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	04/09/2026

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 0686 Level of Harm - 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 the necessary treatment and services to prevent and treat pressure injuries for one (#20) of two residents out of 34 sample residents.Resident #20, who was dependent on staff for all care and mobility and was known to be at risk for skin breakdown, was admitted to the facility on [DATE] with a right hip surgical incision, but did not have any pressure injuries. The facility did not implement interventions to offload the resident's heels or provide a low-air loss mattress upon the resident's admission to the facility.Additionally, the facility failed to conduct a Braden Scale assessment (a tool utilized for predicting pressure ulcer injury risk) upon the resident's admission to the facility.On 4/6/26, seventeen days after the resident's admission to the facility, Resident #20 developed a stage 3 pressure injury to her right heel. Following the development of Resident #20's right heel pressure injury, the facility implemented an intervention to offload the resident's heels at all times. However, multiple observations during the survey revealed the resident's heels were not consistently offloaded.Specifically, the facility failed to implement interventions in a timely manner to prevent the development of a right heel stage 3 pressure injury for Resident #20.Findings include:I. Professional referenceAccording to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved from on 4/9/26 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)Intact skin with nonblanchable 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 1 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 LossPartial 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.Category/Stage 3: Full Thickness Skin LossFull 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 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 LossFull 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 (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 0686 Level of Harm - Actual harm Residents Affected - Few	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 palpableUnstageable: Depth UnknownFull 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 UnknownPurple 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 #20A. Resident statusResident #20, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included a displaced intertrochanteric fracture of the right femur, dementia with behaviors and cognitive communication deficit. The 4/3/26 minimum data set (MDS) assessment revealed the resident was unable to complete the brief interview for mental stats assessment. According to the staff assessment for mental status, the resident had long term and short term memory problems and her cognitive skills for daily decision making were moderately impaired. The resident had impairment on one side of her lower extremities and was dependent on staff for all activities of daily living (ADL).The MDS assessment indicated the resident was at risk for developing pressure injuries.B. Observations and staff interviewDuring a continuous observation on 4/7/26, beginning at 11:42 a.m. and ending at 2:20 p.m., the following was observed:At 11:42 a.m. Resident #20 was transferred from her bed to her wheelchair by physical therapy (PT) staff. At 12:10 p.m. Resident #20 was transferred to her recliner and left with her heels resting on the recliner's surface. At 2:20 p.m. Resident #20 was transferred from the recliner to the bed and left with her heels against the mattress.During a continuous observation on 4/8/26, beginning at 9:40 a.m. and ending at 1:00 p.m., the following was observed:At 9:40 a.m. Resident #20 was in bed covered with a blanket. At 10:20 a.m. an unidentified certified nurse aide (CNA) offered to assist with changing the resident, but the resident's family member who was present in the room said it was not necessary. At 11:07 a.m. Resident #20 was wearing socks and was observed to have a bandage on the right heel. The resident had a pillow under her feet and her heels were not touching the mattress. -However, the resident was not repositioned.At 11:40 a.m. PT staff checked on the resident and tried to help her get out of bed, but they were unable to. The resident remained lying on her back. At 1:00 p.m. two unidentified CNAs transferred Resident #20 to the recliner. -However, Resident #20 was not repositioned from lying on her back for three hours and 20 minutes. Additionally, the resident's heels were left touching the recliner surface after the CNAs transferred her to the recliner.On 4/9/26 at 5:00 a.m. Resident #20 was in bed. The resident's heels were not offloaded. There was a pillow on the floor by her bed, but the resident's heels were lying directly on the mattress.During a continuous observation on 4/9/26, beginning at 5:18 a.m. and ending at 6:27 a.m., the following was observed:At 5:18 a.m. Resident #20 bent her legs and moved her heels back and forth on her bed.At 5:28 a.m. an unidentified staff member entered the resident's room, moved something on the resident's dresser and left the room. Resident #20 was still in bed and the unidentified staff member did not attempt to offload the resident's heels. At 5:45 a.m. another unidentified staff member entered the resident's room, brought water for the resident and did not attempt to offload the resident's heels.At 6:04 a.m. Resident #20 was changed, but her heels remained resting directly on the bed after staff completed the brief change. At 6:14 a.m. a nurse checked on Resident #20 but did not attempt to offload the resident's heels.At 6:27 a.m. two unidentified staff members checked on the resident but did not attempt to offload the resident's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	heels.On 4/9/26 at 8:36 a.m. Resident #20's right heel wound care was observed with the registered nurse (RN) #2, who was the second floor unit manager, and the director of nursing (DON). The resident did not have an air mattress on her bed. After performing hand hygiene, RN #2 removed the dressing from Resident #20's right heel. Yellow slough (a yellowish, soft, or moist devitalized tissue (dead tissue) that adheres to the wound bed, acting as a physical barrier to healing) was observed in the center of the resident's wound with red granulated tissue (new, healthy connective tissue and microscopic blood vessels that form in the base of a healing wound) around the edges of the wound. Reddish drainage was observed coming from the wound. RN #2 cleansed the wound with wound cleanser. She then applied alginate (wound treatment) to the wound, placed an abdominal pad (ABD - a highly absorbent, sterile, multi-layered pad designed for heavily draining wounds) over the alginate and wrapped the resident's heel with Kerlix (high absorbency cotton gauze used for wound dressings). When she was finished applying the dressing to the resident's heel, RN #2 put the resident's sock back on her foot and offloaded the resident's heels.RN #2 said she Resident #20's wound had black eschar (a thick, dry, black or brown layer of dead tissue (necrosis) that forms over severe wounds) present in the wound bed when the wound was initially identified (on 4/6/26) and she thought the wound was going to be an unstageable wound.C. Resident #20's family member interviewResident #20's family member was interviewed on 4/8/26 at 1:07 p.m. The family member said Resident #20's right heel pressure ulcer was found by the facility staff two days ago (4/6/26). She said the facility staff had helped her to schedule an appointment for the resident with the wound care physician.D. Record reviewThe skin care plan, initiated on 3/21/26, revealed Resident #20 had potential for impairment to skin integrity. The resident was admitted with a surgical incision to the right hip. Interventions included assisting the resident with turning and repositioning as needed, reducing friction and shearing with the use of transfer sheets, completing Braden Scale assessments as required, dietary consults for nutritional review, encouraging good nutrition and hydration to promote healthier skin, evaluating the resident's skin condition every week and as needed, providing incontinence care as needed and using caution during transfers and bed mobility to prevent striking all body surfaces against any sharp or hard surfaces.The 3/20/26 nursing admission data collection assessment documented Resident #20 had no history of skin issues.The 3/24/26 nutritional risk review progress note documented the resident had no pressure ulcers.The 3/25/26 comprehensive nursing progress note documented the resident had no pressure ulcers. The 4/7/26 Braden Scale assessment indicated Resident #20 was at moderate risk for developing pressure injuries.-However, the assessment was not completed until after the resident developed the right heel stage 3 pressure injury. Review of Resident #20's April 2026 CPO revealed the following physician's order:Offload the resident's heels at all times, ordered 4/6/26.Wound care: Right heel, cleanse with normal saline/wound cleanser, apply honeygel (wound treatment) to wound bed, cover with bordered foam dressing daily and every four hours as needed for soiled/displaced dressing, ordered 4/6/26 at 2:30 p.m.The 4/6/26 comprehensive nursing assessment note, dated 4/6/26 at 2:57 p.m., revealed the resident's surgical incision site was checked and had no signs/symptoms of infection. The note did not identify that Resident #20 had a new pressure injury to her right heel.-However, a physician's order for wound care to the resident's right heel was entered into the resident's electronic medical record (EMR) on 4/6/26 at 2:30 p.m. (see physician's order above).The 4/8/26 wound care physician note revealed the wound care physician assessed Resident #20's right heel wound on 4/8/26. The wound care physician documented the following wound dimensions: 2.5 centimeters (cm) by 2.0 cm by 0.4 cm. It was described as a right heel stage 3 pressure injury and had 80% (percent) granulation and 20% slough in the wound bed. The wound care physician note documented Resident #20's right heel wound should be listed as unavoidable due to the resident's poor oral intake, non-compliance with offloading the heel, a diagnosis of dementia and she recently had major right hip surgery less than three weeks prior According to the note, the facility had all interventions in place (air mattress, offloading heels, education) prior to the resident developing the wound.-However, observations during (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the survey revealed no air mattress on Resident #20's bed and multiple observations of the resident's heels not being offloaded and no attempts made by staff to offload the resident's heels (see observations above).-Additionally, there was no physician's order in place to offload the resident's heels until 4/6/26, after the identification of the right heel wound (see physician's orders above).III. Staff interviewsThe wound care physician was interviewed on 4/8/26 at 2:15 p.m. The wound care physician said he understood Resident #20 had previous hip surgery, had postsurgical pain and decreased mobility, and a diagnosis of dementia. He said that with this combination of comorbidities, it was not uncommon for a pressure wound to develop. The wound care physician said the wound on Resident #3's right heel was unstageable and unavoidable due to her dementia and inability to understand the required need to keep pressure off of her heel. -However, the facility failed to implement appropriate interventions prior to the development of the wound (see record review above).-Additionally, the wound care physician's 4/8/26 visit note documented the resident's wound was a stage 3 pressure injury (see record review above).CNA #2 was interviewed on 4/9/26 at 11:32 a.m. CNA #2 said he was unaware of Resident #20's right heel pressure ulcer. CNA #2 said the staff would report to the nurses immediately if they found skin lesions, such as pressure wounds. CNA #2 said he checked residents' skin every time he changed or repositioned the residents and during showers. CNA #2 said he received new directions from the nurses and checked the Kardex (comprehensive tool utilized for providing consistent resident care) for updates on interventions for residents, but he said the Kardexes were usually not updated.Licensed practical nurse (LPN) #3 was interviewed on 4/9/26 at 12:00 p.m. LPN #3 said Resident #20 had new treatment orders for her right heel pressure injury that were initiated on 4/8/26, and new interventions were communicated to the CNAs. LPN #3 said she was unaware of the development date of the resident's pressure ulcer and was unable to provide documentation with interventions related to Resident #20's pressure ulcer before 4/8/26. LPN #3 said the only intervention in place for the resident before 4/8/26 was keeping the resident's feet from touching the recliner's surface while she was sitting in it. LPN #3 said residents' skin assessments were usually done once a week. LPN #3 said Resident #20 did not have a pressure ulcer in the first weeks after the resident was admitted to the facility. The DON was interviewed on 4/9/26 at 3:55 p.m. The DON said the wound care physician assessed Resident #20's right heel wound on 4/8/26. The DON said the nurses were currently following the physician's orders for dressing changes to the resident's right heel and the wound care nurse was also monitoring the wound. The DON said she saw Resident #20 crossing her right leg and moving her heel against the mattress, so protective boots were requested.

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F 0689 Level of Harm - 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 residents had adequate supervision and assistive devices to prevent accidents for one (#28) of three residents reviewed out of 34 sample residents. Specifically, the facility failed to ensure supervision was provided, as determined in an assessment, to prevent a fall for Resident #28 that resulted in fractures. Resident #28 was admitted on [DATE] with diagnoses of sepsis (infection of the blood), unsteadiness on feet, generalized muscle weakness, repeated falls and other Alzheimer's disease.Resident #28, was identified as a fall risk and had a history of repeated falls. Resident #28 was found outside by facility staff on 3/29/26. Resident #28 was bleeding from her mouth and had pain when trying to bend her knees. Resident #28 was sent to the emergency department, where it was determined that Resident #28 had sustained a fracture to her coccyx and facial bones. Resident #28 did not return to the facility. Findings include:I. Facility policy and procedureThe Falls Management policy, March 2026, was provided by the nursing home administrator (NHA) on 4/13/26 at 11:07 a.m. It 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 (IDT) assessment of falls and fall risk factors, and coordinate management of acute and recurrent falls. Fall risk data collection should be completed at admission, the evaluation may include: history of falls, cognitive status/behavior symptoms, vision status, continence, mobility, balance, vital signs, age, health conditions/risk factors, and medications. If the resident fall score is equal to or above 10, they should be considered a high risk for falls. The IDT should implement a fall prevention plan to assist with reducing falls related to risk factors and history of falls. Initial interventions may include, but are not limited to room set up, reviewing the resident's balance, footwear review, lighting, call system orientation, personal items within reach.II. Resident #28A. Resident statusResident #28, age [AGE], was admitted on [DATE] and was discharged to the hospital on 3/29/26. According to the March 2026 computerized physician's orders (CPO), diagnoses included sepsis, unsteadiness on feet, generalized muscle weakness, repeated falls and other Alzheimer's disease.The 3/25/26 minimum data set (MDS) assessment revealed Resident #28 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #28 required the use of a walker when ambulating and required substantial to maximal assistance with toilet transfers and partial to moderate assistance with walking 50 feet. The assessment documented walking on uneven surfaces was not attempted due to medical conditions and going up and down a curb was not attempted. The MDS assessment indicated Resident #28 had at least one fall with no injury in the last two to six months prior to admission.B. Facility investigation of Resident #28's fall on 3/29/26Review of the facility's investigation of Resident #28's fall on 3/29/26 revealed the NHA interviewed multiple staff members between the dates 3/30/26 and 4/3/26. The investigation documented registered nurse (RN) #3 was interviewed. RN #3 said he was outside of the building and found Resident #28. He said he was planning on checking on her anyway because she had communicated with him that she was going outside. He said it was about 6:30 p.m. He said when he found her, she was lying on her back, holding a newspaper. He said she was fully clothed and had her shoes on. He said, during his assessment, he noticed she was bleeding from her mouth. He said she had told him she tripped while she was walking and landed on her face. He said he saw Resident #28's walker close to the sidewalk nearby. RN #3 said he asked qualified medication administration person (QMAP) #1 to go get RN #4 from the second floor. He said when he attempted to get Resident #28 to sit up, she complained of pain. He said he had her remain in the lying position and did not note any other scrapes, cuts, or bruises other than the bleeding from her mouth. He said he stayed with Resident #28 until RN #4 and emergency services arrived. He said he then went upstairs to start transfer paperwork. The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	investigation documented RN #4 said QMAP #1 had notified her of the situation. RN #4 said she immediately responded to the location and took over from RN #3. She said she did a head to toe assessment and asked Resident #28 if she could move her legs. Resident #28 said she could not move her legs due to pain. Resident #28 told her she had hit her head and RN #4 noted Resident #28 was bleeding from her mouth. RN #4 said that she and RN #3 stayed with Resident #28 until emergency services arrived. She said she stayed with Resident #28 when emergency services took over. She said when Resident #28 left in the ambulance she went back upstairs to help with notifications and paperwork. She said the last time she saw Resident #28 before she fell was at medication pass at about 6:00 p.m. The investigation documented licensed practical nurse (LPN) #5 was interviewed. LPN #5 said she was not involved in the situation, but RN #4 had told her about the fall. She said the last time that she had seen Resident #28 was about 5:30 p.m. She said she had been sitting in a chair near the nurses' station. She said she had seen Resident #28 go outside at times during the day and she would come back up with no issues. She said she had only done that a few times.The investigation documented certified nurse aide (CNA) #4 was interviewed. CNA #4 said she had last seen Resident #28 sitting in a chair at the nurse's station around 6:30 p.m. or 6:45 p.m.The investigation documented QMAP #1 (who worked in the assisted living residence on the same campus as the skilled nursing facility) was interviewed. QMAP #1 said a family member came to the assisted living residence door and told him about Resident #28 outside. He said he ran outside and saw that RN #3 was already out there with Resident #28. He said RN #3 told him to run and get RN #4. He said after he got RN #4, he stayed outside until emergency services arrived, then went back to his building. -None of the above interviews had a date or time documented on them that indicated when they were conducted. The investigation documented the NHA interviewed the director of rehabilitation on 3/31/26. The interview documented the director of rehabilitation said Resident #28 required stand-by assistance to contact guard assistance for transfers, depending on how tired she was. She said she was walking with a four wheel walker and ambulating 200 feet prior to the fall. She said Resident #28 was safe to ambulate alone. She said Resident #28 was safe to go outside alone and sit near the patio table but not much further than the table. She said as long as Resident #28 stayed in that area, she would be fine. -However, review of physical therapy notes revealed Resident #28 was not independent with ambulation and was not safe to ambulate alone outside (see record review below). An interview with the director of rehabilitation revealed Resident #28 was not independent with ambulation or safe to ambulate outside independently (see staff interviews below). The facility investigation included an IDT post event analysis. The analysis revealed Resident #28 went outside unaccompanied and was found on her back on the ground in the parking lot. The analysis documented Resident #28 said she went for a walk and fell. The resident reported she hurt all over. The analysis documented she was not using an assistive device at the time of the fall, and contributing factors to the fall was she was unaccompanied outside. The analysis documented Resident #28 was on frequent checks at the time of the fall and had one to two falls in the past 90 days. The analysis documented Resident #28 ambulated with no problems with the use of a device. C. Record reviewThe resident at risk for falls care plan, initiated 3/21/26, indicated that Resident #28 was at risk for falling. Pertinent interventions included placing the call light within reach and encouraging Resident #28 to use the call light, placing a call don't fall sign in the resident's room, encouraging proper footwear when ambulating, placing floor mats on either side of the bed when Resident #28 was in bed, completing frequent checks, providing frequent toileting, placing the bed in lowest position, and providing cueing/supervision/assistance as indicated. The special instructions listed at the top of the care plan indicated Resident #28 was at risk for falls. -However, neither the care plan or special instructions indicated how much supervision Resident #28 required when ambulating. A review of Resident #28's electronic medical record (EMR) revealed the following:A nursing admission note, dated 3/20/26 at 11:48 p.m., documented Resident #28 arrived at the facility in a wheelchair and was alert and oriented by two or three at admission. Resident #28 was admitted to the skilled facility after a urinary tract (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	infection (UTI) and sepsis. A comprehensive nursing note, dated 3/21/26 at 8:56 p.m., documented Resident #28 required skilled observation and assessment. The note documented Resident #28 needed one-person assistance with her activities of daily living (ADL). The functional assessment, dated 3/21/26 at 11:10 a.m., documented Resident #28 used a front wheel walker and was a contact guard assist (a level of assistance where a caregiver or therapist maintains physical contact with a resident to provide stability and safety during tasks) with walking on level surfaces and was dependent on staff when walking on uneven surfaces. The note documented the plan of treatment was to work on gait training to normalize gait pattern and facilitation of swing through. The note documented therapeutic activities to work on gross motor coordination, transfer training to increase functional task performance and bed mobility activities to increase functional skills. A comprehensive nursing note, dated 3/23/26 at 10:11 p.m., documented Resident #28 was working with physical therapy (PT) and occupational therapy (OT) for strengthening. The note documented Resident #28 used a wheelchair for her mobility. A comprehensive nursing note, dated 3/24/26 at 10:42 p.m., documented Resident #28 was on frequent room checks due to getting up unassisted, walking with her walker unassisted or holding on to furniture to walk. The note documented Resident #28 was reeducated multiple times on calling for staff assistance with transfers. Resident #28 needed frequent reminders that staff needed to be with her to walk. The physical therapy note, dated 3/24/26 at 11:44 a.m., documented Resident #28 participated in gait training and was able to walk 100 feet with a front wheel walker and contact guard assist for safety. The note documented Resident #28 required verbal cueing to maintain focus on the task, posture and step placement. The note documented Resident #28 also participated in physical therapy, focusing on transfer training. The note documented Resident #28 worked on transfers from the wheelchair using her front wheel walker with contact guard assist. She performed toilet transfers with minimal assistance and constant cueing. The note documented Resident #28 demonstrated impulsive transfer behavior despite maximal verbal cues and physical cues. A social services progress note, dated 3/25/26 at 11:46 a.m., documented Resident #28 required contact guard assist for all of her mobility. The noted documented Resident #28 walked 125 feet with a front wheel walker with a contact guard assist. The physical therapy note, dated 3/29/26 at 6:17 p.m., documented Resident #28 worked on gait training throughout the facility with stand-by assist. Resident #28 performed gait training with head turns, obstacle navigation, change in gait speed to facilitate dynamic standing balance (ability to maintain stability while moving or shifting weight in an upright position) to reduce the risk of falling. The note documented Resident #28 participated in seated therapy exercises to facilitate lower extremity strength to help improve low functional activity tolerance for community distance gait training. -Review of the physical therapy notes did not reveal Resident #28 was able to ambulate safely independently or was able to ambulate independently outside on uneven surfaces. Am eInteract SBAR (situation, assessment, background, recommendation) note, dated 3/29/26 at 7:21 p.m., documented a change in condition of a fall for Resident #28. The note documented she was sent to the emergency department. A nursing progress note, dated 3/29/26 at 7:21 p.m., documented staff notified the RN that a resident was found on the ground outside. The RN responded immediately and requested assistance from another RN for further assessment. Upon assessment, Resident #28 was noted to be lying on her back with both legs extended towards the north and her head towards the south. Blood was observed coming from her mouth. The resident stated she had hit her head. Emergency services were notified. A nursing progress note, dated 3/30/26 at 6:25 a.m., documented Resident #28 was found outside of the facility approximately 30 feet to the left of the front door. Resident #28 was fully clothed and had shoes on and had a newspaper in her hand. The note documented her mouth was bloody and no teeth were noted to have been broken. The note documented no abrasions, cuts or bruises were visible. When the RN asked Resident #28 to sit up, Resident #28 complained of back pain. The RN asked for Resident #28 to stay in place and called 911. A hospital progress note, dated 3/31/26 at 3:14 p.m., documented Resident #28 was admitted to the hospital on [DATE] due to a fall. The progress note documented (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the results of a computed tomography (CT) scan for Resident #28 as loosening of AD 9-11 (upper left central incisor #9, upper left lateral incisor #10, and upper left canine #11) with fractures of the anterior walls of those sockets. The CT scan also documented a closed fracture of the coccyx. III. Staff interviewsCNA #1 was interviewed on 4/8/26 at 10:56 a.m. CNA #1 said Resident #28 had been admitted to the facility prior to her most recent admission on [DATE]. She said Resident #28 was able to walk, but needed assistance. She said there were times when Resident #28 had to use the wheelchair when she was really tired or had lots of pain. She said there were times when she was resistant to care due to pain. She said she could not remember if she was a fall risk, but she said she needed assistance from one person. She said Resident #28 was not supposed to walk alone outside. She said Resident #28 needed assistance. LPN #3 was interviewed on 4/8/26 at 11:08 a.m. LPN #3 said Resident #28 was a one- to two-person assist when she first came to the facility. She said she was a one-person assist when she ambulated with her walker. She said she never saw Resident #28 go outside. She said Resident #28 was not supposed to go outside unattended. She said she had heard that Resident #28 had gone outside and fell. She said she heard it happened during shift change, which may have been how she had gotten outside. CNA #1 was interviewed a second time on 4/8/26 at 1:26 p.m. CNA #1 said she received information regarding the residents from the shift report and also by looking at the special instructions in the computer system. She said the special instructions did not always indicate if a resident was a fall risk or what kind of assistance the residents required. CNA #6 was interviewed on 4/9/26 at 5:46 a.m. CNA #6 said he was informed if a resident was a fall risk during shift change and the nurses would also communicate with him. He said sometimes when a resident was admitted from the hospital, he would see their fall risk wristband on the resident's wrist. He said interventions that the facility always had for fall risk residents were low bed and fall mats. LPN #4 was interviewed on 4/9/26 at 6:41 a.m. LPN #4 said Resident #28 was not independent and was not to go outside alone. She said she was a one-person assist when ambulating. Emergency medical services was interviewed on 4/9/26 at 9:08 a.m. He said they received the call regarding Resident #28 on 3/29/26 at 7:22 p.m.RN #4 was interviewed on 4/9/26 at 9:15 a.m. RN #4 said she started her shift on 3/29/26 at 5:30 p.m. She said at the start of her shift she got report and then did medication pass at 6:00 p.m. She said when she went to give Resident #28 her medications, she remembered seeing Resident #28's visitor leaving with her small dog. She said a little bit later, QMAP #1 came up to get her saying that another RN was asking for her help. She said she went downstairs and outside and saw that Resident #28 was lying on her back. She said she saw blood coming from her mouth. She said when she touched the resident, she screamed in pain. She said when she asked her to move her feet, the resident screamed out in pain. She said RN #3 called 911 from his phone and she ran back upstairs to grab some paperwork and when she had come back, the emergency services were already there. She said that evening was the first time she had worked with Resident #28. The director of rehabilitation was interviewed on 4/9/26 at 10:33 a.m. The director of rehabilitation said physical therapy completed assessments on all of the new residents who came in for rehabilitation. She said that the therapy team used a facility form called therapy to nursing forms to communicate fall interventions, how a resident transferred, ambulated, and if the resident used any assistive devices. She said if a resident had a fall, the fall was discussed during the morning meeting. She said if there were any new interventions or orders, nursing staff would implement the interventions and put in new orders. She said there were also whiteboards that were used in residents' rooms that therapy would use to communicate transfer status and if the resident was independent for ambulating. The director of rehabilitation said Resident #28 was walking 125 feet twice with a stand-by assist with her front wheel walker. She said Resident #28 required stand-by assistance when getting in and out of bed. She said Resident #28 was not cleared to go outside by herself because therapy had not worked with her on uneven surfaces or with navigating curbs. She said that was not a goal of Resident #28's. She said Resident #28 had not been cleared to walk independently in the hallways. She said Resident #28 was not independent with ambulation. She said if Resident #28 was released to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	be independent, it would have been documented in the physical therapist's notes. RN #3 was interviewed on 4/9/26 at 12:33 p.m. RN #3 said he had not worked with Resident #28 prior to that day (3/29/26). He said he did not witness the fall, but did her first assessment. He said he did not recall a visitor being with her at the time of the fall. He said she was bleeding from her mouth and she had told him that she had fallen forward. He said Resident #28 was lying next to the curb. He said the person that had informed him of Resident #28 outside was someone who worked in the assisted living residence (QMAP #1). He said QMAP #1 called him outside. He said he left Resident #28 with another resident's family members to go and get the nurse that had just come on shift. -However, the facility investigation documented RN #3 said he stayed with her until the RN #4 and emergency services arrived (see facility investigation above). RN #4 was interviewed a second time on 4/9/26 at 4:00 p.m. RN #4 said QMAP #1 was the person who had come to get her and told her she was needed outside. She said QMAP #1 worked in the assisted living residence. She said RN #3 was there when she arrived and he had not left Resident #28. The NHA and the regional clinical resource were interviewed together on 4/9/26 at 5:08 p.m. The NHA said she was the one who did the investigation regarding the fall on 3/29/26. She said at one point on 3/29/26, Resident #28 was seen with one of her family members before she fell. She said that Resident #28 had let a staff member know that she was going outside. She said that a family member of another resident who was going to the assisted living residence had told QMAP #1 that there was a resident on the ground outside. She said by the time QMAP #1 had gone outside, RN #3 was already with Resident #28. She said Resident #28 had the basic fall care plan and fall precautions (fall mat, low bed). She said Resident #28 ambulated with a walker and her balance was unsteady. She said to her knowledge, Resident #28 had gone outside by herself once or twice since her admission. She said she was unsure of where she had gotten the newspaper. She said she was unsure of what Resident #28 had tripped on. She said she was unsure of the time that the RN called 911. She said the facility did not have cameras to verify times. She said that they called 911 and they arrived very quickly. She said 6:30 p.m. and 6:45 p.m. were the times that Resident #28 was last seen before RN #3 found her outside. She said she was unsure why RN #3 reported during the interview that he had left Resident #28 with another family. She said she was unsure why she was told that Resident #28 was independent to ambulate if she was not.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in two of two kitchenettes. Specifically, the facility failed to ensure staff used proper hand hygiene during meal service. Findings include: I. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/16/26. It revealed in pertinent part, The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)II. Facility policy and procedureThe Handwashing and Glove Use policy and procedure, revised 4/15/2020, was received from the nursing home administrator (NHA) on 4/13/26 at 11:07 a.m. it read in pertinent part, Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substances (raw chicken to fresh fruit) and following contact with any unsanitary surface (touching hair, sneezing, opening doors). Hand washing procedure, wet hands, apply soap, lather vigorously rubbing hands together for 20 seconds, rinse hands to remove soap and debris, dry hands with disposable paper towel, discard paper towel into waste container without touching the container. Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching ready-to-eat food. When gloves are used, handwashing must occur prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed. Gloves may be used for one task only. It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands.III. ObservationsDuring a continuous observation on 4/6/26, beginning at 11:32 a.m. and ending at 11:53 a.m., the following was observed during meal service in the third-floor kitchenette:At 11:32 a.m. cook (CK) #1 opened a hamburger bun while wearing gloves, he placed the hamburger bun on the plate. He then used tongs to grab a piece of lettuce and placed the lettuce on the hamburger bun. He grabbed the meal ticket with his gloved hand. He took off his gloves and put them in the trash. At 11:36 a.m. without washing his hands, CK #1 put on new gloves. With gloved hands CK #1 used a spoon to scoop yogurt out of a container and onto a plate. He then used his gloved hands to place the plate and a meal ticket onto a meal tray. While wearing the same gloves CK #1 picked up another meal ticket and plate. He opened the microwave and placed the plate inside that included a hamburger, closed the microwave and pushed buttons with his right gloved hand. He then opened the microwave door and took the plate out using his gloved right hand. While wearing the same gloves he opened the hamburger bun. He then picked up and tore lettuce with the same gloves and placed the lettuce on the hamburger bun. While wearing the same gloves, he used tongs to pick up a fresh tomato slice and placed the tomato slice on the hamburger with his gloved hands. He then placed the top of the bun on the burger with the same gloved hands. While wearing the same gloves he then cut the burger holding it with the gloved hand. He then placed the plate and the meal ticket on the tray to be served to the resident. At 11:38 a.m. CK #1 discarded his gloves and washed his hands. CK #1 washed his hands for approximately 10 seconds. He put on new gloves. With his gloved hands he grabbed meal tickets and began putting them into the ticket holder. He grabbed more tickets and put them in the ticket holder. He kept one ticket in his hand and opened (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the reach-in refrigerator. He then put a plate on the counter and began scooping food with utensils. CK #1 continued to wear the same gloves and touch meal tickets and assemble plates. At 11:45 a.m. with the same gloved hands CK #1 was scooping and assembling a plate with the same gloves. At 11:46 a.m. CK #1 was assembling plates with the same gloves and used a food processor with both gloved hands. At 11:47 a.m. CK #1 was assembling a plate he had put in the microwave and then removed from the microwave wearing the same gloves. At 11:48 a.m. CK #1 removed his gloves and washed his hands for approximately seven seconds. At 11:48 a.m. CK #1 put on new gloves and began assembling plates and scooping food. He then placed two hamburger buns on a plate with his gloved hands and placed them in the microwave. He took the buns out of the microwave and opened the buns with his gloved hands. He then picked up a meal ticket with the same gloves. While wearing the same gloves, he used a spatula to put mayonnaise on the bun, holding a bun with his free hand. He placed two hamburger patties on another plate and used his gloved hands to put cheese on the buns, he then placed the plate with the burger patties in the microwave. He opened the microwave with his right hand and used tongs to place the hamburger patties on the bun. While wearing the same gloves, CK #1 picked up pieces of lettuce and placed some on each of the burgers. With the same gloved hands he picked up slices of fresh tomato and placed them on the burgers, then placed the top of the buns on the burgers. During a continuous observation on 4/6/26, beginning at 11:50 a.m. and ending at 12:22 p.m., the following was observed during meal service on the second-floor kitchenette:At 11:50 a.m. an unidentified dietary aide (DA) assisted a male resident in the dining room, the DA touched the resident with her gloves and went back to prepping room trays. She did not change her gloves. With the same gloved hands, she began covering desserts and drinks with plastic wrap While covering the drinks with plastic wrap, she was touching the rim of the glass where residents put their mouths. At 12:04 p.m. the same unidentified DA was cutting pieces of plastic wrap and placing them on the table that other staff members had touched with their bare hands. The table had not been wiped or sanitized. She then used the plastic wrap to cover desserts and drinks for room trays.At 12:09 p.m. the same unidentified DA reached inside of her pocket and brought out a key to open the kitchen door. She went inside of the kitchenette, disposed of her gloves. When she reentered the dining room she put on new gloves without washing her hands. At 12:13 p.m. the same unidentified DA approached a resident in the dining room with the same gloved hands. She bent down to talk to the resident and put her gloves hands on her knees. The unidentified DA went back to preparing more room trays without changing her gloves. At 12:22 p.m. the same unidentified DA continued to prepare room trays with the same glove hands. During a continuous observation on 4/9/26, beginning at 7:27 a.m. and ending at 8:27 a.m., the following was observed during meal service in the third floor kitchenette: At 7:27 a.m. DA #2 brought the food from the main kitchen to the second floor kitchenette, she did not wash her hands upon entering the kitchenette. At 7:29 a.m. without performing hand hygiene DA #2 began to uncover the food and place it in the steam table. At 7:30 a.m. DA #2 washed her hands. At 7:31 a.m. DA #2 opened the ice machine, used the ice scoop to scoop ice into a cup to calibrate the thermometer. She then took the temperatures of the food. At 7:36 a.m. DA #2 washed her hands, put on gloves and opened the microwave. She pulled out a stack of bowls from the microwave with the gloves on. She then grabbed a muffin and took the paper wrapper off and put it on the plate. She chopped bacon and sausage and placed the chopped meats on the plate with her gloved hands. She touched four pieces of bread and placed them in the toaster to make toast, with the same gloved hands. At 7:41 a.m. DA #1 moved two souffle cups of brown sugar by placing her bare fingers inside of the cups, from one tray to another tray. At 7:42 a.m. with the same gloved hands DA #2 picked up a muffin paper off the muffin. She then pulled a piece of toast out of the toaster and put the toast on the cutting board. She then put butter on the toast, cut the toast and placed the toast on the plate, while wearing the same gloves She then placed more toast on the cutting board using the same gloves. At 7:43 a.m. DA #2 was using small tongs to place meal tickets on the trays. She used one of her gloved fingers and tongs to separate the tickets. At 7:44 a.m. with the same gloved hands, DA #2 chopped sausage on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the cutting board, cut and buttered toast on the cutting board.At 7:46 a.m. DA #2, with the same gloved hands, grabbed a muffin and took the paper wrapper off of the muffin and placed the muffin on a plate with the sausage and toast. At 7:47 a.m. with the same gloved hands, DA #2 cracked two eggs. She got raw egg on her gloves. She made two fried eggs. With the same gloved hands, she grabbed bread and put it in the toaster, turned the toaster on. She did not change her gloves. At 7:51 a.m. with the same gloved hands, DA #2 cracked one egg. She got raw egg on her gloves. She made one fried egg. She did not change her gloves. At 7:53 a.m. with the same gloved hands, DA #2 peeled a banana. She used the same gloved hands to chop the banana. She placed the banana peel on the cutting board. She was wearing the same gloves.At 7:54 a.m. with the same gloved hands, DA #2 cracked two eggs. She got raw egg on her gloves. At 8:00 a.m. with the same gloved hands, DA #2 opened the reach-in refrigerator, grabbed a pudding and placed the pudding on a plate. She took off her gloves, washed her hands and put on a new pair of gloves. At 8:07 a.m. DA #2 placed a piece of bread in the toaster and turned the toaster on. At 8:11 a.m. with the same gloved hands, DA #2 cracked three eggs, she held the shells in her left hand. The clear liquid from the egg was dripping from her gloved hand to the counter and floor, she took the banana peel from the cutting board and threw the egg shells and banana peel away. With the same gloved hands, she then grabbed toast from the toaster with her left hand, buttered the toast and served the toast. At 8:15 a.m. with the same gloved hands, DA #2 grabbed another piece toast from the toaster, cut the toast and buttered the toast. At 8:16 a.m. DA #2 opened a bag of small bagels, cut the bagel and placed it in the toaster. She then took off her gloves, washed her hands, and put new gloves on. At 8:21 a.m. DA #2 grabbed toast out of the toaster, buttered the toast, cut the toast and placed the toast on a plate. She then touched a hard-boiled egg, cut the hard-boiled egg. At 8:22 a.m. with the same gloved hands, DA #2 cracked two eggs. While cracking the egg, the raw egg got on her gloves. She did not change her gloves. At 8:23 a.m. with the same gloved hands, DA #2 touched a muffin and took the paper wrapping off the muffin.IV. Staff interviewsDA #2 was interviewed on 4/9/26 at 8:29 a.m. She said she only changed her gloves when she left the service line, or touched things like the reach-in refrigerator, or anything outside of the service line. She said she did not change her gloves when she would crack eggs to make for fried eggs. She said she did not change her gloves because that was part of her service line. The executive chef was interviewed on 4/9/26 at approximately 8:40 a.m. He said the DAs should change their gloves anytime they change tasks such as touching raw meat, and then switching to a cooked meat, they should wash their hands and put on new gloves. He said staff should be changing their gloves and washing their hands when they were cracking eggs and making fried eggs. He said staff should take off their gloves, wash their hands with soap and water, dry their hands, then put on new gloves.

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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 complete grievance forms consistently to address and promptly resolve resident grievances.Specifically, the facility failed to effectively address, resolve, and demonstrate the facility's response to group grievances. Findings include:I. Facility policy and procedureThe Grievance policy and procedure, reviewed March 2018, was provided by the nursing home administrator (NHA) on 4/6/2 at 9:00 a.m. It revealed in pertinent part, A resident, his/her representative, family member, visitor or advocate may file a verbal or written comment, grievance or complaint concerning resident rights, treatment, abuse, neglect, harassment, medical care, behavior of other residents, theft of property without fear of threat or reprisal in any manner. Such grievances or complaints may be made anonymously. For a written grievance or complaint, complete an accurate and detailed complaint/grievance form located at the nurse's station or community designated area. Return the completed complaint/grievance form to the administrator, who is the community's grievance official. The complaint or grievance may also be given to the administrator, the grievance official, verbally.The outcome of the investigation will be reported to the resident and responsible party generally within seven working days of the resident submitting the written or verbal grievance. Progress on investigations will continue at each scheduled morning stand up meetinguntil resolution. Any alleged violation of neglect, abuse, including injuries of an unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the community shall be reported to the administrator. If an alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdiction confirms a violation for any of these residents' rights within its area of responsibility, the community shall take the appropriate corrective action in accordance with state and federal law.II. Resident group interviewA group interview was conducted on 4/7/26 at 3:36 p.m. with four Residents (#12, #19, #62, and #63) residents who were identified as alert and oriented through facility and assessment. Resident #62 and Resident #63 said they were recently admitted to the rehabilitation unit. They said they were not informed of how to submit a grievance.Resident #19 and Resident #63 said the call light wait times depended on how many certified nurses aides (CNAs) were staffed. Resident #19 said sometimes the staffing was worse on the night shift, but low staffing happened on all shifts. Resident #19 said that she asked for more CNAs during resident council meetings for the three years that she has been here. She said that the facility did not do anything about it.The residents said on most weekends the facility had only one CNA for three halls.Resident #63 said she had waited for up to an hour and a half for her call light to be answered. She said the facility had even less staff over the Easter holiday.The residents said staffing was an issue at the facility because they had to wait a long time when they called for assistance and it was worse at night. III. Resident interviewsResident #4 was interviewed on 4/6/26 at 11:23 a.m. Resident #4 said the facility was understaffed. She said she had to wait 45 minutes on the toilet for help. Resident #68 was interviewed on 4/6/26 at 4:37 p.m. Resident #68 said it often took over 30 minutes for staff to respond to her call light. Resident #8 was interviewed on 4/6/26 at 4:48 p.m. Resident #6 said there was only one CNA for an entire shift one weekend. IV. Record reviewGrievances for the last three months were requested during the survey from the nursing home administrator (NHA) on 4/8/26 at 10:26 a.m. The NHA sent an email on 4/8/26 at 4:48 p.m., which documented that the facility did not have any staffing grievances for the last three months.-However, the residents in the group interview and the staff indicated they had ongoing concerns with staffing (see interviews). V. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 4/8/26 at 1:30 p.m. CNA #5 said sometimes there was not enough staff to help with showers, changing/repositioning residents every two hours, or getting people up timely. CNA #5 said the staff had to assist residents who needed meal assistance, deliver room trays, and get residents ready to go to the dining room. She said sometimes this made it so the food got cold. CNA #5 said it led to thirty-minute waits when residents used their call lights. CNA #2 was interviewed on 4/8/26 at 2:17 p.m. CNA #2 said each CNA (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	took care of one hallway and split another hall between two CNAs, which caused showers to get neglected, because when residents needed two people for transfers, they had to wait too long for the other staff member to come to help. CNA #2 said sometimes the staff had to offer a bed bath instead of a full shower. CNA #6 was interviewed on 4/9/26 at 5:46 a.m. CNA #6 said residents frequently complained that the facility did not have enough staff, and this complaint was reported to nursing. A staff member who wished to remain anonymous was interviewed on 4/9/26 at 5:55 a.m. The staff member said they did not think there were enough staff overnight to get work completed because of the resident's needs on the floor. The staff member said the residents complained it took too long to get their call lights answered. The staff member said the staff had to complete showers, baths and meals. The staff member said they were not sure if the managers knew the residents were complaining about staffing issues but the staff member did not fill out a grievance for staffing and asked the families to fill out the grievance form themselves.Licensed practical nurse (LPN) #3 was interviewed on 4/9/26 at 12:00 p.m. LPN #3 said the facility did not have enough staff, and the residents frequently complained about it. LPN #3 said the nursing staff could not focus on the residents the way they should because of this issue, and some staff members quit because of it. LPN #2 said the management was aware of the concerns. LPN #3 said the staff had talked to the management regarding needing more help to provide care to the residents. The assistant director of nursing (ADON) was interviewed on 4/9/26 at 9:47 a.m. The ADON said residents complained about the facility's staffing on weekends. The ADON said when a grievance was filed, it was provided to the NHA. The ADON said residents also complained about long call light times.-However, a request was made for grievances regarding staffing and the NHA said there were no documented grievances (see record review above).The NHA was interviewed on 4/9/26 at 6:27 p.m. The NHA said she was not aware that staff were adjusting their tasks to give residents bed baths instead of showers. She said the staff had reported it was hard to complete all of their tasks including meal service, vital signs and showers. She said the staff had not told her that the residents were complaining about their care. The NHA said the grievances were used to track and trend facility issues and to support process improvement. The NHA said the grievance forms were on both floors by the nurses' stations, and the front desk should have them as well. The NHA said she had talked to the staff regarding their work glow. She said she was not aware of the resident concerns.

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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 ensure infection control practices were established and maintained to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections on two of two units.Specifically, the facility failed to:-Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing direct care to residents who should be on enhanced barrier precautions (EBP);-Ensure an effective process was in place to ensure staff were aware of which residents were on EBP; and,-Ensure nursing staff cleaned blood pressure cuffs between residents. Findings include: I. EBP failures A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 4/9/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent part, 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. 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) and wound care, any skin opening requiring a dressing. B. Observations During a continuous observation on 4/9/26, beginning at 5:00 a.m. and ending at 6:37 a.m., the following was observed: At 5:30 a.m. two unidentified staff members entered Resident #20's room. They provided the resident incontinence care. They failed to put on gowns. The resident's door sign said: Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident activities: dressing, transferring, changing linen, providing hygiene, changing briefs, or assisting with toileting, wound care, and an open wound requiring a dressing change. C. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A CNA who wished to remain anonymous was interviewed on 4/9/26 at 5:55 a.m. The CNA said she had not received any training on the new EBP sign posted on Resident #20's door. The CNA said she did not know why the EBP supplies were there. The CNA said gowns were not available in the PPE hanging on the door anyway. The director of nursing (DON) was interviewed on 4/9/26 at 3:55 p.m. The DON said she was not aware of staff members not using EBP to assist Resident #20, who had a right heel stage 3 pressure wound. The nursing home administrator (NHA) was interviewed on 4/6/26 at 6:30 p.m. The NHA said she thought the facility staff were trained on EBP within the last month. She said the staff received infection control training through the online training platform that the facility used. D. Additional observations On 4/8/26 at 9:55 a.m. Registered Nurse (RN) #1 removed the gauze wrapped on the left leg for Resident #34 while he was sitting in his wheelchair. RN #1 had on gloves on but no gown. There was a sign on the door that indicated Resident #34 was on EBP. On 4/9/26 at 5:05 a.m. certified nurses aide (CNA) #3 was emptying the Resident #30 colostomy bag and changing his bedsheets. The resident's abdomen was exposed while he was lying in his bed, and care was being provided by the staff. There was a sign on the resident's door that indicated the resident was on EBP. CNA had on gloves and a face mask. E. Additional staff interviews The assistant director of nursing (ADON) was interviewed on 4/7/26 at 12:27 p.m. She said she observed a housekeeping staff member enter a resident's room who was on precautions without donning a gown. She said she started education for the staff on infection precautions. CNA #3 was interviewed on 4/9/26 at 5:10 a.m. She said the reason she did not have on a gown on when providing care to Resident #30, because she did not see the sign on the resident's door. She said she should have worn a gown in addition to her gloves because the resident was on EBP. She said the facility provided education regarding the importance of EBP to prevent infections for residents. The infection preventionist (IP) was interviewed on 4/9/26 at 7:22 a.m. The IP said the sign on Resident #30's door should have been changed to contact precautions when he came back from the hospital. The IP said was diagnosed with methicillin resistant staphylococcus aureus (MRSA) while he was at the hospital. She said it was her responsibility as the IP to change the sign on the resident's door and ensurePPE was available. The IP, the NHA and the regional clinical resource were interviewed together on 4/9/26 at 1:31 p.m. The IP said part of her role at the facility included providing staff education regarding donning appropriate PPE for residents on EBP. She said any resident who had an indwelling foley catheter, wound, intravenous device would require being on EBP. She said CNA #3 should have donned a gown before providing care to resident #30. She said donning the correct PPE was important to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA said she would start education immediately for staff regarding procedures and requirements when a resident was on EBP. II. Blood pressure cuff failures A. Observations On 4/9/26 at 6:46 a.m. licensed practical nurse (LPN) #2 took the blood pressure for Resident #46 using an electronic blood pressure cuff before administering medication. On 4/9/26 at 7:02 a.m. LPN #2 took the blood pressure for Resident #12 before administering medication during morning medication pass. -LPN #2 failed to disinfect or sanitize the blood pressure cuff after taking Resident #46's blood pressure and prior to taking Resident #12's blood pressure. B. Staff interviews LPN #2 was interviewed on 4/9/26 at 7:06 a.m. He said he used an electric blood pressure cuff when checking the blood pressure of the facility residents. He said he used the same blood pressure cuff on all residents. He said the residents in the facility did not have an individual blood pressure cuff. He said that if the nurses were using the same device between residents, the blood pressure cuff should be sanitized after each use on residents. He said he forgot to sanitize the blood pressure cuff after it was used on the previous resident. He said the nursing staff were responsible for sanitizing the blood pressure cuffs after each use on a resident. The IP was interviewed on 4/9/26 at 1:31 p.m. The IP said the facility did not provide residents with individual blood pressure cuffs. The IP said the nursing staff used one blood pressure cuff for multiple residents. The IP said nursing staff were responsible for sanitizing the blood pressure cuff after each use on a resident. The IP said blood pressure cuffs should be sanitized after each resident to prevent bacterial contamination.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure consent was obtained for the use of psychotropic medications for one (#4) of five residents reviewed for unnecessary medications out of 34 sample residents. Specifically, the facility failed to ensure informed consents, which included risks versus benefits and side effects of prescribed psychotropic medications. Findings include:I. Facility policy and procedureThe Psychotropic Drug Management policy, revised March 2026, was provided by the nursing home administrator (NHA) on 4/13/26 at 11:07 a.m. It read in pertinent part, Nursing shall not administer the psychotropic medication until informed consent has been obtained from the resident and/or legal representative, except in emergency situations. Informed consent should be obtained from the resident and/or legal resident representative for increase in dose, or PRN (as needed) extension with documented rationale or re-evaluation as indicated.II. Resident #4A. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included delusional disorders, cognitive communication deficit, depression, anxiety disorder, and post-traumatic stress disorder.The 3/29/26 minimum data set (MDS) assessment revealed Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment revealed Resident #4 was dependent on staff for most of her activities of daily living (ADL). The assessment indicated Resident ##4 received antipsychotic medications, antidepressant medication, and hypnotic medication. B. Record reviewThe March CPO revealed the following physician's orders:Clonazepam (antianxiety) .5 milligram (mg) at bedtime for anxiety. Ordered on 3/19/26. Mirtazapine (antidepressant) oral tablet 7.5 mg, give one tablet at bedtime for major depressive disorder. Ordered on 3/19/26. Venlafaxine (antidepressant) oral capsule, give 150 mg by mouth one time a day for major depressive disorder. Ordered on 3/20/26. Olanzapine (antipsychotic) oral tablet 2.5 mg, give one tablet by mouth two times a day for depression. Ordered on 3/19/26. Review of Resident #4's medication administration record (MAR) revealed the following: The first dose of clonazepam was given on 3/19/26. The first dose of mirtazapine was given on 3/19/26.The first dose of venlafaxine was given on 3/20/26.The first dose of olanzapine was given on 3/19/26. A review of Resident #4's electronic medical record (EMR) revealed the following:The informed consent for clonazepam was signed by Resident #4 on 3/23/26. The informed consent for mirtazapine was signed by Resident #4 on 3/23/26. The informed consent for venlafaxine was signed by Resident #4 on 3/23/26. The informed consent for olanzapine was signed by Resident #4 on 3/23/26.-All the informed consents were signed after the medications had been given. C. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 4/9/26 at 9:29 a.m. He said the nurses were in charge of getting the medication consents signed. He said the consents should be signed when the nurses received the medication order. He said it was important for the consents to be signed before the resident starts to take the medication so they know what they were taking and were informed of the side effects of the medication. LPN #3 was interviewed on 4/9/26 at 9:34 a.m. She said nurses were in charge of getting medication consents signed. She said they got them signed during the admission process. She said sometimes the consents would get passed on to the next shift because they could not get everything finished during their shift. She said psychotropic medications needed consents and the consents should be signed before giving the medication because the residents needed to know the purpose of the medication and the side effects. The director of nursing (DON) was interviewed on 4/9/26 at approximately 10:30 a.m. She said the admitting floor nurse was responsible for getting the medication consents signed. She said there was a blue folder with all of the consents and additional information inside. She said the admitting nurse would then go over the consents with the family and resident. She said she or the UM would go over the contents of the folder to ensure the consents were completed. She said once the consents were signed they were scanned into the EMR. She said the medication consents should be signed at (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission or when the medication order changes, or if one was added. She said medications should not be given before the consent was signed. She said it was important for the resident and their family members to know the risks and benefits and side effects of the medication. She said the floor nurses, the unit manager and herself were in charge of ensuring the consents were signed before medications were administered. She said Resident #4's psychotropic medications were given prior to her signing the consents. She said the medications should not have been administered before the consents were signed because she needed to know the clinical side effects and the risks versus benefits of the medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to remove medications and biologicals that were stored and labeled properly according to professional standards in one of five medication carts.Specifically, the facility failed to ensure expired and discontinued medications were removed from the medication cart and disposed of. Findings include:I. ObservationsOn [DATE] at 11:23 a.m. The second floor north medication cart was observed with licensed practical nurse (LPN) #3 and contained the following:The drawer on the medication cart for Resident #29 contained the following: Hydrocodone/acetaminophen (pain medication) oral tablet 5 milligram (mg)/325 mg. The order was on [DATE]. The drawer on the medication cart for Resident #22 contained the following: Hydromorphone (pain medication) oral tablet 2 mg. The order was discontinued on [DATE]. The drawer on the medication cart for over the counter medications contained the following: An opened bottle of senna (laxative) oral tablet 8.6 mg that did not have an expiration date on the bottle. An opened bottle of Simethicone Oral tablet 80 mg that expired on [DATE]. II. Staff interviews LPN #3 was interviewed on [DATE] at 11:30 a.m. She said the nursing staff were responsible for checking the medications in the medication cart every day. She said medication carts need to be checked every day to ensure there were no expired or discontinued medications were left in the medication carts. She said when medications expire, the nursing staff would discard the medication immediately. She said she would remove the medication from her medication cart and advise the director of nursing (DON) to dispose of the medication.The assistant director of nursing (ADON) was interviewed on [DATE] at 12:21 p.m. The ADON said the nursing staff and unit managers were responsible for ensuring that there were no expired or discontinued medications. She said she would immediately provide education to the floor nurses and the unit managers regarding the facility's responsibility of immediately discarding expired and discontinued medications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to meet all requirements for the provision of hospice are for one (#7) of one resident reviewed for hospice out of 34 sample residents. Specifically, the facility failed to demonstrate adequate communication with the hospice staff and facility staff regarding care that the hospice staff provided during visits. Findings include: I. Facility policy and procedureThe Hospice Care policy and procedure, revised October 2016, was provided by the nursing home administrator (NHA) on 4/6/26 at 12:47 p.m. It read in pertinent part, Hospice progress notes shall be included in the resident's medical record and nursing associates shall be informed of any changes recommended by the hospice staff.II. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included dementia, acute kidney failure, and acute chronic respiratory failure with hypoxia (lungs cannot adequately transfer oxygen to the blood). The 2/11/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The assessment revealed she was dependent on staff for all of her activities of daily living (ADL). The assessment indicated the resident was receiving hospice care services. B. Record reviewThe April 2026 CPO documented Resident #7 was admitted to hospice care services on 2/2/26. A review of Resident #7's electronic medical record (EMR) revealed the only documentation from the hospice agency was a verbal medication order for baclofen (muscle relaxant) 5 milligrams (mg) dated 3/23/26.-However, review of the resident's EMR failed to reveal documentation of routine hospice care visits provided to the resident. A review of the hospice binder at the nurse's station revealed Resident #7's hospice team, her hospice care plan, notes on the days that the certified nurse aide (CNA) came and gave Resident #7 a bath and skin checks. The binder contained verbal orders from the physician from 2/2/26, medication report dated 2/2/26. The binder revealed a sign in sheet for the hospice registered nurse (RN). The RN had signed in on the following days: 2/12/26, 2/16/26, 2/19/26, 2/23/26, 2/26/26, 3/2/26, 3/6/26, 3/9/26, 3/12/26, 3/23/26, 3/26/26, 3/27/26, 3/30/26, 4/2/26, and 4/6/26. -However, the binder contained one hospice care visit note from 2/2/26. There was no documentation that communication occurred between the hospice staff and the facility staff regarding the care that was provided on 2/16/26, 2/19/26, 2/23/26, 2/26/26, 3/2/26, 3/6/26, 3/9/26, 3/12/26, 3/23/26, 3/26/26, 3/27/26, 3/30/26, 4/2/26, and 4/6/26.III. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 4/8/26 at 10:11 a.m. He said that Resident #7's hospice CNA asked him for his help at times because Resident #7 refused care. He said Resident #7's hospice team communicated verbally. He said that the hospice team would write things in the hospice binder. He said he did not look in the binder. He said hospice will fax over any new orders. He said he was unaware of any hospice notes being uploaded into the EMR. The health information specialist and the NHA were interviewed together on 4/9/26 at 5:08 p.m. The health information specialist said her process for obtaining hospice care notes was to reach out to the hospice care company. She said she got any updates from either the DON or the unit manager if they were in need of any notes. She said once she received the notes she uploads them into the EMR. The NHA said that Resident #7's hospice care company did not send visit notes over regularly, she said there was not a standing deal where they would send over the resident's records. The NHA said there were barriers at times to getting records. She said there were times when they had to fill out record request forms in order to receive the hospice notes. She said the facility had not reached out to the hospice care company to fix the record request situation.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement policies and procedures related to pneumococcal immunizations for two (#6 and #30) of five residents reviewed for immunizations out of 34 sample residents. Specifically, the facility failed to:-Ensure Resident #6 received the pneumococcal vaccine when consent was given; and,-Ensure Resident #30 was offered the flu vaccine. Findings include:I. Professional Reference According to the Centers for Disease Control and Preventions (CDC) Flu, revised 9/5/24 and retrieved 4/14/26 from https://www.cdc.gov/flu/highrisk/65over.htm, Flu vaccination is especially important for people 65 years and older because they are at higher risk of developing serious flu complications. While flu seasons vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease. CDC and the Advisory Committee on Immunization Practices (ACIP) preferentially recommend the use of higher dose flu vaccines (including high-dose inactivated and recombinant) or adjuvanted inactivated flu vaccine over standard-dose unadjuvanted flu vaccines for people 65 years and older. CDC recommends prompt flu antiviral treatment for people who have flu or suspected flu and who are at higher risk of serious flu complications, such as people 65 years and older. Having the flu increases your risk of getting pneumococcal disease. Pneumococcal pneumonia is an example of a serious flu-related complication that can cause death. People who are 50 years and older also should be up to date with pneumococcal vaccination.II. Facility policy and procedureThe Influenza Vaccine policy, revised March 2026, was provided by the nursing home administrator (NHA) on 4/6/26 at 1:50 p.m. It read in pertinent part, The resident/resident representative should be offered the influenza vaccine annually to encourage and promote the benefits associated with immunizations against influenza. Influenza can occur at any time, but most influenza occurs from October through May. Residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area, unless the vaccination is medically contraindicated or the resident declines the vaccine due to personal, religious or medical reasons. Obtain a written order from the health care provider. Obtain written, informed consent upon admission and annually from the resident or resident representative. The informed consent for influenza vaccine form includes education associated with the benefits and potential side effects or adverse effects if receiving the vaccine. Appropriate entries should be documented in the resident's medical records indicating the date of the receipt or refusal of the annual influenza vaccination, indicating the date of the receipt or medically contraindicated or declination.The Pneumococcal Vaccine policy, revised March 2026, was provided by the NHA on 4/6/26 at 1:50 p.m. It read in pertinent part, Resident/Resident representative should be offered the pneumococcal vaccine in order to maintain up to date status. Before receiving a pneumococcal vaccine, the resident or resident representative should receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Obtain informed consent from the resident or resident representative. Pneumococcal vaccines should be offered and administered to residents (unless medically contraindicated, already given, or refused). If refused, appropriate entries should be documented in the resident's medical record. Vaccinations should not be delayed due to a lack of a written immunization record. If immunization records are not available, it is acceptable to rely on the resident's or resident representative's verbal immunization history to determine if pneumococcal vaccine is indicated.III. Resident #6 A. Resident statusResident #6, age greater than 65, was admitted to the facility on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses including pancreatic insufficiency, depression, and dysphagia (difficulty swallowing).The 3/19/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS assessment indicated the resident was not up-to-date with pneumococcal vaccination due to the vaccine not being offered by the facility.B. Record reviewA review of Resident (continued on next page)

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	065376	A. Building B. Wing	04/09/2026

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

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#6's electronic medical record (EMR) revealed Resident #6 signed a pneumococcal vaccine consent form, marked that he received information about the vaccine and understood the risk and benefit and consented to receiving the vaccine by signing the form. -However, the specific vaccine being offered was not marked on the form and the date the form was signed was not completed, and there was no documentation in the resident's EMR to indicate the pneumococcal vaccine had been administered to the resident.The facility obtained a second consent for the pneumococcal vaccine from Resident #6 on 4/8/26 (during the survey). The form was signed by the Resident's representative, documented the specific vaccine information provided and that the resident did not consent to receiving the vaccine at that time.IV. Resident #30 A. Resident statusResident #30, age less than 65, was admitted on [DATE]. According to the April 2026 CPO diagnoses included hemiplegia or hemiparesis (weakness and paralysis), diabetes mellitus type II, and depression.The 3/29/26 MDS assessment documented the resident had a short term and long term memory problem, was moderately impaired to make decisions regarding tasks of daily life, and cueing and supervision was required.The assessment documented the resident did not receive the influenza vaccine in the facility for this year's influenza vaccination season and that the vaccine was not offered.B. Record reviewA review of Resident #30's EMR revealed the resident did not receive the influenza vaccine. There was an influenza vaccine informed consent form with Resident #30's name on the bottom of it. The form was not signed by the resident or resident's representativeV. Staff interviewsThe infection preventionist (IP) and the NHA were interviewed together on 4/9/26 at 12:30 p.m. The IP said she had recently implemented a spreadsheet to track resident vaccination status in the facility. The IP said she was reviewing all the resident vaccination consent forms to ensure they were uploaded to the resident's medical record and residents who consented to receiving the vaccine would have their vaccine ordered for administration.The NHA said residents were offered a vaccine upon admission, but with a change in the staff at the IP position they were reviewing the residents vaccine information. She said when the residents signed consent or declination forms, the forms were previously sent to a medical records staff member for upload instead of the IP for tracking. She said the IP had created a spreadsheet that would improve their tracking of resident vaccines going forward.V. Facility follow upThe NHA provided additional documentation on 4/8/26 at approximately 4:30 p.m. that the facility followed up with Resident #30's representative for a history of Resident #30's vaccination status. The resident's representative said she would get back to the facility with the information.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement policies and procedures related to immunizations for two (#2 and #7) of five residents reviewed for immunizations out of 34 sample residents.Specifically, the facility failed to:-Ensure the COVID-19 vaccine was provided to Resident #2 after she received education and gave consent; and,-Ensure Resident #7's medical record documented if the resident was offered the COVID-19 vaccine when available and documentation documented if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. Findings include:I. Professional referenceAccording to the Centers for Disease Control's (CDC) Staying Up to Date with COVID-19 Vaccines, updated 11/19/25, retrieved on 4/14/26 from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html, read in pertinent part, Getting the 2025-2026 COVID-19 vaccine is important because:-Protection from the COVID-19 vaccine decreases with time;-Immunity after COVID-19 infection decreases with time; and,-COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. Getting the 2025-2026 COVID-19 vaccine is especially important if you:-Never received a COVID-19 vaccine;-Are ages 65 years and older;-Are at high risk for severe COVID-19; and,-Are living in a long-term care facility.II. Facility policy and procedureThe COVID-19 Vaccine and Reporting policy, revised August 2023, was provided by the nursing home administrator (NHA) on 4/6/26 at 1:50 p.m. It read in pertinent part, COVID-19 vaccines are effective at protecting people from getting seriously ill, avoiding hospitalizations, long-term health outcomes, and death. The COVID-19 vaccine resources should be offered to eligible residents as recommended by the Centers for Disease Control and Prevention (CDC). Resident/Resident Representatives and associates should be provided education regarding the benefits and potential side effects associated with the COVID-19 vaccines. The community should maintain documentation to reflect the required COVID-19 vaccine education was provided, and receipt or declination of the vaccine. A person is up-to-date with COVID-19 vaccines when the current Centers for Disease Control and Prevention (CDC) recommendations have been followed. Prior to COVID-19 vaccine, eligible residents and associates should be provided current educational information regarding the benefits, risks and potential side effects associated with the COVID-19 vaccine. The nurse/designess should document in the resident's medical record the education to the resident or the resident's representative regarding the benefits and potential risks associated with the COVID-19 vaccine; and documentation of the COVID-19 vaccine dose(s) administered, historical COVID-19 vaccinations, medical contraindication or declination. If administered by a community nurse, a COVID-19 informed consent should be completed.III. Resident #2 A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (weakness and paralysis on one side), long-term use of anti-coagulants, chronic respiratory failure and high blood pressure. The 4/3/26 minimum data set assessment (MDS) documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not received.B. Record reviewA review of Resident #2's immunization record in the electronic medical record (EMR) failed to reveal documentation that the facility offered the SARS-COV-2 (COVID 19) vaccination to the resident.IV. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dementia, acute kidney failure, acute respiratory failure, and anxiety. The 2/11/26 MDS assessment documented the resident was severely cognitively impaired with a BIMS score of four out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the vaccine was offered or the reason why the vaccine was not received.B. Record reviewA review of Resident #2's immunization record in the EMR failed to reveal documentation that the facility offered the SARS-COV-2 (COVID 19) vaccination to the resident or their representative.IV. Staff interviewsThe infection preventionist (IP) and the NHA were interviewed together on 4/9/26 at 12:30 p.m. The IP said she had recently implemented a spreadsheet to track resident vaccination status in the facility. The IP said she was reviewing all the resident vaccination consent forms to ensure they were uploaded to the resident's medical record and residents who consented to receiving the vaccine would have their vaccine ordered for administration.The NHA said residents were offered a vaccine upon admission, but with a change in the staff at the IP position they were reviewing the residents vaccine information. She said when the residents signed consent or declination forms, the forms were previously sent to a medical records staff member for upload instead of the IP for tracking. She said the IP had created a spreadsheet that would improve their tracking of resident vaccines going forward.V. Facility follow upThe NHA provided documentation of informed consent for the COVID-19 vaccine for Resident #2 and Resident #7 on 4/9/26 (during the survey) at 12:33 p.m. The NHA said Resident #7's representative declined the COVID-19 vaccine when it was offered on 4/9/26 (during the survey) and Resident #2 consented to receiving the COVID vaccine. The documentation indicated the vaccine would be ordered from the pharmacy and administered to Resident #2 once the facility received the vaccine.