STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065431	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	4356 24th St Rd Greeley, CO 80634

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value and was palatable in taste, texture and temperature.Specifically, the facility failed to ensure the residents' food was palatable in taste, texture and temperature. Findings include:I. Facility policy and procedureThe Standardized Recipes policy, dated 2021, was provided by the nursing home administrator (NHA) on 4/23/26 at 5:06 p.m. It revealed in pertinent part, Standardized recipes will be used when preparing menu items. Standardized recipes (in appropriate portion sizes) for planned menu items will be maintained in the facility. Cooks/chefs are expected to use and follow the recipes provided. Cooks/chefs should discuss problems or concerns about recipes with the director of food and nutrition services so that issues can be resolved.II. Resident representative interview Resident #13's representative was interviewed on 4/20/25 at 1:17 p.m. The resident's representative said the resident had stayed at the facility several times and had no complaints about the food during previous stays. The representative said she complained about the food to the CNAs and staff responded that there had been turnover in the kitchen and whoever was in the building would took over that responsibility, and they did not have a cook at the moment.III. Resident group interviewA group interview was conducted on 4/21/26 at 1:30 p.m. with five alert and oriented residents (#46, #14, #41, #21, and #31) who were interviewable per the facility and assessment. The residents said the food was cold and did not taste good. The residents said the quality of the food was inconsistent. They said the chicken [NAME] served that day (4/21/26) was cold and tasted bland. The residents said they did not always receive what they ordered. They said they received a Coke even though they had ordered cranberry juice. They said they had ordered a pickle with their meal but they did not deliver it.IV. Additional resident interviewsResident #9 was interviewed on 4/20/26 at 1:36 p.m. Resident #9 said the food did not taste good and was bland with no salt. Resident #9 said on 4/19/26 at lunch he ordered meatloaf but received ham with side dishes of bland vegetables. Resident #9 said he asked for French fries and received mashed potatoes. Resident #9 said he told the staff and they said that was what the kitchen gave them. Resident #9 said he had a big problem getting coffee and that he loved coffee and drank it throughout the day. Resident #9 said he had a large mug he would like filled, but he received a small paper cup of coffee. Resident #9 said until 4/20/26, no one took his order or filled out a meal ticket to order from the kitchen.Resident #40 was interviewed on 4/20/26 at 2:16 p.m. Resident #40 said the food was cold, whether it was lunch or dinner. Resident #40 said the last time the food was cold was on 4/18/26. Resident #40 said she ordered one item and received something different. Resident #40 said she told the staff and they said they lost the meal tickets.V. Test trayA test tray for a regular diet was evaluated by four surveyors immediately after the last resident was served their room tray for lunch on 4/21/26 at 12:56 p.m. The test tray consisted of chicken fettuccine alfredo, garden salad and garlic bread. The following was observed:-The chicken fettuccine alfredo was bland in taste and lacked flavor;-The garlic bread was 113 degrees Fahrenheit (F) had a doughy texture, lacked garlic flavor and seasoning, and was bland; and,-The garden salad was 90 degrees F. It was served with no dressing. VI. Record reviewA review of the 1/30/26 resident council meeting revealed resident concerns related to food service. It revealed kitchen concerns (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	included sandwich bread was too hard, stiff and cold, and chicken was overcooked. Breakfast meals were hard to bite or chew, including waffles and sausage. Drink portions were too small, items were missing on trays, including silverware, drinks and food items. There was a delay when requesting missing or extra items, and meals did not match what was on the tickets.The [NAME] chicken fettuccine recipe was provided by the cook (CK) #1 on 4/22/26 at 11:17 a.m. The recipe for [NAME] chicken fettuccine revealed the recipe yield was 50 portions. The ingredient list included salt with the instruction to add to taste. VII. Staff interviewsThe dietary manager (DM) was interviewed on 4/22/26 at 10:50 a.m. The DM said she monitored food quality through tray audits and food temperature checks to assess taste, texture and temperature. The DM said she checked temperatures at the start of service, ensured steam tables worked properly and completed spot checks during service. The DM said she ensured staff followed recipes to maintain taste, texture and quality. The DM said she corrected issues during service by reheating food that was not warm and adjusting items that did not meet quality standards, such as improving texture when food was dry. CK #1 was interviewed on 4/22/26 at 11:03 a.m. CK #1 said he received hands-on training when he started two months ago and brought one year of prior cooking experience. CK #1 said he received training on preparing different textures, including minced and moist diets, and added sauce as needed to achieve appropriate texture. CK #1 said he followed standardized recipes from a recipe book provided by Shamrock (food service distributor) and used them step by step to maintain consistency in taste and texture. CK #1 said he followed recipes for all menu items because not following them would affect taste and resident expectations. CK #1 said he reviewed the menu in advance and ordered ingredients if needed to ensure meals were prepared as planned. CK #1 said he used a thermometer and cut into food to check if it was cooked inside because it could look done on the outside but not be cooked inside. CK #1 said he tasted food before service to check seasoning and overall quality. CK #1 said he tasted the [NAME] chicken that day and said it was bland. CK #1 said the recipe included no salt or approximately half teaspoon of salt for 40 servings due to low sodium and heart-healthy diets. CK #1 said residents could add salt or pepper themselves if they wanted. CK #1 said the sour cream in the [NAME] made it taste bland. - However, a review of the [NAME] chicken fettuccine recipe revealed the ingredients and instructions directed salt to be added to taste and the recipe yielded 50 portions.VIII. Facility follow-upThe DON provided nursing staff an in-service on resident meal feedback on 4/23/26. Staff were to obtain resident meal feedback about taste and flavor of food, food temperature, texture appropriateness, portion size, accuracy of meal trays and overall meal satisfaction. Staff were to report urgent or significant concerns immediately to nursing and dietary leadership, including refusal to eat and repeated dissatisfaction.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment to prevent the development and transmission of diseases and infection on two of two units.Specifically, the facility failed to:-Ensure staff wore the appropriate personal protective equipment (PPE) while providing care to Resident #4; and,-Ensure staff properly cleaned shared vital signs equipment between residents. Findings include: I. EBP failures 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), (4/2/24), retrieved on 4/27/26, from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high-contact resident care activities. 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; wound care: any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions (EBP) policy, revised 1/29/25, was provided by the nursing home administrator (NHA) on 4/23/26. It read in pertinent part, Purpose: To reduce transmission of MDROs (multidrug-resistant organisms) by employing targeted gown and glove use during high-contact resident care activities. Per the CDC, EBP are recommended (when Contact Precautions do not otherwise apply) during high-contact care activities with residents who are at higher risk of acquiring or spreading an MDRO. EBP include use of gown and gloves during the high-contact patient care activities below: dressing; bathing/showering; transferring; when working with patients in the therapy gym that need mobility assistance and/or transfers that require a longer duration; 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. C. Observations and staff interviews On 4/21/2026 at 10:11 a.m. certified nurse aide (CNA) #1 was in Resident #4's room. Outside Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#4's room in the hallway was a small white bin which contained EBP gowns. Resident #4's room had an EBP sign posted on the door to alert staff to use gowns and gloves for high-contact resident care activities. CNA #1 stood next to Resident #4's bed and helped Resident #4 get dressed. A hospital gown with fecal matter was in a trash bag on the floor. CNA #1 was wearing gloves. -CNA #1 failed to put on a gown. CNA #1 was interviewed in the hall after resident care had been completed. CNA #1 said Resident #4's colostomy leaked and got fecal matter onto Resident #4's hospital gown and abdomen. CNA #1 said Resident #4 needed assistance dressing herself. CNA #1 said she helped Resident #4 out of the dirty hospital gown and into a clean hospital gown. CNA #1 said she only wore gloves for the procedure. CNA #1 said she knew Resident #4 was on EBP, but staff only had to wear the PPE gown if they were providing catheter care to the resident. CNA #1 said she was dressing the resident, therefore did not have to wear the PPE gown. On 4/21/26 at 3:01 p.m. registered nurse (RN) #3 was providing education on EBP to an unnamed staff member. RN #3 had the staff member complete a return demonstration of gown donning and doffing. The staff member then signed an education sign-off sheet. RN #3 said he was having all staff complete the education. D. Additional staff interviews The director of nursing (DON) was interviewed on 4/22/26 at 1:44 p.m. The DON said she was the facility's infection preventionist (IP). The DON said CNA #1 should have worn a gown while providing care to Resident #4. The DON said she educated CNA #1 about proper EBP implementation and provided education to all direct care staff on EBP. II. Failure to clean vital signs equipment between residents A. Professional reference The CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities, (2024), retrieved on 4/27/26 from https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/summary-recommendations.html#:~:text=Er read in pertinent part, Clean medical devices as soon as practical after use. Perform either manual cleaning or mechanical cleaning. Perform low-level disinfection for noncritical patient-care surfaces and equipment (blood pressure cuffs) that touch intact skin. B. Facility policy and procedure The Medical Devices/Equipment Disinfection policy and procedure, revised 8/29/22, was received from the NHA on 4/23/26 at 5:06 p.m. It read in pertinent part, The facility will follow the CDC guidelines for disinfection of medical devices/equipment. All non-dedicated, non-disposable medical equipment used for patient care is cleaned and disinfected with an environmental protection agency approved product per CDC guidelines and recommendations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations On 4/21/26 at 10:35 a.m. certified nurse aide (CNA) #5 left room [ROOM NUMBER] with vital sign equipment, entered room [ROOM NUMBER] and began assessing the resident residing in room [ROOM NUMBER]'s vital signs using the vitals equipment. room [ROOM NUMBER] was a single-occupancy resident room which had a sign for enhanced barrier precautions (EBP) on the door and a bin containing personal protective equipment just outside the door to the room. No cleaning wipes were available on the CNA's vital machine. -CNA #5 did not perform hand hygiene after leaving room [ROOM NUMBER] and did not wipe off the vital sign equipment prior to entering room [ROOM NUMBER]. At 10:36 a.m. CNA #5 left room [ROOM NUMBER], performed hand hygiene, and entered room [ROOM NUMBER] to begin assessing the resident's vitals. room [ROOM NUMBER] was a single-occupancy resident room which had a sign for EBP on the door and a bin containing personal protective equipment just outside the door to the room. -CNA #5 did not clean the vitals equipment after leaving room [ROOM NUMBER] or before entering room [ROOM NUMBER]. At 10:37 a.m. CNA #5 left room [ROOM NUMBER], performed hand hygiene, entered room [ROOM NUMBER] and began assessing the resident in room [ROOM NUMBER]'s vital signs. -CNA #5 did not clean the vitals equipment after leaving room [ROOM NUMBER] or before entering room [ROOM NUMBER]. At 10:41 a.m. CNA #5 left room [ROOM NUMBER], performed hand hygiene, entered room [ROOM NUMBER] and began assessing the resident in room [ROOM NUMBER]'s vitals. -CNA #5 did not clean the vitals equipment after leaving room [ROOM NUMBER] or before entering room [ROOM NUMBER]. C. Staff interview The DON who was also serving as the facility's infection preventionist (IP) was interviewed on 4/22/26 at 12:32 p.m. The DON said all vital signs equipment must be cleaned after use and between each resident. The DON said the vital signs equipment should be cleaned using purple top disinfecting wipes by the CNAs.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were provided prompt efforts by the facility to resolve grievances for one (#1) of three residents reviewed for grievances out of 29 sample residents.Specifically, the facility failed to report, document and follow-up on a grievance reported by Resident #1 concerning a lost personal item. Findings include:I. Facility policy and procedureThe Grievance policy and procedure, revised 2/8/21, was received from the nursing home administrator (NHA) on 4/23/26 at 5:06 p.m. It read in pertinent part, Grievances can be communicated to a staff member either verbally or in writing. The facility will make every effort to promptly investigate and resolve any grievances. If a complaint is verbal, it is the responsibility of the staff member who received the complaint to properly complete the grievance form on behalf of the complainant. The completed form must be provided to the NHA or designee immediately. II. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic respiratory failure, type 2 diabetes and acute pulmonary edema (an accumulation of fluid in the lungs).The 4/2/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required substantial or maximal assistance from staff for most activities of daily living (ADL).B. Resident interviewResident #1 was interviewed on 4/20/26 at 11:07 a.m. Resident #1 said she had a gecko stuffed animal, which had gone missing one to two weeks prior. Resident #1 said she had told the nursing staff it went missing. She said the nursing staff had helped her look all over her room but said they could not find it. Resident #1 said she was not sure if it had been taken with her bedding to the laundry room or if it had been accidentally thrown away. Resident #1 said she was upset the stuffed animal had gone missing because she had the stuffed animal for over a year prior.Resident #1 was interviewed a second time on 4/22/26 at 10:23 a.m. Resident #1 said a facility staff member had come in earlier to talk to her about her stuffed animal and said they were letting her look online to find another stuffed animal.C. Record reviewA behavior note, dated 4/4/26 at 9:50 p.m., revealed Resident #1 had a behavioral incident. Resident #1 was anxious and did not know where she had misplaced her green gecko toy. -However, no grievance form was completed at the time for her missing gecko toy.A grievance form, dated 4/21/26 (during the survey), was filed on behalf of Resident #1 by the social services director (SSD). The grievance form revealed Resident #1 said her green gecko stuffed animal was not able to be located after she returned to her room after receiving a shower. Resident #1 said this happened after the second shower she had after admission. Resident #1 said she had reported the item was missing to the nursing staff immediately after her shower.The grievance report summary revealed the SSD spoke with the nursing team members who said they were not aware of any missing items for Resident #1. The SSD spoke with Resident #1 who indicated she would like a new stuffed animal. The SSD documented she would order a new stuffed animal for Resident #1 per her preferences, and that the resident was happy and content with the plan going forward. The grievance was documented as being resolved on 4/21/26.-However, the grievance form was completed and resolved on 4/21/26, 17 days after Resident #1 reported her stuffed animal was missing.III. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 4/21/26 at 3:36 p.m. CNA #5 said if a resident reported an item was missing, she would help the resident look for it then report the missing item to the nurse.CNA #4 was interviewed on 4/22/26 at 9:00 a.m. CNA #4 said if a resident said they were missing any items she would report the missing item to the nurse, the director of nursing (DON) and the housekeeping staff so they could look for it.CNA #3 was interviewed on 4/22/26 at 9:19 a.m. CNA #3 said if a resident said they were missing an item, she would ask the resident where they last saw the item, look through their room and their linens and fill out a grievance form for the resident.Licensed practical (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse (LPN) #2 was interviewed on 4/22/26 at 10:43 a.m. LPN #2 said if a resident said they were missing an item, she would help them look for it and try to check with other staff members or staff members on other shifts to see if they had seen the item. LPN #2 said she did not know if she would need to fill out a grievance form if a resident was not able to locate their personal items, but said she knew she would need to fill out a grievance form if a resident thought someone took something from them.The SSD was interviewed on 4/22/26 at 2:03 p.m. The SSD said any time a resident reported they are missing an item or if staff came to the SSD with concerns about a missing resident item they would fill out a grievance form. The SSD said the staff would first look for the item, then fill out a grievance form, and if they were not able to locate the item they would reimburse the resident or order a new item to replace it. The SSD said because the items can be very personal to the resident, the staff try to level with the resident and see how they can make the situation better. The SSD said the staff typically tried to look for the missing item and fill out a grievance form the same day the item was reported missing. The SSD said the facility did team meetings, at which she would remind the staff to fill out grievance forms for missing resident items so they could have documentation and ensure the grievance process was followed. The SSD said the usual timeline for reviewing and solving a grievance took 72 hours.-However, Resident #1's grievance regarding her missing stuffed animal did not have a grievance form associated with it and was not resolved for 17 days after it was first reported to be missing.The NHA was interviewed on 4/22/26 at 4:35 p.m. The NHA said staff members filled out a grievance form whenever a resident reported a personal item was missing. The NHA said missing personal items needed to be addressed immediately, but at most within a few days. The NHA said she had heard Resident #1 was missing a stuffed animal right before the beginning of the survey (on 4/20/26).-However, a grievance form was not filled out for Resident #1's missing stuffed animal until 4/21/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#6) of two residents reviewed for accident hazards out of 29 sample residents.Specifically, the facility failed to provide adequate supervision for Resident #6, who had previous falls, while showering. Findings include:I. Resident #6A. Resident statusResident #6, age greater than 65, was admitted on [DATE]. According to the April 2026computerized physician orders (CPO), diagnoses included pneumonia, dementia with agitation and generalized muscle weakness.The 1/17/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) assessment score of 12 out of 15.The resident was required partial to maximal assistance from staff for most activities of daily living (ADL). The resident required maximal assistance from staff for most transfer activities.B. Resident interview and observationsResident #6 was interviewed on 4/21/26 at 10:53 a.m. Resident #6 said he had fallen the day prior (4/20/26) in the bathroom and was still feeling a bit woozy. Resident #6 said he slipped and fell in the shower and had hit his head on the shower wall and floor, and said the incident was scary. Resident #6 said there had been a staff member in the bathroom with him, but they had left the bathroom to go get towels. Resident #6 said he was washing his groin and went to reach for the grab bar in the shower when he slipped. Resident #6 said the CNA heard him yell, saw him on the ground and got the nurse to help him. Resident #6 said normally a staff member would stay with him the entire time during his shower, it just so happened the CNA left to go get something when he fell.Resident #6's bathroom door opened into the bathroom, and the shower was at a diagonal from the bathroom door approximately five feet away.C. Record reviewThe fall care plan, revised 4/20/26, revealed Resident #6 was at risk for falls due to impaired mobility secondary to weakness and debility and his drug regimen. The care plan documented Resident #6 had sustained two unwitnessed falls on 3/29/26 and 4/20/26. Pertinent interventions included wearing proper non-slip footwear and keeping the resident's call light within reach. On 4/20/26 an intervention was initiated for staff to provide supervised showering for Resident #6 with the resident remaining seated on the shower bench for all bathing tasks, using non-skid footwear, and staff providing direct assistance for all lower body hygiene.A fall risk evaluation, dated 1/16/26 at 10:22 p.m., revealed Resident #6 was at low risk for falls.A post-fall evaluation, dated 3/29/26, revealed Resident #6 reported to the staff he had fallen when he was adjusting his sheets and fell out of bed. The fall was unwitnessed and no injuries were identified. Resident #6 was assessed, neurological checks were initiated, and the resident's physician was notified.A progress note, dated 3/30/26 at 8:30 p.m., revealed Resident #6 reported an unwitnessed fall on 3/29/26 where he reported he had bumped his head. A root cause analysis indicated Resident #6 likely fell due to an unassisted transfer, impaired safety awareness and environmental weakness. The interdisciplinary team (IDT) reviewed the fall and implemented new interventions including increased observation/rounding, ensuring environment was well-lit and free of clutter, and reinforcing the use of Resident #6's call light.-Review of Resident #6's electronic medical record (EMR) did not reveal the resident's fall risk was re-assessed after his fall on 3/29/26 to evaluate any changes in the resident's fall risk.An IDT note, dated 4/14/26 at 11:40 a.m., revealed Resident #6 was reviewed by the IDT. Resident #6 was able to transfer with a two-wheeled walker and required moderate assistance for ADLs.Review of Resident #6's Kardex (staff directive tool), as of 4/18/26, revealed the following interventions:-Signs for resident to call, not fall placed in the resident's room to remind the resident to call for assistance-Staff to implement increased rounding/observation, ensure the environment is well-lit and free of clutter and reinforce use of call light.-Do not leave the resident alone in the bathroom.-Keep bed in low position while the resident is in bed.A progress note, dated 4/20/26 at 7:30 a.m., revealed a certified nurse aide (CNA) reported (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was taking a shower and was washing his groin when his feet slipped and the resident fell back onto his buttocks. Resident #6 reported he hit the back of his head, his right elbow and his back. Resident #6 was found sitting on the floor with his buttocks outside the shower and his legs in the shower. Resident #6 reported he was trying to wash his groin and his feet slipped out from under him. Resident #6 was assessed by the nurse and found to have a skin tear to the back of his right arm and a superficial abrasion to his mid-back. Resident #6 reported a pain of 4 on a scale from 1 to 10. Resident #6 was assisted to standing position by two staff members using a gait belt, seated on the shower bench and his shower was completed. Resident #6 reported feeling anxious from his fall. Resident #6's physician was notified and gave new orders to send the resident out to the emergency room due to the resident taking Warfarin (an anticoagulant medication). A post-fall evaluation, dated 4/20/26 at 11:02 a.m., revealed Resident #6 had an unwitnessed fall on 4/20/26 when the resident was in the shower and attempted to reach for the grab bar while standing but slipped. Resident #6 sustained a skin tear to his right upper arm and an abrasion to his mid-back. Resident #6 hit his head and neurological checks were initiated. A new recommendation to place a towel on the shower floor for traction was initiated. A progress note, dated 4/20/26 at 12:07 p.m., revealed Resident #6 was evaluated at the emergency room, his diagnostics did not reveal any injuries, and the resident would discharge back to the facility with no changes to his medications.An IDT note, dated 4/20/26 at 1:19 p.m., revealed Resident #6's fall that morning (4/20/26) was reviewed by the IDT. Resident #6 had an unwitnessed fall which occurred during a shower. The CNA involved in the incident reported Resident #6 was standing while washing his groin when his feet slipped despite his use of the grab bar resulting in him falling backwards. Resident #6 said he grabbed the grab bar in the shower and his feet slipped out from under him so he fell and hit his head on the cement. A root cause analysis was performed and determined the fall was related to Resident #6 standing during his shower with decreased traction on a wet surface and potential balance instability despite grab bar use. The IDT implemented a new intervention of supervised showering with Resident #6 remaining seated on the shower bench for the duration of the shower.A progress note, dated 4/20/26 at 6:55 p.m., revealed an update to a prior nursing note which documented Resident #6 was not left alone in the shower. The CNA was within reach and sight and leaned outside of the bathroom door to gather clothing items for Resident #6 during his shower when the resident slipped and fell. The CNA never left the bathroom, and was educated to gather needed supplies prior to assisting a resident in the shower to prevent reoccurrence.-However, an interview with CNA #3 revealed the CNA had left Resident #6 to retrieve his clothes which were placed outside the bathroom (see interviews below).Review of Resident #6's Kardex, as of 4/21/26, revealed a new intervention was added on 4/20/26 for staff to provide supervised showering with the resident and provide direct assistance for all lower body hygiene. Resident #6 was to remain seated on the shower bench for all bathing tasks and use non-slip footwear.-Review of Resident #6's EMR did not reveal the resident's fall risk was re-assessed after his fall on 4/20/26 to evaluate any changes in the resident's fall risk.III. Staff interviewsCNA #5 was interviewed on 4/21/26 at 3:36 p.m. CNA #5 said typically the CNAs assisted residents with their showers. CNA #5 said for stand-by assist residents she would typically get all the residents' items ready and stay with them in the bathroom while they showered. CNA #5 said she stayed in the room because if she left the resident could fall, and said she would never leave a resident who required stand-by assistance alone in the shower. CNA #5 said the therapy team came and updated residents' transfer statuses on the white boards in their room frequently. CNA #5 said residents' mobility needs and transfer statuses were written on the resident's whiteboard in their room and communicated during shift changes.CNA #5 said Resident #6 was not very stable while standing, so she would not leave him alone in the bathroom. CNA #5 said Resident #6 had recently had a fall, after which he needed to go out to the hospital. CNA #5 said another CNA, CNA #3, had been assisting Resident #6 in the shower and had thought the resident could wash himself because she had not previously worked with him. CNA #5 said CNA #3 usually worked on a different unit of the facility and was not familiar (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Resident #6. CNA #5 said CNA #3 had left Resident #6 alone in the shower to go grab something and realized the resident had fallen when she heard him fall.CNA #4 was interviewed on 4/22/26 at 9:00 a.m. CNA #4 said when assisting residents with showering, she would assist the resident into the shower and ask the resident if they needed help. CNA #4 said if a resident was more independent she would give the resident privacy but make sure they had everything they needed within reach before leaving. CNA #4 said if a resident needed stand-by or moderate assistance she would stay with them in the bathroom. CNA #4 said she would not leave the bathroom while a resident showered unless she knew they were independent with showering.CNA #3 was interviewed on 4/22/26 at 9:19 a.m. CNA #3 said residents' transfer statuses and mobility needs were communicated through the nurse's daily report sheet, and said if she was not clear on what a resident was able to do she would clarify with the nurse. CNA #3 said when assisting residents with showering, for some residents she would just stay in the bathroom and help out as needed. CNA #3 said for residents who were more independent she would leave the bathroom but make sure the resident's call light was within reach and ensure there was a towel on the shower floor.CNA #3 said Resident #6 was fairly dependent on staff for ADLs, needed one staff member to assist him with getting up and getting dressed, but could sit up by himself. CNA #3 said Resident #6 had a fall the other day and she was the CNA who was assisting him with his shower. CNA #3 said she felt bad because she felt like Resident #6's fall was her fault. CNA #3 said she had just finished helping Resident #6 wash his body and asked the resident to wash his groin while she grabbed his clothes, which were sitting in his wheelchair outside the bathroom. CNA #3 said she had just grabbed his clothes when she heard a thunk noise and saw the resident had fallen. CNA #3 said she helped Resident #6 sit up and the resident reported he had tried to stand to wash his groin and had slipped. CNA #3 said Resident #6's nurse was just outside his room so she yelled for her to come and assist them. CNA #3 said she had since received education from the administration on not leaving the bathroom when residents were in the shower.Registered nurse (RN) #2 was interviewed on 4/22/26 at 9:53 a.m. RN #2 said residents' transfer statuses were communicated through the whiteboard in the resident's room and through nursing reports each day. RN #2 said the CNAs often floated between units, so the whiteboards in the residents' rooms were a failsafe. RN #2 said Resident #6 needed supervision from staff but was able to get up and go to the bathroom, and needed the assistance of one staff member for showering. RN #2 said she thought the CNAs stayed in the bathroom with residents while they showered both to help the resident as needed and prevent falls. RN #2 said she completed the initial comprehensive assessment but was not sure if or when she would otherwise complete a fall risk assessment.Licensed practical nurse (LPN) #2 was interviewed on 4/22/26 at 10:43 a.m. LPN #2 said residents' transfer statuses were communicated on the whiteboard in the resident's room and on the form the nurses gave the nursing staff each morning. LPN #2 said the nursing staff also gave each other verbal reports each shift to communicate any changes with the residents. LPN #2 said Resident #6 had sustained a few falls and was not steady at all on his feet. LPN #2 said Resident #6 was able to stand but was not safe for him to do so, so he generally used a wheelchair for mobility. LPN #2 said when a CNA assisted a resident with a shower the CNA should be in the bathroom throughout the entire shower and provide stand-by assistance to all residents. LPN #2 said after a resident sustained a fall, the nurse would assess the resident, have an RN complete a full assessment for the resident, talk with the resident and CNA to see what happened, assess the resident's vitals and notify the resident's physician. LPN #2 said she would then need to initiate neurological checks, do a fall evaluation and see what caused the fall and what intervention they needed to use going forward.LPN #2 said nurses needed to fill out a fall risk assessment after any falls or if there were any medication changes or other similar changes. LPN #2 said there was a post-fall checklist with everything they needed to do after a resident fell.RN #2 was interviewed a second time on 4/22/26 at 11:04 a.m. RN #2 said she was not sure what post-fall checklist LPN #2 was talking about because there were multiple, and was not sure where it would have been kept. RN #2 said she did not use a post-fall checklist because she knew what (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation needed to be completed after a resident sustained a fall. RN #2 said there were two or three different post-fall checklists which had been made by different nurse managers or directors of nursing over the last several months, with each list containing different items the nurses needed to complete. The director of nursing (DON) was interviewed on 4/22/26 at 2:49 p.m. The DON said fall risk assessments were completed on admission. The DON said after a resident sustained a fall, the nurses completed a fall evaluation to reassess the resident and ensure they did not miss any risk factors. The DON said the IDT had a process each morning where they discussed residents' falls. The DON said the nursing staff used the fall risk assessment to build the resident's fall care plan.The DON said during Resident #6's fall on 4/20/26 the CNA who was assisting him with his shower was in the bathroom with the resident during his shower and had cracked open the bathroom door to get his clothes which were outside the bathroom. The DON said the CNA (CNA #3) was able to slow Resident #6's fall in time. The DON said residents were generally not left alone in the shower unless the therapy department cleared them to be alone. The DON said she immediately provided CNA #3 with education on supervision during resident showers.IV. Facility follow-upOn 4/23/26 at 4:49 p.m. the NHA provided records of several staff in-services, including fall incident management for nurses (dated 4/20/26), updating a care plan and tasks after a fall (dated 4/20/26) and fall prevention (undated).

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#37) of two residents who required respiratory care received the care consistent with professional standards of practice out of 29 sample residents. Specifically the facility failed to:-Ensure a physician's order was in place for a bilevel positive airway pressure (BiPAP) machine (a type of non-invasive ventilation that helps people breathe by providing pressurized air through a mask or nasal plugs) for Resident #37 to use during the day; and,-Ensure a care plan was in place to clean, sanitize and store Resident #37's BiPAP mask. Findings include:I. Facility policy and procedureThe CPAP/BiPAP policy and procedure, revised 8/4/24, was provided by the nursing home administrator (NHA) on 4/23/26 at 5:06 p.m. It revealed in pertinent part, The patient will receive necessary respiratory care and services in accordance with professional standards of practice, the patient's care plan, and the patient's choice.Patient will have order that includes settings for CPAP/BiPAP and CPAP/BiPAP will be cleaned per manufacturer's guidelines.II. Resident #37A. Resident statusResident #37, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood), unspecified asthma, other disorders of the lung, and congestive heart failure.According to the 4/16/26 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial assistance with mobility, transfers, bathing, and moderate assistance with toileting and dressing. B. Resident interview and observationResident #37 was interviewed on 4/20/26 at 11:18 a.m. Resident #37 said since her admission [DATE]) the staff placed the BiPAP on the nightstand each morning after removing it. Resident #37 said no one had cleaned or washed the BiPAP, and she did not know if it needed to be cleaned. Resident #37 said she was recently in the hospital because she was diagnosed with pneumonia. During the interview, the BiPAP machine, with the mask attached to the tubing was on the nightstand next to the bed without a protective covering. Hair was on the exterior side of the BiPAP mask. Resident #37 said she had applied the BiPAP at night and only during the day if she napped. Resident #37 was interviewed again on 4/21/26 at 10:21 a.m. Resident #37 said she had required assistance with applying and removing the BiPAP. Resident #37 said the certified nurse aide (CNA) removed the BiPAP that morning and placed it inside the drawer of the nightstand. The drawer was halfway open without any other items inside the drawer. Resident #37 said she did not nap the previous day and they did not apply her BiPAP during the daytime. Resident #37 said if she did not nap during the day, then she did not need to apply the BiPAP. Resident #37 was wearing oxygen and said she wore oxygen throughout the day because her oxygen would drop. Resident #37 said during a previous admission to this facility she was missing parts of the BiPAP mask and was unable to wear it, which resulted in hospitalization for one week. Resident #37 said the hospital provided the missing parts and she was now able to use the BiPAP. C. Record reviewReview of Resident #37's April 2026 CPO, revealed the following physician's orders related to the resident's BiPAP machine: BiPAP at 12/5 with a flex of 2 (settings for BiPAP) using a Respironic DreamWear small nasal cushion and frame with 2 liters per minute of supplemental oxygen every shift. Initiate BiPAP at bedtime. Check placement of BiPAP mask every night shift, ordered on 4/12/26.Review of Resident #37's respiratory care plan, initiated 4/14/26 and revised 4/20/26, revealed the resident was at respiratory risk related to pulmonary function. Pertinent interventions included BiPAP use as per physician's orders with settings of 12/5 with a flex of 2 using a respironic dream wear small nasal cushion and frame with 2 liters per minute of supplemental oxygen.-The care plan failed to include cleaning, sanitizing and storage instructions for the BiPAP.The physician's progress note, dated 4/16/26, revealed the resident may require BiPAP use more frequently during the daytime due to a tendency to develop hypercapnia. The note revealed the resident's pulmonology instructed her to wear the BiPAP not only (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at night while sleeping but also for two to three hours during the day regardless of napping.-Review of the resident's electronic medical record (EMR) revealed the facility failed to implement the physician's order for the use of the BiPAP during the day until 4/22/26 (during the survey).-The care plan and CPO failed to include instructions for BiPAP use during daytime.III. Staff interviewsRegistered nurse (RN) #2 was interviewed on 4/21/26 at 3:56 p.m. RN #2 said there was an admissions checklist and the admitting nurse entered the medications, completed the assessment and did as much as possible. RN #2 said then the second nurse reviewed and the unit manager completed anything that the other two nurses were not able to.RN #2 said the physician ordered the BiPAP on 4/12/26 for nighttime use only. RN #2 said she was not aware that the resident was supposed to use the BiPAP during the day. RN #2 said she followed physician orders and there was no order for daytime use of the BiPAP. RN #2 said based on the 4/16/26 physician's progress note there should have been an order for daytime use to prevent carbon dioxide (CO2) retention and the physician should have entered an order after writing that progress note. RN #2 said the nurses generally reviewed progress notes and added or updated orders as needed. RN #2 said refusals were documented in the medication administration record (MAR) and there were no documented refusals for Resident #37 regarding BiPAP use. RN #2 said she would talk to the team and the resident to help coordinate therapy and other tasks to accommodate BiPAP use during the day. RN #2 said they monitored resident compliance during rounds, by checking if the resident was asleep.RN #2 said the BiPAP equipment should have been cleaned daily and rinsed with warm water and soap if needed. RN #2 said the person who removed the mask in the morning was responsible for cleaning it. RN #2 said after washing, the equipment should have been allowed to air dry, and once dried, it should have been placed in a plastic bag. RN #2 said the respiratory team came every two weeks to monitor the equipment and they checked the tubing and replaced it if needed.CNA #2 was interviewed on 4/21/26 at 4:23 p.m. CNA #2 said Resident #37 only wore the BiPAP during the night and the night shift helped put it back on her. CNA #2 said Resident #37 had not been prescribed BiPAP use during the day. CNA #2 said in the morning she made sure to help and took the mask off and ensured the mask and the hose were neatly placed on the nightstand. CNA #2 said if the mask needed to be cleaned, then she would use a little soap and a washcloth to wipe it and let it air dry. CNA #2 said she was not sure if she could use the purple disinfectant wipes to clean the mask. CNA #2 said she had not cleaned the mask and was not sure if it was cleaned since admission. The director of nursing (DON) was interviewed on 4/22/26 at 4:46 p.m. The DON said the facility should have followed the physician's order for BiPAP use during the day. The DON said the nurse manager and the DON were responsible for reviewing the 4/16/26 physician's progress note and ensuring the daytime BiPAP recommendation was implemented. The DON said if the physician did not enter an order for daytime BiPAP use, the facility would not implement it because nursing staff required a physician's order before initiating treatment. The DON said the use of BiPAP during the day was important because it would affect the resident's respiratory status. The DON said the BiPAP mask should have been cleaned according to manufacturer recommendations to ensure proper cleaning and infection prevention.The attending physician was interviewed by phone on 4/23/26 at 11:58 a.m. after the survey. The physician said Resident #37 went back to the hospital after her initial admission to the facility. The physician said there was no physician's order for BiPAP use during the daytime at the time of the initial admission. The physician said the recommendation for daytime BiPAP use was not made until after the second hospitalization. The physician said she spoke with Resident #37's nurses and they said they had been applying the BiPAP during the daytime. The physician said she also spoke with the resident, who said she had been wearing the BiPAP during the daytime except when she accidentally dozed off.IV. Facility follow-upThe DON provided nursing staff an in-service on BiPAP orders, cleaning, and storage on 4/23/26. The nurses were to perform hand hygiene before and after handling BiPAP equipment, use PPE, and clean equipment with facility-approved disinfectants. The nurse was to follow physician orders, the care plan, and manufacturer instructions for cleaning and allow the equipment to dry before reuse.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure one (#15) of two residents reviewed for dialysis care out of 29 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to implement recommendations from the dialysis center for Resident #15 to be on a therapeutic diet and a fluid restriction. Findings include: I. Facility policy and procedure The Dialysis Contract, revised 8/5/22, was provided by the nursing home administrator (NHA) on 4/21/26 at 1:03 p.m. It revealed in pertinent part, Dialysis communication sheet will be given to the dialysis center with facility and patient information. Facility shall ensure appropriate information accompanies the resident to the dialysis center, including treatment presently being provided to the Designated Resident, including medications and any changes in a patient's condition (physical or mental), change of medication, diet or fluid intake. Any other information that will facilitate the adequate coordination of care, asreasonably determined by Center.II. Resident #15A. Resident statusResident #15, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included end stage renal disease (kidney failure), dependence on renal dialysis (blood filtration to remove waste), nutritional anemia (low blood count from poor nutrition), and type two diabetes. The 4/19/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She needed set-up assistance with eating, oral hygiene, substantial assistance with toileting and was dependent with showering/bathing. The MDS assessment indicated the resident was receiving dialysis and was on a therapeutic diet.B. Resident interviewResident #15 was interviewed on 4/20/26 at 10:46 a.m. and said she was on a liberal diet and was not receiving fresh fruits and vegetables with her meals.Resident #15 was interviewed again on 4/22/26 at 8:55 a.m. and said it is hard for the facility to follow dialysis center recommendations because they do not have fresh vegetables. She said she managed her own fluid intake.C. Record reviewA review of the April 2026 CPO revealed the resident was prescribed a liberal renal consistent carbohydrate diet (CCHO), regular texture and thin consistency, initiated 4/9/26.A review of the 4/13/26 dialysis communication form revealed a recommendation for a fluid restriction of 1.5 liters per day.A review of the 4/15/26 dialysis communication form revealed the resident must be on a high protein, low potassium, low sodium, renal and cardiac friendly diet.-Review of the resident's electronic medical record (EMR) did not reveal documentation that the facility followed up on, addressed or clarified the dialysis center recommendations.-Review of the April 2026 CPO did not include the dialysis center recommendation dated 4/13/26 for a fluid restriction of 1.5 liters per day.-Review of the April 2026 CPO did not include the dialysis center recommendation dated 4/15/26 for a high protein, low potassium, low sodium, renal and cardiac friendly diet.The dialysis care plan, initiated 4/19/26, documented the resident had potential for complications related to dialysis. Interventions included communicating with the dialysis center on scheduled dialysis days to report concerns, lab values, medications, weights and changes in condition and sending a dialysis form to dialysis appointments.The chronic kidney disease care plan, initiated 4/19/26, documented the resident had potential for complications from chronic kidney disease. Interventions included encouraging compliance with diet and fluid restrictions.A review of the 4/20/26 nutrition assessment revealed the resident's diet was documented as a liberal renal CCHO diet, and estimated fluid needs were documented as 2000 milliliters (ml) or per physician or dialysis recommendation.-However, the 4/13/26 dialysis communication form indicated the dialysis center recommended the resident to be on a 1.5 (1500 ml) fluid restriction and a high protein, low potassium, low sodium, renal and cardiac friendly diet.-A review of Resident #15's EMR revealed no documentation that the facility had contacted the dialysis center regarding the recommended diet changes, that the recommendations were unclear, that the physician was contacted, or that the dialysis center was contacted (see staff (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviews below).III. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 4/22/26 at 9:10 a.m. CNA #3 said she had worked at the facility for six months and was familiar with Resident #15. CNA #3 said Resident #15 was on a liberal renal CCHO diet with regular texture. CNA #3 said she looked at meal tickets to determine what the resident could and could not eat and the nurses also informed her of any diet changes. CNA #3 said she had not seen any special recommendations from the dialysis center regarding Resident #15's diet. CNA #3 said the nurses would be informed of any diet changes and the nurses would inform the CNA and dietary aides. Registered nurse (RN) #2 was interviewed on 4/22/26 at 9:28 a.m. RN #2 said Resident #15 was on a liberal renal CCHO diet with regular texture. RN #2 said the last diet order update was on 4/9/26 to a CCHO diet. RN #2 said once Resident #15 returned from dialysis she reviewed the dialysis communication form, entered weights and any diet changes would be communicated with the physician. RN #2 said once the physician approved the new recommendations then she completed a diet communication form and placed it on the nurse's desk for the CNA to take to the kitchen. RN #2 said dialysis communication forms were placed in the medical record box and scanned daily.RN #2 said she received the dialysis communication form regarding Resident #15 on 4/15/26 and reviewed it and completed a diet communication form for the kitchen and did not follow up with the kitchen staff after she completed the form. RN #2 said she should have made herself a note to follow up with the dietary staff. RN #2 said when she completed a diet communication form, the CNAs were expected to take it to the kitchen. RN #2 said she did not contact the physician. The director of nursing (DON) was interviewed on 4/22/26 at 10:05 a.m. The DON said once the resident returned from the dialysis center with a dialysis communication form, the nurse reviewed the form and if there were any recommendations, the nurse contacted the physician and obtained orders. The DON said the nurses were responsible for and communicated with the interdisciplinary team (IDT) as well when the dialysis center made recommendations. The DON and RN #3 were interviewed together on 4/22/26 at 10:22 a.m. RN #3 said he was the unit manager. RN #3 said when the floor nurse received the dialysis communication form and if there were recommendations, the nurse would inform the physician and would get updated orders. RN #3 said once the physician approved the diet change then the nurse would complete a diet communication form and would notify the dietary staff. RN #3 said the floor nurse or the CNA would hand deliver the diet change form to the kitchen staff. RN #3 said the unit manager did not get involved in the process unless there was an issue, such as difficulty obtaining updated orders from the physician when there was disagreement and the nurse believed the diet change was necessary. RN #3 said the unit manager would be involved during IDT meetings.Cook (CK) #1 was interviewed on 4/22/26 at 10:29 a.m. CK #1 said the dietary manager (DM) handled nutrition and diet order communication forms. CK #1 said the DM was responsible for gathering diet change information from nurses and family. CK #1 said the dietary aides went upstairs to obtain meal tickets and picked up diet communication forms from the nurse station, and the DM reviewed the forms and adjusted meals accordingly.The DM was interviewed on 4/22/26 at 10:33 a.m. The DM said Resident #15 was on liberal renal CCHO diet with regular thin consistency. The DM said the last diet change for Resident #15 occurred on 4/10/26 to a liberal renal diet. The DM said she had not received any additional diet changes for Resident #15 since 4/10/26.The nurse practitioner (NP) was interviewed on 4/22/26 at 11:32 a.m. The NP said she was not aware of diet recommendations or fluid restrictions for Resident #15. The NP said she did not know anything regarding these recommendations because the nurses did not inform her. The NP said once the nurses informed her, she would follow up with the specialist. The NP said if changes were needed to Resident #15's diet, the nurses were responsible for informing her and she would then order the changes. The NP said she did not know why the dialysis center made diet recommendations on 4/15/26 and they did not send labs. The NP said when recommendations were unclear, the nurses would contact the dialysis center to clarify. The NP said she continued the resident to be on a liberal renal CCHO diet until she checked with nephrology and the dialysis team. The NP said it was important to follow up on dialysis recommendations because (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065431	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	4356 24th St Rd Greeley, CO 80634

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 had multiple complex medical conditions, and for resident safety, the nurses needed to inform her so that she could make appropriate decisions.The DON and licensed practical nurse (LPN) #1 were interviewed together on 4/22/26 at 12:29 p.m. The DON said regarding fluid restrictions, it was her understanding that the nurses were responsible for reviewing the dialysis communication form and would inform the physician, then the physician documented it and once approved, entered orders. The DON said she was not aware of the fluid restriction that was made by the dialysis center regarding Resident #15 and there were no orders for it.LPN #1 said she had reviewed the 4/15/26 dialysis communication form and the diet recommendations were not clear. She said on 4/16/26 she contacted the dialysis center and the dialysis center told her that they would get back with the facility. She said it typically took about two weeks for the dialysis center to clarify that information. She said she had not heard back and the facility had not followed up again with the dialysis center. She said the only documentation of the contact was a sticky note indicating the dialysis center was contacted on 4/16/26. LPN #1 said in addition to the sticky note, she had a printout of the 4/15/26 dialysis communication form, which revealed that the NP had acknowledged reviewing it and had signed it on 4/16/26. The DON said the updated dialysis communication form, including the NP's acknowledgement had not been scanned into the resident's EMR because LPN #1 was working on obtaining clarification.-However, the NP earlier said she was not aware of the recommendations made by the dialysis center (see above).The medical director (MD) was interviewed by phone on 4/24/26 at 5:39 p.m. via phone after the survey. The MD said the physician at the facility made the decision that there was no need for the fluid or dietary restriction. The MD said he encouraged physicians to review the specialists' recommendations but ultimately decide what orders to implement for the resident.-However, there was no documentation indicating the MD physician had reviewed the fluid restriction recommendation.IV. Facility follow-upThe DON provided nursing staff an in-service on dialysis communication form processing on 4/21/26. The receiving nurse was to review all dialysis communication forms upon receipt, interpret the dialysis provider's recommendations, and contact the physician to obtain appropriate orders. The nurse was to enter physician orders accurately into the system, submit the orders to the nurse manager for review, and ensure orders were verified and validated. If the physician did not approve the dialysis recommendations, no changes were to be made to the resident's current orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 residents were free from any significant medication errors for two (#4 and #30) of five residents reviewed for medication errors out of 31 sample residents.Specifically, the facility failed to follow the physician's order parameters for Resident #4 and Resident #30's blood pressure medications. Findings include:I. Resident #4 A. Resident status Resident 4, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included hypertension and peripheral vascular disease.According to the 3/312/26 MDS assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Record review Review of Resident #4's April 2026 CPO revealed the following physician's orders:Amlodipine Besylate oral tablet 10 milligram (mg). Give 10 mg by mouth in the morning for hypertension. Hold if systolic blood pressure is less than 110 milliliters of mercury (mmHg). Ordered on 1/11/25. Losartan Potassium Oral Tablet 50 mg. Give 100 mg by mouth in the morning for hypertension. Hold if systolic blood pressure is less than 110 mmHg. Ordered on 1/22/2026. Review of vital signs record (3/1/26 to 4/20/26) revealed that resident's systolic blood pressure was below 110 mmHG on eight occasions, however the blood pressure medication was still administered. Review of Resident #4's EMR did not reveal supporting progress notes for the days above to clarify why the medications were still administered. II. Resident #30 A. Resident status Resident 30, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included hypertension and stage three kidney disease.According to the 3/12/26 MDS assessment the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Record review Review of Resident #4's April 2026 CPO revealed the following physician's orders:Lisinopril Oral Tablet 10 mg. Give 20 mg by mouth in the morning for hypertension. Hold for systolic blood pressure less than 110 mmHg. Ordered on 3/12/26. -Review of the resident's EMR revealed: On 4/3/26 the resident's blood pressure was 108/58 mmHg and on 4/15/26 it was 103/65 mmHg. However, the lisinopril was still administered. Propranolol HCl Oral Tablet 20 mg. Give 20 mg by mouth two times a day for migraines. Hold for systolic blood pressure less than 100 mmHg or heart rate less than 60 beats per minute (BPM).-On 4/9/26 the resident's heart rate was 54 BPM. The medication was still administered. Review of Resident #30's EMR did not reveal supporting progress notes to clarify why medication was still administered. III. Staff interviews Registered nurse (RN) #1 was interviewed on 4/22/26 at 9:20 a.m. She said blood pressure medication should not be administered when blood pressure was below normal. She said blood pressure medications had specific physician's orders as to when to hold medication. She said it was the nurses responsibility to check the blood pressure and hold medication if blood pressure was below physician's documented parameters. RN #3 was interviewed on 4/22/26 at 9:41 a.m. He said if blood pressure medication had specific parameters defined by the physician, the medication must be held if it meets the parameters. He reviewed electronic records for Resident #4 and Resident #30, he said that unfortunately blood pressure medications were signed as given for both residents when it should have been held. He said administering blood pressure medications when blood pressure was already low could result in a medical emergency. The director of nursing (DON) was interviewed on 9/22/26 at 12:16 p.m. She said it was reported to her today that two residents received blood pressure medications when vitals signs indicated that it should have been held. She said she started immediate education to all nursing staff on duty to ensure that medications were given appropriately. She said nurses should always administer medications as ordered by the physician, and hold medication per physician ordered parameters. The pharmacy consultant was interviewed on 9/22/26 at 12:34 p.m. She said blood pressure medications should not be administered when blood pressure or heart rate were below recommended. She said it is a significant medication error because it could lead to very low blood pressure or below normal heart rate which could become a medical emergency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to provide proper storage for medical supplies and supplements for two of three medication carts and two of two medication storage rooms. Specifically, the facility failed to:-Discard expired insulin;-Discard expired testing supplies; and,-Discard expired supplements. Findings include:I. Facility policy and procedureThe Storage of Medications policy, revised 2/9/26, was provided by the nursing home administrator (NHA) on 4/23/26 at 5:06 p.m. It read in pertinent part, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy as necessary, if a current order exists. Medication storage should be kept clean, well-lit, organized, and free of clutter.II. Observations and interviewsOn 4/21/26 at 9:25 a.m. the second-floor medication cart was observed with registered nurse (RN) #1. The following was observed:-An expired Insulin Lispro pen for Resident #21 with an expiration date of 4/18/26. On 4/21/26 at 9:33 a.m. the third-floor medication storage room was observed with RN #1. The following was observed:-An E-swab collection kit with an expiration date of 10/10/25-A urine collection kit with an expiration date of 3/31/26-Two expired boxes of safety winged blood collection kits.RN #1 said the e-swabs and urine collection system had expired and could not be used because they contained a preservative liquid. RN #1 said she would order new swabs and collection kits and discard the expired supplies. On 4/21/26 at 10:21 a.m. the third-floor medication cart was observed with licensed practical nurse (LPN) #1. The following was observed:-Four packets of Banatrol Plus (a supplement for the treatment of diarrhea) with an expiration date of 4/16/26.On 4/21/26 at 10:33 a.m. the third-floor medication storage room was observed with LPN #1. The following was observed:-Seventeen packets of Banatrol Plus with an expiration date of 4/16/26.IV. Additional staff interviewsThe director of nursing (DON) was interviewed on 4/22/26 at 9:15 a.m. The DON said expired medical supplies should be thrown out. The DON said using expired medical supplies, such as nasal swabs and urinary collection kits, could invalidate the results of any tests conducted from those supplies. The DON said the Banatrol was a food item and should not have been kept in the medication cart. The DON said she had prepared staff education and had begun teaching nursing staff on proper medication storage.V. Facility follow-upOn 4/23/26 at 4:53 p.m. the facility provided documentation which revealed the facility had conducted staff education and in-service training on the following;-Medication room and cart compliance, dated 4/22/26-Expired items and nutritional supplement storage, dated 4/23/26