STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065388	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at St. Andrews Village	2670 S Abilene St Aurora, CO 80014

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans, and resident preferences for two (#74 and #71) of five residents reviewed for pain management out of 32 sample residents. Resident #74 was admitted to the facility from the hospital on 3/22/26, after treatment for sepsis (life threatening condition) from a vertebral (spinal) infection resulting in severe pain in her spine. After the resident's admission to the facility, the facility failed to ensure the resident's prescription for oxycodone was sent to the pharmacy timely so the pain medication could be received and administered. The facility's failure to send the resident's prescription to the pharmacy in a timely manner, resulted in the resident not receiving the narcotic pain medication for 21 hours after leaving the hospital, resulting in severe back pain for Resident #74.Additionally, Resident #71 did not receive pain medication in a timely manner and per physician's orders. Specifically, the facility failed to: -Ensure Resident #74's pain medication was received and administered as ordered in a timely manner, which resulted in severe back pain for the resident; and,-Ensure Resident #71's pain was addressed timely and pain medication was administered per physician ordered parameters.Findings include: I. Facility policy and procedure The Pain Management policy and procedure, revised November 2025, was provided by the director of nursing (DON) on 3/26/26 at 2:08 p.m. It read in pertinent part, It is the policy of this facility to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental , and psychosocial well being. Residents are provided and receive the care and services needed according to established practice guidelines. Resident pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome. The facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by: -Screening to determine if the resident has been or is experiencing pain; -Comprehensive evaluation of the pain. Licensed nurses will complete the Pain Management Review and utilize non-pharmacologic interventions in conjunction with prescribed medications to manage the pain and/or try to prevent the pain consistent with the resident's goals; -Monitor pain status and treatment effects on a regular basis; 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 0697 Level of Harm - Actual harm Residents Affected - Few	-Consult physician for additional interventions if indicated. The resident will be assessed for pain: -On admission with a pain-related diagnosis, or if pain is indicated through the nursing admission assessment; -Upon significant change in condition; -Quarterly if there is a current care plan for pain management; and, -Annually. II. Resident #74 A. Resident status Resident #74, age [AGE], was admitted to the facility on [DATE] and discharged to another facility on 3/24/26. According to the March 2026 computerized physician orders (CPO), diagnoses included sepsis, infection of intervertebral disc, cervical (neck) region, cervicalgia (neck pain), pain in unspecified joint, secondary scoliosis, thoracic region (upper back) and low back pain. A minimum data set (MDS) assessment had not been completed at the time of the survey. According to the 3/24/26 brief interview for mental status (BIMS) assessment, Resident #74 was cognitively intact with a BIMS score of 15 out of 15. According to the 3/23/26 Functional Performance Observation assessment, Resident #74 required substantial/maximal assistance with toileting, personal hygiene, sitting to lying, and was dependent on staff for bathing, dressing, rolling side to side, lying to sitting, sitting to standing, and transfers from bed to chair and to toilet. B. Resident observation and resident/resident's representative interview On 3/23/26 at 10:30 a.m. Resident #74 was lying flat in bed with a furrowed brow and a frown with her resident representative at the bedside. The representative said Resident #74 admitted to the facility at approximately 2:00 p.m. on 3/22/26. The representative said the hospital gave Resident #74 pain medications before they were transported to the facility and were told that by the time they arrived at the facility, it would be time for the resident to receive more pain medication. Resident #74 said she was having pain at the time of her admission to the facility, but no pain medication had been received after leaving the hospital. She said she had not received any pain medication since she was admitted to the facility the day prior (3/22/26). Resident #74's representative said they were told they had to wait on the pharmacy to deliver the pain medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	C. Record review According to the hospital Discharge summary, dated [DATE] at 9:06 a.m., Resident #74 had a chronic pain syndrome diagnosis with intractable (difficult to manage) back pain and had been on routine narcotic pain medication for quite some time and scheduled Tylenol was recently added. Resident #74 had a physician's order for oxycodone IR (immediate release) 5 milligrams (mg) every eight hours PRN (as needed) for severe pain. According to the comprehensive care plan, initiated 3/22/26 at 7:11 a.m. (prior to Resident #74's admission to the facility), the care plan focus for pain indicated Resident #74 had chronic neck and back pain. Interventions included anticipating the resident's need for pain relief and responding immediately to any complaint of pain, following pain scale to medicate as ordered, monitoring/documenting for probable cause of each pain episode, removing/limiting pain causes when possible and completing a pain assessment every shift. According to the admission pain management review assessment, dated 3/22/26 at 9:51 p.m., Resident #74 indicated she had had frequent back pain over the last five days, rated at 8 out of 10 on the 1 to 10 pain scale. The pain affected her sleep, participation in therapy, and limited her day-to-day activities. Resident #74 indicated an acceptable pain level of 2 out of 10. According to the discharge pain interview, dated 3/24/26 at 11:00 a.m., Resident #74 experienced frequent pain that interfered with her sleep and day-to-day activities. Resident #74 indicated the worst pain over the previous five days was 8 out of 10. Review of Resident #74's March 2026 CPO revealed the following physician's order: Oxycodone 5 mg every six hours, ordered 3/23/26 at 6:00 p.m. (the day after the resident was discharged to the facility with a physician's order for the medication). -Review of Resident #74's pain levels documented during the resident's stay at the facility (from 3/22/26 to 3/24/26) revealed the resident's pain acceptable pain level of 2 out of 10 was reached one time. The resident's pain levels were as follows: On 3/22/26 at 8:54 p.m. the resident's pain level was 4 out of 10. -However, because the facility failed to add the oxycodone order to the March 2026 CPO until 3/23/26, there was no documentation to indicate any pain medication was administered to the resident. On 3/23/26 at 11:10 a.m. the resident received a dose of oxycodone however, a pain level was not documented. On 3/23/26 at 5:22 p.m. the resident's pain level was 7 out of 10. Oxycodone was administered at 6:00 p.m. On 3/23/26 at 6:56 p.m. the resident's pain level was still a 7 out of 10, despite the pain medication that was administered at 6:00 p.m. (see above). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-However, there was no documentation to indicate additional pain medication was administered or that the physician was notified about the ineffectiveness of the resident's pain medication. On 3/23/26 at 10:04 p.m. the resident's pain level was 2 out of 10. On 3/23/26 at 11:48 p.m. the resident's pain level was 7 out of 10. Oxycodone was administered at 12:15 a.m. (on 3/24/26). -However, there was no follow-up pain level assessment completed until 5:13 a.m. on 3/24/26, five hours after the pain medication was administered (see follow-up pain level below). On 3/24/26 at 5:13 a.m. the resident's pain level was 5 out of 10. Oxycodone was administered at 6:00 a.m. (45 minutes after the pain level was documented). -However, there was no follow-up pain assessment completed until 9:52 a.m. on 3/24/26, almost four hours after the pain medication was administered (see follow-up pain level below). On 3/24/26 at 9:52 a.m. the resident's pain level was 5 out of 10. -However, there was no documentation to indicate additional pain medication was administered or that the physician was notified about the ineffectiveness of the resident's pain medication. According to the pharmacy controlled drug disposition form, the prescription for the resident's oxycodone 5 mg was filled by the pharmacy on 3/23/26, the day after Resident #74 was admitted to the facility. -The first dose of the medication was administered and signed off by licensed practical nurse (LPN) #1 at 11:05 a.m. on 3/23/26, 21 hours after the resident was admitted to the facility (see facility follow-up below). Review of Resident #74's electronic medical record (EMR) revealed the following progress notes: The admission progress note, dated 3/22/26 at 2:20 p.m., revealed Resident #74 denied pain upon assessment. The resident's vital signs were within normal range and the resident's medications were verified by the on-call physician and faxed to the pharmacy. However, the pain assessment completed on admission indicated the resident had a pain level of 4 out of 10 at the time of the assessment (see above). The nurse progress note, dated 3/22/26 at 9:02 p.m., documented Resident #74's medications were verified with the on-call physician. The physician would send a prescription for oxycodone and diazepam (medication used to treat anxiety and muscle spasms) to the pharmacy. -The progress note, documented almost seven hours after the resident admitted to the facility indicated there had been no prescription sent to the pharmacy when the nurse documented that the medications had been verified by the physician at 2:20 p.m. (see admission note above). There was no documentation to indicate the nursing staff had attempted to reach out to the physician or the pharmacy prior to the nurse progress note documented at 9:22 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The nurse progress note, dated 3/23/26 at 11:10 a.m., documented that at approximately 11:10 a.m. the nurse administered oxycodone 5 mg to Resident #74 as ordered. The nurse was unable to chart the administration in the resident's medication administration record (MAR). -The administration of oxycodone was the first pain medication Resident #74 received since her admission to the facility on the previous day (3/22/26). The physician noted, dated 3/23/26 at 4:15 p.m., documented Resident #74 had chronic pain. The resident was currently on oxycodone 5 mg every 8 hours as needed, and reported that her pain was not managed. The physician discussed ordering oxycodone 5 mg every six hours with the resident. The resident complained of bilateral neck pain. The note indicated the resident's pain management would be adjusted with oxycodone 5 mg every six hours for better pain control. -However, the adjustment to the resident's pain medication frequency did not occur for over 24 hours after Resident #74 was admitted to the facility. The nurse progress note, dated 3/23/26 at 5:23 p.m. documented Resident #74 had pain that was a pain level of 7 out of 10 on the numerical pain scale. The resident's pain originated from an infection located at her neck/spine and was described as throbbing and at times sharp. The nursing discharge summary note, dated 3/23/26 at 5:35 p.m. (documented prior to the resident's discharge), documented Resident #74's pain was currently 7 out of 10. The pain was in her neck. The DON progress note, dated 3/24/26 at 11:24 a.m., documented the purpose of the medication verification was because the DON received communication that not all of Resident #74's medications were verified and entered into the facility's electronic medical system. The DON was also informed there was a delay in receiving the hard copy of the prescription from the physician to the pharmacy. The note documented the facility confirmed the physician sent the prescription to the pharmacy on 3/23/26 around 12:00 a.m. D. Staff interviews The DON, clinical resource nurse #1 and clinical resource nurse #2 were interviewed together on 3/25/26 at 9:35 a.m. Clinical resource nurse #1 said when Resident #74 was admitted to the facility (on 3/22/26), the admitting nurse failed to enter all of the physician's orders from the hospital discharge documentation and to verify physician's orders with a physician timely. The DON said the physician failed to send a prescription for Resident #74's narcotic pain medication to the pharmacy. The narcotic prescription for oxycodone was not sent to the pharmacy until 12:00 a.m. on 3/23/26. The DON, clinical resource nurse #1 and clinical resource nurse #2 said Resident #74's pain medication did not arrive in a timely manner to be administered to the resident as ordered. The DON, clinical resource nurse #1 and clinical resource nurse #2 said two nurses were to verify the physician's admission orders for accuracy and new admission residents' charts were reviewed in the morning meeting for accuracy as well. Clinical resource nurse #1 said if medications did not arrive at the facility in a timely manner, nursing staff was to reach out to the pharmacy and the physician if a prescription (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	was needed for any controlled substance. Clinical resource nurse #1 said the ball was dropped with Resident #74 and the resident did not receive pain medication timely or per physician's orders. The DON, clinical resource nurse #1 and clinical resource nurse #2 said the admitting nurse when Resident #74 was admitted to the facility was an agency nurse that they had now banned from the facility. The DON, clinical resource nurse #1 and clinical resource nurse #2 said they would provide education to the nurse that verified the physician's orders with the agency nurse. Clinical resource nurse #1 and clinical resource nurse #2 said a review of all new admissions over the last 30 days would be completed to identify any issues with residents' admission orders. The pharmacist was interviewed on 3/26/26 at 9:40 a.m. The pharmacist said when a resident was on prescribed narcotic pain medications, it was important to ensure the medication was available to administer in a timely manner. The pharmacist said Resident #74's medication orders were faxed to the pharmacy after the resident's admission and the pharmacy would look for important medications and make sure they were sent to the facility timely. The pharmacist said the pharmacy did not receive a prescription for Resident #74's oxycodone until approximately 12:00 a.m. on 3/23/26. The pharmacist said the normal pharmacy delivery times were 1:00 p.m. and 8:00 p.m. daily, but was unsure what time medications got delivered to the facility related to where the facility fell on the delivery route. The pharmacist said STAT (immediate) deliveries were available as well if a medication was needed ahead of a normal delivery time. The pharmacist was unaware of any calls from the facility requesting the need for a prescription from the physician for Resident #74's oxycodone, access to the facility's emergency medication machine to remove the pain medication, or needing an expedited delivery of the oxycodone. The medical director (MD) was interviewed on 3/26/26 at 9:50 a.m. The MD said it was not okay for a resident to not have needed pain medication available for administration. He said any delay would set the facility up for failure. He said if nursing staff were having trouble obtaining a narcotic prescription from a physician, they were able to notify the MD to send a prescription to the pharmacy so the medication could be pulled from the facility's emergency medication machine until the medication was delivered from the pharmacy to eliminate any delays in treating a resident's pain. The MD said he received no calls from the facility regarding the need for a narcotic prescription for Resident #74. The physician's assistant (PA) was interviewed on 3/26/26 at 10:00 a.m. The PA said when Resident #74 was admitted on [DATE], she (the PA) was not notified until 8:55 p.m. to verify the resident's admission medication orders and a prescription was sent to the pharmacy for Resident #74's oxycodone at approximately 9:15 p.m. on 3/22/26. The physician was interviewed on 3/26/26 at 1:50 p.m. The physician said it was very important that narcotic prescriptions get sent to the pharmacy immediately upon a resident's admission so the medication could be sent to the facility in a timely manner in order to avoid any increase in a resident's pain. She said it was important to have pain medications available to manage a resident's pain without delays. E. Facility follow up On 3/24/26 at 11:04 a.m. a copy of the pharmacy delivery packing slip, dated 3/22/26, was provided by clinical resource nurse #1. The delivery slip revealed medications on the list arrived after 9:00 p.m. but there were no narcotic medications for Resident #74 in the delivery. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper storage of medications for one of four medication storage rooms and two of four medication storage carts.Specifically, the facility failed to:-Ensure eye drops were dated with the date they were opened;-Ensure medications were contained in the original packaging; and,-Ensure expired medical supplies were discarded.Findings include:I. Professional referenceAccording to manufacturer Allergan's Ophthalmic Medication Beyond-Use Date Guide, April 2024, retrieved on 3/30/26 from https://www.hdrxservices.com/Ophthalmic-Medication-Beyond-Use-Date-Guide-Apr-2024, Thera Tears eye drops should be discarded 90 days from opening.According to manufacturer Nephron Pharmaceutical's, Beyond-Use Date, 2026, retrieved on 3/30/26 from https://nephronpharm.com/products/ipratropium-bromide-05-mg-and-albuterol-sulfate-3-mg, Vials should be protected from light before use, therefore, keep unused vials in the foil pouch or carton. Vials should be used within two weeks once removed from the foil package. According to manufacturer Hydrofera Blue's user guide, retrieved on 3/30/26 from https://hydrofera.com/app/uploads/2022/03.pdf, Hydrofera Blue dressings are sterile in their original, unopened packaging. However, they are not guaranteed to remain sterile after opening. Single-Use Only: The dressings are designed for single-use and should not be reused. Handling: Once the package is opened, the dressing is exposed to the environment, compromising its sterility. Do not use a Hydrofera Blue dressing if the individual package has been opened or damaged prior to use.II. Facility policy and procedureThe Medication Access and Storage policy and procedure, revised October 2025, was provided by the director of nursing (DON) on 3/26/26 at 1:00 p.m. It read in pertinent part, The provider pharmacy dispenses medications in containers that meet legal requirements. Medications are kept and stored in these containers. Transfer of medications from one container to another is done only by a pharmacist. Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from pharmacy. Any opened vial without an open date will be discarded immediately, and replaced with a new vial. Any medication that cannot be verified as to the expiration date, either due to not being dated when opened, or unclear shelf life, shall be discarded immediately and replaced.III. Observations and interviewsOn 3/24/26 at 10:43 a.m. the 2 East medication storage cart was reviewed with licensed practical nurse (LPN) #1. The following items were found:-One small unknown yellow tablet in a medication cup in the top drawer that was not labeled with a resident's name. LPN #1 was unaware what the tablet was or why it was in a medication cart in the drawer.-An eight ounce (oz) bottle of hand sanitizer on top of the medication cart that expired September 2022.-One bottle of Thera tears that was opened and was not dated.-One vial of thiamine (vitamin B1) injectable 200 milligram (mg)/2 milliliter (ml) lying loose in the top drawer.-One single dose tablet of potassium chloride 20 milliequivalent (meq) lying loose in the top drawer.-One single use dose of cyclosporine ophthalmic emulsion 0.05 % (antibiotic eye drop) lying loose in the top drawer.-One single use dose of Ipratropium Bromide/Albuterol Sulfate 0.5 mg/3 mg/3 ml (nebulizer inhalation solution) lying loose in the top drawer.-One package of Hydrofera Blue wound dressing that had been opened, cut in half, and was lying in the bottom drawer.On 3/25/26 at 8:05 a.m. the 1 [NAME] medication storage cart was reviewed with LPN #4. The following items were found:-Two medication cups were in the top drawer, one stacked on top of the other, with one unknown tablet in the bottom cup and four unknown tablets in the top cup. The cups were not labeled with resident identifying information. LPN #4 said the resident who the medication was for was eating and she would go give the medications to the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident.On 3/25/26 at 8:20 a.m. the medication storage room on 1 [NAME] was reviewed with LPN #4. The following items were found:-15 blue top blood collection tubes that expired 9/30/25.-15 red top blood collection tubes that expired 2/28/26.-25 yellow top blood collection tubes that expired 2/28/26.-One [NAME] point 3 ml syringe with a needle attached that expired 5/28/22.-Three safety glide needles that expired March 2021.IV. Additional staff interviewsLPN #4 was interviewed on 3/25/26 at 8:30 a.m. LPN #4 said the pharmacist came to the facility monthly and reviewed the medication storage carts and any medications in the medication storage room but she was unaware if the pharmacist checked for expired medical supplies. LPN #4 said the facility would only draw blood if the lab was unable to do it. The DON, the infection preventionist (IP), clinical resource nurse #2 and the nursing home administrator (NHA) were interviewed on 3/25/26 at 3:30 p.m. The DON, the IP, the clinical resource nurse and the NHA said the management staff had recently reviewed the medication storage rooms and medication storage carts for expired medications and medical supplies and missed the items identified on 3/24/26 and 3/25/26 (see observations above). The NHA said the pharmacist was in the facility the week prior (week of 3/15/26) and had reviewed the medication storage carts. The NHA said nurses did not draw blood at the facility and was unaware of the expired blood collection tubes in the 1 [NAME] medication storage room. Clinical resource nurse #2 said night shift nurses were responsible for removing expired medications and medical supplies from the medication storage rooms and medication carts. Clinical resource nurse #2 said the facility's process for ensuring expired medications were removed from the medication carts and medication storage rooms would be addressed.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure care for residents was provided in a manner and in an environment that maintained or enhanced the residents' dignity and respect in full recognition of their individuality for three (#19, #74 and #75) of 10 residents reviewed for dignity out of 32 sample residents. Specifically, the facility failed to ensure Resident #19, Resident #74 and Resident #75 had the right to a dignified existence by being provided privacy in their personal bathrooms.Findings include:I. Resident #19A. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included stroke, unspecified dementia, anemia and hypertension.The 1/26/26 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident required partial staff assistance for transferring and toileting. She used a wheelchair for mobility and was able to propel herself. B. ObservationResident #19's room was observed on 3/23/26 at 9:13 a.m. The bathroom had a track for a sliding curtain but there was no curtain or bathroom door in the resident's personal bathroom. Resident #19's room was observed on 3/24/26 at 12:00 p.m. Resident #19 was observed propelling herself out of her bathroom. The bathroom had a track for a sliding curtain but there was no curtain or bathroom door in the resident's personal bathroom. Resident #19's room was observed again on 3/24/26 at 1:15 p.m. with the maintenance director (MTD). The bathroom had a track for a sliding curtain but there was no curtain or bathroom door in the resident's personal bathroom. C. Resident interviewResident #19 was interviewed on 3/24/26 at 12:00 p.m. Resident #19 said she took herself to the bathroom and was unable to have privacy in the bathroom because she was supposed to have a curtain to close but she had not had a curtain for at least two days. Resident #19 said she could not get to her room door to close it and then to the bathroom before she had an incontinence episode, so she just had to go straight to the bathroom and hope that no one came into her room. II. Resident #74A. Resident statusResident #74, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included sepsis and infection of the spine. The 3/24/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required setup from staff for transferring and toileting. She used a wheelchair for mobility and was able to propel herself. B. ObservationResident #74's room was observed on 3/23/26 at 11:45 a.m. The resident's bathroom had a sliding door but the door would not close all the way and closed less than halfway. Resident #74's room was observed on 3/24/26 at 8:15 a.m. The resident's bathroom door was still askew and would not shut all the way.Resident #74's room was observed again on 3/24/26 at 1:05 p.m. with the MTD. The resident's bathroom door was still askew and would not shut all the way. The MTD tried to close the door, but it was not on the track and it took the MTD five minutes to align the door back on the track.C. Resident interview Resident #74 was interviewed on 3/23/26 at 11:45 a.m. Resident #74 said her sliding bathroom door had been broken since she was admitted to the facility on [DATE]. She said the door would not close all the way when she was trying to use the bathroom and it was embarrassing to her when she tried to use the toilet and could not close the door all the way.III. Resident #75A. Resident statusResident #75, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included fracture of the left femur and unspecified fall. The 3/21/26 MDS assessment had not been completed at the time of the survey. According to the 3/21/26 at 1:55 p.m. admission progress note, the resident was alert and oriented times four (person, place, time and reason for care) and required one-person assistance with activities of daily living (ADL) and transfers. B. ObservationResident #75's room was observed on 3/23/26 at 11:45 a.m. The resident shared a room with Resident #74 (see above). The resident's bathroom had a sliding door but the door would not close all the way and closed less than halfway. Resident #75's room was observed on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/24/26 at 8:15 a.m. The resident's bathroom door was still askew and would not shut all the way. Resident #75 was observed walking to the bathroom. When Resident #75 tried to close the bathroom door, she could not get the door to close beyond halfway and she sat on the toilet, visible to anyone in the room.Resident #75's room was observed again on 3/24/26 at 1:05 p.m. with the MTD. The resident's bathroom door was still askew and would not shut all the way. The MTD tried to close the door, but it was not on the track and it took the MTD five minutes to align the door back on the track.C. Resident interviewResident #75 was interviewed on 3/23/26 at 11:45 a.m. Resident #75 said her sliding bathroom door had been broken since she was admitted to the facility on [DATE]. Resident #75 said the door was always askew and would not close all the way, leaving her using the bathroom exposed. Resident #75 was interviewed again on 3/24/26 at 1:05 p.m. Resident #75 said not being able to close her bathroom door when using the toilet had been horrible. IV. Staff interviewsThe MTD was interviewed on 3/24/26 at 1:20 p.m. The MTD said his housekeepers cleaned the residents' bathrooms daily and no one had reported to him that there was a problem with the door in Resident #74 and Resident #75's shared room. The MTD said that the housekeepers had taken down the privacy curtain in Resident #19's room to clean the curtain and there was a turnaround time from laundry of 24 to 48 hours on returning the curtain. He said in the meantime, the staff encouraged her to close her bedroom door when using the toilet. Certified nurse aide (CNA) #2 was interviewed on 3/24/26 at 4:12 p.m. CNA #2 said she was aware of the bathroom door in Resident #74 and Resident #75's shared room that would not close all the way and said she did not submit a work order to maintenance because she thought someone else had. CNA #2 said the residents' bathroom door had been that way for at least three days. The laundry aide was interviewed on 3/25/26 at 9:00 a.m. The laundry aide said there was not a shortage of bathroom privacy curtains in the laundry room and she showed a stack of clean curtains. The laundry aide said a resident should not have to wait 24 to 48 for a curtain to be replaced. She said when the CNAs sent down a curtain to the laundry, they did not put a room number on it, so if the laundry aide was not made aware of where the curtain needed to be returned to, this delayed getting a curtain put back up. CNA #1 was interviewed on 3/25/26 at 1:00 p.m. CNA #1 said the CNAs put dirty linens down a laundry chute to be collected by the laundry staff and washed. CNA #1 said the CNAs did not touch the bathroom privacy curtains. She said the housekeepers collected the privacy curtains and put them back up after cleaning. Housekeeper (HK) #1 was interviewed on 3/26/26 at 8:39 a.m. HK #1 said the laundry aides took the privacy curtains in the residents' bathrooms down, cleaned the curtains and then returned the curtains. HK #1 said the housekeepers did not do anything with the privacy curtains. The MTD, the nursing home administrator (NHA) and the regional plant resource were interviewed together on 3/26/26 at 9:40 a.m The MTD said the curtain in Resident #19's bathroom had not been replaced yet because there were not any clean curtains that would fit and the only curtains available were too long. He said he had not considered putting a longer curtain up to ensure privacy for the residents, instead he had planned on letting the housekeepers put up the original curtain once it was clean. The MTD was unable to explain the inconsistencies in the process of removing, cleaning, and replacing the privacy curtains reported by the laundry aide, CNA #1 and HK #1 (see interviews above). The NHA said the residents should never be without a curtain for privacy. The regional plant resource said he would order more curtains to ensure a clean curtain could be put up immediately once a dirty curtain was taken down.V. Facility follow upOn 3/26/26 at approximately 11:30 a.m. the MTD provided a training in-service sheet which indicated education had been completed with the housekeepers on 3/26/26 to identify a curtain cleaning schedule that ensured a clean curtain was always available.-However, the curtain cleaning schedule was not created until the concern with residents' privacy in the bathroom was brought to the facility's attention during the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that the residents had a safe, clean, comfortable, and homelike environment for three out of 12 rooms. Specifically, the facility failed to ensure the facility's process of reporting and responding to repairs in the resident's rooms was being utilized to maintain three damaged closets in Resident #8, Resident #74, and Resident #33's rooms. Findings include:I. Observations and staff interviewResident #8's room was observed on 3/23/26 at 9:13 a.m. The hinge holding the resident's closet door to the frame was loose, coming out of the door and the wood around it was damaged. Resident #33's room was observed on 3/23/26 at 9:20 a.m. The hinge holding the resident's closet door to the frame was detached from the frame.Resident #74's room was observed on 3/23/26 at 11:45 a.m. The hinge holding the resident's closet door to the frame was loose, coming out of the door and the wood around it was damaged. Resident #8's room was observed again on 3/24/26 at 1:10 p.m. with the maintenance director (MTD). The hinge holding the resident's close door to the frame was loose, coming out of the door and the wood around it was damaged. Resident #33's room was observed again on 3/24/26 at 1:15 p.m. with the MTD. The hinge holding the resident's closet door to the frame was detached from the frame.Resident #74's room was observed again on 3/24/26 at 1:25 p.m. with the MTD. The hinge holding the resident's close door to the frame was loose, coming out of the door and the wood around it was damaged.The MTD said he was not aware of the damaged closet doors in Resident #8, Resident #33 and Resident #74's rooms and he had not received a work order to repair them. The MTD said the facility's process when things needed to be fixed was for an electronic work order to be submitted so he could repair items inside of residents' rooms. II. Resident interviewResident #74 was interviewed on 3/23/26 at 11:45 a.m. Resident #74 said the hinge on her closet door had been loose and coming out of the door since she was admitted to the facility on [DATE]. Resident #74 said she had complained to the staff and they told her that maintenance would repair it, but no one from maintenance had come to see her about it.III. Additional staff interviewsCertified nurse aide (CNA) #1 was interviewed on 3/25/26 at 1:00 p.m. CNA #1 said when something in the facility needed repair, the CNAs would submit a work order to maintenance through an electronic reporting system. She said things that should be reported would be anything in the residents' rooms that was broken or needed repair. CNA #1 said work orders were submitted by CNAs and nurses.Licensed practical nurse (LPN) #4 was interviewed on 3/25/26 at 1:12 p.m. LPN #4 said when something in the facility needed repair, the nurses would submit a work order to maintenance through an electronic reporting system. She said things that should be reported would be anything in the residents' rooms that was broken or needed repair, such as a bed not working, bathroom doors and or closet doors. LPN #4 said work orders were submitted by CNAs and nurses.LPN #3 was interviewed on 3/25/26 at 1:34 p.m. LPN #3 said she was an agency nurse but most facilities she had worked in used an electronic reporting system to submit work orders to their maintenance department for repairs. She said she would try to submit it that way or ask the charge nurse. The MTD was interviewed again on 3/26/26 at 11:30 a.m. The MTD said he had submitted a ticket to the electronic work order help desk in order to open up access to submitting work orders for all staff, not just CNAs and nurses. IV. Facility follow upOn 3/26/26 at approximately 11:30 a.m. the MTD provided a training in-service sheet, dated 3/26/26, on the importance of the electronic work order system, which indicated education had been completed with the 13 administrative staff, one activities assistant, two transportation drivers and one regional clinical resource. Of the facility's six housekeeping staff, one was trained; of the facilities 28 CNAs, three were trained; of the facilities nine LPNs, none were trained and of the facility's nine registered nurses, one was trained. -The MTD did not provide documentation of a plan to ensure all staff were trained and understood the electronic work order system.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure three (#30, #55 and #71) of eight residents received treatment and care in accordance with professional standards of practice out of 32 sample residents.Specifically, the facility failed to:-Ensure physician's orders for post-void residual measurements (PVR - measures the amount of urine remaining in the bladder immediately after urination) were followed for Resident #71;-Ensure physician's orders were in place for a wound dressing for Resident #55; and,-Ensure Resident #30 received wound prevention care in accordance with the physician's orders.Findings include: I. Failed to ensure physician's orders for PVRs were followed for Resident #71 A. Resident status Resident #71, age [AGE], was admitted on [DATE] and discharged to the hospital on 1/14/26. According to the January 2026 computerized physician orders (CPO), diagnoses included need for assistance with personal care, cognitive communication deficits, acute kidney failure and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland). The 3/15/26 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments, per the staff assessment for mental status. The resident required moderate to substantial assistance from staff for all activities of daily living (ADL). The assessment documented the resident had an indwelling urinary catheter and was frequently incontinent of bowel and bladder. B. Resident #71's representative interview Resident #71's representative was interviewed on 3/26/26 at 1:25 p.m. The resident's representative said the facility removed Resident #71's indwelling Foley catheter and the physician said the nursing staff would need to scan his bladder several times over the coming days. The resident's representative said when the nursing staff attempted to scan Resident #71's bladder, they could not find the bladder scanner. C. Record review Review of Resident #71's January 2026 CPO revealed the following physician's orders: Remove Foley catheter on 1/9/26 for voiding trial. Check PVR for 48 hours and notify the physician if it is greater than 300 milliliters (ml), ordered 1/8/26 and discontinued 1/11/26. Monitor PVR every six hours, try to check after resident voids, though he is incontinent. Insert Foley catheter if PVR is greater than 300 ml. Notify the physician if you have to insert Foley so a referral to urology can be made, ordered 1/12/26 and discontinued 1/13/26. Monitor PVR every six hours, try to check after resident voids, though he is incontinent. Insert Foley catheter if PVR is greater than 300 ml. Notify the physician if you have to insert Foley so a referral to urology can be made, ordered 1/13/26 and discontinued 1/13/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Measure PVR every six hours for 24 hours for recent urinary retention after Foley catheter removal, ordered 1/14/26 at 12:46 p.m. A progress note, dated 1/9/26 at 5:07 a.m., revealed Resident #71's Foley catheter order was discontinued and removed per physician's order. Physician's orders for PVRs for the next 48 hours were in place, and the physician was to be notified for any PVR greater than 300 ml. A physician's note, dated 1/12/26 at 10:38 a.m., revealed Resident #71 was seen by his physician to examine a new skin concern. The note documented the resident's PVRs had been less than 200 ml each time, according to the nursing staff. Resident #71's representative was concerned his abdomen looked distended, so the physician performed a bladder scan and observed 600 ml of urine in the resident's bladder. Resident #71 had a straight catheter placed and 700 ml of urine was drained from the resident's bladder. The physician documented the resident was scheduled to have PVRs measured every six hours for 48 hours. The physician documented Resident #71 had also reported possible constipation and a suppository was administered. A progress note, dated 1/12/26 at 1:32 p.m., revealed Resident #71 had a PVR of 609 ml and had 700 ml of urine drained from a straight catheter. Resident #71's physician was notified. A physician's note, dated 1/13/26 at 8:30 a.m., revealed Resident #71 was seen by his physician for a follow-up visit. The physician documented the resident was scheduled to have PVRs measured every six hours for 48 hours. A physician's note, dated 1/14/26 at 8:39 a.m., revealed Resident #71 was seen by his physician to follow up on his voiding trial. The note revealed the physician had not seen any documentation of Resident #71's PVR amounts. The physician spoke with the nursing staff and ordered PVRs to be measured every six hours over the next 24 hours to ensure Resident #71 was not having any urinary retention. A progress note, dated 1/14/26 at 1:27 p.m., revealed Resident #71 had been administered an as-needed opioid pain medication. A progress note, dated 1/14/26 at 2:42 p.m., revealed Resident #71's pain level had been reassessed by the nursing staff and was measured to be a 3 out of 10. A progress note, dated 1/14/26 at 7:46 p.m., revealed Resident #71 had been transported to the emergency department while attending an outside appointment. The medical director, the director of nursing (DON) and the nursing home administrator (NHA) were notified. Review of Resident #71's January 2026 medication administration record (MAR), from 1/1/26 through 1/14/26, revealed the following: PVRs were measured and documented twice daily from 1/9/26 through 1/11/26 and were consistently below 300 ml. A PVR was measured on 1/12/26 at 7:07 p.m. -However, the nurse did not document the volume measured on 1/12/26 at 7:07 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PVRs were measured on 1/13/26 at 6:00 a.m. and 6:00 p.m. The PVRs were documented as 57 ml and 55 ml, respectively. -The January 2026 MAR revealed the facility obtained one PVR measurement on 1/12/26, two PVR measurements on 1/13/26 and no PVR measurements on 1/14/26, despite the physician's orders indicating PVRs were to be obtained every six hours, beginning on 1/12/26 (see physician's orders above). D. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 3/26/26 at 9:42 a.m. LPN #4 said whenever the physician put in orders to remove a Foley catheter, the facility would typically also put in physician's orders to measure PVRs for the next 72 hours. LPN #4 said the nursing staff recorded the PVR measurements in the MAR. LPN #4 said the frequency of PVR measurements depended on the physician and were typically measured two to three times per shift. The DON, an unidentified member of the regional support team and the assistant director of nursing (ADON) were interviewed together on 3/26/26 at 10:44 a.m. The DON said PVRs were used to measure voiding after removing an indwelling urinary catheter for a certain period of time. He said the nursing staff would communicate their measurements with the physician to see if the resident needed to continue using a urinary catheter. The ADON said typically for voiding trials, the nursing staff would monitor PVRs and voiding every six to eight hours for three days, and use a straight catheter if the PVR measured greater than 350 ml. The ADON said Resident #71 had physician's orders to have a PVR measured every six hours after his Foley catheter was removed on 1/9/26. The regional support team member said the PVR frequency and length of the physician's order depended on what the resident's diagnoses were and what the indwelling catheter was being used to treat. The regional support team member said the nursing staff had documented Resident #71's PVRs in the MAR, and said there was a physician's order on 1/9/26 to remove the Foley catheter and monitor PVRs twice daily and document their output from 1/9/26 through 1/12/26. The DON reviewed Resident #71's medical record and said the resident had a physician's order, initiated 1/13/26, to monitor PVRs every six hours for 48 hours. -However, the physician's order to monitor PVRs every six hours was initiated on 1/12/26 (see physician's orders above). The regional support member reviewed Resident #71's MAR and said there were two PVRs recorded on 1/13/26. -However, per the physician's order, PVRs were supposed to be measured every six hours (see physician's order above). The DON said Resident #71 had an appointment on 1/14/26 and was picked up for the appointment by the transportation staff at 1:45 p.m. that afternoon. The DON said by the time the physician's order for additional PVRs was put into the resident's medical record (on 1/14/26 at 12:46 p.m.), it was too close to his appointment time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, according to the resident's progress notes, the resident was still in the facility on 1/14/26 at 1:27 p.m., when he was administered a medication for pain (see progress notes above). The ADON said the physician may have given the order to the nursing staff later in the morning after Resident #71's exam on 1/14/26, which would account for the gap between the exam and when the order was put in for additional PVRs. The ADON said the nurse or the physician put in the orders for the PVR and the physician would verify the orders later. The ADON and the DON both said if the physician ordered PVRs to be measured every six hours, they would expect the nursing staff to measure the resident's PVR every six hours. Resident #71's attending physician was interviewed on 3/26/26 at 11:24 a.m. The attending physician said orders for PVRs after removing a Foley catheter typically involved measuring the PVR every six hours for two days to see if there were any significant measurements. The attending physician said he would expect the nursing staff to measure and record the PVR every six hours if the physician's order specified to measure the PVR every six hours. II. Failed to ensure physician's orders were in place for a wound dressing for Resident #55 A. Resident status Resident #55, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included cognitive communication deficits, need for assistance with personal care and fracture of the right fibula (the smaller bone in the lower leg). The 3/11/26 MDS assessment revealed the resident had significant cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. The resident required supervision to maximum assistance from staff for all ADLs. The assessment documented the resident did not have any issues with her skin. B. Observations On 3/24/26 at 8:30 a.m. Resident #55 was lying in bed in her room. Resident #55 had a dressing on her right forearm arm, dated 3/19/26. On 3/25/26 at 8:50 a.m. Resident #55 was sitting up in her wheelchair in her room. Resident #55 had a dressing on her right forearm, dated 3/19/26. C. Resident #55's representative interview Resident #55's representative was interviewed on 3/25/26 at 8:50 a.m. The resident's representative said she had seen that Resident #55 had a big bandage on her arm. The resident's representative said she had no idea why Resident #55 had the dressing on her arm. The resident's representative said she had hoped the facility would have contacted her if Resident #55 had any changes, or if she had fallen or had any procedures done. D. Record review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #55's March 2026 CPO revealed the following physician's order: Monitor the right forearm dry skin patch to ensure proper healing. The area is currently approximately 1 centimeter (cm) by 1 cm with no open areas noted. Monitor for redness, drainage, signs and symptoms of infection and notify the physician if noted, ordered 3/27/26 at 9:21 a.m. (during the survey process). A skilled nursing note, dated 3/19/26 at 8:49 p.m., revealed Resident #55 had some healing bruising above her right eye with no other skin issues or concerns noted, and no active skin conditions or treatments observed. A skin assessment, completed 3/21/26 at 10:09 p.m., revealed Resident #55's skin was assessed by the nursing staff. Resident #55 had redness noted to her coccyx with treatments in place and her heels and all other bony prominences were intact. -The assessment did not document Resident #55's dressing in place or any irritated areas on her arm. A progress note, dated 3/25/26 at 4:27 p.m., revealed the nursing staff assessed the bandage on Resident #55's right forearm and noted there appeared to be a patch of dry skin under the bandage with no open areas noted. Resident #55 denied any pain to the area and declined to have the dressing removed. -However, a physician's order for the dressing that was observed on the resident's right forearm by the nurse on 3/25/26 at 4:27 p.m. was not obtained until 3/27/26 at 9:21 a.m., during the survey (see physician's orders above). E. Staff interviews The infection preventionist (IP) was interviewed on 3/25/26 at 9:06 a.m. The IP said for any dressings, the nursing staff needed to get orders from the physician for wound care. The IP said all wounds, no matter the size, were to be dressed appropriately and followed by the in-house wound care nurse (WCN). The IP reviewed Resident #55's March 2026 CPO and found wound care orders including for barrier cream to the resident's coccyx and monitoring her pacemaker site. The IP said she was not sure why Resident #55 had a dressing on her arm but thought the WCN may have been following the resident. The IP contacted the WCN by phone, who said she did not see any other wound care orders for Resident #55. The IP said she thought maybe the resident had a bony prominence on her arm that the nursing staff were trying to cover. The IP said residents had their skin assessed on admission and weekly. The IP said if the nursing staff saw any changes with a resident's skin, they would document it in the assessment, consult the physician and fill out a change in condition report. The WCN was interviewed on 3/25/26 at 10:53 a.m. The WCN said she reviewed Resident #55's EMR and did not see any physician's orders for wound care, so she was not sure why she had any dressings on. The WCN said Resident #55's skin was assessed on admission and not found to have any skin tears or areas of concern, and the resident had been assessed weekly since her admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #4 was interviewed on 3/25/26 at 1:23 p.m. CNA #4 said if she noticed any changes with a resident's skin, she would notify the nurse and document the change in the resident's tasks in the electronic medical record (EMR). CNA #4 said she would also pass along the information regarding the change in the resident's skin to the next shift so they knew to monitor it. LPN #3 was interviewed on 3/25/26 at 1:59 p.m. LPN #3 said if she saw a dressing on a resident during her shift, it would trigger her to look at the resident's physician's orders for any wound care orders. LPN #3 said sometimes residents asked the nursing staff for bandages and the nursing staff applied a bandage for the resident without thinking, so she would want to look into the resident's EMR to see why the resident had the dressing and if it needed to be changed. The IP was interviewed a second time on 3/25/26 at 3:48 p.m. The IP said she had assessed Resident #55's skin under the dressing on her forearm and found an irritated area approximately 2 inches by 2 inches which looked similar to a psoriasis plaque (an itchy, raised, inflamed, and scaly skin patch). The IP said Resident #55's skin assessment did not reveal any open areas or any areas which would require wound care orders. The IP said Resident #55 said she wanted to keep a bandage on the area, so another dressing was placed. The IP said she did not know who put the dressing on Resident #55's arm or if anyone had attempted to change the bandage since it was first applied. The IP said she would have expected to see documentation in the progress notes about the bandage being placed or any attempts to replace the bandage. The WCN was interviewed a second time on 3/26/26 at 10:18 a.m. The WCN said the area under the bandage on Resident #55's arm was a patch of dry skin, and the resident had requested the bandage herself. The WCN said she did not know when Resident #55 had requested for the bandage to be applied. The WCN said if Resident #55 wanted to continue wearing the bandage, she would put in physician's orders so the bandage could be changed and monitored. III. Failed to ensure Resident #30 received wound prevention care in accordance with the physician's orders A. Facility policy and procedure The Wound Care Treatment and Guidelines policy, revised May 2026, was provided by the nursing home administrator (NHA) on 3/25/26 at 4:11 p.m. It revealed in pertinent part, Treatments will be placed in the electronic record. Treatments can be triggered in the EMR or treatment record. A licensed nurse will monitor the wounds with treatments and scheduled assessments. B. Resident #30 1. Resident status Resident #30, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included dementia, heart failure, anemia, a urinary tract infection and aphasia. The 3/16/26 MDS assessment revealed the resident was cognitively impaired with a BIMS score of nine out of 15. The resident was dependent on staff for bathing, transferring, toileting, dressing and bed mobility. She used an electric wheelchair for mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment indicated the resident had an unstageable, deep tissue injury and a pressure injury. The resident had a pressure relieving device for her bed and received pressure injury care. 2. Observations On 3/23/26 at 1:38 p.m. Resident #30 was lying in her bed in her room. Her feet were resting on top of a pillow with a reddened area on her right heel directly on the pillow. The resident had bandages to her first and second right toes and a bandage on her first left toe. The date on the bandages was 3/21/26. On 3/24/26 at 8:45 a.m. Resident #30 was lying in her bed in her room. Her feet were resting on top of a pillow with a reddened area on her right heel directly on the pillow. The bandages to her right and left toes had been changed and were dated 3/23/26. On 3/24/26 at 2:40 p.m. Resident #30 was lying in her bed in her room. Her feet were resting on top of a pillow with a reddened area on her right heel directly on the pillow. On 3/25/26 at 9:17 a.m. Resident #30 was lying in her bed in her room. Her feet were resting on top of a pillow with a reddened area on her right heel directly on the pillow. 3. Resident #30's representative interview Resident #30's representative was interviewed on 3/23/26 at 1:38 p.m. The representative lifted up the resident's bed covers to expose the resident's right and left feet, which were both sitting directly on a pillow (see observations on 3/23/26). The representative said he had told the staff several times that Resident #30 needed her heels floated and not placed directly on the pillows to prevent pressure injuries. The representative said the resident had a reddened area to her right heel that would develop into a pressure injury if her feet continued to be placed directly on a pillow and not floated. He said the physician had ordered daily dressing changes to the abrasions on her right and left toes but the date on her bandage was for 3/21/26 (see observations above). 4. Record review The skin integrity care plan, revised 3/19/26, revealed Resident #30 had the potential for pressure ulcers related to impaired mobility and incontinence of bowel and bladder. The resident admitted with an abrasion to the first and second right toes and the first left toe. The resident was admitted with a deep tissue injury (DTI) to the right heel. Interventions, dated 3/19/26, included applying moon boots (a heel floatation device used to suspend the heel to reduce friction and pressure) to the bilateral lower extremities (BLE) and providing the resident with assistance to apply the boots. Review of Resident #30's March 2026 CPO revealed the following physician's orders: Float heels as tolerated, ordered 3/16/26. Wound care to right heel: paint with betadine and leave open to air two times a day, ordered 3/17/26. Wound care to left great toe: cleanse with wound cleanser, pat dry, apply skin prep to wound, apply silver hydrogel to wound base, and cover with a bordered gauze dressing - change daily every day shift for wound care, ordered 3/17/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound care to right second toe: cleanse with wound cleanser, pat dry, apply skin prep to wound, apply silver hydrogel to wound base, and cover with a bordered gauze dressing - change daily every day shift for wound care, ordered 3/17/26. Wound care to right great toe: cleanse with wound cleanser, pat dry, apply skin prep to wound, apply silver hydrogel to wound base, and cover with a bordered gauze dressing - change daily every day shift for wound care, ordered 3/17/26. Apply moon boots to BLE in bed as the resident tolerates every shift, ordered 3/19/26. -However, observations revealed the resident's wound dressings were not changed as ordered and the resident was not wearing moon boots in bed (see observations above). Review of Resident #30's electronic treatment administration records (TAR), from 3/16/26 to 3/24/26 revealed the following: The wound care to the resident's left great toe was not documented as being completed on 3/22/26. The wound care to the resident's right second toe was not documented as being completed on 3/22/26. The wound care to the resident's right great toe was not documented as being completed on 3/22/26. Apply moon boots as the resident accepts was documented as accepted by the resident on 3/22/26 and 3/23/26. -However, observations on 3/23/26 revealed the resident was not wearing her moon boots in bed (see observations above). Apply moon boots as the resident accepts was documented as N on 3/24/26. However, the only choices on the TAR legend was an A for accepted or an R for refused. Float heels was documented as being performed every shift on 3/16/26 to 3/24/26. -However, observations on 3/23/26, 3/24/26 and 3/25/26 revealed the resident's heels were not floated in bed (see observations above). Review of Resident #30's EMR, from 3/16/26 to 3/24/26 revealed the following: The skin ulcer non-pressure weekly assessment, dated 3/16/26, revealed Resident #30 was admitted to the facility with an abrasion to the right great toe measuring 1 inch by 0.8 inches with 0.3 inch depth, an abrasion to the right second toe measuring 0.4 inches by 0.4 inches with 0.2 inch depth, an abrasion to the left great toe measuring 0.7 inches by 0.6 inches with 0.2 inch depth, and a pressure injury to the right heel measuring 5 inches by 4 inches with 0 inch depth. Review of the CNA documentation tasks revealed instructions to apply moon boots. -The EMR failed to reveal documentation of the resident's refusals for moon boots or floating the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heels. C. Staff interviews CNA #1 was interviewed on 3/25/26 at 1:00 p.m. CNA #1 said if a resident needed devices, such as boots for pressure injuries, the nurses would verbally tell the CNAs. CNA #1 said if a resident refused to wear the boots, the CNAs would report the refusals to the nurse to document in the EMR. She said Resident #30 wore boots on her feet every day when laying in bed. CNA #1 said the CNAs would use a pillow to float her heels by placing the pillow under her ankles if not wearing her boots. LPN #4 was interviewed on 3/25/26 at 1:12 p.m. LPN #4 said the nurses would verbally communicate to the CNAs any devices or care necessary for a resident's wound care and if a resident refused, the CNAs would tell the nurses so it could be documented in the resident's EMR progress notes. LPN #4 said Resident #30 wore boots on her feet every day when lying in bed and the staff would place a pillow under her ankles to float her heels while in bed if she did not want her boots. -However, despite CNA #1 and LPN #4 indicating the resident wore the boots or had her heels floated whenever she was in bed, observations on 3/23/36, 3/24/26 and 3/25/26 revealed the resident was not wearing her boots and did not have her heels floated (see observations above). -Additionally, there was no documentation to indicate the resident refused the boots or to float her heels (see record review above). LPN #3 was interviewed on 3/25/26 at 1:34 p.m. LPN #3 said that the nurses would verbally communicate to the CNAs any devices or care necessary for resident's wound care. LPN #3 said she was an agency nurse and did not know how the facility handled refusals by residents. She said if a physician's order directed for staff to float a resident's heels, the pillow would be placed under the resident's calf and not the resident's foot. The DON, the NHA, and clinical resource nurse #2 were interviewed on 3/25/26 at 3:21 p.m. clinical resource nurse #2 said treatment orders, such as boots, splints or floating the heels, were communicated to the nurses and CNAs through the CPO and the CNA charting tasks. He could not explain what N indicated on a TAR for wound care. The DON said if a resident accepted treatments, such as a boot and then refused it later, the facility had no method of having the staff document this other than to make a progress note in the EMR. He said the correct way to float a resident's heels was with a pillow placed under the ankle so the foot was suspended away from any surface, such as the bed, that it could rub on. The DON said if the heels were directly touching the pillows, it could restrict blood flow and cause tissue to compress against the pillow, making the resident more susceptible to skin breakdown. The DON, the NHA and clinical resource nurse #2 were unaware the staff were floating Resident #30's heels directly on a pillow. The DON said the facility monitored the execution of wound treatments by reviewing the TARs for the residents. He said he was not aware of the missed wound care treatment for Resident #30 on 3/21/26. The DON said there was always someone available and on shift to complete a wound care treatment if the nurse was unable to complete it for some reason. He said Resident #30's wound care treatment should not have been missed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%).Specifically, the facility had a medication error rate of 13.33%, or four errors out of 30 opportunities for error.Findings include:I. Professional referenceAccording to Stat Pearls Nursing Rights of Medication Administration, 9/4/23, retrieved on 3/30/26 from https://www.ncbi.nlm.nih.gov/books/NBK560654, Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the ?five rights' or ?five R's' of medication administration.-Right patient;-Right drug;-Right route;-Right time; and,-Right dose.II. Facility policy and procedureThe Medication Administration policy and procedure, reviewed January 2022, was provided by the director of nursing (DON) on 3/26/26 at 1:00 p.m. It read in pertinent part, It is the policy of this facility to ensure that the six rights of medication administration are followed in order to ensure safety and accuracy of administration. -Right resident-identified prior to medication administration;-Right time-medications are administered within prescribed time frames;-Right medication-medications are checked against the order before they are given;-Right dose-medications are administered according to the dose prescribed;-Right route-medications are administered according to the route prescribed; and,-Right documentation-document administration or refusal of the medication after the administration or attempt and note any concerns.III. Observations and InterviewsOn 3/24/26 at 11:40 a.m. licensed practical nurse (LPN) #2 was observed administering medications to Resident #64. LPN #2 dispensed one tablet of Guaifenesin (expectorant medication) 600 milligram (mg). -However, Resident #64's March 2026 medication administration record (MAR) indicated the physician's order for the resident's Guaifenesin was 400 mg every morning. Upon prompting, LPN #2 reviewed the physician's order, then discarded the 600 mg tablet of Guaifenesin. LPN #2 was unable to locate a 400 mg tablet of Guaifenesin. LPN #2 requested assistance from nursing management who could not locate the medication in a 400 mg dose. -Resident #64 failed to receive his Guaifenesin medication. LPN #2 said the physician would be contacted for clarification of the physician's order. LPN #2 next gathered Resident #64's Fluticasone (allergy anti-inflammatory medication) 50 microgram (mcg)/actuation nasal spray and Trelegy Ellipta (lung inflammation reducing medication) 100-62.5-25 mcg respiratory inhaler medications and carried them to the resident's bedside. Resident #64 asked for applesauce for the other medications and LPN #2 left the room. While LPN #2 was out of the room, Resident #64 picked up the Trelegy Ellipta inhaler and breathed in once. The resident did not rinse his mouth with water afterward. -However, Resident #64's March 2026 MAR indicated the resident needed to rinse his mouth after using the inhaler. -LPN #2 failed to instruct Resident #64 to rinse his mouth after using the inhaler. When LPN #2 returned to the resident's room, Resident #64 picked up the Fluticasone nasal spray and dispensed two sprays into each nostril. -However, Resident #64's March 2026 MAR indicated the nasal spray was to have one spray to each nostril. -LPN #2 failed to instruct Resident #64 on how many sprays of Fluticasone were ordered and the resident received the wrong dose of nasal spray. LPN #2 prepared Resident #64's psyllium powder (laxative medication for constipation). The resident's March 2026 MAR indicated the resident was to receive two teaspoons of the psyllium powder every morning. -However, LPN #2 did not use a measuring medication cup to administer the correct dose, but used a white plastic spoon to measure the powder instead. LPN #2 acknowledged the need to use an accurate measuring device when administering powder medications.IV. Additional interviewsThe DON and the nursing home administrator (NHA) were interviewed on 3/25/26 at 3:53 p.m. The DON and the NHA said when a nurse identified a medication that was not available to administer, the nurse should check the stat safe (emergency medications machine) to see if the medication was in the machine and if not, the nurse was to reach out to the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy or nursing management staff to help locate a medication. The NHA and the DON said when there was an identified medication issue, the facility would put together a group text so communication would be among several staff members to help resolve the issue. The NHA and the DON said nursing should notify the physician if medications were missed or were unavailable to administer in order to obtain physician's orders for alternate medications if there were options available.

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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 three (#74, #43 and #55) of eight residents reviewed for medication management were free from significant medication errors out of 32 sample residents.Specifically, the facility failed to:-Ensure Resident #74 received scheduled intravenous (IV) antibiotics as ordered; and, -Ensure Resident's #43 and #55's blood pressure medications were administered or held per physician ordered parameters. Findings include: I. Failed to ensure Resident #74 received scheduled IV antibiotics as ordered A. Professional reference According to Vancomycin Hub 2021, retrieved on 3/31/26 from https://doseme-rx.com/vancomycin, Keeping IV vancomycin and piperacillin-tazobactam (Zosyn) on a strict routine schedule is critical to maintain therapeutic efficacy against severe infections, prevent the development of drug-resistant bacteria, and manage the increased risk of kidney injury (Acute Kidney Injury - AKI) associated with their combined use. Because both drugs are time-dependent, consistent dosing ensures blood levels remain within a stable, effective range, while delays increase mortality risk in septic patients. For vancomycin to be effective, a person must receive doses at regular intervals with the goal of getting to a point where the drug levels in the body remain stable or consistent, known as steady-state. B. Resident #74 1. Resident status Resident #74, age [AGE], was admitted on [DATE] and discharged to another facility on 3/24/26. According to the March 2026 computerized physician orders (CPO), diagnoses included sepsis (life threatening infection), infection of intervertebral disc, cervical (neck) region, cervicalgia (neck pain), pain in unspecified joint, secondary scoliosis, thoracic region (upper back) and low back pain. A minimum data set (MDS) assessment had not been completed at the time of the survey. According to the 3/24/26 brief interview for mental status (BIMS) assessment, Resident #74 was cognitively intact with a BIMS score of 15 out of 15. According to the 3/23/26 Functional Performance Observation assessment Resident #74 required substantial/maximal assistance with toileting, personal hygiene, sitting to lying, and was dependent on staff for bathing, dressing, rolling side to side, lying to sitting, sitting to standing, and transfers from bed to chair and to toilet. 2. Resident #74 and resident's representative interview On 3/23/26 at 10:30 a.m. Resident #74 and the resident's representative were interviewed. Resident 74's representative said Resident #74 arrived at the facility around 2:00 p.m. on 3/22/26. The resident's representative said the hospital gave Resident #74 a dose of IV vancomycin at 11:00 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3/21/26 and the next dose was due at 11:00 a.m. on 3/22/26 but they were discharged from the hospital in order to be admitted to the facility, so that dose was missed. The representative said the last dose of IV piperacillin was given at 8:00 a.m. at the hospital and the next dose was due to be given at 4:00 p.m. at the facility, which was missed as well. Resident #74, who said she had been a nurse, said it was important that the antibiotics continued as they were scheduled so there were consistent levels in her bloodstream. Resident #74 and her representative said no antibiotics had been administered since the resident was admitted to the facility on the previous day (3/22/26). 3. Record review Review of the hospital medication administration record (MAR) revealed the last dose of IV vancomycin was administered to Resident #74 at 11:26 p.m. on 3/21/26. The scheduled 11:00 a.m. dose of vancomycin on 3/22/26 was missed because of the resident's transfer to the facility. The hospital MAR revealed the last dose of IV piperacillin was administered at 8:41 a.m. on 3/22/26 and the scheduled 4:00 p.m. dose of piperacillin was missed as Resident #74 had been transferred to the facility. Review of the comprehensive care plan, initiated 3/22/26 at 7:11 a.m. (prior to the resident's admission to the facility), indicated Resident #74 had an IV for antibiotics related to a sepsis infection and staff were to administer antibiotics per the physician's orders. The infection surveillance assessment, dated 3/23/26 at 2:15 p.m., indicated Resident #74 was admitted to the facility on two IV antibiotics and was to continue the current antibiotic therapy related to an abscess in the epidural (area between vertebrae and spinal cord membrane) space. Review of Resident #74's March 2026 CPO revealed the following physician's orders: Piperacillin Sodium-Tazobactam intravenous solution four and a half (4.5) grams (gm) every eight hours for sepsis, ordered 3/22/26. Vancomycin hcl (hydrochloride) intravenous solution one (1) gm every 12 hours for sepsis, ordered 3/22/26. Call pharmacy: they will manage vancomycin trough (laboratory test to measure vancomycin level in the blood) and vancomycin dosage until 4/20/26 or until infectious disease (ID) will instruct us to stop vancomycin for cervical spine infection/discitis, ordered 3/23/26. -However, there was no documentation in Resident #74's electronic medical record (EMR) to indicate the pharmacy was contacted and no physician's order for a vancomycin trough was entered. Review of the pharmacy delivery packing slip, dated 3/22/26, indicated six doses of IV piperacillin and four doses of IV vancomycin were delivered to the facility for Resident #74 on 3/22/26 after 9:00 p.m. -However, neither of the antibiotics was administered to Resident #74 after they were delivered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note, dated 3/22/26 at 2:10 p.m., documented verbal consent was received from the on-call physician to continue Resident #74's vancomycin order after the missed 11:00 a.m. dose at the hospital. -However, despite the antibiotics being delivered to the facility later on the evening of 3/22/26, the IV vancomycin and the IV piperacillin were not administered. Review of Resident #74's March 2026 medication administration record (MAR) revealed the following documentation for the resident's IV piperacillin: -On 3/22/26 at 10:00 p.m., a dose of IV piperacillin was scheduled to be given to Resident #74 but was not administered; -On 3/23/26 a dose of IV piperacillin was scheduled to be started at 6:00 a.m. but was not administered until 9:26 a.m., even though the last dose of the medication at the hospital was given at 8:00 a.m. on 3/22/26. The delay resulted in a gap of 25 hours between doses of the IV medication. -On 3/23/26 the scheduled 2:00 p.m. dose of IV piperacillin was administered at 2:41 p.m., approximately 5 hours after the morning dose instead of the required every eight hour dosing. Review of Resident #74's March 2026 MAR revealed the following documentation for the resident's IV vancomycin: -On 3/23/26 a dose of IV vancomycin was scheduled to be started at 8:00 a.m., even though the last dose was given at the hospital on 3/21/26 at 11:00 p.m. The scheduled 8:00 a.m. dose on 3/23/26 was not administered until 11:54 a.m. resulting in a gap of 37 hours between doses that should have been administered every 12 hours. -On 3/23/26 at 8:00 p.m. a dose of IV vancomycin was administered at 8:08 p.m., roughly eight hours after the morning dose rather than the required 12 hour dosing. The nursing progress note, dated 3/23/26 at 10:50 a.m., documented Resident #74's 8:00 a.m. vancomycin was rescheduled related to the previous IV and (peripherally inserted central catheter) PICC line having a slow drip rate. The physician note, dated 3/23/26 at 7:54 p.m. documented The infectious disease (ID) team was consulted during the resident's hospitalization. Resident #74 arrived at the facility on IV vancomycin 1 gm twice daily and piperacillin/tazobactam 4.5 gm IV every eight hours. The resident's IV antibiotics were to be continued until 4/20/26. -However, there was no documentation to indicate, the facility or the physician had notified the ID team of the delays in administering the antibiotics to the resident. C. Staff interviews The director of nursing (DON), clinical resource nurse #1 and clinical resource nurse #2 were interviewed together on 3/25/26 at 9:35 a.m. The DON said when Resident #74 was admitted to the facility on [DATE], the admitting nurse failed to enter all of the physician's orders from the hospital's discharge documentation. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan, revised 7/30/24, revealed Resident #43 had hypertension and coronary artery disease. Pertinent interventions included giving anti-hypertensive medications as ordered and monitoring for side effects, including increased heart rate, orthostatic hypotension and effectiveness. Review of Resident #43's March 2026 CPO revealed the following physician's orders: Lisinopril 2.5 milligram (mg) oral tablet, give one tablet by mouth in the morning for hypertension, hold for systolic blood pressure (SBP) less than 110 millimeters of mercury (mmHg), ordered 11/19/25 and discontinued 12/23/25. Lisinopril 2.5 mg oral tablet, give one tablet by mouth at bedtime for hypertension, ordered 12/23/25. Metoprolol succinate 25 mg tablet, give one tablet by mouth at bedtime for hypertension; ordered 3/15/25. A progress note, dated 12/13/25 at 11:12 p.m., revealed Resident #43 had a physician's order for metoprolol succinate 25 mg tablets, give one tablet by mouth at bedtime for hypertension, hold for SBP less than 110 or heart rate less than 60 beats per minute(BPM). -However, the parameters to hold the medication were not included in the December 2025 CPO. A nurse practitioner's note, dated 12/29/25 at 8:57 a.m., revealed Resident #43's medications were reviewed and reconciled by the nurse practitioner. Resident #43's medication orders included metoprolol succinate 25 mg tablet, give one tablet by mouth at bedtime for hypertension, hold for SBP less than 110 mmHg or heart rate less than 60 BPM. -However, the parameters to hold the medication were not included in the December 2025 CPO. A physician's note, dated 1/22/26 at 9:45 a.m., revealed Resident #43's medications were reviewed and reconciled by her physician. Resident #43's medication orders included metoprolol succinate 25 mg tablet, give one tablet by mouth at bedtime for hypertension, hold for SBP less than 110 mmHg or heart rate less than 60 BPM. -However, the parameters to hold the medication were not included in the January 2026 CPO and did not match the physician's orders the nursing staff were following, as documented in Resident #43's progress notes (see below). A progress note, dated 1/23/26 at 12:03 a.m., revealed Resident #43 had a physician's order for metoprolol succinate 25 mg tablets, give one tablet by mouth at bedtime for hypertension, hold for SBP less than 100 mmHg or heart rate less than 60 BPM. -However, the parameters to hold the medication were not included in the January 2026 CPO. A nurse practitioner's note, dated 2/23/26 at 1:24 p.m., revealed Resident #43's medications were reviewed and reconciled by the nurse practitioner. Resident #43's medication orders included metoprolol succinate 25 mg tablet, give one tablet by mouth at bedtime for hypertension, hold for SBP less than 110 mmHg or heart rate less than 60 BPM. -However, the parameters to hold the medication were not included in the February 2026 CPO. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse practitioner's note, dated 3/13/26 at 2:00 p.m., revealed Resident #43's medications were reviewed and reconciled by the nurse practitioner. Resident #43's medication orders included metoprolol succinate 25 mg tablet, give one tablet by mouth at bedtime for hypertension, hold for SBP less than 110 mmHg or heart rate less than 60 BPM. -However, the parameters to hold the medication were not included in the March 2026 CPO. Review of Resident #43's December 2025 medication administration record (MAR), from 12/1/25 through 12/31/25, revealed the following: -On 12/2/25 the resident's blood pressure (BP) measured 107/60 mmHg and metoprolol was marked as administered; -On 12/8/25 the resident's BP measured 108/56 mmHg and metoprolol was marked as administered; and, -On 12/29/25 the resident's BP measured 100/54 mmHg and metoprolol was marked as administered. -However, Resident #43's metoprolol order had physician ordered parameters to hold the medication for any SBP below 110 mmHg (see physician's orders and progress notes above). Medication regimen review notes, dated 12/10/25, revealed the following pharmacist's recommendations: Resident #43 had a physician's order to hold Lisinopril 2.5 mg tablets for low BP, however the BP was not being documented on the MAR prior to medication administration. The pharmacist recommended that the supplementary documentation be added to the physician's order. The pharmacist requested that the facility follow the facility's policy for documenting the following medication error: Resident #43 had an order for metoprolol 25 mg, hold for SBP less than 110 mmHg or heart rate less than 60 BPM. However, the medication was given on the following days outside of the hold parameters: on 12/2/25 BP was 107/60 mmHg and 12/8/25 BP was 108/56 mmHg. Review of Resident #43's January 2026 MAR, from 1/1/26 through 1/31/26, revealed the following: -On 1/3/26 the resident's BP measured 105/62 mmHg and metoprolol was marked as held; -On 1/7/26 the resident's BP measured 109/68 mmHg and metoprolol was marked as held: -On 1/15/26 the resident's BP measured 107/57 mmHg and metoprolol was marked as held; and, -On 1/22/26 the resident's BP measured 104/66 mmHg and metoprolol was marked as held. -However, Resident #43's metoprolol order had parameters to hold the medication for a SBP lower than 100 mmHg. Medication regimen review notes, dated 1/10/26, revealed the following pharmacist recommendations: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #55's March 2026 CPO revealed the following physician's orders: Amlodipine besylate 5 mg tablet, give one tablet by mouth two times a day for hypertension, ordered 3/8/26 and discontinued 3/16/26. Isosorbide dinitrate 5 mg oral tablet, give one tablet by mouth three times a day for hypertension, ordered 3/8/26 and discontinued 3/10/26. Isosorbide dinitrate 5 mg oral tablet, give one tablet by mouth two times a day, hold for SBP less than 110, ordered 3/10/26. Sotalol 80 mg tablets, give 40 mg by mouth two times a day for hypertension, ordered 3/8/26. Review of Resident #55's March 2026 blood pressure records, from 3/8/26 through 3/26/26, revealed the following: -On 3/8/26 at 5:58 p.m. the resident's BP was 93/59 mmHg; -On 3/8/26 at 6:14 p.m. the resident's BP was 93/59 mmHg; -On 3/8/26 at 10:35 p.m. the resident's BP was 121/61 mmHg; -On 3/11/26 at 2:02 p.m. the resident's BP was 105/62 mmHg; -On 3/16/26 at 9:44 p.m. the resident's BP was 105/62 mmHg; -On 3/19/26 at 11:36 p.m. the resident's BP was 107/60 mmHg; -On 3/22/26 at 8:36 p.m. the resident's BP was 108/60 mmHg; and, -On 3/26/26 at 1:07 a.m. the resident's BP was 103/60 mmHg. Review of Resident #55's March 2026 MAR, from 3/8/26 through 3/26/26, revealed the following: -The resident received doses of amlodipine, isosorbide and sotalol on the evening of 3/8/26; -The resident's isosorbide was administered on 3/11/26 during the morning shift and on 3/16/26, 3/19/26, 3/22/26 and 3/25/26 during the evening shifts; and, -The resident did not receive her scheduled dose of sotalol on 3/24/26. -However, Resident #55's SBP was below the 110 mmHg hold parameter in the physician's order during these medication administrations. -Review of the resident's electronic medical record (EMR) did not reveal any documentation of the physician being contacted regarding the resident's low blood pressure prior to administration of her hypertensive medications on 3/24/26. A progress note, dated 3/25/26 at 4:27 a.m., revealed Resident #55's sotalol medication was not (continued on next page)

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	065388	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at St. Andrews Village	2670 S Abilene St Aurora, CO 80014

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered. The note documented the facility was waiting for the medication to be delivered. -Review of Resident #55's progress notes did not reveal any documentation of Resident #55's physician or the pharmacy being contacted regarding the missing medication. 3. Staff interviews The nursing home administrator (NHA) was interviewed on 3/25/26 at 4:14 p.m. The NHA said the nursing staff had all been trained on the facility's procedures for when a medication ran out. The NHA said the nursing staff had been informed of who to contact at the facility's pharmacy if they were out of medications, and any agency staff nurse had a list of pharmacy contact information available to them. LPN #4 was interviewed on 3/26/26 at 9:42 a.m. LPN #4 said if she ran out of a medication, she would call the pharmacy and the resident's physician to notify them about the missing medication and document this information in the resident's progress notes. The DON was interviewed on 3/25/26 at 3:48 p.m. The DON said when a medication was unavailable, the nurse should contact the resident's physician and the pharmacy to notify them the medication was out of stock, and the physician would usually put the medication on hold or give further orders. The DON said the nurse would also need to monitor the resident for any changes related to the missing medication. The DON said Resident #55's physician should have been contacted on 3/24/26 when the resident's sotalol medication was unavailable.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interviews, the facility failed to ensure mechanical equipment was in safe, operational condition.Specifically the facility failed to ensure one of three washing machines in the facility's laundry room was in appropriate operational condition.Findings include:I. Observations On 3/25/26 at 8:50 a.m. an observation of the facility's laundry room revealed the following:Behind washing machine #1, four floor tiles were detached with water underneath them. A portable blower (industrial dryer) was set up behind washing machine #1 and pointed towards the detached tiles.Behind washing machine #3 was a puddle of water underneath a supply hose. A rolled up blanket was tucked to the left side of washing machine #3 and another blanket was tucked in the front of washing machine #3. Underneath the blankets, water was observed.II. Staff interviewsThe laundry aide was interviewed on 3/25/26 at 9:00 a.m. The laundry aide said she had worked at the facility in the laundry room for seven months. She said the leak behind the washing machines had been going on the entire time she had worked in the facility and the maintenance director (MTD) was aware of the issue. The laundry aide said she put a new rolled up blanket in the front and the side of washing machine #3 every morning to prevent the water from coming out onto the floor and creating a fall hazard. A representative with the facility's laundry chemical supply provider was interviewed on 3/25/26 at 12:45 p.m. The representative said his company managed the laundry chemicals and any repairs to the equipment associated with the chemicals and refilling the chemicals. The representative said he had repaired the supply hose on washing machine #3 when he came out on 3/25/26 at 11:30 a.m. (during the survey) as a favor because it only needed a new washer (a simple mechanical component that is used in conjunction with a bolt, screw, or nut). He said his company was not responsible for any mechanical repairs to the washing machines, including the supply hose. He said when he came out to the facility on 1/15/26, he did observe water behind the washing machines but could not recall if he had told anyone. The MTD was interviewed on 3/26/26 at 9:40 a.m. The MTD said that he supervised the housekeepers, the laundry staff and any as needed (PRN) maintenance staff. He said he was responsible for basic inspections of the washers and dryers in the laundry room. The MTD said the technician from the facility's laundry chemical supply provider had come out on 3/25/26 (during the survey) and replaced a washer in the supply hose of washing machine #3 (where the leak was coming from). He said the laundry chemical supply provider was responsible for refilling the laundry chemicals and any service to the equipment which distributed those chemicals into the washing machines. The MTD said the supply hose maintenance was a facility responsibility. The MTD could not explain why he had not made the repairs himself prior to the survey. The MTD said he and the laundry aide had put the portable blower behind the washing machines to address the water coming from the leak in the supply hose, but he could not recall exactly when the blower had been put back there. He said he was aware of the detached tiles behind the washing machines and said the tiles had been that way since the facility's acquisition by another corporation on 6/1/24. The MTD said he conducted monthly inspections of the laundry room machines and washing machine #3 had been leaking on and off since February 2026. He said he should have gone to the home repair store and purchased supplies to repair the leaking hose but he had not done so. The MTD said that the laundry aide had put blankets around washing machine #3 to prevent water from leaking outward and causing safety and trip hazards, however, he said this was not an appropriate way to address a leak.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, sanitary, functional and comfortable environment for the residents. Specifically the facility failed to:-Ensure one of four resident shower rooms was free of deterioration and water damage and had a properly operational shower head;-Ensure resident room corridors were free of deterioration and water damage;-Ensure one of 12 resident rooms had a properly operational sink faucet; and, -Ensure two of 12 resident personal bathrooms were free of deterioration and water damage.Findings include:I. Failure to ensure one of four resident shower rooms was free of deterioration and water damage and had a properly operational shower head A. Observations On 3/23/25 at 9:12 a.m., the facility's [NAME] One shower room was observed. The shower room had four 12 by12 inch tiles on the lowest part of the shower wall, held to the wall with six strips of vertical duck tape. The tile closest to the exit door had a gap of one half an inch with a visible black substance underneath. When light pressure was applied to the last tile, it bowed inward toward the surface underneath the tile. The corner of the shower room wall, closest to the exit door, revealed signs of warping and there was peeling paint to the wall above the baseboard. There were signs of warping and peeling paint around the door stop of the exit door. The inner doorframe of the exit door, from the bottom of the door to approximately five inches up the door, revealed discoloration, peeling paint and soft wood. The exterior door frame of the exit door (facing the exterior hallway), from the bottom of the door to approximately five inches up the door, revealed discoloration, peeled and missing paint and exposed soft wood with disintegrated wood flakes on the carpet.Additionally, the shower head in the [NAME] One shower room had a continuous, steady leak dripping down the wall and onto the floor with a visible puddle of water. On 3/23/25 at 1:51 p.m. the facility's [NAME] One shower room was observed. The shower head had a continuous, steady leak dripping down the wall and onto the floor with a visible puddle of water.On 3/24/26 at 8:42 a.m. the facility's [NAME] One shower room was observed. The shower head had a continuous, steady leak dripping down the wall and onto the floor with a visible puddle of water. On 3/24/26 at 11:29 a.m. the facility's [NAME] One shower room was observed. The shower head had a continuous, steady leak dripping down the wall and onto the floor. B. Record reviewOn 3/24/26 at 9:45 a.m., the maintenance director (MTD) provided a typed timeline he had created showing the process of repairs to the [NAME] One shower room. The timeline revealed that staff had notified him of the loose wall tiles in the shower room on 3/4/26. The MTD began working on cleaning and replacing the tiles on 3/4/26 and had continued to work on the tile repair (between staff using the shower room for showering residents) up until the day of the survey entrance on 3/23/26. Between 3/4/26 and 3/23/26, the MTD had worked in the [NAME] One shower room seven times. On 3/25/26 at approximately 10:00 a.m. the MTD provided a print out of all the closed work orders from 1/1/26 to 3/24/26. Work order #1172, for a shower without pressure in the [NAME] One shower room, was highlighted in the work order history.-However, there was no date for when the work order was submitted or completed. On 3/25/26 at approximately 11:30 a.m. the MTD provided a print out of a supply purchase order for a shower cartridge and a new handheld shower head, which was scheduled to arrive at the facility on 3/25/26. -However, there was no date on the purchase order for when the order for the shower cartridge and a new handheld shower head was placed. C. Staff interviews and observations Certified nurse aide (CNA) #1 was interviewed on 3/24/26 at 8:42 a.m. CN! #1 said she worked on the [NAME] One hallway and she was also a shower aide. CNA #1 said the loose tiles and water damage in the shower room had been there for at least a month. CNA #1 said the leaking shower head in the shower room had been that way for at least a month. The [NAME] One shower room was observed with the MTD on 3/24/26 at 12:50 p.m. The MTD said the housekeeping staff cleaned the shower room daily and he was aware of the water damage to the tiles and walls. He said he had been working on (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	replacing the tiles for two weeks. The MTD said he had to do the repairs between residents continuing to be showered in the [NAME] One shower room. He said he did not have documentation of his repairs to the shower room and he had not been providing documentation to the nursing home administrator (NHA) of his progress with the shower room's repairs. The MTD said he was not aware of the shower head leak in the [NAME] One shower room.The [NAME] One shower room was observed with the NHA on 3/25/26 at 8:45 a.m. The NHA said the [NAME] One shower room would be closed and the [NAME] Two shower room would be the only shower room used on the facility's [NAME] unit until the water damage to the interior and exterior of the [NAME] One shower room were addressed. The MTD and the regional plant resource were interviewed together on 3/26/26 at 9:40 a.m. The MTD said he started to notice the leak in the [NAME] One shower head the week prior to the survey (the week of 3/16/26). He said he had purchased a replacement shower head and installed it on 3/20/26, however, he had no documentation of the purchase, the installation or a work order. The MTD said during the survey, it was determined the [NAME] One shower head needed a cartridge (a component of the shower system that regulates water flow from the showerhead) replacement. The MTD said continuous leaks could create water damage and compromise surfaces.The MTD acknowledged that due to a leak in the shower head and the staff's use of the shower room on a daily basis, the prolonged water saturation would compromise the adhesiveness of the duct tape holding the tiles to the shower wall. He said after observing the shower room during the survey, he determined the project needed more extensive work and made his regional plant resource aware. The MTD said it was his decision to not close down the [NAME] One shower room to expedite the repairs and ensure the tiles were secured to the backing board. The MTD was unable to give a reason for this decision, but he said it was a mistake and he should have closed down the shower room. He said the [NAME] One shower room was now closed until it was fully repaired. The regional plant resource said that he was unaware of the repairs the MTD was doing in the [NAME] One shower room prior to the survey and when he came in to inspect the repairs, he said he found the surface behind the tiles to be compromised from water damage. He said the tiles had since been removed, the backing board repaired and new tiles placed. The regional plant resource said if ,while showering residents, the staff were to hit the wall with a shower chair, it would have caused the tiles to collapse inwards from the water damage. II. Failure to ensure resident room corridors were free of deterioration and water damageA. Observations On 3/23/25 at 9:12 a.m. the corridor outside the [NAME] One shower room revealed an area of the carpet below the wood frame, and running along approximately six inches of the baseboard, that was discolored, soft and damp. C. Staff interviews and observationsThe corridor outside the [NAME] One shower room was observed with the MTD on 3/24/26 at 12:55 p.m. The MTD said he was not aware of the water damage to the exterior baseboard and the carpet. He said the damage would have resulted from leaks in the shower room. The MTD was interviewed again on 3/26/26 at 9:40 a.m. The MTD said he had noticed the water damage to the exterior baseboard and carpet outside the [NAME] One shower room and had used carpet fans to attempt to dry the area. The MTD said he was waiting to finish the repairs inside the shower room first before repairing the exterior corridor and he had obtained bids on a new carpet. -However, the MTD did not provide documentation of the bids for the carpet replacement.III. Failure to ensure one of 12 resident rooms had a properly operational sink faucet. A. Observations On 3/24/26 at 11:45 a.m. resident room [ROOM NUMBER] was observed. The observation revealed a dripping bathroom sink faucet B. Staff interviews and observationsroom [ROOM NUMBER]'s resident bathroom was observed with the MTD on 3/24/26 at 12:50 p.m. The MTD said he had not been made aware of the bathroom sink faucet drip and had not received a work order to repair it. The MTD said his housekeepers cleaned the residents' bathrooms daily, to include the sinks, and he would have expected the housekeepers to submit a work order or verbally tell him about the leaking faucet in room [ROOM NUMBER]'s bathroom. IV. Failure to ensure two of 12 resident personal bathrooms were free of deterioration and water damageA. ObservationsOn 3/24/26 at 11:58 a.m., two resident rooms (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the facility's [NAME] unit were observed. room [ROOM NUMBER] had a triangular area from the resident's personal bathroom ceiling to the exhaust vent and around the vent of peeled and missing paint. The area was approximately two feet wide by six inches long. room [ROOM NUMBER] had an area on the resident's personal bathroom wall of approximately three feet long by two feet wide of discolored, bubbled and peeling paint. B. Staff interviews and observationsroom [ROOM NUMBER] and room [ROOM NUMBER] were observed with the MTD on 3/24/26 at 1:05 p.m. The MTD identified the damage to the bathroom walls in the rooms as being caused by water damage and said he had not been aware of the damage and the staff had not submitted a work order for the damage. He said a few months prior, there was a toilet leaking on the second floor that probably was the cause of the water damage, but he could not pull up the work order for the toilet to show when that leak was reported and repaired. The MTD and the regional plant resource were interviewed together on 3/26/26 at 9:40 a.m. The MTD said his housekeepers cleaned the residents'personal bathrooms daily but had never reported to him the water damage to the walls in room [ROOM NUMBER] and room [ROOM NUMBER]. He said after observing the water damage, during the survey, he believed it resulted from the second floor's previously leaking toilet. The regional plant resource was able to pull the work order report showing the ticket for the leaking toilet was opened on 1/17/26 and completed 1/19/26.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure adequate outside ventilation by means of windows, or mechanical ventilation for three out of 12 residents' personal bathrooms. Specifically, the facility failed to ensure ventilation fans were kept operational in the resident personal bathrooms.Findings include:I. Professional referenceAccording to the United States (U.S.) Department of Energy's Office of Energy Efficiency and Renewable Energy, April 2021 retrieved on 3/30/26 from: https://docs.nrel.gov/docs/fy21osti/79150.pdf., Proper ventilation helps reduce the concentration of bioaerosols (bioaerosols consist of aerosols originated biologically such as metabolites, toxins, or fragments of microorganisms), which can be particularly important in nursing homes due to the presence of vulnerable adults. Good ventilation can improve the health and well-being of the residents by reducing infection risks and preventing respiratory issues. By ensuring proper ventilation, nursing homes can significantly enhance the safety and quality of life for their residents. II. Observations On 3/24/25 at 11:58 a.m. three resident personal bathrooms were observed. In room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER], the resident personal bathroom ventilation systems revealed there was no air flow present.III. Staff interviews and observations Rooms #110, room [ROOM NUMBER] and room [ROOM NUMBER] were observed with the maintenance director (MTD) on 3/24/26 at 1:05 p.m. The MTD said he was not aware of decreased air flow in the vents in the three rooms. The MTD said the facility used a mechanical ventilation system. He said the ventilation system prevented airborne contaminants within the facility. The MTD said to ensure the ventilation system was working properly in the bathrooms, a piece of tissue paper could be put up to the vent. The MTD said if there was proper air flow, the tissue paper would be pulled to the vent. During the observation, the MTD held tissue paper up to the vents, however the tissue papers were not pulled into the vents in room [ROOM NUMBER], room [ROOM NUMBER] or room [ROOM NUMBER]. In room [ROOM NUMBER], the MTD removed the vent cover and had to put his hand, up to the wrist, into the vent opening to detect any sense of air flow. The MTD said he was unable to explain the reason for the decreased air flow in the resident personal bathrooms. On 3/25/26 at approximately 10:00 a.m., the MTD provided a work history report of inspections he had completed on the exhaust fans. The work history report revealed an inspection was completed on the exhaust fans on 3/20/26. -However, the report did not reveal which specific resident personal bathroom exhaust fans were inspected.