

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Continuing Care at Wind Crest		STREET ADDRESS, CITY, STATE, ZIP CODE 3420 Mill Vista Rd Highlands Ranch, CO 80129	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 on two of four halls. Specifically, the facility failed to:-Ensure staff performed hand hygiene during medication pass; -Ensure medications were administered in a sanitary manner;-Ensure vital signs equipment was sanitized between resident use;-Ensure respiratory equipment was stored in a sanitary manner; and,-Ensure infection control practices were followed during wound care. Findings include:I. Medication pass failuresA. Facility policy and procedureThe Medication Administration policy, revised October 2023, was provided by the nursing home administrator (NHA) on 6/16/26 at 11:48 a.m. It read in pertinent part, Medications are administered in accordance with nursing standards of practice and state law. Medication will be administered using appropriate infection control and prevention practices.B. ObservationsOn 6/15/26 at 8:30 a.m. licensed practical nurse (LPN) #1 was observed preparing medications to administer to Resident #44, who was seated at a dining room table. LPN #1 did not perform hand hygiene prior to preparing the medications. LPN #1 placed the medication cup containing several tablets on the dining room table then bumped the cup and caused it to spill two tablets onto the table. She started to pick the medications up with her hand but then used the plastic spoon she had used to administer the medications to the resident and scooped the tablets onto the spoon. LPN #1 placed the two medications back into the medication cup. She then used the same spoon and placed the medications into Resident #44's mouth. LPN #1 returned to her medication cart and began to prepare Resident #12's medications. -LPN #1 failed to perform hand hygiene after administering Resident #44's medications and prior to dispensing Resident #12's medications into a medication cup and administering them to the resident. C. Staff interviewsLPN #1 was interviewed on 6/15/26 at 9:00 a.m. LPN #1 said that when the medication tablets landed on the dining room table, she should have discarded them and dispensed new tablets. She said she was supposed to sanitize her hands between administering medications to multiple residents but failed to do so. The director of nursing (DON) was interviewed on 6/15/26 at 11:00 a.m. She said LPN #1 should have discarded the medications that landed on the dining room table and dispensed new medications. She said nurses were to sanitize their hands between residents when administering medications.D. Facility follow upOn 6/16/26 at 11:48 a.m. the NHA provided documentation of an inservice, started on 6/15/26 (during the survey) and completed on 6/16/26, with nursing staff on medication administration and infection control policy reminders. Seventeen staff members attended the inservice. The education read, Wash hands or use hand sanitizer before and after administration of medications. If a medication is dropped onto any surface during administration, that medication should be disposed of and a new medication pulled.-However, the education was not provided until the concern was brought to the (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's attention during the survey.II. Equipment failuresA. Facility policy and procedureThe Infection Prevention and Control Safe and Sanitary Environment policy, revised August 2025, was provided by the NHA on 6/16/26 at 11:48 a.m. It read in pertinent part, To maintain a safe and sanitary environment through the cleaning and disinfection of environmental surfaces as well as the equipment routinely used by residents. The type and frequency of cleaning required for a piece of equipment is dependent on the principles of cleaning and disinfecting surfaces and equipment and takes into account the intended use of the equipment in patient care and the potential of contamination. Non-critical items are those items that touch a resident's intact skin, (stethoscopes, blood pressure cuffs, pulse oximeters). Clean these items with a hospital grade disinfectant labeled as tuberculocidal (destroys tuberculosis bacteria).B. ObservationsOn 6/10/26 at 9:00 a.m. portable oxygen canisters were observed sitting on the floor outside of room [ROOM NUMBER] and room [ROOM NUMBER].On 6/15/26 at 7:15 a.m. portable oxygen canisters were observed sitting on the floor outside of room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]. On 6/15/26 at 10:00 a.m. registered nurse (RN) #1 was observed obtaining blood pressures on two unidentified residents with the blood pressure cuff touching their bare arms. RN #1 placed a pulse oximeter on their fingers to obtain oxygen saturations and used a stethoscope that was hanging on the vital signs machine to listen to the residents' lung sounds. She did not sanitize the equipment in between the two residents, even though sanitizing wipes were readily available in the basket of the vital signs machine. On 6/15/26 at 10:15 a.m. a continuous positive air pressure (CPAP) mask was observed lying on top of Resident #43's bedside table behind the CPAP machine and between the telephone and a lamp base. It was not stored in a sanitary manner, even though a plastic storage bag for the mask was hanging from the top drawer pull of the bedside table.C. Staff interviewThe DON was interviewed on 6/16/26 at 11:48 a.m. The DON said CPAP masks were to be cleaned, air dried, and placed in a bag when not in use, and portable oxygen canisters were not to be placed on the ground. She said vital signs equipment was to be cleaned between resident use with the disinfecting wipes provided on the machines. She said the certified nurse aides (CNA) were interviewed and they said they placed the oxygen canisters on the floor as a reminder to refill them. D. Facility follow upOn 6/16/26 at 11:48 a.m. the NHA provided documentation of an inservice, started on 6/15/26 (during the survey) and completed on 6/16/26, with nursing staff on equipment cleaning and CPAP and oxygen. Seventeen staff members attended the inservice. The education read, CPAP tubing and masks should be rinsed using mild soap and water after use (in the morning) and allowed to air dry. Place mask and tubing in bag when dry and not in use. Portable oxygen tanks should not be placed on the ground. After use, vital signs equipment should be cleaned with Oxyvir (disinfectant), including the vital signs machine, the blood pressure cuff, and any probes.-However, the education was not provided until the concern was brought to the facility's attention during the survey.III. Wound care failureA. Facility policy and procedureThe Skin Integrity Program policy, revised November 2025, was provided by the NHA on 6/16/26 at 11:48 a.m. It read in pertinent part, When an alteration in skin integrity is present, an interdisciplinary and comprehensive approach will be taken to provide necessary care and treatment to promote healing and prevent infection. The approach to the management of skin injuries and preventions will be consistent with professional standards of practice to promote healing, prevent infection, and prevent new injuries from developing.B. ObservationsOn 6/15/26 at 1:30 p.m. LPN #1 was observed completing wound care for Resident #16. LPN #1 gathered the wound care supplies that were in a plastic container and placed them within easy reach. She donned (applied) the appropriate personal protective equipment (PPE), which included a gown, gloves, and eye protection. After removing the old dressing from the resident's wound, she removed her gloves, performed hand (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for one (#3) of one resident reviewed for dialysis out of 25 sample residents. Specifically, the facility failed to:-Ensure thorough dialysis documentation was in place for Resident #3; and,-Ensure staff consistently and thoroughly completed the dialysis communication forms between the facility and the dialysis center for Resident #3. Findings include:I. Facility policy and procedureThe Dialysis policy, revised May 2021, was provided by the nursing home administrator (NHA) on 6/16/26 at 9:00 a.m. It read in pertinent part, The facility will establish a process for residents who require dialysis to receive services, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. The facility will create a communication book for each resident who is receiving dialysis. The dialysis communication worksheet accompanies the resident during each dialysis visit to enhance communication. Prior to dialysis, the worksheet will be completed by the licensed nurse or designee of the community which will indicate the current status of the resident. The dialysis team will review the worksheet completed by the licensed nurse or designee prior to dialysis and record pertinent information on the worksheet at the end of the dialysis treatment. Upon return of the resident to the community, the licensed nurse or designee will review the worksheet and follow up on any concerns written by the dialysis team. Any identified concerns/changes in condition documented on the worksheet will be reported to the medical provider.II. Resident #3A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included end stage renal disease and dependence on renal dialysis (process to filter wastes from the body). The 5/29/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was independent with most activities of daily living (ADL). He had impairment of one lower extremity, he used a walker and wheelchair for mobility, and he required supervision and set up assistance for bathing.The MDS assessment indicated the resident received hemodialysis treatment. B. Record reviewReview of Resident #3's dialysis care plan, initiated 6/1/26, revealed the resident received dialysis three times weekly and had a right upper extremity fistula (surgically created dialysis access site). Interventions included avoiding performing procedures on the resident's right arm, coordinating medication administration, weights, and lab results with the dialysis center and monitoring the resident's dialysis access site for complications and signs of infection. -However, the care plan did not include the dialysis center's contact information, the resident's chair time (time spent at dialysis), the transportation company's contact information, or pre- and post-dialysis treatment instructions. -Review of Resident #3's June 2026 CPO revealed no physician's orders related to dialysis.Review of Resident #3's dialysis communication forms for the month of May 2026 and June 2026 revealed the following:-The 5/1/26, 5/6/26, 5/8/26, 5/11/26, 5/13/26, 5/20/26, 5/22/26, 5/27/26, 6/3/26, 6/5/26, 6/8/26, and 6/10/26 dialysis communication forms were not signed by the nurse upon his return to the facility. -The resident's weight was marked as N/A (not applicable) on the 5/6/26 form. -No weight was documented in the pre-dialysis section on the 5/20/26 form. -The nurse that completed the pre-dialysis section on the 6/3/26 form did not sign it. -An undated dialysis communication form did not include pre-dialysis vital signs or a weight and was not signed by the nurse when the resident returned to the facility.-Review of the vital signs and nursing progress notes on Resident #3's dialysis days in May 2026 and June 2026 revealed no nursing (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes were documented pre- or post-dialysis. Vital signs were documented pre-dialysis but no vital signs were documented post-dialysis. III. Staff interviews Registered nurse (RN) #2 was interviewed on 6/11/26 at 11:00 a.m. RN #2 said when a resident returned from dialysis, the nurse was to obtain a set of vital signs, assess the resident's fistula site for bleeding and check for adequate blood flow by listening and feeling the site. She said the nurse was to review the dialysis communication binder to see if the dialysis center documented any new orders or if anything pertinent happened during the resident's dialysis treatment. The NHA was interviewed on 6/11/26 at 3:00 p.m. The NHA acknowledged that the dialysis communication forms for Resident #3 lacked the needed documentation the facility nurse should complete when a resident returned from a dialysis appointment, such as vital signs, assessing the dialysis access site, and the overall condition of the resident. She said nursing pre- and post-dialysis progress notes were not being completed. Licensed practical nurse (LPN) #2 was interviewed on 6/16/26 at 8:30 a.m. LPN #2 said prior to a resident going to dialysis, the nurse was to complete the pre-dialysis section on the dialysis communication form. She said the nurse was to obtain the resident's weight and vital signs. She said any medications the resident took during the day while at dialysis were to be sent with the resident for dialysis staff to administer. She said if a resident was out of the facility through meal time, food was sent with them. She said Resident #3 would eat breakfast before he left the facility and snacks were sent with him. LPN #2 said Resident #3 would eat dinner upon returning to the facility. She said a pre-dialysis nursing note should be entered that documented the resident's condition prior to dialysis. She said upon the resident's return to the facility, the nurse was to check the dialysis communication form for any new orders or important information from dialysis, obtain vital signs, a weight, and check the fistula site to ensure adequate blood flow and document all findings in a post-dialysis progress note. RN #1 was interviewed on 6/16/26 at 8:37 a.m. RN #1 said prior to a resident going to dialysis, the nurse was to complete the pre-dialysis communication form that included the resident's weight, vital signs, any medications given, and the fistula site condition. She said the nurse was to document a pre-dialysis progress note that included the resident's condition information prior to dialysis. She said when the resident returned from the dialysis appointment, the nurse was to check the communication form for any new orders or pertinent information from the dialysis center, obtain vital signs, a weight, and assess the dialysis fistula site for bleeding and adequate blood flow and enter a post-dialysis progress note. She said there were no physician's orders for nursing to monitor the status of Resident #3's fistula site on a daily basis. The NHA and the director of nursing (DON) were interviewed together on 6/16/26 at 1:00 p.m. The NHA said Resident #3 was the first dialysis resident they had had in the facility in 10 years. She said he transferred to long-term care last year from assisted living and the dialysis orders were not adequate. She agreed the dialysis communication form the facility had been using did not include all the needed information, and nursing staff were not completing all required documentation pre- and post-dialysis. The DON said nursing staff had not been completing all the needed information on the post-dialysis communication form and they were not documenting progress notes before or after Resident #3's dialysis appointments. She said nursing staff had not been documenting their assessments of the resident's fistula sight for adequate blood flow on a daily basis. She agreed it was important for the fistula to be assessed every day and not just on dialysis days. IV. Facility follow up On 6/16/26 at 9:00 a.m. the NHA provided the following: A copy of a new dialysis communication form that included the post-dialysis nursing documentation needed when a resident returned from a dialysis appointment, such as vital signs and instructions for the nurse to enter a post-dialysis progress note that included the resident's condition and assessment of the fistula site. A copy of dialysis care education provided to nursing staff that started on 6/12/26 (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(during the survey) and was completed on 6/16/26. The education included the new dialysis communication form with required information, fistula site assessment, and reporting any issues to dialysis. The education additionally included examples of how to write a pre- and post-dialysis progress note. Thirteen nursing staff attended the education. A copy of Resident #3's updated care plan that included the addition of the resident's chair time, and the dialysis center and the transportation company's contact information. Additional instructions added to the care plan included to complete the dialysis communication form to send with the resident and upon return review the form for any new orders from the dialysis center. Vital signs were to be obtained and the fistula site was to be assessed. An updated physician's order that indicated Resident #3's dialysis days, the pick up time, and the dialysis center's contact information, as well as copies of completed dialysis communications forms, dated 6/12/26 and 6/15/26, and the pre- and post-dialysis nursing progress notes on those dates.-However, above changes were not implemented until the concern was brought to the facility's attention during the survey.		