STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065397	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Cont Care Sr Campus, Skilled Nursing	1919 68th Ave Greeley, CO 80634

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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 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. Based on observations, record review and interviews, the facility failed to ensure proper storage of medications in one of two medication storage rooms and two of three medication storage carts.Specifically, the facility failed to:-Ensure medications were labeled with accurate dates opened; and,-Ensure expired medications were removed and discarded from medication carts and storage rooms.Findings include:I. Professional referenceThe United States Food and Drug Administration (USFDA) (10/31/24) Don't Be Tempted to Use Expired Medications, was retrieved on 2/27/26 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.II. Manufacturer's recommendationsAccording to the manufacturer's recommendations for Lantus (glargine) insulin, retrieved on 2/27/26 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/021081s078s079lbl.pdf, Lantus insulin is a long-acting human insulin analog indicated to improve glycemic control in adult and pediatric patients with diabetes mellitus. Storage: 10 milliliter (ml) multiple dose vials, in-use and opened, should be stored for 28 days in the refrigerator or at room temperature.III. Facility policy and procedureThe Storage of Medications policy and procedure, dated September 2016, was provided by the nursing home administrator (NHA) on 2/26/26 at 10:46 a.m. It read in pertinent part, Medications will be stored in a secured manner that will provide a safe environment for residents and avoid misplacing and diversion. No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing pharmacy or destroyed in accordance with the procedure governing the destruction of medication.IV. Observations and interviewsOn 2/24/26 at approximately 3:10 p.m., the first floor medication storage room was observed with the assistant director of nursing (ADON). The following items were found:Two bottles of Vitamin B12 100 micrograms (mcg) with an expiration date of July 2025.The ADON was interviewed on 2/24/26 at 3:29 p.m. The ADON said her expectation was for staff to check the medication expiration dates when pulling floor stock from the storage closet, and again before administering any medications to residents. The ADON said she was unsure why expired Vitamin B12 was in the storage closet.On 2/24/26 at 3:37 p.m., the first floor front hallway medication cart was observed with licensed practical nurse (LPN) #2. The following items were found:An open, resident-labeled box containing a 10 mL multi-dose vial of Lantus insulin, with an expiration date of October 2027. -An open date was not written on the vial of insulin or the box it was contained in. An open bottle of One Daily Women's Vitamins, that had a current resident's name written on it, with an expiration date of September 2024. LPN #2 was interviewed on 2/24/26 at approximately 3:45 p.m. LPN #2 confirmed an open date was not written on the insulin vial or box. LPN #2 said she was the one who initially opened the vial, 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she forgot to write the date she opened it. LPN #2 confirmed the resident had been administered Lantus insulin after the vial was opened, even though there was no open date documented. LPN #2 said it was important to write the open dates to know when medications should be discarded and prevent dispensing expired medications. LPN #2 said the once daily vitamins were provided by the resident's family, and the resident had not taken them in a while. LPN #2 confirmed the vitamins should have been discarded.On 2/25/26 at 2:44 p.m., the second floor medication cart was observed with LPN #3. The following items were found:An open box of Lumigan 0.01% eye drops (medicated drops used to lower eye pressure), labeled for Resident #14. The box had the date 1/4/26 written on it. Inside the box was an opened bottle of Lumigan 0.01% eye drops. The bottle had the date 12/25/25 written on it. LPN #3 was interviewed on 2/25/26 at approximately 3:00 p.m. LPN #3 confirmed there were two separate open dates (see above) written on Resident #14's Lumigan 0.01% eye drops. LPN #3 said she was unsure why different dates were written. LPN #3 confirmed Resident #14 had a current order for Lumigan eye drops, and said Resident #14 normally received the medication at night. The director of nursing (DON) was interviewed on 2/25/26 at 3:33 p.m. The DON said it was not appropriate for two separate open dates to be written on resident medications. The DON said it was important staff accurately labeled medications with open dates to ensure medication effectiveness and when medications needed discarding to help prevent potential negative side effects. The DON said she was not aware of the expired Vitamin B12 or the undated insulin that were found. The DON said the potential risks of giving expired medications were decreased effectiveness and/or increased side effects.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection. Specifically, the facility failed to ensure facility staff followed appropriate infection control practices and hand hygiene when providing wound care to Resident #1 and Resident #46.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers, updated 2/27/24, retrieved on 3/4/26 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html: Know when to clean your hands: immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal.Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings, always clean your hands after removing gloves, remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil your hands.II. Facility policy and procedureThe Nursing Procedures Caring for Wounds policy and procedure was received from the nursing home administrator (NHA) on 2/26/26 at 10:46 a.m. It read in pertinent part, Wound care will be done in a manner that reflects infection control practices and promotes healing while following physician orders or facility protocols that have been approved by the attending physician.Wound Care: Establish a sterile field, including equipment and supplies, sterile dressing set, and povidone-iodine swabs. If ointment is ordered, squeeze the amount needed onto a sterile field. If using antiseptic from an unsterile bottle, pour antiseptic cleaning agent into a sterile container so gloves will not become contaminated. Avoid using cotton balls as they may shed particles in the wound. Obtain wound culture, if ordered, before cleaning the wound.III. Observations and staff interview On 2/26/26 at 8:30 a.m. licensed practical nurse (LPN) #1 was observed performing wound care on Resident #1's right second toe wound, with the assistance of the director of nursing (DON). The following observations were made:LPN #1 was in the first floor medication room, retrieving wound care supplies from the wound cart. LPN #1 obtained a spray bottle of wound cleanser, one pack of four inch by four inch (4 by 4) gauze, one sealed povidone-iodine swab (antiseptic topical treatment), and one bandaid. LPN #1 exited the medication room and entered Resident #1's room. Upon entering the resident's room, Resident #1 was sitting at the side of her bed with her bedside table next to her. LPN #1 placed the wound care supplies on top of Resident #1's bedside table, next to approximately seven to eight of Resident #1's personal items on top of the table. LPN #1 performed hand hygiene and donned a gown and gloves. The DON removed four items closest to the wound care supplies from Resident #1's bedside table and placed them on the resident's dresser. -LPN #1 failed to establish a clean field for wound care supplies on top of Resident #1's bedside table by removing the resident's personal items from her bedside table, disinfecting the table surface, or placing a Chux pad (disposable moisture absorbent pad) on the table, prior to setting the clean wound care supplies down on the bedside table. LPN #1 returned to Resident #1's bedside. Resident #1's left leg was resting on her bed, and her left foot was hanging over the side of the bed. LPN #1 squatted down in front of Resident #1 and placed her gloved left hand on the resident's bed. LPN #1 removed the previous band-aid covering Resident #1's wound and discarded it into a trash bin next to the resident's bedside table. The DON entered Resident #1's bathroom and exited carrying a folded hand towel with ungloved hands. The DON unfolded the towel and placed it on Resident #1's bed near her left leg. -LPN #1 failed to change her gloves or perform hand hygiene after touching Resident #1's bed and before removing the old band-aid dressing from the resident's wound. -Additionally, LPN #1 failed to establish a clean field underneath Resident #1's left leg before she initiated wound care. -The DON failed to don gloves before grabbing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and handling the hand towel and placing it on Resident #1's bed. LPN #1 discarded her gloves and donned a new pair of gloves. LPN #1 used her left gloved hand and elevated Resident #1's leg by supporting her heel. LPN #1 used her right gloved hand, grabbed the rim of the trash can, and pushed the trash can directly underneath Resident #1's left foot. LPN #1 grabbed various edges of the hand towel and repositioned it directly underneath Resident #1's left leg. LPN #1 opened the 4 by 4 gauze, removed the gauze from the package, and grabbed the bottle of wound cleanser. LPN #1 held the gauze underneath Resident #1's toes and sprayed the wound six times with the wound cleanser. -LPN #1 failed to perform hand hygiene between changing her gloves. -Additionally, LPN #1 failed to change her gloves and perform hand hygiene after touching the trash can, repositioning the towel, and opening the supplies before she began cleansing the resident's wound. LPN #1 said she needed additional 4 by 4 gauze. The DON exited Resident #1's room, then quickly re-entered and told LPN #1 she needed the medication storage keys. LPN #1 removed and discarded her gown and gloves, retrieved her keys from her scrub pocket, and handed them to the DON. The DON exited Resident #1's room and returned approximately one to two minutes later with approximately two to four individually wrapped 4 by 4 gauze pads. LPN #1 donned a new gown and gloves. LPN #1 retrieved the wound cleanser and opened two packages of 4 by 4 gauze. LPN #1 sprayed Resident #1's wound five times with the wound cleanser. LPN #1 folded over a gauze pad, placed it between Resident #1's first and second left toes, dabbed the wound approximately two to three times, and discarded the gauze. LPN #1 opened another package of gauze, dabbed the wound three times to dry it, then discarded the gauze.-LPN #1 failed to perform hand hygiene after she removed her gown and gloves, and handed her keys to the DON. -Additionally, LPN #1 failed to perform hand hygiene before donning a new gown and gloves and resuming wound care. LPN #1 discarded her gloves and donned a new pair of gloves. LPN #1 opened the povidone-iodine swab package, removed the swab, dabbed the resident's wound with the swab eight times, then discarded the swab in the trash can. LPN #1 waited approximately one minute and 15 seconds for the povidone-iodine to dry, opened the band-aid, and applied it to Resident #1's wound. LPN #1 removed and discarded her gown and gloves, dated Resident #1's dressing, and assisted the resident with putting on non-skid socks. LPN #1 discarded any residual supply trash and placed the wound cleanser in the bottom drawer of a plastic storage bin in the resident's bathroom. LPN #1 performed hand hygiene and exited Resident #1's room. -LPN #1 failed to perform hand hygiene before she donned a new pair of gloves.LPN #1 was interviewed on 2/26/26 at 8:49 a.m. LPN #1 said staff should perform hand hygiene before and after preparing/administering any medications or treatments. LPN #1 said hand hygiene was not needed in between glove changes because she cleansed her hands beforehand and changed her gloves. LPN #1 was unaware that hand hygiene needed to be performed after glove changes. LPN #1 said establishing a clean field depended on whether the procedure was a sterile or clean process. LPN #1 said the area around a resident's wound and/or wound care supplies should be clear of resident belongings or other objects. LPN #1 said it was important to help with infection control processes. On 2/26/26 at 10:58 a.m. LPN #3 was observed performing wound care on Resident #46's left hand skin tear, with the assistance of the DON. The following observations were made:LPN #3 obtained a handled plastic bin containing various wound care supplies from the medication room. LPN #3 pulled approximately three pairs of gloves from a box of gloves in the medication room and placed them on top of the supplies in the plastic bin. LPN #3 exited the room and headed towards Resident #46's room. LPN #3 said the plastic bin was the general wound care bin for the unit.LPN #3 and the DON entered Resident #46's room. The DON removed items from Resident #46's bedside table and placed them on his dresser. LPN #3 entered Resident #46's bathroom and grabbed a folded hand towel hanging next to the resident's sink. LPN #3 exited the bathroom, placed the towel on top of the resident's bedside table, then placed the bin of wound care supplies on top of the towel. LPN #3 removed the following items from the plastic bin and placed them on the top of the towel: a bottle of hand sanitizer, two individually sealed 4 by 4 gauze pads, two individually sealed non-adhesive pads, and one roll of Kerlix (absorbent wound dressing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Kerlix was already opened and stored in a large plastic bag inside the plastic wound care bin. Three opened rolls of Kerlix were inside the bag. While removing the Kerlix from the plastic bag, the roll fell and touched Resident #46's left forearm. LPN #3 grabbed the Kerlix and placed it in the plastic bin, on top of sealed wound care supplies. LPN #3 gathered the gloves she obtained in the medication room (see above), balled them up with her right hand, and placed them on the towel. LPN #3 performed hand hygiene and donned gloves. LPN #3 unwrapped the old Kerlix dressing on Resident #46's left hand and discarded it in a trash bin next to the bedside table. An old Xeroform gauze dressing (non-adherent, petrolatum impregnated wound care dressing) was on the resident's left hand. LPN #3 retrieved a bottle of wound cleanser from the plastic bin. LPN #3 sprayed the Xeroform gauze to saturate it and assist with removal, holding the wound cleanser approximately one to two inches away from the dressing. LPN #3 removed the Xeroform dressing and discarded it. LPN #3 discarded her gloves and performed hand hygiene.LPN #3 donned new gloves, opened two packages of 4 by 4 gauze, and placed them on top of the towel. LPN #3 retrieved one 4 by 4 gauze and saturated it with wound cleanser. LPN #3 patted the wound and wound perimeter with the gauze 14 times, then discarded the gauze. LPN #3 retrieved the second 4 by 4 gauze, patted the wound and wound perimeter nine times, folded the gauze, patted the wound seven times, then discarded the gauze and her gloves. LPN #3 donned a new pair of gloves and retrieved a closed Xeroform gauze and scissors from the plastic bin. LPN #3 opened the Xeroform gauze, used the scissors to cut an approximately two by three inch strip, and placed the Xeroform on top of Resident #46's wound. LPN #3 opened the two absorbent pad dressings and placed them on top of the Xeroform dressing. LPN #3 retrieved one of the opened rolls of Kerlix gauze from the plastic bag and began wrapping it over the absorbent pads and around Resident #46's hand. The DON assisted by elevating and supporting Resident #46's left arm with her left hand underneath his forearm and her right hand underneath his fingers. After sufficiently wrapping the resident's left hand, LPN #3 retrieved the scissors and cut off the extra Kerlix gauze. LPN #3 placed the additional Kerlix gauze in the plastic bin, on top of sealed wound care supplies. LPN #3 retrieved a roll of paper tape from the plastic bin, tore off approximately two to three strips of tape, and applied strips to the Kerlix gauze to secure it. LPN #3 discarded her gloves, obtained a pen from her pants pocket, and dated the dressing. -LPN #3 failed to perform hand hygiene before donning a new pair of gloves. -LPN #3 failed to maintain a clean field by using gloved hands to open, then apply, wound care treatments and dressings. -LPN #3 failed to sanitize scissors before using them to cut Xeroform and Kerlix dressings. -Additionally, the DON failed to don gloves before she assisted with elevating Resident #46's left arm. LPN #3 picked up the extra tape, Xeroform dressing, hand sanitizer, and wound cleanser, and placed the supplies in the plastic bin. LPN #3 removed the hand towel from the resident's bedside table and placed it in a plastic trash bag inside Resident #46's bathroom. The DON obtained a disposable washcloth wipe from a package located in Resident #46's bathroom, wiped off the resident's bedside table, discarded the wipe, and then moved the resident's personal items from his dresser back to his bedside table. LPN #3 discarded her gloves and performed hand hygiene. The DON removed the trash bag from Resident #46's trash can, placed it in the resident's bathroom, then performed hand hygiene. -LPN #3 placed used wound care supplies on top of, or around, unopened supplies, potentially cross-contaminating the other supplies. -The DON failed to use an antiseptic wipe to disinfect and cleanse Resident #46's bedside table. LPN #3 picked up the trash bag, the bag with the hand towel, the scissors, and the plastic wound care bin, and exited Resident #46's room. LPN #3 walked to the nurses' station and placed the used scissors and plastic wound care supply bin on a desk at the station. LPN #3 walked to the dirty utility room to discard the trash bag and put the hand towel in the laundry basket. LPN #3 performed hand hygiene, exited the dirty utility room, and returned to the nurses' station. LPN #3 unlocked the medication room and retrieved a container of Micro-kill One antiseptic wipes. LPN #3 donned gloves and obtained an antiseptic wipe. LPN #3 wiped all sides of the hand sanitizer bottle and placed it on the desk. LPN #3 retrieved the bottle of wound cleanser, wiped all sides of the bottle with the same antiseptic wipe, (continued on next page)

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