STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065381	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand River Health Care Center	701 E 5th St Rifle, CO 81650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from accidents or hazards for one (#6) of four residents reviewed for accidents out of 28 sample residents. Specifically, the facility failed to ensure swallowing precautions were implemented for Resident #6, who had a diagnosis of dysphagia (difficulty swallowing). Resident #6 was identified as being at risk for choking upon admission. On 9/16/25, the resident experienced a choking episode in the dining room. The Heimlich Maneuver was not needed; however, the nurse had to reposition the resident forward and to the side in order for him to successfully expel chunks of food with liquid from his throat.On 9/29/25 Resident #6 experienced another choking episode after drinking water. The speech pathologist recommended for the resident to use straws for all liquids, taking only small sips at a time, and for staff to continue monitoring Resident #6 during meals.On 11/18/25 Resident #6 experienced another choking episode and the speech pathologist recommended all beverages in a cup with a lid and straw and staff supervising him in the dining room.On 11/29/25 Resident #6 experienced a fourth choking episode after drinking a cup of hot cocoa.On 12/9/25 the nurse was called to the dining room to assist Resident #6 who was choking.On 12/11/25 a physician's order instructed that Resident #6 must be supervised at all times for eating due to multiple choking events. The order directed staff to have the resident sit at a table where a certified nurse aide (CNA) was present. According to the order, Resident #6 should not be served his meal until a staff member was present. The resident's risk for aspiration care plan, initiated 6/12/24, directed staff to provide Resident #6 supervised meal assistance while making sure he sat upright to reduce his choking risk, encouraging him to take small bites of food and eat at a slow pace and take single sips of liquid with a straw, while ensuring that his food was cut up small and the meat was minced and moist (initiated 3/5/25).On 1/15/26 during a breakfast meal observation, Resident #6 was provided with a beverage in a sippy cup with a straw, instead of a regular cup with a straw. The resident tilted his head back to drink out of the sippy cup spout and began coughing and choking. There was no staff member sitting with Resident #6 when the choking episode occurred. Failure to provide appropriate supervision (sitting the resident at the same table with staff present at all times during meals), verbal support (cueing, prompting to tuck chin, taking small bites, slowing his eating pace, taking small sips with a straw every few bites) and a cup with a straw (not a sippy cup) to ensure safe eating and drinking made serious harm or death from choking likely to occur for Resident #6 if the deficient practice was not corrected immediately. On 1/29/26 at 1:31 p.m. immediate jeopardy was identified based on the facility failures above that created a situation of potential serious harm for Resident #6, requiring immediate corrective action.Findings include: I. Immediate Jeopardy A. Situation of immediate jeopardy (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure staff provided appropriate supervision and implemented the identified care-planned interventions for Resident #6 after the resident had multiple choking incidents. The facility's failure to ensure staff provided appropriate supervision and implemented care-planned interventions led to a continued risk of further choking incidents for Resident #6. B. Imposition of immediate jeopardy On 1/29/26 at 1:31 p.m., the nursing home administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failure to ensure Resident #6 received appropriate supervision during times of food intake. C. Facility plan to remove immediate jeopardy On 1/29/26 at 6:30 p.m. the facility submitted a plan to remove the immediate jeopardy. The removal plan read: 1. Immediate correction implemented for removal of immediate jeopardy. On 1/15/26 the following actions were taken: a. Resident #6 had the proper vessel (cup with lid and straw) provided on 1/15/26 at 11:30 a.m. b. Resident #6's swallowing interventions (sit up straight while eating, eat small bites, eat slowly, take a drink between each bite, drink slowly, one sip at a time, tuck chin with each drink) were communicated on 1/15/26 to all staff on all shifts and through email to all nursing, activities, housekeeping, dietary, therapy and administration staff (signatures to be collected for all who read email) if any questions from staff are to be addressed, they can be answered by the DON (director of nursing) or the ADON (assistant director of nursing). c. The director of rehabilitation began education regarding resident swallowing safety, regarding safety measures around specific dietary orders, effective and properly communicated interventions, adaptive equipment and care plan on 1/15/26 to all staff (including to all staff on shift and through email to all nursing, activities, housekeeping, dietary, therapy and administration staff). d. A member of nursing staff or trained professional will be present in the dining area each meal. 2. On 1/29/26 at approximately 3:00 p.m. other residents possibly affected were identified. a. The DON and the ADON reviewed residents and identified other residents at risk of choking and aspiration. All resident charts were audited by the interdisciplinary team (IDT), including the DON, the ADON, and the speech therapist, and 12 other residents were identified as being at risk for the alleged deficient practice. Care plans were updated on all identified residents as applicable. 3. Systemic changes a. Education was provided to the IDT and facility staff (including to all staff on shift and through email to all nursing, activities, housekeeping, dietary, therapy and administration staff) regarding safety (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 12/1/25 minimum data set (MDS) assessment revealed Resident #6 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. According to the MDS assessment, Resident #6 needed supervision or touching assistance for eating. The MDS assessment indicated the resident had a mechanically altered diet but he did not have signs or symptoms of a swallowing disorder. He used a wheelchair for mobility. The assessment did not identify the resident had rejections of care behaviors. B. Observations During a continuous observation on 1/15/26, beginning at 8:16 a.m. and ending at 8:50 a.m., the following was observed: At 8:16 a.m. Resident #6 was assisted into the dining room by certified nurse aide (CNA) #5. He was placed at a dining counter facing the kitchenette. The nurses' station was behind the kitchenette. Two registered nurses (RN) were at the nurses' station. Dietary aide (DA) #1 plated and served the residents their meals in the dining room. At 8:20 a.m. DA #1 served Resident #6 oatmeal in a bowl, scrambled eggs with cheese and a beverage. The beverage was served in a sippy cup with a straw. The sippy cup lid was fashioned with a spout and a separate hole. The straw was placed on the top of the lid in the hole. At 8:22 a.m. Resident #6 proceeded to feed himself. He did not take sips of his beverage between each bite. CNA #2 was in the back of the dining room, behind Resident #6, assisting another resident with her meal. RN #1 walked back and forth from the dining room to the nurses' station while administering medications to the residents. RN #2 prepared the medications from the nursing cart in the nurses' station, facing a wall. -Throughout the meal service, staff were not consistently in the dining room. CNA #2 assisted residents out of the dining room, DA #1 plated and served residents in the rooms once all the residents in the dining room were served and RN #1 remained at the nurses' station as RN #2 walked back and forth from the nurses' station to the resident rooms. CNA #5 did not return to the dining room during the observation. At 8:29 a.m. RN #1 provided Resident #6 his crushed medications mixed in with apple sauce. The resident was offered a sip of water in between each spoonful of medication. He was not encouraged or reminded to tuck his chin when he sipped the water. RN #1 left the dining room and he continued to eat his eggs and oatmeal. At 8:41 a.m. Resident #6 attempted multiple times to suck on the spout of the sippy cup without being able to drink the beverage until he started to drink from the straw. He did not tuck his chin as he sipped on the beverage. At 8:45 a.m. Resident #6 stopped drinking from the straw and attempted to suck on the spout again as CNA #2 and RN #1 walked in and out of the dining room. The resident was not reminded to use the straw while drinking his beverage from the sippy cup. At 8:49 a.m. Resident #6 started using his straw again. He attempted to finish the last few sips of his beverage with his straw but the straw was pressed against the wall of the sippy cup. He placed his (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #5 was interviewed on 1/15/26 at 12:25 p.m. CNA #5 said Resident #6 needed to be in a supervised dining room, in view of nursing staff at all times. She said he should tuck his chin after each bite and use a straw with drinks so he did not choke. She said she was not in the dining room during breakfast on 1/15/26 because she was giving a resident a shower. The DM was interviewed on 1/15/26 at 1:59 p.m. The DM said the dietary aides could not supervise Resident #6 in the dining room but they could remind him to look at his strategy sign and let the nursing staff know if he was exhibiting signs of choking. She said the nursing staff would be responsible for supervising and making sure he was following his swallowing precautions. The DM said she did not realize staff were serving Resident #6 a sippy cup with a straw. She said he should have been served his drink in a regular cup with a straw. The DM said she educated DA #1 and other dietary staff to not provide Resident #6's drink in a sippy cup. The DON was interviewed on 1/15/26 at 3:08 p.m. The DON said Resident #6 was admitted to the facility a year ago (2025) because of his increased confusion and he needed more help with his activities of daily living (ADL). She said Resident #6 tended to eat too fast and got distracted. She said he was very routine but had cognitive deficits and poor safety awareness. The DON said he had a hard time comprehending why the swallowing precautions were in place and retaining the precautions. She said he continued to require cues to follow his swallowing precautions. She said he had had only one choking incident, a year ago, when he actually choked and required the Heimlich maneuver. She said most of the other incidents were identified as near choking because he did not have to have the Heimlich maneuver and the incidents were more of an aspiration concern. She said he had not had pneumonia as a result of his aspiration. The DON said speech therapy was notified after each incident. She said the speech therapist felt most of the concerns were related to reflux and he was placed on the swallowing precautions. The DON said the interdisciplinary team (IDT) frequently reviewed Resident #6's needs and made sure he had the most appropriate interventions in place related to food. The DON said he needed to have his medication crushed and be supervised in the dining area with frequent cues to slow down when eating and chin tuck with every bite and drink. She said there was a sign where he ate to provide the resident cues. The DON said the staff tried get Resident #6 to move to another spot in the dining room so he could be next to other residents who needed staff assistance and he could receive increased cueing and supervision but he did not want to move and sit at the table. The DON said staff should have eyes on him during his meals ideally. She said visual supervision would be best if he started choking but the staff could hear him if they were nearby. The DON said he had standard reflux precautions on his order with a single straw cup and to clear his throat with every two to three sips of liquid. She said his order was updated today (1/15/26) to include a regular cup with a straw and no sippy cup. The DON said she reviewed Resident #6's swallowing precautions today (1/15/26) with the DOR and they felt someone should sit with him during meals and ensure that he followed his swallowing precautions. The DON said Resident #6 was at risk for the potential of aspiration pneumonia. She said she was in the process of providing additional education for all staff for safety during meals. The DON said because another CNA was not available during the 1/15/26 breakfast observation, she would look at the times of resident showers to ensure staff were available in the dining room. She said she would take a big picture look at how staff could meet all residents' needs and ensure safety during meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA was interviewed on 1/29/26 at 6:32 p.m. The NHA said Resident #6 would continue with one-on-one staff supervision while eating until the speech therapist determined he was safe to eat his meals with distant nursing staff supervision.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months, and provide regular in-service education based on the outcome of these reviews.Specifically, the facility failed to complete a performance review of certified nurse aide (CNA) at least once every 12 months.Findings include:I. Facility Policy and ProcedureThe policy and procedure for annual performance evaluations was requested from the nursing home administrator (NHA) and the director of nursing (DON) on 1/15/26 at 12:37 p.m. On 1/20/26 at 10:46 a.m., the ADON said the facility did not have an applicable policy and procedure for annual performance evaluations As of 1/21/26, no additional policy and procedure documents had been provided by the facility.II. Annual performance reviews for CNA #4, CNA #5, CNA #6, CNA #7 and CNA #8The annual performance reviews for CNA #4, CNA #5, CNA #6, CNA #7 and CNA #8 wererequested from the NHA on 1/13/26 at 6:09 p.m. -However, the facility was unable to provide documentation of annual performance reviews for CNA #4, CNA #5, CNA #6, CNA #7 and CNA #8 prior to the survey exit on 1/15/26 (see interviews below).III. Staff interviewsThe NHA was interviewed on 1/15/26 at 12:02 p.m. The NHA said he was unable to produce any records of annual performance evaluations for the CNA #4, CNA #5, CNA #6, CNA #7 and CNA #8. The NHA said he would check with the DON, but to his knowledge, the facility did not complete annual performance evaluations. He said if the DON confirmed that the facility did not conduct annual performance reviews, then it was what it was and they would have to make corrections. The ADON, the DON and the NHA were interviewed together on 01/15/26 at 1:50 p.m. The DON said she did not complete an individual performance review with each CNA in the facility. The DON said staff members completed healthstream education modules as well as in-person in-service education. The DON said the leadership team met monthly to discuss areas of education to provide to all staff and to review if any events occurred requiring education for individual staff members. The DON said when an individual staff member was given education, the facility typically gave the same education to all staff in the next in-service training. The DON said the facility additionally met with the education department of the hospital to collaborate on education topics.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide ongoing communication to residents about their rights; and failed to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility for one (#50) of three residents reviewed out of 28 sample residents.Specifically, the facility failed to provide Resident #50 with a written copy of the facility's room change/move policy and procedure upon the resident's request.Findings include:I. Facility policy and procedureThe Patient Rights and Responsibilities policy and procedure, reviewed 6/4/25, was provided by the nursing home administrator (NHA) on 1/15/26 at 5:19 p.m. It read in pertinent part, The statement of patient rights shall include, but is not limited to, the patient's right to: Receive information in a manner that he/she understands. Communications with the patient shall be effective and provided in a manner that facilitates understanding by the patient. Written information provided shall be appropriate to the age, understanding and, as appropriate, the language of the patient. Be informed of the facility's policies for transfer, routine or involuntary discharge and discontinuation of services. Know which facility rules and policies apply to his/her conduct while a patient. Have all patient's rights apply to the person who shall have legal responsibility to make decisionsregarding medical care on behalf of the patient. The patient shall be responsible for following facility policies and procedures.II. Resident #50A. Resident statusResident #50, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (progressive lung disease), major depressive disorder, chronic respiratory failure and chronic kidney disease.The 12/19/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set up assistance with one person for bathing. She was independent with bed mobility, upper and lower body dressing, eating, sit to stand transfers and bed to chair transfers. She used a motorized wheelchair for mobility.B. Resident interviewResident #50 was interviewed on 1/14/26 at 1:05 p.m. Resident #50 said she had requested a copy of the resident rights from the social services director (SSD) because she had lost her copy that she originally obtained upon admission. Resident #50 said she received the resident rights from the SSD and then requested a written copy of the room change/move policy. Resident #50 said the SSD went to the NHA to obtain a copy of the policy. She said the SSD came back and said she was not allowed to give Resident #50 a copy of the room change/move policy, according to the NHA, and Resident #50 could go see the NHA if she had any questions. Resident #50 was upset and said she felt very disappointed and sad.III. Staff interviewsThe SSD and the social services assistant (SSA) were interviewed together on 1/14/26 at 3:03 p.m. The SSD said if a resident requested a copy of the facility's resident rights it would be provided to them at any time. The SSD said Resident #50 had asked her for a copy of the resident rights and that was provided to her, but she said what Resident #50 really wanted was the facility's room change/move policy. The SSD said she went to the NHA and asked for the room change/move policy and was told that legally he did not have to provide the policy and said if Resident #50 had any questions, she could come ask him and he would answer the resident's questions.The NHA was interviewed on 1/14/26 at 3:42 p.m. The NHA said if a resident requested a facility policy, his compliance and legal team had said they were happy to discuss the policy but they did not provide a copy to the resident. The NHA said from a legal standpoint, the compliance and legal team were just not comfortable providing residents with copies of policies because it could be a legal question. The NHA confirmed that the facility was not going to provide Resident #50 with a copy of the requested room change/move policy because it was a legal safe guard. IV. Facility follow upOn 1/15/26 at 9:48 a.m. the NHA said he would be providing Resident #50 with the requested room change/move policy when she returned from the store outing activity later that afternoon.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#10) of five residents reviewed for medication errors out of 28 sample residents.Specifically, the facility failed to:-Ensure that Resident #10 received warfarin (an anticoagulant medication), a medication with a narrow therapeutic index (a medication where the difference between an effective dose and a toxic dose is very small); and,-Determine how the significant medication error occurred and provide education to nursing staff in order to prevent future occurrences. Findings include:I. Professional referenceAccording to [NAME], P.A., [NAME], A.G et.al, Fundamentals of Nursing, 10th ed., (2023). Elsevier, St. Louis, Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications:1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Medication Administration Procedure policy, reviewed 12/13/24, was provided by the nursing home administrator (NHA) on 1/15/26 at 5:19 p.m. It read in pertinent part, Patient safety is demonstrated by the use of the seven rights: right medication, right patient, right dose, right route, right time, right reason, and right documentation. Medication errors and adverse reactions to medications must be documented in the electronicincident reporting system and reported to physician. Adverse reactions should be reported tothe pharmacy as well.III. Resident #10A. Resident statusResident #10, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included personal history of venous thrombosis and embolism (blood clot), epilepsy (chronic brain disorder characterized by recurrent seizures) and chronic obstructive pulmonary disease (progressive lung disease).The 12/15/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She was dependent on staff assistance for bed to chair transfers, toilet transfers and shower transfers. She required substantial/maximal assistance for bathing, upper and lower body dressing, personal hygiene and bed mobility (rolling left and right). She required the use of a wheelchair for mobility.The assessment revealed the resident was taking an anticoagulant medication.B. Record reviewResident #10's risk for complications related to Coumadin (warfarin) care plan, dated 12/19/24, documented a goal of INRs (international normalized ratio - how quickly blood clots) to remain at therapeutic levels. Pertinent interventions, initiated 12/29/24, included to administer medications as ordered; obtain and monitor labs as ordered; monitor for Coumadin complications including unexplained bruising, bleeding from mucosal membranes, or difficulty with stopping bleeding; Coumadin education as needed on Coumadin therapy, diet, and interactions with other medications; INR per Coumadin nurse, Coumadin nurse would monitor INR/labs and adjust medication accordingly.A review of Resident #10's January 2026 CPO revealed the following physician's orders:Warfarin (hazardous) 2 milligram (mg) tablet, administer 2 mg tablet Monday, Wednesday, Thursday, Saturday at 8:00 p.m. Diagnosis: Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (legs), start date 11/26/25.Warfarin (hazardous) 5 mg tablet, administer 5 mg tablet Sunday, Tuesday, Friday at 8:00 p.m. Diagnosis: Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, start date 11/25/25.The January 2026 medication administration record (MAR), reviewed from 1/1/26 to 1/13/26, documented all warfarin doses were administered. -However progress notes revealed that Resident #10 was not administered her warfarin 5 mg dose on 1/9/26 (see progress notes below).The 1/6/26 progress note documented the residents' INR was 2.8 and within range. There was no change in warfarin dosage and the INR would be retested on [DATE].The 1/10/26 progress note documented Resident #10's 5 mg warfarin tablet was found on the morning of 1/10/26 in the resident's bed. The 1/12/26 progress note, documented by the Coumadin clinic registered nurse (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RN), revealed Resident #10's INR levels were in the low range (out of therapeutic range) due to the resident missing her 5 mg Coumadin (warfarin) dose on 1/9/26.The 1/13/26 progress note documented Resident #10's INR was 1.3. The resident missed a 5 mg dosage on Friday (1/9/26). The plan was to continue with the current dosage and retest the INR on 1/20/26.The 1/13/26 progress note revealed the INR that morning was 1.3 and a physician's order was placed for the lab to draw PT/INR per protocol. The 1/14/26 progress note, documented by the Coumadin clinic RN, revealed the INR was rechecked and remained at 1.3 and Resident #10's Monday, Wednesday, Thursday and Saturday 2 mg dosage of Coumadin would be increased to 3 mg for the week. The resident's INR would be retested on [DATE].-The facility's failure to administer Resident #10's anticoagulant therapy on 1/9/26 led to a non-therapeutic INR level (indicating the resident's blood clotting time was too low) and potentially placed Resident #10 at greater risk for a blood clot. IV. Staff interviewsThe director of nursing (DON) was interviewed on 1/15/26 at 10:02 a.m. The DON said the Coumadin clinic monitored the residents who were taking Coumadin. The DON said the nurses obtained residents' INRs on Tuesday and sent the results over to the Coumadin clinic RN and she put in the formulary to make sure dosing was correct. The DON said the Coumadin clinic RN could get physician's orders as needed and documented those Coumadin order changes in the progress notes. The DON said the standard therapeutic range for INR was 2.0 to 3.0. The DON said the facility could also do INR tests on off days if needed but the standard testing was once per week. The DON said if a Coumadin dosage was missed, the nurse would notify the physician and get any further testing orders or dosage changes. The Coumadin clinic RN was interviewed on 1/15/26 at 10:15 a.m. The Coumadin clinic RN said she ran the Coumadin clinic at the hospital (part of the same healthcare system as the facility) and at the facility. She said she followed those residents in the facility taking Coumadin. The Coumadin clinic RN said the residents taking Coumadin got an INR check every Tuesday and the nurses at the facility did a finger stick test for that check. The Coumadin clinic RN said most of the residents' therapeutic ranges were usually between 2.0 and 3.0, including Resident #10. The Coumadin clinic RN said she was aware that Resident #10 had missed a 5 mg Coumadin dose on 1/9/26 but she did not know why the medication was missed or why the MAR continued to show that the medication was given. The Coumadin clinic RN said if she noticed a resident was in range one week but the next week they were not in range, she would talk to the facility nurses to find out why there was a change, such as was there a new antibiotic added to the resident's drug regimen. The Coumadin clinic RN said in the case of Resident #10, there was a change in the resident's INR from the previous week to the next week and a facility nurse emailed her and said Resident #10 had missed a dose but the nurse did not say why. The Coumadin clinic RN said it was important for her to know what was going on with each resident on Coumadin because if the INR was really high, she would say to stop the medication due to the increased risk of bleeding. The Coumadin clinic RN said because Resident #10 missed a dose of warfarin, she would have to be extra cautious and check the next day to make sure she was okay. The Coumadin clinic RN said if a Coumadin dose was missed, the resident would require additional lab monitoring and the provider should be notified. The Coumadin clinic RN said Resident #10's INR was low, meaning it was out of therapeutic range and the blood clotted too fast. The Coumadin clinic RN said Resident #10 may need more medication (Coumadin) so her blood did not clot too fast. The Coumadin Clinic RN said the resident's Coumadin medication was given mixed in applesauce at the facility so she was not sure how the resident's medication wound up in the resident's bed and it was not noticed that the resident did not swallow it.The Coumadin clinic RN said according to the INR management guideline policy, Resident #10's missed dosage required extra monitoring of the resident and an extra dose of Coumadin medication to bring the resident back to a therapeutic range. The DON, the assistant director of nursing (ADON) and the NHA were interviewed together on 1/15/26 at 2:28 p.m. The DON said the protocol for a missed medication was for the nurse to notify the physician, make a comment on the MAR, and document in the progress note so that other nursing staff knew about the missed medication in case there was a negative effect due (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the missed medication. The DON said she was not made aware that Resident #10 had missed a 5 mg Coumadin dose on 1/9/26. The ADON said he was handling Resident #10's case and the nurse had reported the missed medication to the Coumadin clinic. The ADON said they did an INR recheck on Resident #10 and it was low, so a Coumadin medication dosage was added this week. The ADON said he was not sure why the medication was missed, it was just found in the resident's bed the next morning (1/10/26). The ADON said he was not sure why the Coumadin was still marked on the MAR, dated 1/9/26, as given, but he would follow up with the nurse who marked it as administered. The ADON said the nurse's first shift back would be that evening (1/15/26) and then she could correct the administration note. The ADON said he did not put in an incident report or investigate the medication error incident yet, but he would investigate it in the future. The DON said Resident #10's Coumadin medication was given to prevent a recurrent deep vein thrombosis and if the resident was not kept in the therapeutic range, she risked getting a blood clot. The DON said when the nurse realized she made an error, the nurse should notify the administrator on call, notify the Coumadin clinic and write a progress note. The ADON said one nurse found the pill but another nurse was the nurse that gave it on 1/9/26. The ADON said when a nurse administered medication, the nurse should make sure to watch the resident to ensure the resident took and swallowed the medication. The ADON said the investigation of the medication error would be completed later that evening (1/15/26) and then would go through an internal review after the investigation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.Specifically, the facility failed to:-Ensure Resident #3's wound care supplies were not taken into Resident #33's bathroom during Resident #33's wound care dressing change; and,-Ensure registered nurse (RN) #3 followed enhanced barrier precautions (EBP), including wearing a protective gown when providing wound care for Resident #33. Findings include:I. Professional referenceAccording 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 1/20/26 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 employs 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.II. Facility policy and procedureThe Infection Prevention and Control plan, revised October 2022, was provided by the nursing home administrator (NHA) on 1/14/25 at 6:52 p.m. It read in pertinent part, The Infection Preventionist has the authority to institute any surveillance, prevention or controlmeasures or investigate any resident, personnel or visitor with possible infection. This authority and responsibility includes, but may not be limited to the following: Develop and implement a preventive and corrective action program designed to minimize infection hazards. Develop a system for identifying, reporting and analyzing the incidence and causes of nosocomial infections. Develop, review, and approve policies and procedures related to infection surveillance, prevention and control activities in all departments/services Determine when isolation precautions, barrier precautions, or environmental cultures are required and implement these processes.III. ObservationsOn 1/14/26 at 2:57 p.m., wound care for Resident #33 was observed. RN #3 rolled a metal table to set up the wound care supplies into Resident #33's bathroom. RN #3 prepared her wound care supplies, including opening Resident #33's alginate (sterile, freeze-dried dressing designed to kickstart healing in chronic wounds by forming a gel, controlling infection, and creating an optimal moist environment for new cell growth) and new dressing while Resident #33 was using the bathroom. -A plastic basket was sitting on the lower level of the metal table containing wound care supplies for Resident #3 (a different resident in another room). After Resident #33 was finished going to the bathroom, RN #3 changed the resident's brief and completed peri cares for Resident #33. RN #3 cleaned off a small amount of stool on Resident #33's toilet seat. RN #3 completed hand hygiene and changed gloves between completing peri care and the wound care for Resident #33. -However, all of the wound care supplies had been opened before RN #3 completed peri cares. RN #3 additionally failed to wear a protective gown during wound care for Resident #33, in accordance with EBP guidelines.On 1/15/26 at 10:42 a.m. certified nurse aide (CNA) #3 placed a bin with protective gowns and signage in Resident #33's room to indicate EBP was implemented for Resident #33.IV. Staff interviewsRN #3 was interviewed on 1/14/26 at 3:16 p.m. RN #3 said she normally did not bring the metal wound table into the resident's bathroom, but decided to because Resident #33 needed to use the bathroom and did not like to lay in bed during wound care. RN #3 said she forgot she kept the wound care supplies for Resident #3 on the bottom of the metal table (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when she went into Resident #33's bathroom. She said she placed Resident #3's wound care supplies on the table because she initially planned to complete the wound care for Resident #3 first, but Resident #3 was bathing at the time. She said she forgot to remove Resident #3's supplies when she switched to complete Resident #3's wound care first. RN #3 said she was aware of and had received training on EBP, but she said did not wear a protective gown during the wound care for Resident #33 because the resident did not have an order for EBP. The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 1/14/26 at 3:32 p.m. The ADON said he was also the infection preventionist (IP) for the facility and oversaw wound care. The ADON said he provided education on using the metal table to complete wound care. The ADON said the table could be brought into a resident's room based on the preferences of each resident's wound care. The ADON said the table should be wiped down completely before and after each use, including between residents. The ADON said RN #3 should not have taken the wound care supplies for Resident #3 into Resident #33's room or bathroom. The ADON said he provided education specifically to only bring in the supplies for the resident a nurse provided wound care for, so he was surprised to find out RN #3 brought the wound care supplies for Resident #3 into the bathroom of Resident #33. The ADON said having the wound care supplies in a ziploc bag reduced the risk for cross contamination, but there was still risk of contaminating the wound care supplies for Resident #3. The ADON said he planned to provide individual education with RN #3 and planned to replace Resident #3's wound care supplies. The ADON and the DON were interviewed together again on 1/14/26 at 6:14 p.m. The ADON said Resident #33 was not on EBP because the resident's wound was an abrasion and did not meet criteria based on his interpretation of the CDC's guidelines. The ADON said he based this interpretation off of the CDC frequently asked questions section. The ADON said he referred to the guidance that EBP was not required for residents with only shorter-lasting wounds, such as skin breaks or skin tears covered with a band-aid or similar dressing. The ADON said he disagreed that the wound care ordered for Resident #33 was more complicated than a dressing similar to a band-aid. The ADON, the DON and the NHA were interviewed together on 1/15/26 at 1:50 p.m. The ADON said he spoke with the nurse practitioner (NP) who specialized in wound care for the facility regarding Resident #33. The ADON said the NP did not change any physician's orders or recommendations. The ADON said he and the NP reviewed the use of alginate in the wound bed. The ADON said the alginate was added because the wound healing was stalled for 2 weeks.