STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

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

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one (#7) of three residents reviewed for change of condition assessments out of 25 sample residents.Resident #7, who was diagnosed with alcoholic polyneuropathy (nerve damage that causes pain, tingling, and numbness in the limbs), history of traumatic brain injury, congestive heart failure (CHF), type 2 diabetes mellitus, alcoholic cirrhosis of liver without ascites (liver disease without fluid in the abdomen), hypertension (high blood pressure), long term use of anticoagulants (blood thinners), and alcohol use with unspecified alcohol-induced disorder was admitted from the hospital to the facility on 7/17/25.Specifically, on 1/27/26 Resident #7 signed out of the facility at 8:30 a.m. and was returned to the facility at approximately 2:30 p.m. by the police due to intoxication (when alcohol or drugs impair your mental and physical abilities). The facility failed to thoroughly assess Resident #7 and ensure he received care. Although the resident had a change of condition, no change of condition assessment was completed, there was no registered nurse (RN) assessment documentation and the staff did not call his physician or guardian. The facility failed to assess the resident, call the physician, or send to the hospital and he died at the facility three hours later on 1/27/26 at approximately 5:30 p.m. of respiratory failure, aspiration event and alcoholism according to the death certificate.In addition, the facility failed to have an alcohol use or an intoxication care plan for Resident #7.The facility failed to address a significant change of condition when Resident #7 returned to the facility intoxicated and required a wheelchair transport from the front door to his room, normally he used no mobility devices. The facility's failure to assess and monitor the resident's alcohol use and change in conditions, failure to document changes, and failure to seek medical treatment when required and notify the resident's physician, contributed to serious harm for Resident #7 and death. The potential for further serious resident harm if the facility's system for assessing, monitoring, documenting and communicating changes were not immediately corrected. Findings include:I. Immediate jeopardyA. Findings of immediate jeopardyReview of Resident #7's alcohol use, monitoring records, assessment documentation and staff interviews revealed the facility failed to take immediate and comprehensive steps following discovery of Resident #7's intoxication.There was no evidence the facility thoroughly investigated the incident to uncover and address root cause analysis and uncover why the nurses did not complete a change in condition assessment.The facility's failure to implement an immediate and comprehensive review of the facility's system and response to Resident #7's intoxication, placed residents at risk for serious harm if not immediately corrected. B. Facility notice of immediate jeopardyOn 3/3/26 at 5:40 p.m. the temporary emergency licensed nursing home administrator (NHA) who was also acting as the fulltime director of nursing (DON), the chief nursing officer (CNO) of the south region, the regional director of clinical operations (RDCO), and the regional vice president of operations (RVPO) were notified that the facility's failure to identify and respond to the worsening condition of Resident #7 created an immediate jeopardy situation. -Cross-reference F727 Failure to employ a fulltime DON when the DON became the temporary fulltime NHA (temporary permit for emergency situations 12/30/25 to 3/30/26).C. Facility plan to remove immediate jeopardyOn 3/4/26 (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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Concerns were not identified.-A 30 day look back of current and discharge residents audit was initiated on 3/3/26 to ensure that if residents had a change in condition, the facility policy was followed.During the review, it was identified that one current resident did not have the required 72-hour alert monitoring order in place. This order would have increased nursing oversight to include monitoring for signs and symptoms of decline or infection and to notify PCP (primary care physician) if it shows signs of worsening and would be documented on the TAR and in progress notes every shift for three days. The assigned nurse was educated on 3/3/26 regarding the expectation to timely initiated 72-hour alert monitoring order promptly after completing the eInteract change in condition evaluation to ensure appropriate ongoing assessment and oversight by nursing staff was completed each shift for the full 72-hour period. The 72 hour change in condition alert monitoring order was initiated for the resident identified above. The 72-hour monitoring order would be triggered to alert the nurse per the frequency indicated by the physician (such as once per shift, every two hours, every 15 minutes, etc). The monitoring included nursing assessment based on the clinical condition being monitored, which may include vital signs, monitoring for pain or injuries, monitoring for signs or symptoms of infection, or any other relevant clinical information based on the change of condition.2 . Actions to prevent occurrence/recurrence:The facility took the following actions to prevent an adverse outcome from reoccurring.-The resident change in condition and notification of changes policies and procedures were reviewed by the CNO for clinical accuracy on 3/3/26. No changes to policies were needed.-Beginning on 3/3/26 and ongoing all nursing staff will be educated by the DON/designee on appropriately addressing changes of condition including nursing assessment, monitoring of ongoing medical or physical condition, physician and family notification requirements, physician orders, and facility policies and procedures. Staff members were not permitted to work a shift until education was completed.-Beginning on 3/4/26 new hires (licensed nurses and nurse aides) will be educated on change of condition and physician and family notification requirements, as well as facility policies and procedures, during orientation.-Starting on 3/3/26 the DON/designee will conduct audits five times/week for three months of the 24-hour report and progress note report. These audits would ensure that if residents experienced a change of condition that facility policies andprocedures were followed. DON/designee would conduct daily nursing staff huddles, Monday through Friday, to monitor for change in resident condition.-Starting on 3/4/26 clinical and administrative oversight/supervision by regional director of clinical services and regional vice president will be conducted daily for four weeks, then weekly for three months to ensure all education and audits are completed and accurate. DON was educated on 3/3/26 by the CNO on appropriately addressing changes of condition including nursing assessment, monitoring of ongoing medical or physical condition, physician and family notification requirements, physician orders, and facility policies and procedures.-Starting on 3/4/26 the DON/designee will also complete chart audits as follows: three residents weekly for four weeks, then two residents weekly for two weeks, then two residents a month for two months. These audits will ensure that there are detailed observations and gathering of relevant and pertinent information for the provider to include vital signs and completed assessment of resident, and other information prompted by the eInteract change of condition evaluation and documenting in resident's medical record, notifying physician and family of change of condition.-The Regional Director of Clinical Services/RDCS will visit the facility two times per month to provide general oversight and monitoring of the plan.D. Removal of immediate jeopardyBased on the facility's plan above, the immediate jeopardy was removed on 3/4/26 at 4:25 p.m. However, deficient practice remained at a G level, actual harm, isolated. II. Explanation of (continued on next page)

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The most common cause of death due to alcohol intoxication is respiratory depression with hypoxia, lung atelectasis, and airway aspiration of stomach contents. Hypothermia is also common in fatal alcohol intoxication. All patients, including those intoxicated with alcohol, have the right to good general care and to be treated with respect. Determine the appropriate level of care, but keep in mind that consciousness and breathing may fluctuate suddenly. In uncomplicated alcohol intoxication , a sick bag, fluids, sleep under observation, and antacids may be sufficient. In more severe cases of intoxication or when complicating factors are present, the situation is different: Closely monitor consciousness and breathing; administer oxygen; suction the mouth and throat if there is an increase in mucus; support breathing and circulation as needed (ensure a clear airway, treat hypoxia/hypercapnia, fluids). If paradoxical breathing is present, better airway conditions are needed, and intubation is usually required. Monitor body temperature; treat acute confusion and motor agitation; administer fluids, either orally or intravenously. Poisoned patients typically need rehydration with IV (intravenous) fluids; administer buffered glucose solutions. If necessary, correct electrolyte imbalances. In case of hypothermia, provide warming. If airway aspiration is suspected, order a chest X-ray and administer antibiotics for a respiratory infection. Consider prophylaxis for delirium and generalized seizures. Gastric lavage and activated charcoal are administered only in cases of mixed poisoning with medication when the patient arrives within one hour of ingestion. Free airways: The airway may be partially or fully obstructed in alcohol intoxication. Securing a free airway is the highest priority. Suction the mouth and throat if there is an increase in mucus. Nasal or oropharyngeal airways are the first-line devices. Be aware that nasal airways may cause severe nosebleeds, and the risk of nosebleeds is increased in alcohol intoxication (due to alcohol's vasodilating effect). The patient's position should be in the recovery position, with the tongue pulled forward through a firm jaw thrust. Patients who cannot maintain a free airway in the supine position or are unresponsive should be monitored in an intensive care unit. Breathing: avoid hypoxia and hypercapnia by administering liberal amounts of oxygen.B. Facility policy and procedureThe Resident Change of Condition/Status policy and procedure, implemented 3/3/26, was provided by the DON/acting NHA on 3/4/26 at 10: 26 a.m. It read in pertinent part, To address changes in a resident's condition or status, this facility will provide the necessary care andtreatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Policy explanation and compliance guidelines:1. The nurse will notify the resident's attending physician or physician on call when there has been a change in a resident's condition or status. This can include, but is not limited to:a. an accident or incident involving the resident;b. the discovery of injuries of an unknown source;c. an adverse reaction to medication;d. a significant change in the resident's physical/emotional/mental condition; to include activesubstance use/abuse.e. a need to alter the resident's medical treatment significantly;f. refusal of treatment or medications two or more consecutive times;g. need to transfer the resident to a hospital/treatment center;h. discharge without proper medical authority; and/[NAME]. specific instruction to notify the physician of changes in the resident's condition.2. A significant change of condition is a major decline or improvement in the resident's status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting);b. (continued on next page)

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Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source;b. there is a significant change in the resident's physical, mental, or psychosocial status; to include active substance use/abuse.c. there is a need to change the resident's room assignment;d. a decision has been made to discharge the resident from the facility; and/ore. it is necessary to transfer the resident to a hospital/treatment center.5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.6. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments.7. In addition to notifying the resident and/or representative, the state mental health agency or state intellectual disability agency will be notified within 24 hours of a significant change in the mental or physical condition of a resident with a mental disorder or intellectual disability.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.9. A 72-hour monitoring order should be put into place to monitor the status of change in resident's condition.III. Resident incident1. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE], readmitted on [DATE] and discharged on 1/27/26 (deceased). According to the January 2026 computerized physician orders (CPO), diagnoses included alcoholic polyneuropathy, history of traumatic brain injury, CHF, type 2 diabetes mellitus, alcoholic cirrhosis of liver without ascites, hypertension, long term use of anticoagulants and alcohol use with unspecified alcohol-induced disorder.The 1/16/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of 5 out of 15. He required partial/moderate assistance with toileting hygiene, shower/bathing, upper and lower body dressing, rolling left/right, sitting to lying down, lying to sitting on side of bed, sitting to stand, chair to bed transfers, and toilet transfers. He required setup or clean-up assistance with eating, oral hygiene, personal hygiene, and walking. He did not require any mobility devices for walking.The assessment revealed there were no behavioral symptoms or rejection of care.B. Record reviewReview of Resident #7's comprehensive care plan revealed there was no care plan related to use of alcohol, intoxication or potential for substance use. There were no interventions related to his history of alcohol abuse and consuming alcohol while away from the facility. Record review revealed there was no documented discussion with the resident/resident guardian concerning hospice or palliative care.The January 2026 CPO revealed the following orders:Potential for substance use. Monitor for the following (change from baseline): Red eyes, dry mouth, lack of coordination, slowed reaction time, slurred speech, anxiety or paranoia, confusion, hallucinations, violent behavior, change in mood, irritability, increased sex drive, lack of inhibition, falls, dizziness, vomiting, needle marks, dilated or constricted pupils, breath and/or clothing smells, excessive talking. If any noted, write a progress note and notify the physician, every shift. Order date 9/22/25.-In the month of January 2026 the TAR documented that the resident had had no substance use behaviors indicating no pattern for Resident #7 in the month of January. Apixaban oral tablet five MG (milligrams) (Apixaban). Give 1 tablet by mouth two times a day for atrial fibrillation, order date 9/22/25. Gabapentin tablet 600 MG. Give one tablet by mouth three times a day for neuropathy, order date 9/22/25.Carvedilol oral tablet 25 MG (Carvedilol). Give one tablet by mouth two times a day for hypertension at breakfast and dinner, order date 12/16/25.Dapagliflozin propanediol oral tablet 5 MG (Dapagliflozin Propanediol). Give two tablets by mouth in the morning for diabetes mellitus, order date 12/30/25.-Significant medications with increased risks due to alcohol consumption included Dapagliflozin propanediol for diabetes, Apixaban (blood thinner), Carvedilol for (continued on next page)

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Record review revealed there was no documentation that the physician was notified that Resident #7 had returned to the facility with a change of condition-intoxication.Record review revealed there was no documentation that a change of condition assessment had been performed by the nurse upon Resident #7's return to the facility intoxicated.Record review revealed there was no documentation in the progress notes what time Resident #7 had returned back to the facility and his intoxication condition upon return to the building or how he got to his bed. -Record review and interviews (see below) failed to reveal that the resident was assessed upon his return to the facility or that his condition was documented and monitored between 2:30 p.m. and 5:30 p.m. There was also no evidence the resident's physician was notified of his change of condition.The 1/27/26 at 1:33 p.m. police dispatch call for service report revealed in pertinent part, that a caller at a hotel in Longmont reported that a male (later identified as Resident #7) was yelling for help and the male was on the ground. The caller passing by was not wanting to get close to him. The male had a shopping cart on the sidewalk. The male was still yelling for help, unknown what was going on with the male, the male was wearing a black coat. No weapons seen, the caller was 20 yards away. The male was still yelling. The male was laying down now, yelling for help. A third caller to police dispatch was saying male was saying he needed help getting up. The male was identified as Resident #7 and was returned to his facility on 1/27/26 at 2:04 p.m.-Record review revealed there was no documentation that the facility conducted a post-fall evaluation/assessment of Resident #7 after he was brought back to the facility by the police.The 1/27/26 at 6:26 p.m. nurses note revealed that the resident was visualized in his room lying face down next to his bed at approximately 5:30 p.m. The resident was unresponsive to verbal stimuli and sternal rub. The DON/acting NHA and charge nurse were alerted. Vitals were attempted, no pulse and no heart rate upon auscultation. Emergency services alerted by another nurse, guardian notified by DON/acting NHA and coroner notified by another nurse on duty. The physician pronounced the time of death at 5:30 p.m. The funeral home was notified by the charge nurse. The facility awaits the coroner to examine the body for transport.An IDT (interdisciplinary team) note dated 2/4/26 (one week after the event) revealed that on 1/27/26 at 8:30 a.m. Resident #7 signed himself out of the facility. Later the same day (no time given), the police department returned the resident to the facility. Officers reported the resident was intoxicated. Police assisted the resident in removing his shoes and coat and helped him into bed. The resident was observed to be resting in his room afterward (not specified). At 5:30 p.m., during dinner service, the certified nursing aide (CNA) entered the resident's room to deliver his dinner tray. The resident was found face down on the floor, unresponsive.The CNA immediately notified the nurse on duty. The physician pronounced the time of death at 5:30 p.m.The death certificate revealed the date of death was 1/27/26 at 5:30 p.m. and cause of death was respiratory failure, aspiration event, and alcoholism as recorded by Resident #7's PCP.IV. Staff interviewsThe frequent visitor was interviewed on 3/2/26 at 2:05 p.m. and she said she found out from a family member that there had been an unexpected death in the facility. The frequent visitor said she went and asked the DON/acting NHA about it and was told that Resident #7 had come home to the facility intoxicated on 1/27/26 at 2:30 p.m. and the police brought him home and helped him get into bed. The frequent visitor said she told the DON/acting NHA that she needed to do an occurrence report for an unexpected death and for Resident #7 coming back intoxicated. The frequent visitor said the DON/acting NHA did not think she needed to and was not aware that it was required. The frequent visitor said the DON/acting NHA finally did submit an occurrence report to the State eight days after Resident #7's death which meant the body was gone. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	CNA #3 said he went out in the morning and came back and she saw the police around the DON/acting NHA's office. CNA #3 said no one said anything to her, she did not know anything about his intoxication and was not even aware when he had returned. CNA #3 said she did not know if the police had come down the hall or if the police had put Resident #7 to bed. CNA #3 said close to dinner time she was handing out tickets for the next day's food orders and saw him in bed asleep. CNA #3 said there was another CNA, she did not remember who, and that CNA took in his food tray for dinner and found Resident #7 on the floor in his room, unresponsive. CNA #3 said that Resident #7 typically would not come back to the facility intoxicated, she may have seen that two times in the eight months that she had worked there.The maintenance director (MTD) was interviewed on 3/2/26 at 5:36 p.m. he said on 1/27/26 he did not see the police bring back Resident #7 to the facility. The MTD said he had seen the police in the building before at other times but not on that day. CNA #1 was interviewed on 3/3/26 at 8:50 a.m. and she said she was the staff member who discovered Resident #7 on the floor in his room the day he died [DATE]). CNA #1 said she delivered Resident #7's dinner tray around the end of the shift between 5:30-6:00 p.m. and found Resident #7 face down, holding onto the end of the leg of the bed, and the lights in his room were off. CNA #1 said when the nurses turned him over his body vomited. CNA #1 said the nurses did some checks and assessments and later the DON/acting NHA came. CNA #1 said Resident #7's head was toward the head of the bed and she did not smell anything or see blood. CNA #1 said she initially thought he had just had a fall. CNA #1 said she had heard about the police bringing Resident #7 into the facility, but did not see them and had no idea about how Resident #7 got back to his bed. CNA #1 said she saw Resident #7 in the morning of 1/27/26, he had come out of his room and was asking for towels and was joking around and then said she never saw him again. CNA #1 said that Resident #7 was not intoxicated in the morning and was in a good mood. CNA #1 said she had worked in the facility for about one year and had never seen him drunk/intoxicated. CNA #1 said the Resident #7 walked without an assistive device. Licensed practical nurse (LPN) #1 was interviewed on 3/3/26 at 9:00 a.m. she said she heard from CNA #1 and LPN #2 that Resident #7 was down on the floor. LPN #1 said she went to Resident #7's room and saw him laying flat, face down on the floor. LPN #1 said that LPN #2 assessed him and touched him and said he was cold. LPN #1 said she called the DON/acting NHA and the assistant director of nursing (ADON). LPN #1 said she noticed Resident #7's mouth was blue, with mucus, and he had urinated so his pants were wet. LPN #1 said she had worked in the facility since August of 2025 and had not noticed Resident #7 drunk/intoxicated, but said he may have drunk alcohol but never to the point of being intoxicated. LPN #1 said Resident #7 usually walked back from wherever he went and she had not noticed the police bringing him back to the facility.The ADON was interviewed on 3/3/26 at 9:29 a.m. she said she was working on the day shift on 1/27/26. The ADON said Resident #7's guardian had said he was allowed to go out and would sign in/out when he went. The ADON said she did not see Resident #7 come back to the facility with the police on the afternoon of 1/27/26 but she thought that LPN #2 had. The ADON said she did not see the resident come in but said usually when he came back he would go and lay down. The ADON said she had worked in the facility since June 2025 and said Resident #7 had admitted [DATE] but over that time she had not seen him totally intoxicated, but could smell that he may have had a few drinks sometimes. The ADON said to assess for alcohol intoxication or poisoning she would look at respirations, call the physician, and get an order to hold his medications and do a total head to toe assessment including a change of condition evaluation, risk management report and alert monitoring. The ADON said she would also look for slurred speech and unstable walking however she did not see Resident #7 return to the building. The ADON said that evening, on 1/27/26, she was called to come to Resident #7's room because he was lying down on the floor, his head was toward the head of the bed. The ADON said there were no vital signs, she did not see any blood, bruises or scratches. The ADON said she did not remember smelling anything but saw a littl

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NAME OF PROVIDER OR SUPPLIER: Accel at Longmont Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interviews, the facility failed to designate a registered nurse (RN) to serve as the director of nursing (DON) on a full-time basis.Specifically, the facility did not designate an RN to serve as the DON on a full-time basis, after the current DON was reassigned to be the temporary emergency licensed nursing home administrator (NHA) on 12/30/25 to 3/30/26. Cross-reference F684: The facility failed to provide quality care by not assessing, monitoring, documenting, and communicating a resident's change in condition when indicated, resulting in the death of the resident. Findings include:I. Record reviewReview on 2/26/26 of the acting NHA license revealed an active temporary permit for emergency situations issued 12/30/25 with expiration on 3/30/26. The review of the facility staffing list on 3/4/26 revealed there was no full time DON in the building. The facility's DON job position description, undated but signed by the DON on 10/23/25, was provided by the acting NHA on 3/5/26 at 6:34 a.m. It read in pertinent part, The primary purpose of this job position is to plan, organize, develop and direct the operations of the nursing department in accordance with federal, state and local standards, guidelines and regulations to ensure that the highest quality of resident care is maintained at all times. The director of nursing services reports to the nursing home administrator and regional nurse consultant. Reporting to this position are: registered nurses, licensed practical nurses, certified nurse assistants. The director of nursing services' primary responsibility is to ensure the provision of quality nursing care on a 24-hour basis to the residents of the facility in accordance with federal, state and local standards and regulations. The director of nursing services is responsible for the recruitment and hiring of licensed personnel and managing the nursing staff schedule. This position monitors the job performance of the nursing staff andrecommends employee promotions and terminations to the nursing home administrator. The director of nursing services monitors the staffing levels of the facility to ensure all resident needs can be met safely and in a timely manner. The director of nursing services is responsible to oversee the implementation of nursing service objectives, policies and procedures. T The director of nursing services is responsible for managing all clinical systems of the facility and participating as the lead committee member for these systems including but not limited to: the infection prevention and control program, psychotropic system and controlled substance management, skin and weight system, risk management system, hospice program liaison, Implements nursing service objectives, policies and procedures to maintain quality nursing care and ensure all federal, state and local guidelines and regulations are followed at all times II. Staff interviewsThe chief nursing officer (CNO) was interviewed on 3/4/26 at 10:39 a.m. She said that the full time temporary NHA was also acting as the full time DON. Licensed practical nurse (LPN) #1 was interviewed on 3/4/26 at 3:39 p.m. She said she did not know that the DON had been appointed as the temporary NHA. LPN #1 said the DON was her supervisor. Registered nurse (RN) #2 was interviewed on 3/4/26 at 3:46 p.m. She said she did not know the DON had been appointed as the temporary NHA. RN #2 said she was not notified and there had been no announcement and the DON was her supervisor. The full time temporary NHA was interviewed on 3/4/26 at 4:55 p.m. She said she was the full time temporary NHA starting on 12/30/25 and she was also serving as the full time DON. She said there was no one else appointed. The temporary NHA said the census was low enough and she had two unit managers and an assistant director of nursing (ADON) who was an LPN who helped her with the clinical duties and audits. The temporary NHA said she also had an infection preventionist (IP) who helped with wound care and other clinical portions. The acting NHA said that as the administrator she did occurrence reporting to the state, she was the abuse coordinator and did the abuse investigations. The acting NHA said she led out in the stand up meetings however she had not made an announcement to her staff that she was the acting NHA and the DON. The CNO and the acting NHA were interviewed together on 3/4/26 at 5:08 p.m. The CNO said again that the full time temporary NHA was also acting as the full time DON (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	however she did not know there was a regulation preventing that. The CNO said the regulation did make sense that there should be a full time DON working at least 40 hours per week. The CNO said she would work on what they needed to do. The CNO said there had not been an announcement to the staff concerning the temporary NHA appointment but they should have told the staff because the acting NHA was also the abuse coordinator and staff needed to report to the acting NHA. The CNO said there was no signage that the acting NHA was the abuse coordinator. The acting NHA said the residents and family also did not know that she was the temporary acting NHA. The acting NHA said it would be important to tell the residents and families so they would know who to go to if they had concerns. The acting NHA said it would be beneficial to let the residents and staff know that she was the acting NHA and would make that announcement right away.The CNO said she would immediately have a regional clinical RN step in as the fulltime DON and be present in the facility full time until the new NHA began.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#9) of three residents reviewed for medication errors out of 25 sample residents.Resident #9 readmitted to the facility after being hospitalized from [DATE] to [DATE]. Upon return to the facility, the facility failed to ensure that metolazone (a diuretic), which was entered into the electronic medical record (EMR) as a daily scheduled order instead of as needed (PRN), was not administered to Resident #9. The resident received the medication scheduled daily over eight days instead of PRN (based upon a weight gain of five pounds (lbs) over baseline). Thereafter, Resident #9 developed a change in condition for significant weight loss and the resident experienced severe and significant weakness, fatigue, discomfort, excessive somnolence, tiredness and exhaustion, as well as hypokalemia (low potassium).Specifically, the facility failed to ensure the resident was administered medications per physician's orders. Findings include:I. Professional referenceAccording to [NAME], P.A., [NAME], A.G et.al, Fundamentals of Nursing, 10th ed., (2023). Elsevier, St. Louis, Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications:1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Medication Error policy and procedure, implemented [DATE], was provided by the chief nursing officer on [DATE] at 11:28ˆa.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Definitions: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. The facility shall ensure medications will be administered as follows:-According to physician's orders;-Per manufacturer's specifications regarding the preparation, and administration of the drug or biological; and,-In accordance with accepted standards and principles which apply to professionals providing services.III. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE], and was readmitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included acute on chronic congestive heart failure (CHF), morbid obesity, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and hypertension (high blood pressure).The [DATE] 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. She required substantial/maximal assistance with toileting hygiene, showering/bathing, upper and lower body dressing, personal hygiene, sit to lying, toilet transfers and bed to chair transfers. She required partial/moderate assistance with rolling left and right, lying to sitting on the bed side and sitting to standing. She required setup or clean-up assistance with eating and oral hygiene. She used a manual wheelchair for mobility with supervision or touching assistance.The assessment revealed the resident was taking a diuretic medication, a high-risk drug class, per pharmacological classification.B. Resident and resident representative interviewsResident #9's representative was interviewed on [DATE] at 8:36 a.m. She said the dietitian had approached her about Resident #9's weight loss and said the resident might need a protein shake and that the nurse practitioner (NP) had stopped the incorrect medication. The resident's representative said she asked the director of nursing (DON)/acting nursing home administrator (NHA) which medication was incorrect and she told her that metolazone was supposed (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	to be PRN. The representative said the facility had administered the medication as a scheduled medication instead of following the parameters. The representative said Resident #9's baseline weight was 190 pounds (lbs). She said Resident #9 had lost significant weight from the medication error. She said Resident #9 was harmed because she had gotten so weak and could not regain her strength. The representative said Resident #9 told her with tears in her eyes that she just could not hang on any longer and she did not know what was wrong because she had never been this tired and exhausted before. The representative said she did not know at the time that there was a medication error that had lasted eight days. She said she felt like they were losing her and she was giving up. The representative said if registered nurse (RN) #2 had not noticed Resident #9's weight loss and spoken up to the NP, the resident would have died. She said she would not have known the cause of death and she would have just blamed it on COVID-19. The representative said the facility did not alert her of the medication error. She said she had to ask the facility about the error. The representative said when Resident #9 returned from the hospital on [DATE], she gave the hospital discharge paperwork (hard copy) to the assistant director of nursing (ADON) because the facility's phone lines were down that day. The representative said that the ADON took the discharge paperwork and typed everything (all the physician's orders) into the computer. She said that was how the incorrect medication got entered into the facility system for the resident to receive metolazone daily instead of PRN, which contributed to the resident's weakness and weight loss. Resident #9 was interviewed on [DATE] at 11:03 a.m. Resident #9 said it made her feel sad that the facility made a mistake and gave her the wrong medication. Resident #9 said she had felt weak and sick since returning from the hospital and it was one thing after another. C. Record reviewResident #9's diuretic therapy related to CHF care plan, revised [DATE], revealed pertinent interventions, initiated [DATE], included to administer diuretic medications as ordered by physician, to monitor for side effects and effectiveness; monitor for other medications that may interact; monitor/document/report adverse reactions to diuretic therapy such as dizziness, postural hypotension, fatigue, and an increased risk for falls; report pertinent lab results to physician especially hematocrit, sodium, and potassium. Review of Resident #9's [DATE] and February 2026 CPO revealed the following physician's orders:Spironolactone (diuretic) oral tablet 25 milligrams (mg). Give 25 mg by mouth one time a day for CHF, ordered [DATE]. Furosemide (Lasix - diuretic) oral tablet 40 mg. Give two tablets by mouth one time a day for CHF, ordered [DATE] and discontinued [DATE]. Potassium Chloride ER tablet extended release 20 MEQ (milliequivalent). Give two tablets by mouth one time a day for hypokalemia. Order date [DATE], discontinue date [DATE].Metolazone tablet 2.5 mg. Give one tablet by mouth one time a day for weight gain related to pulmonary edema and CHF take 30 minutes before Lasix. Notify primary care physician (PCP) for weight gain over 5 lbs over baseline, ordered date [DATE] and discontinued date [DATE].-However, the metolazone order that was entered on [DATE] did not match the physician's hospital discharge orders. The [DATE] hospital discharge paperwork documented the following physician's order:Metolazone 2.5 mg tablet. Commonly known as: Zaroxolyn for pulmonary edema due to chronic heart failure. Take 2.5 mg metolazone once daily, as needed, for weight gain 5 lbs over baseline. Take 30 minutes prior to Lasix.Resident #9's [DATE] and February 2026 medication administration records (MAR) were reviewed and documented that the metolazone 2.5 mg was administered once daily from [DATE] to [DATE] (for eight days), despite the resident not having a 5 lbs weight change. The February 2026 MAR documented that the resident's weight was not taken prior to administering the metolazone medication on [DATE] and [DATE]. Record review of the resident's weights revealed the following:-On [DATE] the resident's weight was 190.3 lbs;-On [DATE] the resident's weight was 190.2 lbs;-On [DATE] the resident's weight was 188.2 lbs. (Date the resident was sent to hospital);-On [DATE] the resident readmitted from the hospital and no weight was obtained;-On [DATE] the resident's weight was 188.8 lbs;-On [DATE] the resident's weight was 189.0 lb;.-On [DATE] the resident's weight was 186.2 lbs;-On [DATE] the resident's weight was 186.0 lbs;-On [DATE] no weight was recorded;-On [DATE] no weight was (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	recorded;-However, the resident was administered the medication on [DATE] and [DATE], despite the facility failing to obtain a weight to determine if the PRN medication was needed.-On [DATE] weight was 186 lbs; and,-On [DATE] weight was 176.6 lbs.-The resident's weight the day after she was readmitted from the hospital, was 188.8 lbs on [DATE]. On [DATE] when the medication error was discovered her weight was 176.6, which was a difference of 12.2 lbs. -However, per the resident representative's interview (see above) Resident #9's baseline weight was 190 lbs, which indicated a 13.4 lbs weight loss. The [DATE] progress note revealed Resident #9 reported nighttime breathing difficulty and the on-call physician recommended hospital evaluation. The resident was transported to the hospital.The [DATE] progress note revealed Resident #9 was readmitted to the facility via stretcher accompanied by the daughter following an acute inpatient hospitalization. The resident was admitted with a documented history of MDRO (multidrug-resistant organism) and prior COVIDˆ19 infection. The note documented current laboratory data indicated intermediate susceptibility to a carbapenemˆresistant organism (a class of last-resort antibiotics typically used to treat severe infections). Per infection prevention protocol and state guidance, the resident was placed on contact and droplet precautions upon admission. The resident remained on enhanced barrier precautions to continue for the duration of indwelling foley catheter use. The [DATE] progress note revealed Resident #9 was exhibiting significant weakness. The note documented she had been excessively sleepy during therapy today. The residents' vital signs were taken. The physician was notified immediately.The [DATE] change of condition note documented the resident had an abnormal weight change. The resident's weight was 176.6 lbs. The nurse received orders to discontinue the scheduled metolazone and keep metolazone as PRN if the resident gained weight 5 lbs from the baseline.The [DATE] eInteract change in condition evaluation was completed and revealed the resident's weight was 176.6 lbs. The nurse received orders to discontinue the current scheduled metolazone and start metolazone as PRN if the resident gained weight 5 lbs from the baseline.The [DATE] weight change note revealed the resident's current weight was 177.2 lbs, which indicated the resident had weight loss. The note revealed the resident was triggering for significant weight loss and a reweigh was requested. The weight was reviewed with nursing, resident, and daughter. The resident had a decline following recent COVID-19 infection and hospitalization. The resident was also receiving three diuretics (one discontinued on [DATE]). The representative reported significant weakness and fatigue. The resident reported a fair appetite. The staff were documenting the resident was consuming 50% to 75% of her meals. The representative requested oral supplements and the resident was in agreement to take. The plan was to implement 120 milliliters (ml) Med pass (oral nutrition supplement) BID (twice a day) to provide 510 kilocalorie (kcals) and 20 gram protein for 30 days. The dietitian would closely monitor.The [DATE] nurse note revealed the entry reflected followˆup communication and actions taken in the days after the resident's episode of severe weakness while receiving metolazone in addition to scheduled Lasix and Spironolactone. During this period, the resident demonstrated significant weakness, with vital signs remaining within normal limits and no dizziness, chest pain, or shortness of breath reported. The provider was notified and stated she was not concerned at that time, noting the resident was already on scheduled diuretics and that vital signs were stable. No new orders were issued other than continued monitoring. A followˆup call was made to the pharmacy for clarification regarding the metolazone order. The pharmacy reported they did not always receive hospital discharge orders directly and entered medications based on information provided during reconciliation. The pharmacy also stated they did not add parameter labels for conditional diuretics and advised that nursing staff ensure parameters were reviewed and followed during administration. Nursing staff were educated on conditional diuretics, including the need to verify weightˆbased parameters prior to administration and to document the triggering parameter when applicable. The resident continued to be monitored for hydration status, intake, urine output, and changes in strength. No acute decline noted. The provider to be notified of any change in condition.The [DATE] alert charting note revealed receiving metolazone and potassium daily instead (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of PRN. The note documented the nursing staff was monitoring for acute changes, weakness, abnormal vital signs, weight loss, every shift for three days. The [DATE] at 10:11 a.m. IDT (interdisciplinary team) note revealed that the medication error was noted when Resident #9 returned from the hospital with a physician's order for metolazone 2.5 mg to be given PRN and administered only when the resident gained weight over 5 lbs. The error was identified on [DATE] and the root cause was identified as medication reconciliation was not completed upon admission. Education was provided to the floor staff. New interventions implemented included all medications must be verified by two nurses.-The IDT note incorrectly documented that the medication error was identified on [DATE], when per record review, it was identified on [DATE]. However, the alert charting was not activated until [DATE] and the resident's labs were not collected until [DATE]. The [DATE] nurse note revealed the NP was notified regarding the medication error. Per the NP, the resident was okay to stay on potassium daily due to the resident receiving 80 mg of Lasix. Metolazone was changed into PRN and to administer if the resident gained weight of 5 lbs from resident baseline weight. order updated on EMR. Upon assessment, the resident appeared to be within her baseline, vital signs were stable with no major adverse effect noted. The medical director was notified and aware of the incident.On [DATE] the nurse alert note revealed Resident #9 had received metolazone and potassium daily instead of PRN. The note documented the nursing staff were monitoring for acute changes, weakness, abnormal vitals, weight lost, every shift for three days. The [DATE] laboratory result report revealed the residents potassium was low at 3.2 milliequivalents per liter (mEq/L). (The normal range for potassium is 3.5 to 5.1 mEq/L.)On [DATE] the nurse note revealed recent lab results were reviewed by the physician's assistant and received an order for potassium ER 20 mEq one time only, order updated in the EMR. The resident was encouraged to drink plenty of fluids.IV. Staff interviewsRegistered nurse (RN) #2 was interviewed on [DATE] at 5:08 p.m. RN #2 said there was a medication error with Resident #9 that started on [DATE] when the resident came back from hospital. RN #2 said she discovered the medication error on [DATE] after noticing the resident's significant weight loss. RN #2 said she told the NP and they corrected it. RN #2 said the error was that the ADON entered the metolazone medication into the computer as scheduled daily instead of PRN. RN #2 said there should have been two nurses for the entry of medication orders to double check the orders and prevent errors. RN #2 said the risk to Resident #9 if she had continued to be administered the wrong medication order was weight loss, weakness, hospitalization, and possible death. RN #2 said she had also asked the dietitian to check on Resident #9's weight.The ADON was interviewed on [DATE] at 9:47 a.m. The ADON said when Resident #9 returned to the facility from the hospital on [DATE], the phone lines were down and had been down for a few days. The ADON said she did not know why the phone lines were down but she had tried to call for labs and noticed she was unable to. The ADON said normally the hospital would call to give report but they were unable to, so they gave the discharge packet to Resident #9's daughter. The ADON said she did not know why admissions staff did not get the paperwork ready electronically through the hospital charting system EMR and process the admission. The ADON said the normal process was for the admissions staff to upload the hospital discharge orders into the EMR into the miscellaneous section and then the nurses would print out and enter into the EMR orders section and then two nurses put in the orders to verify the orders. The ADON said on [DATE] when Resident #9 came back from the hospital she just entered the orders in only without a second nurse double checking. The ADON said another nurse was going to double check the orders but it did not get done and she did not know why. The ADON said the second double check was important to catch errors and prevent errors.The ADON said a medication error ended up occurring for a PRN metolazone medication. She said the order was put in as scheduled daily instead. The ADON said the medication error was discovered nine days later on [DATE]. The ADON said the physician was notified of the error on [DATE] that the metolazone was scheduled daily versus put in as PRN based on the resident's weight. The ADON said per the representative, Resident #9's baseline weight was 190 lbs. The ADON said the IDT note and the risk (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	management report were completed on [DATE] although she did not know why it was entered so late after discovering the error on [DATE] (five days later). The ADON said the risk to Resident #9 for taking the metolazone medication daily instead of PRN was losing weight and she did lose weight. The ADON said in addition, weakness was also a side effect and the possibility of sodium and potassium depletion. The ADON said the facility completed a lab draw after discovering the error and found that Resident #9's potassium level was low. The ADON said Resident #9 was just coming back from hospitalization and recovering from Covid-19 so she was already weak and the medication error added a little bit of an exacerbation of the weakness with this error. The ADON said the error occurred for about eight days before being corrected. The ADON said Resident #9's weight loss from her 190 lbs baseline to 176 lbs on [DATE] was about 14 lbs. The ADON said when the resident went to the hospital on [DATE], she weighed 188 lbs, which indicated she sustained a 12 lbs weight loss in 13 days. The ADON said the reason the medication reconciliation did not happen was because the resident was admitted on a Friday and the medication reconciliation was usually done the next day, so that was not happening on the weekend. The ADON said that residents admitted to the facility on the weekends and on Fridays and there was education done that the floor nurses needed to verify the orders. The ADON said Monday through Friday, the DON and herself verified all the orders but there was a risk for the weekends so the nurses were educated to verify with two nurses. The DON/acting NHA was interviewed on [DATE] at 10:33 a.m. The DON/acting NHA said the medication error for Resident #9 was discovered on [DATE] and the resident was receiving the medication in error for eight days. The DON/acting NHA said when the medication error was discovered they completed an incident/risk management report and a change of condition alert with monitoring for three days. The DON/acting NHA said the medication error was discovered by a floor nurse when she weighed Resident #9 and it was low so she alerted the physician that her weight was low. The DON/acting NHA said the physician discovered the medication error and gave an order to discontinue the scheduled daily metolazone and correct the order to be PRN when the resident gained more than 5 lbs from baseline. The DON/acting NHA said the consequences from receiving the medication daily when not needed was weight loss, which Resident #9 had, and weakness, especially if the error had continued for a prolonged period. The DON/acting NHA said Resident #9 was already weak after being at the hospital with a UTI (urinary tract infection) and COVID-19, so the staff started using two person transfers for Resident #9 when she returned from the hospital. The DON/acting NHA was sure the medication error did not help her with her weakness. The DON/acting NHA said on [DATE], when Resident #9 returned from the hospital, the phone lines were down. The DON/acting NHA said the questions of why the phones were down would need to be asked of the admissions/former operations manager for dealing with that situation. The DON/acting NHA said usually they were able to view the admission paperwork through the EMR/hospital charting system and the hospital would also send a hard copy of the discharge paperwork. The DON/acting NHA said what usually happened with a hard copy was the nurses entered the medications into the computer and then another nurse was supposed to double check the orders to prevent an entry error. The DON/acting NHA said on that day the ADON put in the orders for Resident #9 but there was no second nurse review but she had provided education to the nurses to double check and they now did audits. The DON/acting NHA said she did not realize there was a break in the system so there was a new admissions checklist, and the audits were newly implemented and the second nurse verifications could happen on the weekends and everyday.Primary care physician (PCP) #2 was interviewed on [DATE] at 9:34 a.m. PCP #2 said he had been working in the facility for one month but would be retiring and going back to urgent care work. PCP #2 said that related to the medication error for Resident #9 and the medication metolazone, it was a special diuretic and worked like a turbo charger since the resident was already receiving the diuretic Lasix. PCP #2 said the metolazone medication was not typically used by itself but in combination with other medications. PCP #2 said the metolazone medication order was supposed to be PRN for when the resident gained 5 lbs from her baseline. PCP #2 said the side effects of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

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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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	medication were weight loss and the speed of weight loss, noting the resident lost 10 lbs in one day which was very hard to do and could contribute to weakness. PCP #2 said that Resident #9 had a multi-factorial global decline and it was possible that the medication error if continued could cause the resident to die, it was possible but not likely or probable. PCP #2 said he did not think that Resident #9 suffered permanent harm from the medication error, but there was a recognition that something had gone wrong and that error was caught in time. The pharmacist was interviewed on [DATE] at 4:20 p.m. The pharmacist said the biggest side effect of giving the metolazone to Resident #9 when not needed, would be an electrolyte abnormality, the drug worked by pulling water from the kidneys and could also get a low potassium lab in synergetic effect with use of the furosemide (Lasix). The pharmacist said additionally, the side effects would definitely be some weight loss and 13 lbs would be considered significant. The pharmacist said electrolyte imbalance was directly related to dizziness and muscle cramps as one affects the other in a chain reaction. The pharmacist said if the medication was administered incorrectly (by being given when not needed) for eight days, it would be a moderate error and would continue to increase the electrolyte depletion and would require close monitoring.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life and resident safety.Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of care by not assessing, monitoring, documenting, and communicating a resident's change in condition when indicated that rose to the level of immediate jeopardy and created a situation where a serious adverse outcome occurred and caused harm. Findings include:I. Facility policy and procedureThe Quality Assurance and Performance Improvement (QAPI) policy, implemented 5/25/25, was provided by the chief nursing officer (CNO) on 3/9/26 at 11:28 a.m. It read in pertinent part, It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Develop and implement appropriate plans of action to correct identified quality deficiencies. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. The QAPI committee must review all plans of correction written. The QAPI plan will address the following elements: Design and scope of the facility's QAPI program and QAPI Committee responsibilities and actions. Policies and procedures for feedback, data collection systems, and monitoring. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: Tracking and measuring performance. Establishing goals and thresholds for performance improvements. Identifying and prioritizing quality deficiencies. Systematically analyzing underlying causes of systemic quality deficiencies. Developing and implementing corrective action or performance improvement activities. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. A prioritization of program activities that focus on resident safety, health outcomes, autonomy, choice and quality of care, as well as high-risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves. The facility must also consider the incidence, prevalence, and severity of problems or potential problems identified. Program development guidelines: Program design and scope - The QAPI program will be ongoing, comprehensive, and will address the full range of care and services provided by the facility. II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correctF684 Quality of careDuring the recertification survey on 9/11/25 F684 was cited at a D scope and severity, a potential for more than minimal harm, isolated.During the recertification survey on 8/29/24 F684 was cited at a D scope and severity, a potential for more than minimal harm, isolated. III. Cross-reference citationsCross-reference F684: The facility failed to provide quality care by not assessing, monitoring, documenting, and communicating a resident's change in condition when indicated, resulting in the death of the resident. The facility's failure to provide quality of care put residents in a situation where a serious outcome occurred and created an immediate jeopardy situation. IV. Staff interviewsThe medical director (MD) was interviewed on 3/5/26 at 11:27 a.m. He said he was in the facility at least twice a month. The MD said the role he provided while in the facility was to talk to the administrator and the director of nursing (DON) and look at any special cases. The MD said he would plan to provide any education to the staff as indicated. The MD said he received and reviewed reports that were provided to him of any resident cases that needed to be reviewed. The MD said based on the facility he would be there tomorrow or the next week to follow up and provide oversight and follow up suggestions to the (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing home administrator (NHA), DON and regional directors. The MD said he reviewed any resident records that were presented to him as needing review. The MD said he reviewed policies and made changes to policies based on what was presented to him during QAPI. The MD said he had been the medical director at the facility for a few months. The MD said that the facility had informed him on 3/3/26 that the survey team had called immediate jeopardy for F684 quality of care regarding an unexpected death. The MD said he was not made aware that the DON was also acting as the full-time temporary emergency licensed NHA from 12/30/25 to 3/30/26. The MD said there had been a lot of leadership changes at the facility. The MD said his understanding and thoughts about the nature of the IJ situation was that there was a dilemma when finding the balance between a resident going out and doing what they want and not letting them go out in order to keep them safe since this was their home and the challenge became could they go out. The MD said as far as monitoring and evaluating the resident who came back intoxicated it depended if it was routine or not but the documentation and processes needed to be improved and he had talked to the facility about that. The MD said his recommendation for the facility's next steps would be a deep dive and a deep clean regarding the game plan going forward. The MD said that since he was now aware that the DON was also acting as the NHA, there needed to be a lot of process improvement and standardization, The DON/acting NHA was interviewed on 3/5/26 at 4:54 p.m. She said the last QAPI meeting was on 2/24/26 and prior to that it was held 1/8/26. The DON/acting NHA said the QAPI committee met monthly and the committee included all the required members plus other staff members such as the pharmacist, therapy and social services. The DON/acting NHA said problems that were brought up, such as through occurrences, grievances, resident council, PIP, plan of corrections the committee was aware of the issues. The DON/acting NHA said that some issues they work on were standard topics such as admissions, discharges, falls, hiring/staffing and abuse. The DON/acting NHA said the infection preventionist (IP) gives a report on wound care, antibiotic stewardship and infections. The DON/acting NHA said she brought up call lights at every meeting. The DON/acting NHA said she educated the committee so they knew what corrective actions had been implemented and she tried to capture everyone on every shift and anything identified by the audits. The DON/acting NHA said she brought up grievances and would now be bringing up the grievance process for improvement. The DON/acting NHA said they had an audit tool for every department and there were graphs that mapped our progress and there was a spreadsheet that helped them track progress on the issues. The DON/acting NHA said as far as change of condition evaluations they were doing that for skin alterations and falls and the staff knew that came with a risk management report and neurological checks. But they were new to the other types of change of condition assessments, which would include a thorough assessment, notification to physician and family/guardian. The DON/acting NHA said they would now add change of condition evaluation to QAPI as there were more types of changes of condition.