skin tears and abrasions on his elbows and knees from his falls, and presented with decreased activity tolerance, strength, and functional mobility. Resident #2 was assessed to need skilled nursing services to restore independence and reduce his risk for falls.-However, the facility failed to take into account the hospital diagnostics findings when developing the resident's care plan to implement appropriate fall prevention interventions upon Resident #2's admission to the facility. The resident's orthostatic hypertension diagnosis connection to his falls was not care planned. The primary care physician hospital discharge special instructions, dated 5/29/25, documented: You came to the hospital after another fall, and we suspect this was due to your blood pressure dropping when you stand up and also possibly due to dehydration. We placed an order for compression stockings on your left leg and an abdominal binder to be worn prior to standing.Be sure to wear your stocking and abdominal binder if you stand. If you are able to find a larger stocking for your right leg then also wear a compression stocking on our right leg.2. Record review Comprehensive nursing note, dated 6/2/25 at 4:13 a.m,. documented nursing observations, evaluation, and recommendations: after arriving to Resident #2's room the resident was found on the bathroom floor with the following positioning. His head near the bathroom door, feet near the toilet. The resident was observed to have bleeding on the back of his right forearm. The RN was called to assess the resident immediately: all extremities were within normal limits. The resident denied hitting his head and experiencing pain.A change of condition note dated 6/2/25 at 9:45 a.m. documented the resident's blood pressure: was 106/64 while sitting.-The resident's standing blood pressure was not assessed to rule out orthostatic hypotension drops in blood pressure as a potential factor of a related cause of the resident's fall. The change of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition note revealed that the RNs physical assessment resulted in positive findings for the resident experiencing increased confusion (e.g. disorientation) but no changes in functional status. The primary care provider recommendations included: apply steri-strips to skin tear and an appointment with the physician. Nursing progress note dated 6/2/25 at 10:02 a.m. documented : The RN was informed at 9:45 a.m.by the resident's attending nurse that the resident was on the floor in his bathroom in front of his toilet laying on his right side. The RN assessed the resident for injuries a skin tear was noted on the resident's right wrist; the resident denied pain and refused pain medication. The resident said he was attempting to transfer off the toilet without assistance and fell. Initial neurological checks are without changes to the resident's baseline and the first set of vitals were within normal limits.Physician assistant exam note, dated 6/2/25, documented Resident #2 was seen sitting upright in bed alert, comfortable, no distress with his daughter by his side. Nursing staff reported a fall this morning. The resident denied headaches, vision changes, nausea, or vomiting following the fall. The resident sustained a small skin laceration on the right hand which was cleaned and steri-strips placed. The resident was attempting to ambulate to use the restroom on his own when he fell. Discussed fall precautions and the resident understood. Additionally, his daughter requested to add an order for use of an abdominal binder for orthostatic hypotension as the resident was found to have low blood pressure when he was found down.The physician note documented the resident had multiple comorbidities requiring medication management that necessitated frequent clinical evaluations. Without regular monitoring and management, the resident is at moderate to high risk of symptom exacerbation and complications resulting in hospitalization or death. The resident has functional impairments with potential high risk for frequent falls, bowel or bladder complications, and new or worsening wounds and requires frequent monitoring.The post fall investigation, dated 6/2/25, documented Resident #2 was assessed to continue to be a fall risk. The IDT reviewed the fall assessment and fall interventions. Interventions in place included providing call light in; encouraging appropriate footwear; providing occupational and physical therapy as needed. The resident's fall care plan, initiated 5/29/25 and revised 6/2/25, identified Resident #2 was at risk for falls. Pertinent intervention included:-Keeping the call light in reach; encourage resident to use the call light when he needed assistance, initiated 5/29/25; -Providing occupational and physical therapy evaluation and treatment, as ordered, initiated 5/29/25-Encouraging the resident to wear appropriate footwear when ambulating or mobilizing in wheelchair, initiated 5/30/25After the 6/2/25 fall the following interventions were added:-Providing rest periods as needed initiated, 6/2/25; -Ensuring the resident was wearing an abdominal binder when out of bed for hypotension management, initiated, 6/2/25.-Despite Resident #2 being diagnosed at the hospital preadmission with orthostatic hypotension as a correlating factor to be the cause of the Resident #2's falls interventions to manage his orthostatic hypertension was not initiated as a care plan focus or factor of the resident's falls until after the 6/2/25 fall. -The abdominal binder was not implemented as an intervention to prevent the resident from experiencing orthostatic hypertension and falling related to the symptoms of experiencing orthostatic blood pressure until after the resident fall on 6/2/25 and the resident representative requesting there was an order for the binder so staff would consistently apply the device. The resident activities of daily living (ADL) care plan, initiated 5/29/25, documented Resident #2 had an ADL self care performance deficit. -The care plan failed to document the resident transfer care and assistance needs. Progress note, dated 6/2/25, documented Resident #2 had functional impairments with potential high risk for falls, bowel or bladder complications, and new or worsening wounds and required frequent monitoring. Review of May 2025 and June 2025 Resident #2's point of care task record, accessed and maintained by the certified nurse aides (CNA), revealed that Resident #2 was dependent on staff for all transfers. Review of June 2025 medication administration record (MAR) revealed documentation abdominal binder was not applied prior to the fall incident on 6/2/25 despite the hospital discharge orders giving instructions for the resident to wear an abdominal binder when standing to help to prevent falls (see preadmission hospital records above).IV. Staff (continued on next page)

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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 two (#1 and #4) of three residents who required respiratory care received care consistent with professional standards of practice out of seven sample residents.Specifically, the facility failed to:-Ensure Resident #1 and Resident #4 were provided their physician-ordered continuous positive airway pressure (CPAP) treatment consistently; and, -Ensure Resident #4's CPAP machine was cleaned and stored properly. Findings include:I. Facility policy and procedureThe admission Data Collection and Orders policy, revised September 2025, was provided by the director of nursing (DON) on 9/23/25. It read in pertinent part, The charge nurse who admits the resident is responsible for completing the nursing admission data collection, verifying orders are present for admission, additional corresponding data collections, and reviewing the information sent by the discharging community, hospital, and/or attending physician.The CPAP/BiPAP (bilevel positive airway pressure policy, revised September 2017, was provided by the DON on 9/23/25. It revealed in pertinent part, Review and follow health care provider's orders and manufacturer's instructions for CPAP/BiPAP support, machine setup and oxygen delivery. CPAP therapy is used to improve arterial oxygenation in residents with respiratory (oxygen) insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. To promote resident comfort and safety. Review and follow the health care provider's orders and manufacturer's instructions for CPAP/BiPAP support, machine setup and oxygen delivery. Use distilled water for the humidification chamber, interior filter, tubing, and mask cushion. Filtered or tap water should not be used. Storage and cleaning: make sure the machine and parts are kept out of direct sunlight. Use mild detergent and a damp cloth to wipe the surface of the machine, then dry it thoroughly with a lint-free towel. Never submerge the machine in water. Wash the mask daily in mild, fragrance-free soap and warm water, then rinse well in warm water and air dry. Soak mask weekly in one part vinegar to three parts water for 20 minutes, followed by a rinse in distilled water. The sturdy plastic or soft fabric part of the mask should be cleaned weekly in warm soapy water.II. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included metabolic encephalopathy (brain dysfunction caused by metabolic imbalances), end stage renal disease, dependence on renal dialysis, obstructive sleep apnea (OSA), type II diabetes and hypertension (high blood pressure).The 7/2/25 minimum data set (MDS) assessment revealed the resident required substantial assistance for activities of daily living (ADL). The MDS assessment revealed the resident required oxygen use. B. Resident #1's representatives interviewResident #1's representative was interviewed on 9/23/25 at 11:24 a.m. The representative said they saw Resident #1 on 7/10/25 and the resident told the representative that she had not been assisted in using her CPAP machine. The representative said on the day of admission, the staff asked the family to bring in the CPAP machine and did so without delay. The representative said when at home, Resident #1 was compliant about wearing her CPAP at night. C. Record reviewThe preadmission paperwork, dated 6/24/25, indicated Resident #1 was on two liters of oxygen per minute (LPM) and utilized a CPAP machine at home (prior to admission). The hospital referral and Discharge summary, dated [DATE], identified that Resident #1 had a diagnosis of OSA and required the use of CPAP therapy. Review of the June 2025 CPO revealed respiratory orders for oxygen at two LPB via nasal cannula every shift for hypoxia.-However, the June 2025 MAR did not document any order to administer CPAP therapy, although the hospital documentation indicated the use of the CPAP. Review of the July 2025 CPO revealed a physician's order for the use of the CPAP and indicated the settings with oxygen at 14 centimeters (cm) water (H2O) at bedtime for OSA, ordered on 7/8/25. -However, Resident #1 was admitted on [DATE] and the CPAP orders were not implemented until 7/8/25.III. Resident #4A. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included arthritis due to other (continued on next page)

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	065376	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Greenwood Village	6450 S Boston St Greenwood Village, CO 80111

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bacteria in the right knee, idiopathic gout (inflamed arthritis), chronic kidney disease and obstructive sleep apnea (OSA).The 9/19/25 MDS assessment revealed Resident #4 was cognitively intact with a BIMS score of 15 out of 15. Resident #4 required a CPAP machine and was dependent on staff for ADLs.B. ObservationsResident #4 was interviewed on 9/22/25 at 2:47 p.m. Resident #4 said the nursing staff assisted him every night and every morning with his CPAP machine. Resident #4 said the staff filled the water reservoir with distilled water in the morning. The resident said if there was water left over, the staff left the water in the machine and topped it off the next morning. During the interview, Resident #4's CPAP mask was sitting on the resident's nightstand, uncovered and exposed to potential contaminants on the surface of the stand. Resident #4 was interviewed on 9/23/25 at 8:45 a.m. Resident #4 said the nursing staff did not place the machine or mask under any covering. Resident #4 said the mask and machine sat on the nightstand next to his bed. Resident #4 said he had not seen any staff members clean the machine, tubing or mask since his admission to the facility (9/15/25).During the interview, Resident #4's CPAP machine was placed on the nightstand and the mask was not on any protective surface or under a protective covering.C. Record reviewReview of Resident #4's baseline care plan on 9/25/25, revealed the facility failed to implement a baseline care plan until 9/18/25. Review of the September 2025 CPO revealed a physician's order for the CPAP mask to be soaked weekly on Sunday, day shift in one part vinegar to three parts water for 20 minutes, followed by a rinse in distilled water, ordered on 9/21/25. -However, RN #1 said in an interview she was unaware that she was to use vinegar to clean the resident's CPAP (see interview below). IV. Staff interviewsRegistered nurse (RN) #1 was interviewed on 9/23/25 at 10:33 a.m. RN #1 said she washed Resident #4's CPAP mask in warm soapy water and dried it with a towel before putting it back next to Resident #4's bed side every morning. RN #1 said the CPAP did not come with a manual or instructions, she just knew to clean the machine because of working in the hospital. RN #1 said the masks could smell like mildew if they were not properly cleaned. RN #1 said she would not store the CPAP in a bag because the moisture would make it so the mask would not dry. RN #1 said any nurse could assist with a CPAP. She said physician's orders should be obtained at the time of admission. The DON was interviewed on 9/23/25 at 3:17 p.m. The DON said the RN that was on duty at the time of admission was responsible for completing the new admission paperwork. The DON said depending on how many admissions the facility was getting in a day, the facility would have an RN scheduled to assist with the admissions. The DON said admission paperwork could be completed by either an RN or licensed practical nurse (LPN). The DON said that at the time of admission, the care plan should be initiated. The DON said the staff needed to have the baseline care plan completed within 24 hours of the resident's admission. The DON said he thought the baseline care plan needed to be completed within 48 to 72 hours. The DON said he was filling in for the DON position currently. He said he had just started working at the facility a month ago. He said he was not aware of any recent training provided to nursing staff on the proper use and cleaning of CPAP machines. The DON said the vinegar was being used to clean the masks. The DON said the vinegar should be kept at the nurses' station. The DON said the staff reported when Resident #1 was admitted to the facility on [DATE], the family member did not bring the CPAP machine in until July 2025.-However, Resident #'1 representative said she brought it in upon admission, (see interview above).RN #1 was joined the DON interview on 9/23/25 at 3:17 p.m. RN #1 said she obtained a large container of vinegar from the kitchen and was taking it up to the nurses' station to be stored for use to clean residents' CPAP machines. RN #1 was interviewed on 9/23/25 at 3:26 p.m. RN #1 said she did not know where the vinegar was stored. She said she did not know what the vinegar was used for. LPN #1 and certified nurse aide (CNA) #1 were interviewed together on 9/23/25 at 3:29 p.m. LPN #1 said she did not know what vinegar would be used for. CNA #1 said she would use the vinegar to clean a catheter bag. LPN #1 unlocked the medication room and looked in the room for vinegar, she confirmed that there was no vinegar. LPN #2 was interviewed on 9/23/25 at 3:31 p.m. LPN #2 said she did not have vinegar stored at the nurses' station or in the medication room. LPN #2 said she could go to the kitchen staff and ask them for it so that the nursing staff could use it to clean the residents' CPAP machines.

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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 that food was stored, prepared, distributed, and served in accordance with professional food safety standards in the main kitchenSpecifically, the facility failed to ensure:-The kitchen was kept in a sanitary manner;-Perishable foods were properly labeled, stored, and maintained; and, -The ice machine was maintained in a sanitary condition. Findings include:I. Failure to ensure the kitchen was kept in a sanitary mannerA. Professional referenceAccording to the U.S. Food and Drug Administration Food Code (Effective 2022) retrieved on 10/1/25, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. (3-178) After cleaning and sanitizing, equipment and utensils: Shall be air-dried or used after adequate draining before contact with food. (chapter 4) Physical facilities shall be maintained in good repair. (chapter 6) Physical facilities shall be cleaned as often as necessary to keep them clean. (chapter 6)B. Facility policy and procedureThe Kitchen Cleaning policy, effective July 2024, was provided by the nursing home administrator (NHA) on 9/23/25 at 5:20 p.m. It read in pertinent part, All kitchens and food preparation areas must be cleaned according to federal, state and local regulations. Kitchen areas (walls, cupboard doors, ceiling, lights and vents) are clean, free from dust and in good repair (free of cracks and holes).C. ObservationsThe initial kitchen tour was conducted on 9/22/25 at 10:50 a.m. The following was observed:-The paper towel dispenser over the hand washing sink was soiled with smudges and had white and brown dried debris on it. -The walls behind the handwashing station, and the walls around the walk-in refrigerator had dime sized brown and yellow streaks and splatters across their surfaces.-The drying rack had multiple food storage bins and pans stacked on top of each other, trapping moisture. Between two of the pans on the clean drying rack were unidentifiable food debris.II. Ensure perishable foods were labeled and stored and stored appropriatelyA. Professional referenceAccording to the Colorado Retail Food Establish Regulations (3/16/24) retrieved on 9/25/25, A date marking system that meets the criteria marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. (chapter 3) Except for containers holding food that can be readily and unmistakablyrecognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. (chapter 3) Food shall be protected from contamination by storing the food: In a clean, dry location; Where it is not exposed to splash, dust, or other contamination; and at least 15 cm (centimeters) (6 inches) above the floor. (chapter 3) A food specified in shall be discarded if it: Is inappropriately marked with a date or day that exceeds a temperature and time combination. (chapter 3) The food in unmarked containers or packages, or marked with a time that exceeds the six (6) hour limit shall be discarded. (chapter 3)B. Facility policy and procedureThe Food Storage policy, revised June 2024, was provided by the NHA 9/23/25 at 5:20 p.m. It read in pertinent part, The storerooms and walk-ins should be maintained free from dirt, dust, insects, rodents or any potential sources of contamination. All foods should be stored on storeroom shelving that is no less than six inches from the floor. Dented cans must be marked with a large X and set aside in a separate area so that theywill not be used.C. ObservationsThe initial kitchen tour was conducted on 9/22/25 at 10:50 a.m. The following was observed in the dry storage area:-An opened bag of chips.-A container of pastries and pies that were uncovered and undated.-A bag of expired popcorn.-A dented can was on the same shelf as non-dented cans.-The flour bin lid had smudges and dried debris on it. There was a use-by date of 8/1/25 written on it. -Boxes of food were on the floor.In the main kitchen the following was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observed:-Under the food preparation counter there was a bin of grains that was left open without a lid and did not have a use-by date on it. In the walk-in refrigerator the following was observed:-Food boxes were stacked on the floor in the walk-in refrigerator and dry storage room. -A box of carrots was in the freezer and was left open.-A separate bin of carrots in the walk-in refrigerator was labeled as watermelon and had an expiration date of 8/1/25 on it. III. Ensure the ice machine was maintained in a sanitary conditionA. Professional referenceAccording to the U.S. Food and Drug Administration Food Code (Effective 2022) retrieved on 10/1/25, In equipment such as ice makers, a frequency specified by the manufacturer, or the absence of manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. Ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. (chapter 4)B. ObservationsThe initial kitchen tour was conducted on 9/22/25 at 10:50 a.m. The ice machine had debris across the front and sides of the machine. There were dark smudges, brown splatters and a crusted white substance were visible on the outside and inside door of the ice machine. The inside door-flap of the ice machine had similar smudges, splatters and debris. C. Record reviewAccording to the 2025 Ice Machine Cleaning Log was for the year 2025 provided by the NHA on 9/23/25 at approximately 3:20 p.m.On the top of the log it read, The ice machine should be cleaned and sanitized at least once a month and cleaned and sanitized by a professional service provider every six (6) months. Please refer to your ice machine's manual for cleaning instructions. The ice machine log documented a monthly cleaning being completed by the facility from January 2025 through August 2025. According to the log, a professional service provider came on 5/27/25 for a repair to the ice machine in the main kitchen. IV. Staff interviews The dietary manager (DM) was interviewed on 9/23/25 at approximately 1:00 p.m. The DM said that he recognized that many food items had expired or lacked food labels and that he would monitor expiration dates closely in the future. He said the kitchen staff tried to deep clean the kitchen every Sunday. The DM said the kitchen recently got a new power washer and he would schedule the kitchen for a deep cleaning using the power washer. The DM said he was unable to provide documentation that the main kitchen's ice machine was been deep-cleaned by a professional service provider in the last six months and said that the facility no longer contracted with the outside service to provide the deep sanitation and chemical disinfection for the ice machine (see ice machine cleaning record above). The NHA was interviewed on 9/23/25 at 4:22 p.m. The NHA said that she conducted weekly walkthroughs of the kitchen and that her last walkthrough was last week. The NHA said that her expectation of the kitchen was for it to be clean and to have all food items dated properly. The NHA said she understood why kitchen staff was confused about the process for servicing kitchen equipment, specifically the malfunctioning ice machine in the main kitchen that did not keep ice frozen. She said that the kitchen staff was to place a work order for the maintenance department. From there the maintenance department was responsible for contacting the equipment vendor or completing the maintenance themselves.