

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER The Center at Cordera		STREET ADDRESS, CITY, STATE, ZIP CODE 9208 Grand Cordera Pkwy Colorado Springs, CO 80924	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure staff provided respiratory care consistent with professional standards of practice for one (#40) of two residents reviewed for respiratory services out of 29 sample residents. Specifically, the facility failed to ensure there was a physician's order in place for Resident #40's bilevel positive airway pressure (BiPAP) machine and routine maintenance of the BiPAP. Findings include: I. Professional reference According to Nursing Skills, Open Resources for Nursing (Open RN); Ernstmeyer K, [NAME] E, editors. Eau [NAME] (WI): [NAME] Valley Technical College; published 2021, accessed on 7/29/26 from https://www.ncbi.nlm.nih.gov/books/NBK593208/, Devices such as high flow oxymasks, CPAP (continuous positive airway pressure), BiPAP (bilevel positive airway pressure), or mechanical ventilation may be initiated by the respiratory therapist or provider to deliver higher amounts of inspired oxygen. (Chapter 11) Manage oxygen therapy and equipment: If the patient is already on supplemental oxygen, ensure the equipment is turned on, set at the required flow rate, correctly positioned on the patient, and properly connected to an oxygen supply source. If a portable tank is being used, check the oxygen level in the tank. Ensure the connecting oxygen tubing is not kinked, which could obstruct the flow of oxygen. Feel for the flow of oxygen from the exit ports on the oxygen equipment. II. Facility policy and procedure The Respiratory Equipment policy, revised 2/8/21, was provided by the nursing home administrator (NHA) on 7/28/26 at 1:15 p.m. It read in pertinent part, The resident will receive necessary respiratory care and services in accordance with professional standards of practice, the resident's orders and care plan and the resident's choice. The resident will have an order that includes settings when indicated (for CPAP/BiPAP). Respiratory equipment will be cleaned and stored according to manufacturer's guidelines. III. Resident #40A. Resident status Resident #40, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included obstructive sleep apnea, hypertension, and dependence on supplemental oxygen. The 7/22/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The resident used a motorized wheelchair. She was independent with eating and dependent with toileting. She required substantial to maximum assistance with showers and supervision, or touch assistance, with personal hygiene. The MDS assessment revealed Resident #40 used a BiPAP machine and was on supplemental oxygen. B. Observations On 7/27/26 at 9:13 a.m. Resident #40 was sitting in her motorized wheelchair in her room on the east side of her bed. Resident #40's BiPAP machine was positioned on her bedside drawer, with a mask and with the tubing connected to the BiPAP. The part of the BiPAP mask that connected to the resident's nose was lying on top of the bedside drawer without a protective cover. Laying beside the BiPAP and the mask was a plastic storage bag. -However, the mask was not being stored in the protective storage bag. On 7/27/26 at (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:30 p.m. Resident #40's BiPAP mask was on the bedside drawer next to the BiPAP machine. The mask was lying on top of a puzzle and was not contained in a storage bag. On 7/28/26 at 11:20 a.m. Resident #40's BiPAP machine remained in the same position on top of the bedside drawer. The tubing and the mask were connected to the BiPAP machine and the mask was hanging beside the drawer. The plastic protective storage bag was on top of the bedside drawer. However, the mask was not stored in the protective storage bag. C. Resident interview Resident #40 was interviewed on 7/27/26 at approximately 2:00 p.m. Resident #40 said she used her BiPAP machine every night for sleep and received assistance from the facility staff to set up the device. She said nursing staff assisted her by ensuring the machine was turned on and properly connected to supplemental oxygen at a flow rate of 1 liter per minute (LPM). Resident #40 said when her BiPAP machine was not in use during the day, the staff usually left her BiPAP mask resting on top of her bedside drawer without using a protective storage cover or bag. Resident #40 said no facility staff member had cleaned, sanitized, or performed maintenance on her BiPAP machine, mask, or tubing since her admission to the facility (on 7/13/26). D. Record review-Review of Resident #40's July 2026 CPO revealed no physician's order for the use of the BiPAP and no instructions for maintenance and cleaning of the device. The respiratory care plan, initiated 7/14/26, revealed Resident #40 was at respiratory risk related to deficiencies/abnormalities in pulmonary function and sleep apnea. Interventions included CPAP use according to physician's orders, monitoring the resident's pulse oximetry (level of oxygen in the blood) every shift and if it was less than 88%, starting oxygen at 1 to 5 LPM continuously. -The care plan failed to include the use of the BiPAP machine (instead of a CPAP machine) or instructions for the cleaning/maintenance of the equipment. IV. Staff interviews Registered nurse (RN) #2 was interviewed on 7/23/26 at 2:58 p.m. RN #2 said upon admission, all medical equipment brought into the facility by a resident was required to be documented in the resident's electronic medical record (EMR). RN #2 said the necessary physician's orders were to be obtained for any device requiring medical oversight. RN #2 said Resident #40 used a BiPAP machine; however, she could not find physician's orders for the use and maintenance of the BiPAP machine. RN #1 was interviewed on 7/27/26 at 3:35 p.m. RN #1 said Resident #40 used a BiPAP machine at night. RN #1 said facility staff were responsible for obtaining physician's orders for all medical equipment. She said she could not find a physician's order for BiPAP administration and routine maintenance in Resident #40's EMR. RN #1 said it was important to obtain physician's orders for the administration and maintenance of the BiPAP to ensure proper settings. The director of nursing (DON) was interviewed on 7/27/26 at 4:06 p.m. The DON said all medical equipment brought into the facility by residents upon admission required a physician's order. The DON said the staff should notify the physician and obtain a physician's order for the administration and maintenance of BiPAP/CPAP machines. She said BiPAP use and maintenance should be included in the resident's care plan. The DON said Resident #40 used a BiPAP machine at night; however, she did not know why the staff had failed to obtain a physician's order for the administration and maintenance of the resident's equipment. The DON said failing to obtain a physician's order for a BiPAP machine could lead to significant adverse effects for the resident, including improper pressure delivery, hypoventilation (breathing too slowly or too shallowly, causing a harmful buildup of carbon dioxide), inadequate oxygenation, and an increased risk of severe respiratory infections caused by unmaintained or improperly sanitized equipment. The DON said she would provide immediate education to all licensed nursing staff regarding the facility's respiratory care and medical equipment policies. The DON said she would immediately contact the physician to obtain complete physician's orders for the administration settings, routine cleaning and maintenance, and proper hygienic storage of Resident #40's BiPAP machine.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 for two of two medication storage rooms and one of three medication carts. Specifically, the facility failed to: -Ensure expired medications were disposed of; -Ensure medications were contained in the original packaging; and, -Ensure the controlled medication box was permanently affixed in the medication storage room refrigerator. Findings include: I. Professional reference According to the United States (U.S.) Food and Drug Administration guidelines, dated 10/31/24, retrieved on 7/29/26 at 9:00 a.m. from https://www.fda.gov/drugs/safe-disposal-medicines/dont-be-tempted-use-expired-medicines, In 1979, the U.S. Food and Drug Administration began requiring an expiration date on prescription and over-the-counter medicines. The expiration date is a critical part of deciding if the product is safe to use and will work as intended. The expiration date can be found printed on the label or stamped onto the bottle or carton. It is important to know and stick to the expiration date on your medicine. Using expired medicines is risky and possibly harmful to your health. 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. According to the Drug Enforcement Administration (DEA), failing to safely dispose of old medications can cause harm if taken by mistake. II. Facility policy and procedure The Medication Storage policy and procedure, revised 1/29/25, was provided by the nursing home administrator (NHA) on 7/28/26 at 12:35 p.m. It read in pertinent part, Ensure safe, secure, and compliant storage of medications. All medications are stored in locked carts and medication rooms. All controlled substances are stored in a double-locked system under advisement of facility pharmacy. For over-the-counter medications in bulk, the label contains the original manufacturer's medication name, strength, quantity, accessory instructions, lot number, and expiration date. The facility ensures that medication labeling in response to order changes is accurate and consistent with applicable state requirements. Multi-dose vials are dated upon opening and discarded upon the date designated by the manufacturer. Expired medications are removed; Bulk over-the-counter products that remain in the manufacturer's original container can be used until the manufacturer's expiration date, noted on the product label. Expired/discontinued medications are segregated in designated bins/areas. III. Observations and staff interviews On 7/27/26 10:24 a.m. the #2 South medication cart and the medication storage room were observed with licensed practical nurse (LPN) #1. The following items were found: -The medication refrigerator was unlocked and contained three multi-use vials of sodium chloride injection 0.9%. One vial was open but was not dated and all three vials had expired in August 2025. -One foil medication card containing four bisacodyl 10 milligram (mg) suppositories and one foil wrapped hemorrhoidal suppository were in the top drawer of the medication cart and were not contained in the original packaging. LPN #1 said the nurses were supposed to review the medication carts for expired medications and remove them. She said central supply monitored and stocked over-the-counter medications in the medication room. She said the pharmacist made routine visits to the facility to go through the medication carts to remove any expired or loose medications. She said she did not know when the pharmacist had been at the facility last. On 7/27/26 at 10:30 a.m. the third (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor medication room was observed with the director of nursing (DON). The following items were found:-The medication refrigerator was unlocked and on the top shelf inside the door, there was a black metal box that contained lorazepam (a schedule IV controlled substance) provided by the pharmacy. The box was not permanently affixed inside the refrigerator. -Nine elastomeric pump devices (small, disposable, non-electric medical devices used to deliver intravenous (IV) medications, such as antibiotics) were in the bottom drawer of the medication refrigerator. The devices contained Daptomycin (antibiotic) 700 mg/100 milliliters (ml). The medication had been dispensed from the pharmacy on 5/26/26 with instructions to discard the medication after 6/5/26. The DON said when the physician's order for the refrigerated IV antibiotic medication was discontinued on 6/4/26 and was not to be used after 6/5/26, staff failed to discard the expired medication. She said any expired or discontinued medications were to be discarded to ensure staff did not use them. She said expired medications were not to be used because of the potential for diminished effectiveness or adverse reactions. She said the floor nurses and management staff were responsible for reviewing the medication carts and the medication refrigerators routinely to discard expired or discontinued medications. The DON said the medication refrigerators should be locked because all nurses had a key for them. She said the black box in the refrigerator was provided by the pharmacy but she did not know that it needed to be permanently affixed inside the refrigerator. The DON said since the refrigerator was unlocked and the black box was not permanently affixed inside, she agreed that anyone could remove the box from the refrigerator. She said if a nurse needed to administer the lorazepam, the nurse had to obtain the key from the emergency medication machine to open the box. She said the pharmacist made routine visits to the facility to review the medication carts and she thought the pharmacist reviewed the refrigerators as well. She said the pharmacist had been at the facility recently but she did not recall the exact date. IV. Facility follow up On 7/28/26 at 2:14 p.m. the NHA provided a copy of a work order from the maintenance department. The work order indicated that on 7/28/26, a chain and lock had been installed on the black box that affixed it to the inside of the third floor medication storage room's medication refrigerator to prevent the potential of someone removing the box. -However, the black box was not permanently affixed inside the medication refrigerator until after it was brought to the facility's attention during the survey on 7/27/26 (see observation above).		