STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065413	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Cordera, Llc, The	9208 Grand Cordera Pkwy Colorado Springs, CO 80924

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure self-administration of medications was clinically appropriate for three (#3, #8 and #13) of three residents out of 21 sample residents.Specifically, the facility failed to: -Ensure Resident #3, Resident #8 and Resident #13 were assessed for the appropriateness and safety of self-administration of medications;-Ensure there was a physician order for self-administration of medications; and,-Ensure there was a physician order for medications at the bedside for Resident #8 and Resident #13.Findings include: I. Facility policy and procedure The Self-administration of Medications policy, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 2:09 p.m. It read in pertinent part, “The nursing staff will assess each resident’s mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident’s medications.” “The nursing staff will document their findings and the choices of residents who are able to self-administer medications. The nursing staff will routinely check self-administered medications and will remove expired, discontinued, or recalled medications. Nursing staff will review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered.” II. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (air flow blockage), acute and chronic respiratory failure (decrease in the ability to bring oxygen into the bloodstream) and dysphagia (difficulty swallowing). A minimum data set (MDS) assessment had not been completed at the time of the survey. According to the resident’s nursing comprehensive admission data collection, dated [DATE], the resident was alert and oriented to person, place, time and situation. The resident required supervision for activities of daily living (ADL). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations and resident interview On [DATE] at 5:20 p.m. an albuterol sulfate inhaler with a spacer was observed on Resident #3’s bedside table. Resident #3 said the albuterol sulfate inhaler with the spacer was her rescue inhaler. She said the frequency she used the rescue inhaler depended on the day. On [DATE] at 11:15 a.m. an albuterol sulfate inhaler with a spacer was observed on Resident #3’s bedside table. On [DATE] at 3:12 p.m. an albuterol sulfate inhaler with a spacer was observed on Resident #3’s bedside table. On [DATE] at 5:30 p.m., an albuterol sulfate inhaler with a spacer was observed on Resident #3’s bedside table. Licensed practical nurse (LPN) #1 identified the medication as albuterol sulfate HFA (hydrofluoroalkane) 90 micrograms (mcg). There were zero puffs remaining in the inhaler. C. Record review -Review of Resident #3’s electronic medical record (EMR) failed to reveal that a self-administration evaluation assessment to keep the resident’s albuterol sulfate inhaler at the bedside was completed. Review of Resident #3’s [DATE] CPO revealed a physician’s order for albuterol sulfate HFA 90 mcg two puffs inhaled every four hours as needed for shortness of breath and wheezing, ordered [DATE]. -Resident #3’s [DATE] CPO failed to reveal a physician’s order for the resident to keep the albuterol sulfate inhaler at the bedside and self-administer the medication. -Review of Resident #3’s comprehensive care plan, initiated [DATE], failed to identify the resident was safe to keep medications at the bedside. -Resident #3’s [DATE] MAR revealed there were no self-administered doses of the albuterol sulfate documented. A Self-Medication Evaluation form, dated [DATE] (during the survey), documented Resident #3’s cognitive ability was adequate with no identified limitations to the self-administration of albuterol sulfate. D. Staff interviews LPN #1 was interviewed on [DATE] at 5:30 p.m. LPN #1 said she was aware Resident #3 had the albuterol sulfate inhaler on the bedside table. LPN #1 reviewed Resident #3’s EMR and was unable to locate a physician’s order for the resident to self-administer the medication. After confirming the self-administration evaluation assessment and form had not been completed, LPN #1 said she would notify the physician to obtain a self-administration order. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on [DATE] at 5:50 p.m. The DON said that all residents with medications at the bedside should be evaluated by cognitive ability to determine the clinical appropriateness of holding medications at the bedside. III. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the [DATE] CPO, diagnoses included hemiplegia (paralysis on one side of the body) affecting the right dominant side, cerebral infarction (stroke), diabetes mellitus type 2, breast cancer, and hypothyroidism. The [DATE] minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. She was dependent on staff for all ADLs. B. Observations and resident representative interview On [DATE] at 10:02 a.m., registered nurse (RN) #1 entered Resident #8’s room. RN #1 informed Resident #8 that she was going to administer the resident’s Refresh Tears ophthalmic solution eye drops. The resident's representative indicated that they had already administered the eye drops. The eye drops were sitting on the resident’s bedside table. Resident #8’s resident representative was interviewed on [DATE] at 10:02 a.m. The resident’s representative said he administered the eye drops for Resident #8 when he believed the resident needed them. C. Record review Review of Resident #8’s [DATE] CPO revealed a physician’s order for Refresh Tears ophthalmic solution. Instill one drop in both eyes in the morning. -Resident #8’s [DATE] CPO failed to reveal a physician’s order for the resident to keep the Refresh Tears eye drops at the bedside and self-administer the medication. -Review of Resident #8’s EMR failed to reveal that a self-administration evaluation assessment to keep the resident’s Refresh Tears eye drops at the bedside was completed. -Review of Resident #8’s comprehensive care plan, initiated [DATE], failed to reveal a care plan for the self-administration of eye drops. D. Staff interview RN #1 was interviewed on [DATE] at 10:15 a.m. RN #1 reviewed Resident #8’s EMR and confirmed there was no physician's order to allow the resident’s representative to administer the medication. She said,” I will contact the physician for an order to self-administer the medication, which would allow the resident’s representative to administer the medication to the resident. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #13 A. Resident status Resident #13, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included malignant neoplasm of the pancreas (cancerous abnormal growth in the pancreas), malignant neoplasm of the liver (liver cancer), and intrahepatic bile duct (cancer of the bile duct). The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15 The resident had generalized muscle weakness and needed assistance with gait and mobility (walker use) and needed assistance with personal care. B. Observations and resident interview On [DATE] at 10:00 a.m. Resident #13 had a bottle of Rolaids at the bedside. The resident was sitting up in bed watching a TV program. At 3:15 p.m. the bottle of Rolaids remained on the resident’s bedside table. Resident #13 was interviewed on [DATE] at 3:30 p.m. Resident #13 said, “I needed to take a Rolaids tablet every other day, after medication, due to acid reflux.” On [DATE] at 8:35 a.m. the same bottle of Rolaids continued to be on Resident #13’s bedside table. On [DATE] at 8:45 a.m. the bottle of Rolaids remained on Resident #13’s bedside table within reach of the resident. C. Record review -Review of Resident #13’s [DATE] CPO failed to reveal a physician’s order for Rolaids or for the resident to self-administer medications. -Review of Resident #13’s EMR failed to reveal that a self-administration assessment for medications had been completed. D. Staff interview LPN #1 was interviewed on [DATE] at 5:20 p.m. LPN #1 reviewed Resident #13’s physician’s orders and said there was no physician’s order for the resident to self-administer the Rolaids. She said there was no assessment for the resident’s self-administration of medications. LPN #1 said she would call the physician for an order and complete the assessment form for self-administration. The director of nursing (DON) was interviewed on [DATE] at 12:00 p.m. The DON said he had completed an audit (during the survey) of all residents to ensure they did not have medications in their rooms. He said assessments and physician’s orders would be obtained for the residents who were assessed to be appropriate for self-administration of medications.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide written notice of room changes for two (#14 and #19) of five residents reviewed for notifications out of 21 sample residents.Specifically, the facility failed to ensure Resident #14 and Resident #19 received written notice of a room change. Findings include: I. Resident #14A. Resident status Resident #14, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included aftercare following surgery on the circulatory system, type 2 diabetes with diabetic kidney complication, end stage renal disease, dissection of the ascending aorta (tear in the lining of the aorta), encephalopathy (altered brain function or structure), dysphagia (difficulty swallowing) and muscle weakness.B. Record reviewThe progress note, dated 6/5/25, revealed a message was left for the resident's son, requesting a callback. The resident's friend was contacted to discuss a room change. The resident's friend mentioned that she would also reach out to the resident's son and inform him.Review of Residents #14's electronic medical record (EMR) revealed no documentation that the resident or their representative was provided written documentation of the room change. II. Resident #19 A. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the July 2025 CPO, diagnoses included displaced intertrochanteric fracture of the right femur with subsequent fracture with routine healing, subluxation of the cervical vertebrae, Alzheimer's disease, dementia, systemic inflammatory response syndrome, and abnormalities of gait/mobility. B. Record reviewThe progress note, dated 6/16/25, the note documented that the writer contacted the resident's representative to provide an update regarding a room transfer. The note documented the family preferred the resident to be placed nearer to the nurses' station while waiting for an observation room. The note documented both the son and other family members were informed of the move and assisted in relocating the resident to room [ROOM NUMBER].-However, review of Residents #19's EMR revealed no documentation that the resident or their representative was provided written documentation of the room change. III. Staff interviewsThe caseworker was interviewed on 7/23/25 at 11:30 a.m. The caseworker said the social services department did not have anything to do with the room changes. She said the nurses were responsible for notifying the family.The director of nursing (DON) was interviewed on 7/23/25 at 5:30 p.m. The DON said he reviewed the record for both Resident #14 and Resident #19 and confirmed there was information in the record for the reason for the room change and notification. He said the facility did not have a policy for resident room changes. The DON said prior to each resident's room reassignment, a written progress note or formal documentation was provided to the individual. The DON said the documentation outlined the specific rationale for the room change, such as care needs, compatibility with a new roommate, or facility logistics. The DON said the family members were notified via telephone. The DON said during these calls, the staff clearly communicated the reason for the room change and allowed for any necessary discussion.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure services provided to residents met professional standards of quality for two (#10 and #8) of one resident out of 21 sample residents. Specifically, the facility failed to ensure physician's orders for pain medications included parameters for when to administer specific pain medications for Resident #10 and Resident #8.Findings include: I. Facility policy and procedure The Analgesia policy and procedure, dated 2/1/18, was provided by the nursing home administrator (NHA) on 7/23/25 at 12:24 p.m. The policy read in pertinent part, “Nurses must follow pain parameters and enter pain scales for pain medicines. If a resident wants one pain pill and they rate their pain 7-10 and the order reads to give two for pain of 6-10, it must be charted that it was per resident request. Nurse management must be notified so it can be care planned.” II. Resident #10 A. Resident status Resident #10, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included nondisplaced fracture of left radial styloid process (bony projection located on the thumb side of the wrist), hypertension (high blood pressure) and type 2 diabetes. The Nursing Comprehensive admission Data assessment, dated 7/9/25, revealed the resident was alert and oriented to person, place, time and situation. She required setup and clean-up assistance for eating and substantial/maximal assistance for transfers and toileting. B. Record review Review of Resident #10’s July 2025 CPO revealed the following physician’s orders for as needed (PRN) pain medications: Oxycodone HCL oral tablet five milligrams (mg), give one tablet by mouth every eight hours as needed for pain, ordered 7/9/25. Acetaminophen oral tablet, give 650 mg by mouth every four hours as needed for pain, ordered 7/9/25. Record review of the MAR shows Resident #10 received oxycodone for four out of ten pain on 7/9/25 and 7/10/25 when the resident could have received acetaminophen prior to giving an opioid pain medication. -Review of the physician’s orders for Resident #10’s pain medications failed to include pain level parameters for when to administer each specific pain medication or which pain medication to administer based on the resident’s pain level. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Staff interview Licensed practical nurse (LPN) #2 was interviewed on 7/23/25 at approximately 10:15 a.m. LPN #2 said Resident #10 had pain in her arm due to a fractured wrist. LPN #2 said Resident #10 had both acetaminophen and oxycodone for PRN pain medications. LPN #2 said the nurses used their prior education, nursing judgement and the resident’s pain rating to decide whether to give Resident #10 acetaminophen or oxycodone. LPN #2 said that in general, any physician’s order that was more specific could be more helpful. D. Facility follow-up On 7/23/25, during the survey, Resident #10’s physician’s order for oxycodone HCL was changed to read oxycodone HCL oral tablet five mg, give one tablet by mouth every eight hours as needed for pain level of 6-10 out of 10. III. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 CPO, diagnoses included hemiplegia (paralysis on one side of the body) affecting the right dominant side, cerebral infarction (stroke), diabetes mellitus type 2, breast cancer, and hypothyroidism. The 5/21/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired, with a brief interview for mental status (BIMS) score of zero out of 15. She was dependent on staff for all activities of daily living (ADL). B. Record review Review of Resident #8’s July 2025 CPO revealed the following physician’s orders for PRN pain medications: Morphine sulfate (concentrate) oral solution 100 mg/5 milliliters (ml). Give 0.5 ml via PEG-Tube (percutaneous endoscopic gastrostomy tube - a feeding tube inserted through the abdominal wall into the stomach) every four hours as needed for pain of 1-10 out of 10, ordered 5/12/25. -Oxycodone HCl oral tablet 5 mg. Give one tablet by mouth every six hours as needed for pain of 1-10 out of 10, ordered 5/7/25. -Review of the physician’s orders for Resident #8’s pain medications failed to include pain level parameters for when to administer each specific pain medication or which pain medication to administer based on the resident’s pain level. Review of Resident #8’s July 2025 medication administration record (MAR) revealed morphine was administered on the following dates: -7/7/25 for a pain level of 5; and, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	–7/7/25 for a pain level of 7. Review of Resident #8’s July 2025 MAR revealed oxycodone was administered on the following dates: -7/12/25 for a pain level of 5; -7/13/25 for a pain level of 5; -7/18/25 for a pain level of 7; and, -7/22/25 for a pain level of 5. C. Staff interview The director of nursing (DON) was interviewed on 7/23/25 at 3:54 p.m. The DON said all physician’s orders were to be followed. He said Resident #8 was nonverbal. He reviewed the resident’s medical record and confirmed that the morphine and the oxycodone did not have specific pain parameters. The DON said the nurse manager reviewed the physician’s orders to ensure they were entered into the residents’ medical records properly with pain parameters. However, he said the floor nurses did not consistently add pain parameters to medications when they entered physician’s orders for pain medications.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide adequate supervision during the use of assistive devices to keep residents free from safety hazards for three (#20, #21, and #5) of the six residents out of 21 sample residents. Specifically, the facility failed to ensure Resident #20, Resident #21, and Resident #5's foot pedals were in place on their wheelchairs when staff were transporting the residents. Findings include: I. Resident #20 A. Resident status Resident #20, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing, history of falls, difficulty walking, muscle weakness, and a need for assistance with personal care. The 7/10/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required assistance with personal hygiene. The MDS assessment revealed the resident had a history of falls. B. Observations and resident interview On 7/22/25 at 2:20 p.m., Resident #20 was being pushed in her wheelchair by a front office staff member without foot pedals attached to her wheelchair. C. Record review Review of Resident #20’s fall care plan, initiated on 7/10/25, identified the resident as high risk for falls. Interventions included physical therapy and occupational therapy. -The care plan did not include an intervention to ensure that Resident #20’s foot pedals were in place when transporting the resident in the wheelchair to prevent potential falls. II. Resident #21 A. Resident status Resident #21, age [AGE], was admitted on [DATE]. According to the July 2025 CPO, diagnoses included fracture of the right femur and muscle weakness. The 7/5/25 MDS assessment revealed that Resident #21 had moderate cognitive impairment with a BIMS score of eight out of 15. The resident needed set up with eating and needed moderate assistance transferring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment revealed that Resident #21 was a high fall risk and had a fall in the month prior to admission. B. Observations On 7/22/25 at 12:10 p.m. an unidentified certified nurse aide (CNA) was observed pushing Resident #21 to her room in her wheelchair. There were no foot pedals attached to the wheelchair. On 7/22/25 at 12:47 p.m. Resident #21 was transported in her wheelchair away from the table by an unidentified CNA. There were no foot pedals attached to the wheelchair and the resident’s feet were dangling. On 7/22/25 at 2:32 p.m. Resident #21 was being pushed in her wheelchair by an unidentified CNA. The resident did not have foot pedals on her wheelchair and her feet were dangling as she was being pushed. On 7/22/25 at 4:45 p.m. Resident #21 was again being pushed in her wheelchair by an unidentified CNA. There were no foot pedals on her wheelchair and the resident’s feet were dangling. III. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included dementia, Alzheimer’s disease and history of falling. The 5/30/25 MDS assessment revealed the resident had both short term and long term memory impairments. The resident was severely cognitively impaired with a BIMS score of zero out of 15. The resident was dependent on staff for ADLs. B. Observations On 7/21/25 at 5:05 p.m. Resident #5 was sitting in her wheelchair in her room. There were no foot pedals attached to the wheelchair, causing the resident’s feet to dangle. On 7/22/25 at 11:25 a.m. Resident #5 was sitting in her wheelchair near the nurses’ station. There were no foot pedals attached to the wheelchair, which caused the resident’s feet to dangle. On 7/22/25 at 12:02 p.m. Resident #5 was being pushed through the hallway in her wheelchair by an unidentified staff member. There were no foot pedals attached to the wheelchair, which caused the resident to drag her feet across the floor. Other staff members were in the vicinity; however, no staff members intervened. C. Record review The fall care plan, initiated 8/29/24, identified Resident #5 as a high fall risk and identified interventions to prevent potential falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the care plan failed to include an intervention to ensure Resident #5’s foot pedals were in place when transporting the resident in her wheelchair in order to prevent potential falls. The fall risk assessment, dated 8/30/24, revealed Resident #5 was a high fall risk. -The 3/17/25 fall intervention and prevention checklist failed to include an intervention to ensure Resident #5’s foot pedals were in place when transporting the resident in her wheelchair in order to prevent potential falls. IV. Staff interviews The director of nursing (DON) was interviewed on 7/23/25 at 12:05 p.m. The DON said when residents were pushed in their wheelchairs, they needed to have foot pedals on their wheelchairs for safety. The DON said staff should always be using foot pedals when pushing residents. The director of rehabilitation (DOR) was interviewed on 7/23/25 at 3:30 p.m. The DOR said that while working with therapy, removing the wheelchair pedals could benefit the residents by allowing them to build and maintain muscle strength. He said the residents’ feet should not dangle from the wheelchair or drag across the floor when staff were transporting the resident due to the risk of gravity taking over and causing the resident to fall forward out of the wheelchair. The DON was interviewed a second time on 7/23/25 at 4:45 p.m. The DON said he had started education with the staff on the importance of ensuring foot pedals were on wheelchairs when transporting residents.

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	065413	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Cordera, Llc, The	9208 Grand Cordera Pkwy Colorado Springs, CO 80924

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure residents with a feeding tube received appropriate treatment and services for two (#8 and #3) of the four residents reviewed with a feeding tube out of 23 sample residents.Specifically, the facility failed to ensure:-Resident #8's physician's orders were complete and accurate, with the correct route, and orders were followed; and,-Resident #3 received adequate hydration per the registered dietitian's (RD) recommendations. Findings include: I. Facility policy and procedure The Administering Medications Through an Enteral Tube policy, revised on 3/19/24, was provided by the nursing home administrator (NHA) on 7/23/25 at 9:44 a.m. It read in pertinent part, “If at any time the patient cannot tolerate the feeding, place the feeding on hold and notify the provider. “Tablets that must be crushed before administration through an enteral tube require a specific order related to crushing. “When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml (milliliter) of warm sterile or purified water (or prescribed amount).” II. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2025 computerized physician’s orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) affecting the right dominant side, cerebral infarction (stroke), diabetes mellitus type 2, breast cancer, and hypothyroidism (decreased function of the thyroid). The 5/21/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired, with a brief interview for mental status (BIMS) score of zero out of 15. The resident was experiencing coughing and choking during medication administration and meals, which increases the resident's risk for aspiration. She was dependent on staff for all activities of daily living. The resident has a percutaneous endoscopic gastrostomy (PEG) tube. B. Observations On 7/21/25, at 4:40 p.m. Resident #8 was receiving a scheduled tube feeding. The tube feeding pump indicated the formula was running at 50 ml/hr, with 150 ml of water flush every four hours. On 7/23/25 at 9:25 a.m., registered nurse (RN) #1 was administering Resident #8’s medication via her peg tube. She administered the medications by syringe push. C. Resident #8’s representatives interview (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8’s representative was interviewed on 7/22/25 at p.m. The resident’s representative said Resident #8 had a swallow study, 5/25/25, and she continued to be at risk for aspiration. She said it was recommended for the resident’s PEG tube to remain permanent at this time. D. Record review Review of the July 2025 CPO revealed the following physician’s orders related to Resident #8’s percutaneous endoscopic gastrostomy (PEG) tube: Nothing by mouth (NPO), ordered 3/21/25; Enteral feed order every shift for tube feeding, 30ml flush before and after medications, ordered 1/31/25; Glucerna 1.5-calorie oral liquid (nutritional supplements). Give 50 ml per hour (ml/hr) by mouth two times a day for nutrition for 18 hours, off for six hours daily with 150 ml water flushes every four hours, ordered 7/15/25; Furosemide oral tablet (water pill). Give 20 milligrams (mg) by mouth in the morning for fluid volume overload, ordered 5/21/25; and, Guaifenesin oral tablet 400 mg. Give one tablet by mouth three times a day for congestion, ordered 7/9/25 . -The physician’s orders indicated to give the furosemide and Guaifenesin orally. However, Resident #8 was NPO. The nutrition assessment, dated 2/4/25, documented the resident had lost 9.4 pounds (lbs) in 30 days. The tube feeding regime was changed and the resident then gained 10 lbs. The feedings were adjusted. The assessment documented the resident's weight was 152.2 lbs on 2/3/25. E. Staff interviews The director of nursing (DON) was interviewed on 7/23/25 at 11:20 am. The DON said she reviewed the physician’s orders for Resident #8. The DON said some of the physician’s orders were not accurate and indicated for the licensed nurses to administer medications orally. The DON said all of the resident’s medications needed to be administered via the PEG tube. She said she would review the resident’s physician’s orders and ensure the orders were accurate as to what route the medication needs to be administered. The DON said the nurse who entered the physician’s orders into the electronic system was responsible to ensure the orders were complete and accurate. The RD was interviewed on 7/23/25 at 12:42 p.m. The RD said the resident was nothing by mouth as she had a peg tube. He said that he assesses the resident and then puts in a recommendation for the formula and the rate. He said that he then provides it to the nurses who then contact the physician. He said the nurses were responsible for putting the orders in and ensuring it was written correctly. F. Facility follow-up (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at 3:00 p.m. (during the survey), the DON provided documentation indicated the physician’s orders for Resident #8 were updated with the correct route of administration. III. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included chronic obstructive pulmonary disease (air flow blockage), acute and chronic respiratory failure (decrease in the ability to bring oxygen into the bloodstream) and dysphagia. According to the nursing comprehensive admission data collection, dated 7/18/25, the resident was alert and oriented to person, place, time and situation, requiring supervision for activities of daily living. B. Resident interview Resident #3 was interviewed on 7/21/25 at 5:20 p.m. Resident #3 said she was experiencing nausea and had refused her tube feedings. She said the nurses administered feedings and medications by gravity feeds. Resident #3 was interviewed again on 7/22/25 at 11:15 a.m. Resident #3 complained of increased nausea. She said the nausea was a new symptom, and she was unsure what caused it. C. Observations On 7/22/25 at 3:55 p.m. LPN #1 was administering an oxycodone-acetaminophen (pain medication) tablet and a water flush through Resident #3’s feeding tube per the resident’s request. The medication was administered by gravity. -LPN #1 did not measure the water flush. LPN #1 administered an unidentified amount of water into Resident #3’s feeding tube before and after she administered the oxycodone-acetaminophen tablet (see interview below). D. Record review Review of the July 2025 CPO revealed the following physician’s orders related to Resident 3’s PEG tube: Isosource 1.5 cal (enteral nutritional supplement) 250 ml to be administered four times a day. Give 100 ml water flush before and after each feed, ordered 7/17/25. Give 60 ml water flush four times a day to provide an additional 240 ml of hydration each day, ordered 7/17/25. -Review of the July 2025 medication administration record (MAR) did not reveal documentation indicating Resident #3 was administered 60 ml of water four times a day per physician's orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3’s electronic medical record (EMR) revealed the physician’s orders failed to specify the amount of water that should be administered during the medication administration process. Review of Resident #3’s EMR revealed LPN #1 documented that she administered 100 ml of water following the medication administration of oxycodone-acetaminophen. Resident #3’s nutrition assessment, dated 7/20/25, revealed the registered dietitian (RD) documented the current enteral nutrition physician’s orders did not meet Resident #3’s estimated fluid needs based on his assessment. The RD documented the resident said she got dehydrated and had headaches. The RD recommended to increase the water flush from 100 ml to 150 ml before and after each feed administration to meet Resident #3’s hydration needs. -However, review of the July 2025 CPO did not reveal the physician's order was updated to direct staff to administer 150 ml of water before and after each feed as recommended by the RD. E. Staff interviews LPN #1 was interviewed on 7/22/25 at 3:55 p.m. LPN #1 said when she was administering an enteral feed for Resident #3, she administered 100 ml of the water flush before and after the feed administration per physician's orders LPN #1 said she would likely hold Resident #3’s 4:00 p.m. tube feeding as a result of the resident’s continued symptoms of nausea and constipation. She said she decided to administer 100 ml of the water flush during the administration of the oxycodone-acetaminophen tablet. The RD was interviewed on 7/23/25 at 12:55 p.m. He said he completed a nutritional assessment for each resident upon admission. He said when he thought it was necessary to change an enteral feed formula, he completed a new assessment. He said through the assessment he reevaluated the resident’s nutritional needs. He said he then compared the resident’s nutritional needs to the nutritional value the current physician's order was providing. The RD said he was unable to enter nutritional orders into the residents’ EMR. He said the physician wrote the orders.