STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065429	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Longmont Health and Rehab, LLC	1960 S Fordham St Longmont, CO 80503

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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 - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#5) of three residents out of nine sample residents. Specifically, the facility failed to ensure an assessment was conducted to determine whether the self-administration of medications was clinically appropriate for Resident #5.Findings include:I. Resident #5A. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included chronic respiratory failure, sleep apnea, muscle weakness, chronic obstructive pulmonary disorder (COPD) and depression. The 10/2/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required moderate assistance with toileting, bathing, dressing and set up assistance with eating and oral hygiene. B. Resident observation and interviewOn 12/10/25 at 1:00 p.m. Resident #5 was observed sitting in his wheelchair in his room. An albuterol respiratory inhaler was observed on the bedside table next to Resident #5. Resident #5 said staff at the facility allowed him to keep the albuterol inhaler at his bedside. He said he preferred to have the medication available after his meals and any other time he needed to use it. Resident #5 said he was not aware of an assessment being conducted to determine if he was able to safely administer his own medications. He said he had taken the medication for years prior to coming to the facility. Resident #5 said he did not remember if he used his inhaler medication today (12/10/25). C. Record reviewThe respiratory care plan, initiated 10/1/25, documented Resident #5 had altered respiratory status with difficulty breathing related to COPD. Interventions included monitoring the resident for signs and symptoms of respiratory distress and reporting to physicians as needed, administering medications or inhalers as needed and monitoring for effectiveness and side effects. -The care plan did not indicate that Resident #5 was able to self-administer his albuterol inhaler.A review of Resident #5's December 2025 CPO revealed the following physician's order:Albuterol Sulfate HFA (hydrofluoroalkane) Inhalation Aerosol Solution 108 (90 Base) microgram (mcg)/actuation (act), two puffs inhaled orally every four hours as needed for COPD, ordered 9/29/25. -A review of Resident #5's electronic medical record (EMR) did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #5 was able to safely administer his own medications.-The EMR did not reveal a physician's order for Resident #5 to self-administer the albuterol inhaler and approval for it to be kept at the resident's bedside. II. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 12/10/25 at 1:31 p.m. LPN #1 said Resident #5 always administered his own albuterol inhalers. LPN #1 said there should have been an assessment completed to make sure he was capable of administering his own medication. She said if the resident had a self-administration of medications assessment, the assessment would be located in the resident's EMR. -However, there was no self-administration of medications assessment in Resident #5's EMR. Registered nurse (RN) #1 was interviewed on 12/11/25 at 11:10 a.m. RN#1 said she only worked at the facility a couple of times a month. She said she was unaware of Resident #5 being in possession of his inhaler. She said medications should not be left at the bedside without a physician's order. RN #1 said before a resident was able to self-administer their own medication, the nursing staff should determine if the resident knew how to administer their own medications correctly through an assessment. RN #1 said she could not recall if a specific assessment was required in the facility's policy for self-administration of medications. The director of nursing (DON) was interviewed on 12/15/25 at 10 am. The DON said if a resident had requested to self-administer medication, the nursing staff would be responsible for completing a self-administration assessment. She said there should also be a physician's order in the EMR for the resident to be allowed to self-administer medications. She said the resident's care plan should reflect the resident's ability to self-administer their own medications. The DON said she was familiar with Resident #5 because he often requested to administer his own medications. The DON said she was unsure if a medication self-administration assessment was completed for Resident #5.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interviews, the facility failed to ensure that clean linens were provided in sufficient quantities for residents in two of three linen storage closets. Specifically, the facility failed to ensure there were enough clean linens for residents.Findings include:I. ObservationsOn 12/10/25 at 1:30 p.m., the linen storage closet located in hallway 100 was observed to contain six flat sheets, ten large comforter sheets, four pillowcases, and five blankets. No fitted sheets were present in the storage closet at the time of the observation.On 12/10/25 at 1:40 p.m., the linen storage closet located in hallway 200 was observed to contain three flat sheets, four large comforter sheets, and thirteen blankets. No pillowcases or fitted sheets were present in the storage closet at the time of the observation.II. Resident interviewsResident #1 was interviewed on 12/10/25 at 10:10 a.m. Resident #1 said linens were often unavailable or insufficient for residents because the facility did not have any clean linens.Resident #2 was interviewed on 12/10/25 at 12:48 p.m. Resident #2 said the facility appeared to lack an adequate supply of linens. She said there were not enough clean linens available to meet the needs of all residents. She said the facility had consistently failed to maintain sufficient linens and described this as an ongoing issue.III. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 12/10/25 at 2:30 p.m. CNA #3 said the facility did not maintain an adequate supply of linens. She said she first observed the shortage following the purchase of the facility by a new company. She said due to the insufficient supply, staff were required to collect soiled linens and have them laundered to provide residents with clean linens and regular blankets.The laundry aide was interviewed on 12/11/25 at 11:00 a.m. The laundry aide said the facility did not consistently have enough linens to provide each resident with a full set of sheets as needed. She said due to the shortage of linens, she managed by rotating and prioritizing linens to ensure residents had clean items, even though supplies remained limited. She said she made every effort to uphold cleanliness and resident dignity; however, she acknowledged that the facility's linen inventory was insufficient to fully meet regulatory expectations. She said, despite these constraints, she was committed to doing her best to ensure that residents received clean linens, though not always in the quantity or frequency that would be ideal.The maintenance director (MTD) was interviewed on 12/15/25 at 12:30 p.m. The MTD said he began working at the facility approximately four years ago but only recently assumed his current role. He said he was officially hired as the MTD three weeks ago, and since taking over, he had become aware of ongoing issues with clean linens. He said the situation affected the facility's compliance with regulatory requirements, which mandate that residents live in a safe, sanitary, and comfortable environment.The NHA was interviewed on 12/12/25 at 12:15 p.m. The NHA said the facility had a shortage of linens. He said he was aware of the current linen shortage affecting the facility and said he had already contacted the corporate office regarding the issue. He said an order for additional linens had been placed to ensure an adequate supply for all residents and said the shipment of new linens was expected to arrive during the week of 12/15/25. The NHA said the new shipment of linens was anticipated to resolve the shortage of linens and restore appropriate linen availability for resident care.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review interviews, the facility failed to ensure residents were kept free from abuse, as one (#2) of four residents reviewed for abuse out of the nine sample residents.Specifically, the facility failed to protect Resident #2 from abuse by Resident #3.Findings include:I. Incident of abuse of Resident #2 by Resident #3 on 12/7/25A. Facility investigationThe facility's investigation, dated 12/7/25, documented that the dietary manager (DM) witnessed a resident to resident altercation between Resident #3 and Resident #2 in the dining room during meal service, during which Resident #3 struck Resident #2 on the right arm. The DM immediately reported the incident to the nursing staff. Nursing staff assessed Resident #2 in the comfort of her room following the event, and the initial assessment identified what appeared to be a pinch mark on Resident #2's right arm; the resident also reported arm pain. Resident #2 was reassured and monitored for any changes in condition or discomfort. Resident #3 was placed on one to one supervision with certified nurse aide (CNA) #2 to prevent further incidents and ensure the safety of all residents. Resident #2 reported that on 12/7/25, she took a sugar packet from Resident #3's dining table and that Resident #3 then went to Resident #2's table, reached out, and grabbed Resident #2's right arm. Staff intervened immediately to separate the residents and escorted Resident #3 back to her room. Resident #2 described pain in her right arm, and staff observed bruising to her right upper arm following the incident. The facility documented the injury with photographs of Resident #2's right arm, and facility actions consisted of immediate intervention, notification, and documentation.The facility conducted a skin assessment of Resident #2 and documented three vertical fingernail marks to the resident's right arm, including one open area measuring 0.1 centimeters (cm) by 0.5 cm with no active bleeding, localized redness to the posterior right arm measuring 1 cm by 1 cm, an approximately quarter sized bruise to the right wrist, and a redness mark at the base of the posterior head; these findings were recorded in the resident's electronic medical record (EMR) with the assessment.B. Resident #3 (assailant)1. Resident statusResident #3, age less than 65, was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included cerebral infarction due to unspecified occlusion or stenosis of the right anterior cerebral artery, lack of coordination, hemiplegia, and hemiparesis following infarction affecting the left non-dominant side, dysphagia following cerebral infarction, apraxia following infarction, vascular dementia with behavioral disturbance, and adjustment disorder with mixed disturbance of emotions and conduct.The 11/10/25 minimum data set (MDS) assessment revealed the resident was cognitively intact, with a brief interview for mental status (BIMS) score of eight out of 15. The resident was independent with activities of daily living (ADL).The MDS assessment documented that the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.2. Record reviewReview of Resident #3's behavior care plan, initiated 10/31/25 and revised 11/1/25, revealed the resident had episodes of yelling, cursing, and throwing objects, including plates and trays, when the resident was served a diet with an inappropriate texture. Interventions included administering medications as ordered, monitoring for side effects, assessing effectiveness, anticipating and meeting the resident's needs, and intervening to protect the rights and safety of others by approaching the resident calmly, diverting attention, and removing the resident from the triggering situation when necessary. The 12/7/25 nurse progress note revealed Resident #3 informed facility staff that she was involved in an altercation with Resident #2. She reported that she grabbed Resident #2's arm after Resident #2 took sugar packets from her table, as documented in the facility's record report.C. Resident #2 (victim)1. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the December 2025 CPO, diagnoses included schizoaffective disorder, Parkinson's disease, other seizures, and mild cognitive impairment.The MDS assessment revealed the resident was cognitively intact, with a brief interview for mental status score (BIMS) of 14 out of 15. The resident does require assistance with ADLs.The 10/6/25 MDS assessment documented that the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.2. Resident interview and observationsOn 12/10/25 at approximately 11:00 a.m. Resident #2 and his family member were interviewed regarding the incident involving Resident #2 and Resident #3 on 12/7/25. Resident #2's family member said Resident #3 routinely entered the facility's dining room unattended. During the interview, Resident #3 was observed entering the dining room without staff supervision, despite having been placed on one on one supervision on 12/7/25. Resident #3 remained unsupervised for approximately three to four minutes before CNA #2, the staff member assigned to

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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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide respiratory services for two (#4 and #5) of three residents reviewed out of nine sample residents. Specifically, the facility failed to:-Ensure Resident #4's bilevel positive airway pressure (BiPAP) machine was set up and monitored and adjusted by the physician in order for the resident to utilize it at night; -Ensure Resident #4's care plan included the use of a BiPAP machine and settings; and, -Ensure Resident #5's physician's orders included application of his continuous positive airway pressure (CPAP) machine at night.Findings include:I. Resident #4A. Resident statusResident #4, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder, sleep apnea (breathing stops while asleep) and narcissistic personality disorder. The 10/20/25 minimum data set (MDS) assessment revealed Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required moderate assistance to roll side to side, and required substantial assistance with eating, hygiene, bathing, toileting, and dressing. He was dependent on staff assistance for transfers and used a motorized wheelchair for mobility. B. Resident interviewResident #4 was interviewed on 12/10/25 at 11:00 a.m. Resident #4 said he was admitted to the facility with his BiPAP machine, but he had not used it for approximately two months because the settings were incorrect. He said he had not used it because he had not seen a respiratory physician to adjust the settings. He said he slept poorly most nights and was tired throughout the day because he did not have his BiPAP machine working correctly. Resident #4 was interviewed a second time on 12/11/25 at 10:19 a.m. Resident #4 said he did not wear his BiPAP machine again last night (12/10/25) because he was scared of the machine not working correctly. He said he had only seen a respiratory therapist one time during his stay at the facility. He said the respiratory therapist did not place his BiPAP machine on the correct settings, and it still needed to be adjusted. Resident #4 said the facility should be following the same setting he had when he was admitted to the hospital prior to coming to the facility. He said the infection preventionist (IP) came into his room early this morning (12/11/25) and asked him what were the correct settings for his BiPAP machine. He said he became frustrated because he relied on the facility staff to know this information. C. Record reviewThe respiratory care plan for Resident #4, initiated on 7/22/25 and revised on 10/1/25, revealed the resident was at risk for altered respiratory status and difficulty breathing related to quadriplegia, left humerus fracture, atrial fibrillation and sleep apnea. Pertinent interventions included encouraging sustained deep breaths by using demonstration and emphasizing slow inhalation, holding end inspiration for a few seconds, and passive exhalation, using an incentive spirometer placed close for convenient resident use, maintaining a clear airway by encouraging the resident to clear his own secretions with effective coughing and if secretions could not be cleared, suction as ordered/required to clear secretions (initiated 7/22/25), monitoring for signs and symptoms of respiratory distress and reporting to physician as needed (initiated 7/22/25), monitoring/documenting/reporting abnormal breathing patterns to physician such as increased respiratory rate, decreased respiratory rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring (initiated 7/22/25), positioning the resident with proper body alignment for optimal breathing pattern (initiated 7/22/25), teaching the resident when to inhale and exhale while doing strenuous activities (initiated 7/22/25), and assisting the resident to change position routinely to facilitate lung expansion (initiated 7/22/25). The pulmonary clinic after visit summary revealed Resident #4 went to his pulmonology appointment on 11/25/25. The physician's notes revealed that the resident attended the appointment without his BiPAP machine. The notes indicated Resident #4 would require another appointment and he would need to bring his BiPAP machine, along with all of his associated equipment to download and adjust the BiPAP settings as needed. The physician's note recommended deactivating the smart stop feature as his machine would turn off in the middle of the night if there was excessive leaking. Resident #4 would need assistance putting on his BiPAP mask and ensuring it was adequately sealed each night at bedtime. His BiPAP mask would need to be taken on and off with the hooks. The Velcro on the BiPAP mask should only be adjusted if there was excessive leaking. Resident #4's machine would need to be filled with distilled water nightly, equipment would need to be cleaned weekly and supplies replaced regularly. -However, there was no record of Resident #4 attending a follow-up visit to the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of three units. Specifically, the facility failed to: -Ensure staff performed hand hygiene after emptying the resident's catheter and prior to providing incontinence care for Resident #4;-Ensure staff followed appropriate infection control guidelines and ensured the facility's shower chair was cleaned after use and not covered in stool prior to being used by Resident #4; and,-Ensure the facility's hot water heater was functioning appropriately in order to launder residents' clothes and linens at the appropriate water temperature.Findings include: I. Failed to ensure staff performed hand hygiene prior to providing incontinence care and cleaning shower chair after use appropriately for Resident #4. A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 12/13/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Observations On 12/10/25 at 11:15 a.m. there was a sign on Resident #4's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 12/10/25 at 11:17 a.m. Resident #4 was lying on his bed. He had an indwelling urinary catheter draining yellow urine attached to his bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/25 at 11:40 a.m. certified nurse aide (CNA) #3 was gathering facility supplies to assist Resident #4 with his shower. CNA #3 obtained a shower chair and placed it outside the room of Resident #4. The shower chair was soiled and visibly covered with stool. On 12/10/25 at 11:45 a.m. CNA #3 assisted an unidentified staff member with incontinent care for Resident #4 in preparation for his requested shower. CNA #3 proceeded to empty Resident #4's foley catheter. After emptying Resident #4's foley catheter. CNA #3 did not change her gloves or perform hand hygiene, but instead use the same gloves to assist with incontinence care for Resident #4. C. Staff interviews CNA #3 was interviewed on 12/10/25 at 11:55 a.m. CNA #3 said it was facility policy for her to have changed her gloves after emptying Resident #4's foley catheter. She said she was expected to have removed her gloves, wash her hands and don a fresh, clean pair of gloves before assisting with incontinence care. CNA #3 said she did not have any additional gloves in her pocket or in the resident's room. She said it was the responsibility of the nursing staff to make sure residents' rooms were stocked with plenty of personal protective equipment (PPE). CNA #3 said it was the facility's expectation to clean a shared shower chair after each use. CNA #3 said she used the shower chair earlier this morning (12/10/25) when showering another facility resident. CNA #3 said she forgot to clean the shower chair after use earlier and said that was unacceptable. She said it was important to maintain a clean environment for Resident #4 because he had wounds on his bottom and he could get an infection. The infection preventionist (IP) was interviewed on 12/11/25 at 11:52 a.m. The IP said all of the nursing staff had been provided education and training regarding effective infection control protocols. The IP said if the nursing staff were to ever run out of gloves or any other type of PPE, they should use the call bell to call for assistance and have another staff member provide them with additional supplies. The IP said not changing gloves and not performing hand hygiene between care tasks was unacceptable. The IP said she would provide education on infection control standards immediately. The IP said the soiled shower chair should never had arrived to Resident #4's room without being thoroughly cleaned with disinfectant wipes first. The director of nursing (DON) was interviewed on 12/15/25 at 12:46 p.m. The DON said the facility had an infection control policy in place that the nursing staff was expected to follow. The DON said it was extremely important to maintain infection control standards to prevent the spread of harmful infection-causing bacteria to the residents of the facility. The DON said the staff should wash or disinfect their hands before and after emptying residents' foley catheters and before and after assisting with incontinence care. II. Failed to ensure the facility's water heater was functioning appropriately to launder residents' clothes and linens at the appropriate water temperature A. Professional reference According to the CDC's Guidelines for Environmental Infection Control in Health-Care Facilities - Laundry and Bedding, 1/8/24, retrieved on 12/22/25 from https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html, (continued on next page)

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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	Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids. The antimicrobial action of the laundering process results from a combination of mechanical, thermal, and chemical factors. Dilution and agitation in water remove substantial quantities of microorganisms. Soaps and detergents function to suspend soils and also exhibit some microbicidal properties. Hot water provides an effective means of destroying microorganisms. A temperature of at least 160 degrees Fahrenheit (F) for a minimum of 25 minutes is commonly recommended for hot-water washing. B. Observations On 12/10/25, it was observed that the facility's primary water heater was broken. The nursing home administrator (NHA) confirmed this fact and reported that a repair order had been placed to replace the broken unit. The facility was utilizing two industrial-sized washing machines. The laundry aide reported that the water temperature during wash cycles was sixty eight degrees Fahrenheit. This temperature was substantially below the threshold required for effective sanitation and infection control. On 12/10/25, all resident clothing and linens, except for certain linens, will be laundered in the rehabilitation area. This area is not equipped with industrial washers and dryers and instead utilizes a domestic washer and dryer to process some of the facility's residents' clothing and linens. It was further observed that laundry operations in the rehabilitation area are not maintaining appropriate infection control or isolation measures for soiled clothing and linens. In addition, there is no physical barrier separating the laundry area from resident spaces, thereby failing to uphold required isolation precautions. C. Staff interviews The NHA was interviewed on 12/11/25 at 10:50 a.m. The NHA said the laundry services, particularly those conducted within the rehabilitation area, did not meet required standards. He said the laundry operations in the rehabilitation area failed to isolate soiled linens and adequately separate the laundry area from residents and staff, creating infection prevention challenges. The NHA said the facility's laundry practices fell below minimal standards and constituted noncompliance with regulatory requirements. The laundry aide was interviewed on 12/11/25 at 11:00 a.m. The laundry aide said the main laundry facility's water heater was broken and had been broken for three weeks. She explained that she managed the laundry services by rotating and prioritizing laundry to ensure residents had clean items. She said the facility has been using the rehabilitation area's washer and dryer to assist with laundering certain items because the washer in the rehabilitation area had a separate water heater supply. The laundry aide emphasized that she made every effort to maintain cleanliness and resident dignity, but acknowledged that the facility did not currently have a functioning water heater in the main laundry facility to meet regulatory expectations. She said she tried to do her best within these constraints to make sure that residents received clean clothes and linens, though it was not always in the quantity or frequency that would be ideal.