STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065432	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine and Charles Hover Green Houses	1425 Belmont Dr 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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure two (#4 and #28) out of three residents received services and assistance to prevent a reduction in range of motion out of 31 sample residents. Resident #4 was admitted to the facility on [DATE]. According to diagnoses on admission, Resident #4 did not admit to the facility with a contracture to her hands, but based on observations and interviews on 1/26/26 to 1/29/26, the resident was unable to extend her fingers independently and/or without pain. The facility failed to provide the resident interventions to prevent a reduction in the resident's range of motion of her hands. The facility's failure to provide services to maintain the resident's mobility contributed to a decline in the mobility of the resident's left and right hand. Specifically, the facility failed to ensure Resident #4 and Resident #28's contracture prevention devices were consistently in place. Findings include:I. Resident #4A. Resident status Resident #4, age [AGE], was admitted on [DATE]. The resident was admitted to hospice care on 1/23/23. According to the January 2026 computerized physician orders (CPO), diagnoses included fracture to the left femur with surgical intervention, difficulty walking, muscle weakness and a history of falls prior to admission. The 11/15/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. The resident required extensive one-two person physical assistance with bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The resident had functional limitations in range of motion of her upper and lower extremities. She was enrolled in hospice and had not received any therapy or restorative services during the MDS look back period. -No splint or brace assistance were indicated on the MDS. B. Resident representative interview The resident representative was interviewed on 1/29/26 at 1:46 p.m. She said Resident #4 did not have contractures when she was first admitted to the facility. She said Resident #4 developed the contractures in both of her hands while residing at the facility. She said sometimes there was a lack of communication from the therapy staff to the nursing staff. She said because of this lack of communication, the nursing staff were unaware of interventions such as splints needed to be applied to to prevent contractures. She says she had to put large signs on Resident #4's door to remind the nursing staff how to care for Resident #4. She said the contractures have gotten significantly worse over the past few years while Resident #4 resided at the facility.C. ObservationsOn 1/26/26 at 9:56 a.m. Resident #4 was lying in bed, supine, with her arms folded at her chest and covered with a blanket. Resident #4 had contractors to both hands, wrist and fingers with no splints in place. On 1/26/26 at 3:14 p.m. Resident #4 remained lying supine with her arms folded at her chest. Resident #4 had contractures of bilateral hands, wrist and fingers with no splints in place. The fingers on the resident's left and right hand curled in touching the palm of her hand.On 1/29/26 at 1:30 p.m. Resident #4 was lying in her bed on her back with cloth fabric between her fingers and the palm of her hands. Registered nurse (RN) #5 attempted to open the palm of the hands of Resident #4 for a skin check. Resident #4 started to grimace in her face. Resident number four was unable to completely open both of her hands. -There were no palm protectors or hand rolls observed on the resident's hands. RN #5 (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 0688 Level of Harm - Actual harm Residents Affected - Few	did not offer palm protectors to the resident before she left the room. D. Record reviewA review of Resident #4's mobility care plan, revised X, revealed the resident had a potential for limited physical mobility due to dementia and had a habit to clasp her hands in tight fists. She was able to grasp cups usually on demand or with assistance. Palm protectors have been offered, but Resident #4 takes them off and preferred not to use them. She had many stuffed animals which she could hold (initiated 12/27/21and revised on 7/25/24). Pertinent interventions included physical therapy and occupational therapy referrals as ordered and as needed, monitoring, documenting and reporting any signs and symptoms of immobility, contractures forming or worsening and skin-breakdown (initiated 12/27/21) and providing gentle range of motion as tolerated with daily care. (initiated 7/25/24).-The care plan did not mention the resident had an actual hand contracture on both hands and was not able to extend her fingers. In addition, no interventions were in place to minimize the contracture. Intervention for gentle range of motion did not mention the location of motion of the area. A review of Residents #4's CPO revealed the following order.Gently apply handgrips to bilateral hands daily. Leave in place unless showering or providing hand hygiene every day shift and every night shift. Ordered 11/12/25-However, observations revealed the facility staff failed to apply the palm protectors to her bilateral hands. -Resident's hand contractures were not monitored for worsening. There was no documentation of progression of the contractures, monitoring or measurements of the contracture to the resident's left and right hand in the most recent OT evaluation or elsewhere in the resident's record. II. Resident #28A. Resident statusResident #28, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the January 2026 CPO, diagnoses included spastic hemiplegia (a form of cerebral palsy causing one-sided muscle stiffness) affecting the right dominant side, contracture of muscles of right thigh, contractures of the right knee, muscle weakness, contracture of the right elbow and contracture of the right hand. The 1/7/26 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of nine out of 15. The resident required extensive one-two person physical assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing. The MDS assessment indicated she had functional limitations in range of motion for both the upper extremity and lower extremity on one side. B. Observation On 1/26/26 at 1:44 p.m. Resident #28 was in her bed lying on her back without a splint on her right hand, elbow or right leg. On 1/28/26 at 8:23 a.m. Resident #28 was sitting in her wheelchair in her room receiving medication from licensed practical nurse (LPN) #1. A hand splint, elbow splint and knee braces were in a wooden chair in the corner of her room. -LPN #1 did not apply hand splints or knee braces before she left the room. She did not offer the resident to move to a recliner as recommended in the care plan below for positioning and contracture management. C. Record Review A review of the Resident #28's mobility care plan revealed the resident had limited physical mobility related to contractors and stroke (initiated 4/16/25 and revised on 7/15/25. Pertinent interventions included monitoring, documenting and reporting as needed any signs and symptoms of immobility, contractures forming or worsening and skin-breakdown (initiated 4/16/25) and offer passive range of motion for 60 seconds four times, on each joint with tone inhibition for contracture management during showers and dressing, positioning in recliner with pillow lateral right lower extremity for hip midline and pillow under right heel for knee extension to decrease contracture (initiated 4/16/25).A review of Residents #28's CPO revealed the following order.Resting hand splint up to two times a day up to two hours with checks after 90 minutes every day shift and evening shift. Ordered 1/29/26 at 3:00 p.m. (during the survey).Right elbow splint while up in chair as tolerated every day shift and evening shift. Ordered 1/29/26. -However, observations revealed the facility staff failed to apply the hand and elbow splint and the knee brace. -There was no documentation for monitoring or measurements of the contracture to the resident's right hand and right elbow in the most recent OT evaluation or elsewhere in the resident's record. D. Staff interviews LPN #1 was interviewed on 1/28/26 at 8:30 a.m. LPN #1 said Resident #28 should have her hand and elbow splints on her as much as she could tolerate. LPN #1 said the nursing staff should have applied these blunts after getting Resident #28 up into her (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	wheelchair. CNA #10 was interviewed On 11/28/26 at 11:54 a.m. He said he had worked at the facility for approximately a year. He said the nurses would tell him if a resident needed hand splints to be applied. CNA #10 said information for the need to apply hand splints would be passed verbally from staff to staff during shift reports. He said he was aware Resident #4 and Resident #28 hands were contracted, however, he was unaware Resident #4 and Resident #28 needed hand splints to be applied. CNA #11 was interviewed on 1/28/26 at 12:55 p.m. She said she Resident #28 need total assistance with care. She said the resident needs assistance from the staff to get her out of bed, getting dressed, and partial assistance with meals. She said the resident has contractures on the left side of her body. She said the residents will refuse to wear her hand, arm and knee braces because it will cause her pain. CNA #1 said the braces were to prevent her contractures from getting worse. CNA #1 said nursing staff can apply the braces for as long as the resident can tolerate wearing them. RN #5 was interviewed on 1/29/26 at 1:30 p.m. RN #5 said Resident #4 needed to have a hand splint in her hands in the past at all times because of her contractors in her hands. RN #5 transitioned from a hand splint to a palm guard because her contractures had gotten worse. RN #5 said sometimes the nursing staff forgot to apply the splint to her hand. RN #5 said the nursing staff tried to keep her nails clean and short. RN #5 said Resident #4 developed a pressure wound in her hand due to her contractures but it healed. RN #5 said it was very difficult to open the resident's hands because of her contractures and that's why a thin piece of cloth between resident's fingers and the palm of her hand was used for skin protection. RN #5 said a gentle range of motion could not be done due to how contracted Residents #4 hands were and because she was having pain. RN#5 said Resident #4 uses a thin piece of cloth because she was unable to open her hands. RN #5 said Resident #4 is very weak and was not likely to refuse her palm protector. Occupational therapist (OT) was interviewed on 1/28/26 at 2:56 p.m. He said Resident #4 was not receiving any therapy services at this time. He said the facility did not have restorative staff or a restorative program. The OT said the nursing staff was aware of the availability of the splints to be applied to Resident #28. The OT said he would communicate verbally with the nursing staff regarding how and when to apply the splints to prevent contractures. The director of nursing (DON) and the director of rehabilitation services were interviewed on 1/29/26 at 2:14 p.m. The director of rehabilitation services She said Resident #4 was not receiving occupational therapy because she was on hospice services. The director of rehabilitation services said Resident #28 was currently receiving occupational therapy. She said Resident #28 contractors were monitored by her level of participation in her therapy services. The director of rehabilitation services said there were no measurements for the contractors of Resident #4 and Resident #28. The director of rehabilitation services said there were many ways to measure contractures including the use of a goniometer to quantify the angles of joint restriction. The director of rehabilitation services said the rehabilitation team measured the contractures by the level of pain and the ability to grip items. The director of rehabilitation services said she was unable to find documentation that Resident #4 contractors had been measured while living at the facility. The DON said she was aware of Resident #4 and Resident #28 had contractors but did not know if there were splints ordered for the residents to wear. The DON said the contractures for Resident #4 and Resident #28 had gotten worse. The DON said nursing staff were responsible for applying the splints on the Resident #28.

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F 0689 Level of Harm - 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 residents had adequate supervision and assistive devices to prevent accidents for one of one (#2) residents reviewed out of 31 sample residents. Resident #2, who was at risk for falls and had a history of falls, experienced eleven falls since her date of admission of 12/2/25. The interdisciplinary team (IDT) determined Resident #2 had poor safety awareness and was impulsive. On 12/12/25 Resident #2 self-propelled herself outside, where her wheelchair tipped off of the sidewalk. Resident #3 was sent to the hospital and was diagnosed with three rib fractures. On 12/17/25 Resident #2 sustained an unwitnessed fall and was bleeding from her head and was running down her neck. She was sent to the hospital.On 12/20/25 the facility implemented a one-to-one caregiver for Resident #2 from 7:00 a.m. until 7:00 p.m. due to Resident #2 having most of her falls during the day. However, Resident #2 had five falls after the one-to-one was implemented; three of the five falls were after 7:00 p.m. and two happened while the one-to-one was present. On 12/30/25 at 6:30 p.m. Resident #2 experienced an additional unwitnessed fall which resulted in her hitting her head and an abrasion on her left pinky and was sent to the emergency department (ED). The resident was supposed to have a one-to-one caregiver, but sustained an unwitnessed fall.Specifically, the facility failed to:-Review the resident's fall to determine if the fall interventions were appropriate; and, -Ensure the fall interventions were consistently in place. Findings include:I. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included Parkinson's disease (neurodegenerative disease of the central nervous system that affects movement), history of falling, dementia and long-term use of anticoagulants (blood thinners). The 12/29/25 minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The assessment revealed Resident #2 needed partial to moderate assistance with most of her activities of daily living (ADL) and needed substantial to maximal assistance with her mobility. The MDS assessment indicated Resident #2 had more than two falls not resulting in injury since admission and one with an injury. B. ObservationsOn 1/27/26 at 3:32 p.m. observations of Resident #2's room revealed her bed could not be seen from the doorway of her bedroom. Resident #2's bed and entry to her bathroom could only be seen by entering her room completely. Resident #2's bed was in the lowest position and had fall mats on either side of the bed. Her bed did not have a weighted blanket on it. On 1/28/26 at 9:05 a.m. Resident #2 was sitting on the couch in the common area. An unidentified staff member was standing a few feet away from the couch, slightly behind and to the side of the couch. The unidentified staff member was looking at his cell phone. On 1/28/25 at 12:44 p.m. Resident #2 was sitting at the dining room table for lunch. The unidentified staff member was going back and forth from the dining room to the kitchen, leaving Resident #2 at the dining room table. -The unidentified staff member was assigned to be the one-to-one caregiver for Resident #2. C. Resident interviewResident #2 was interviewed on 1/26/26 at 4:02 p.m. She said she was admitted to the facility in December 2025. She said she was falling all the time at home. She said she did have some falls at the facility, which was why she had a certified nurse aide (CNA) with her all the time. She said she had fallen in the bathroom, the living room, outside, almost everywhere in the facility. She said she remembered going to the hospital after a fall when she hit her head. She said she was working with physical therapy (PT) and occupational therapy (OT). She said she had Parkinson's which caused her to be unsteady. D. Record reviewThe falls with injury care plan, initiated 12/3/25 and revised 12/10/25, revealed Resident #2 had the potential for falls due to confusion, deconditioning, history of falls, impaired balance, Parkinson's disease, and was on psychoactive and anticoagulant medications. Pertinent interventions included anticipating and meeting her needs, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	clipping the call light to Resident #2 when she was in bed, placing the bed in the lowest position, offering a weighted blanket for comfort when resting, ensuring the bedside mats were in place as needed for safety, encouraging and assisting Resident #2 to participate in activities that promote exercise, ensuring Resident #2 was wearing appropriate footwear, having commonly used articles within reach, offering activities to minimize potential for falls but to use caution to not over stimulate Resident #2 which can cause anxiety, offering books on tape and word searches, having OT and PT to evaluate and treat as needed, offering the restroom throughout shift, keeping Resident #2 in line of sight as much as possible when she is out of her room and offering to rest in her recliner in the common area. -The care plan did not indicate the resident was to with a one-to-one caregiver from 7:00 a.m to 7:00 p.m. (see below).Review of Resident #2's electronic medical record (EMR) revealed Resident #2 had eleven falls since admitting on 12/2/25. 1. Fall on 12/2/25 at 6:00 p.m. - unwitnessedThe 12/2/25 fall report documented Resident #2 was in her room and was unable to give an account of what happened. The report documented Resident #2 was agitated and flailing her arms. It documented she possibly hit her right elbow on furniture, which caused a skin tear. -Review of Resident #2's EMR did not reveal the facility reviewed the resident's fall to determine if new fall interventions were needed.2. Fall on 12/8/25 at 3:30 p.m. - unwitnessedThe 12/8/25 fall report documented Resident #2 was found on the floor in the visitor's restroom. Resident #2's wheelchair was in the living room. The report documented Resident #2 stated she walked over to use the restroom. The note documented no injury was reported. The 12/9/25 IDT note documented the root cause was Resident #2 had to use the bathroom and chose to walk to the closest bathroom. She then lost her balance and fell. The interventions that were implemented were offering to assist her to the bathroom and to keep in line of sight as possible. 3. Fall on 12/12/25 at 9:21 a.m. - unwitnessed. The 12/12/25 fall report documented Resident #2 had an unwitnessed fall on the sidewalk at 9:21 a.m. The report documented Resident #2 hit her head and was bleeding and was sent to the ED. The report documented the resident said she was going out for a walk and fell. The 12/12/25 IDT note documented the root cause of her fall was the wheels of her wheelchair went off the edge of the sidewalk and her wheelchair tipped and she fell. The fall resulted in minor injuries. (However, the hospital discharge summary documented the resident sustained a fracture of three ribs). It was also reported by staff that Resident #2's wheelchair had been pulling to the right when in use. Interventions implemented after the fall were encouraging the resident to go for walks with staff and have maintenance check her wheelchair function. The 12/14/25 hospital discharge summary revealed Resident #2 was admitted on [DATE] due to a fall. She was discharged on 12/14/25 with diagnoses of a closed fracture of three ribs on the left side and a scalp laceration on the back of her head. 4. Fall on 12/14/25 at 3:15 p.m. - unwitnessedThe 12/14/25 fall report documented Resident #2 was found in the dining room, lying on her back next to the dining room table and her wheelchair was near. The report documented the fall was unwitnessed. Resident #2 sustained a skin tear to her right elbow and was unable to state what happened. The 12/15/25 IDT note documented the root cause was the resident continued to transfer and ambulate without assistance, poor safety awareness and impulsivity. New interventions implemented were continuing to work with therapy and offering to ambulate with the resident. 5. Fall on 12/17/25 at 6:20 a.m. - unwitnessedThe 12/17/25 fall report documented Resident #2 was found on the floor mat next to her bed, sitting upright on both of her knees. Blood was noted on the carpet and floor mat. Resident #2 was noted to have blood dripping from her head running down her neck and onto her night gown. The nurse was unable to determine the exact location of the injury. The report documented Resident #2 was not having any pain and was sent to the ED. The 12/17/25 IDT note documented the IDT reviewed falls from 12/8/25, 12/12/25, 12/14/25 and 12/17/25. The note documented interventions upon admission were low bed with mats, educating the resident on the call system, having the resident in a room that was off the common area, and the resident was evaluated by therapy. The interventions listed post falls were keeping in line of sight as possible, offering assistance to bathroom frequently, medication review with (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	increased pain medication, and offering to ambulate Resident #2 so she has help. The note documented that the interventions were for mitigating injuries rather than preventing falls. 6. Fall on 12/19/25 at 1:35 p.m. - unwitnessed. The 12/19/25 fall report documented Resident #2 had an unwitnessed fall from her chair to the floor. The report documented Resident #2 could not say what happened or why she was on the floor. The report documented no injuries were noted. The 12/22/25 IDT note documented the fall on 12/19/25 did not result in injury. They determined the root cause was Resident #2 had Parkinson's and did not know her limits. The note documented she had poor safety awareness. Resident #2 stood up and attempted to ambulate without assistance and fell. New interventions were to move her recliner to the common area and to keep her in line of sight as much as possible. The 12/24/24 IDT note documented the team reviewed Resident #2's falls from 12/17/25 and 12/19/25. The team initiated a one-to-one on 12/20/25 during daylight hours. The team determined she only fell during the day. The root cause was determined to be Resident #2 had no safety awareness, was confused, her cognition fluctuated, and she was impulsive. -However, the one-to-one intervention was not added to her care plan (see care plan above) and the one-on-one caregiver was not consistently with the resident (see observations above).7. Fall on 12/30/25 at 6:30 p.m. - unwitnessedThe 12/30/25 fall report documented the CNA that was assigned to provide one-on-one care for Resident #2, left the resident sitting at the dining room table and went to assist another resident in a room. She then heard a loud crash and came out to dining room. The CNA found Resident #2 on the floor and had hit her head on the ground. The registered nurse (RN) assessed Resident #2 and noted the area on the back of her as feeling soft and a small abrasion on her left pinky finger. Resident #2 was sent to the ED. The 12/31/25 IDT note documented the 12/30/25 fall resulted in an abrasion on Resident #2's left pinky finger and an injury to the back of her head. The note documented the root cause was Resident #2 had no safety awareness and was impulsive due to her diagnosis of Parkinson's disease. Interventions were to continue the one-to-one caregiver and have the medical doctor do a medication review. -However, the one-to-one caregiver left the resident assisted on 12/30/25, when the resident sustained an unwitnessed fall and hit her head.8. Fall on 1/1/26 at 9:00 p.m. - unwitnessedThe 1/1/26 fall report documented Resident #2 was found on her floor mat next to her bed. The bed was in the lowest position. The report documented Resident #2 was unable to describe what happened and no new injuries were found. The 1/2/26 IDT note documented the root cause was Resident #2 was confused and did not call for assistance when needed. No new interventions were implemented. The 1/7/26 IDT note documented the team reviewed the fall that occurred on 1/1/26. The root cause was Resident #2 did not have safety awareness and did not know her limitations. The note documented the one-to-one was from 7:00 a.m. to 7:00 p.m. and the team was considering expanding the one-to-one to around the clock.9. Fall on 1/12/26 at 10:49 a.m. - witnessedThe 1/12/26 fall report documented the resident sustained a witnessed fall in the television room. The report documented the CNA said I was right there with her when she fell. Resident #2 was on the floor next to her chair. Resident #2 obtained a skin tear to her left forearm. The 1/13/26 IDT note documented the root cause was Resident #2 had no safety awareness, was impulsive, had a shuffling gait, poor balance and jerky turns. There were no new interventions put in place. 10. Fall on 1/12/26 at 9:00 p.m. - unwitnessedThe 1/12/26 fall report documented Resident #2 was found on the floor mat between her bed and the window. Resident #2 was unable to say what happened. No injuries were noted. The 1/13/26 IDT note documented the root cause was Resident #2 rolled from her low bed to the fall mat. New interventions implemented clip call cord to Resident #2's clothing while she esd in bed. -However, review of the care plan revealed this intervention was already implemented on 12/3/25. The 1/14/26 IDT documented the two falls on 1/12/26 were reviewed. The note documented new interventions were one-to-one supervision, and in line of sight and to explore providing weighted blanket when she was in bed. -However, the one-to-one was implemented on 12/20/25 and the weighted blanket was originally implemented on 12/3/25.11. Fall on 1/14/26 at 7:55 p.m. - unwitnessedThe 1/14/26 fall report documented Resident #2 was found on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her bedside fall mat perpendicular to her low bed. The report documented Resident #2 stated I was adjusting my blanket and fell. There were no injuries documented. The 1/15/26 IDT note documented the root cause for the 1/14/26 fall was Resident #2 was adjusting her blankets and rolled off the low bed onto the fall mat. The new intervention was to offer a trial weighted blanket. The 1/21/26 IDT note documented the team reviewed Resident #2's 1/14/26 fall. The team determined she rolled off her bed while adjusting her blankets. The intervention was to ask the family to bring a weighted blanket. The note documented the blanket is pending. -However, the weighted blanket was originally implemented on 12/3/25.II. Staff interviewsCNA #5 was interviewed on 1/27/26 at 3:22 p.m. She said Resident #2 was on a one-to-one caregiver because she frequently fell while she was by herself. She said she was unsure of how long she had been on the one-to-one caregiver. CNA #6 was interviewed on 1/27/26 at 3:32 p.m. She said Resident #2 was on a one-to-one caregiver because she had frequent falls due to her dementia. She said Resident #2 had a one-to-one caregiver seven days a week from 7:00 a.m. to 7:00 p.m.Licensed practical nurse (LPN) #1 was interviewed on 1/28/26 at 9:15 a.m. She said Resident #2 was a high fall risk. She said she had fallen and sustained sutures and staples in her scalp. She said she had also sustained skin tears from falling. She said she thought her one-to-one caregiver started the beginning of January 2026.CNA #7 was interviewed on 1/28/26 at 9:51 a.m. She said Resident #2 was impulsive, she would be fine one minute and then the next she would not. She said not having a one-to-one caregiver with Resident #2 was not an option for her. She said Resident #2 has been on the one-to-one caregiver since about the time she was admitted to the facility. She said she would have to go over the one-to-one expectations with the agency staff that was there that day. She said she expected the agency to engage with her and to be next to her and to keep her occupied (see observations above). CNA #8 was interviewed on 1/28/26 at 11:29 a.m. She said Resident #2 had been on the one-to-one caregiver for over a month. She said she was on the one-to-one caregiver because of her frequent falls. She said staff always tried to keep a close eye on Resident #2 and talk to her. She said staff would constantly check on her. She said staff could find interventions in the Kardex (a reference guide that has important information on residents). She said there was also a communication book for reporting any changes or updates that CNAs need to know. She said anyone could write in the communication book, but it was information that needed to be passed on to CNAs. The director of nursing (DON) and assistant director of nursing (ADON) were interviewed together on 1/29/26 at 10:30 a.m. They said Resident #2 was admitted to the facility as a high fall risk. They said when she was living at her previous place of residence, she had fallen and broken bones. They said she was here for therapy and was planning on going back to her assisted living facility. They said they thought she would do better in a memory care facility. They said Resident #2's family would need to hire a 24/7 one-to-one caregiver for Resident #2 since she would no longer be on therapy services starting on 1/30/26. They said Resident #2 did not realize she could not walk alone. They said she did not not realize her gait and balance were impaired due to her diagnosis of Parkinson's disease. They said she had a short attention span. They said the resident could be distracted by eating and walking. They said the interventions that were implemented upon admission included placing her bed in a low position, ensuring the fall mats were in place, having the resident reside in a room close to the common area and clipping the call light to her while in bed. They said the interventions that were added were medication review, pain medication review, keeping her in line of sight, frequent toileting and a weighted blanket. They said they were still waiting for the family to bring in the weighted blanket. They said she was officially put on the one-to-one on 12/20/26 from 7:00 a.m. to 7:00 p.m. They said they implemented the 7:00 a.m. to 7:00 p.m. because she was falling during the day. They said she recently started falling in the evening. They said they have not had the ability to officially put her on a one-to-one 24 hours because of staffing. They said they had been completing frequent checks after 7:00 p.m. and if they noticed she was restless they would offer her to go to the common area. They said if they felt she needed to be on a one-to-one caregiver then they would pull the float CNA. They said they felt like they had put every intervention (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	in place to prevent falls and injuries. III. Facility follow-upThe facility sent additional information on 1/30/26 provided by the NHA documenting that Resident #2's falls were clinically unavoidable due to her diagnosis of Parkinson's and her being educated to not stand without assistance but she continued to do so. -However, observations revealed the facility failed to consistently implement the one-to-one caregiver as recommended (see observations above).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to ensure an infection prevention and control program was maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of four units. Specifically, the facility failed to: -Implement an effective water management plan to monitor for Legionella-Ensure staff wore the appropriate personal protective equipment (PPE) when providing incontinence care and transfers for Resident #14 and Resident #24, who was on enhanced barrier precautions (EBP) for wounds; and,-Ensure hand hygiene was performed appropriately in the dining areas. Findings include: I. Water management failures A. Professional reference According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, retrieved on 1/27/26 from https://ww.cdc.gov/contro.-legionella.php/toolkit/potable-water-systems-module.html Operation, maintenance, and control limits guidance: Monitor temperature, disinfectant residuals, and pH frequently based on Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 degrees F (fahrenheit) or 60 degrees C (celsius). Ensure hot water in circulation does not fall below 120 degrees F (49 degrees C). Recirculate hot water continuously, if possible. Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 degrees F, 25-45 degrees C). Legionella may grow at temperatures as low as 68 degrees F (20 degrees C). Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Ensure disinfectant residual is detectable throughout the potable water system. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. Consider testing for Legionella in accordance with the routine testing module of this toolkit. B. Record review A request for the facility's water management plan was made on 1/28/26 at 11:00 a.m The NHA said the facility did not have a water management plant (see interview below). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Staff interviews The NHA was interviewed on 1/29/26 at 12:33 p.m. The NHA said she was unable to locate the facility water management plan . She said the facility should have a water management plan. The water management plan prevents the introduction and spread of Legionella in the facility water system. The plant operations director was interviewed on 1/29/26 at 12:43 p.m. He said the facility had tankless hot water heaters. He said these heaters did not have standing water, so he did not need to have a water management plan. II. EBP failures A. Facility policy and procedure The Infection Control policy, undated, was received from the nursing home administrator (NHA) on 1/28/26 at 5:36 a.m. The policy read in pertinent part, The enhanced barrier precautions refers to infection prevention and control interventions designed to reduce the transmission of multi drug resistant organisms (MDRO) during high contact resident care activities. Enhanced barrier precautions are applied when a resident is infected or colonized with a MDRO or if a resident has a wound or indwelling medical device during high contact activities. Examples of high contact resident care activities requiring the use of gown and gloves include dressing, bathing and showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing Linens, prolonged High contact activity with internal medical devices, and wound care. B. Observations On 1/27/26 at 9:36 a.m. licensed practical nurse (LPN) #1 completed wound care for Resident #14. She completed hand hygiene and donned (put on) gloves. There was a sign on Resident #14's door that indicated she was on EBP. -LPN #1 failed to put on a gown prior to completing wound care for Resident #14, who was on EBP. On 1/27/26 at 2:12 p.m. certified nurse aide (CNA) #3 and CNA #4 were assisting Resident #24 transfer from her wheelchair to her bed using a mechanical lift. Both CNA #3 and CNA #4 completed hand hygiene and donned gloves and a mask prior to assisting the resident. CNA #3 and CNA #4 provided incontinence care forResident #24 during the transfer. There was a sign on Resident #24's door that indicated she was on EBP because of her pressure wounds. -CNA #3 and CNA #4 failed to put on a gown prior to completing cares for Resident #24, who was on EBP. On 1/27/26 at 2:32 p.m.LPN #1 completed wound care for Resident #24LPN #1 completed hand hygiene and donned gloves. There was a sign on Resident #24's door that indicated she was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-LPN #1 failed to put on a gown prior to completing wound care for Resident #24, who was on EBP. C.Staff interviews CNA #3 and CNA #4 were interviewed together on 1/27/26 at 2:55 p.m. CNA #3 said she only wore gloves when providing care to Resident #24 because she was helping with toileting hygiene. She said the only staff that wore gowns were the nurses when they were changing the resident's wound dressing. She said she did not know she was required to wear a gown when providing incontinent care. CNA #4 said she did not know Resident #24 was on precaution for any reason. She said she always wore gloves when assisting a resident to prevent the resident from getting an infection. She said she did not remember receiving training on infection control from the facility. LPN #1 was interviewed on 1/28/26 at 2:00 p.m. She said she was supposed to wear a gown with gloves when doing wound care for Resident #14 and Resident #24. She said she did not wear a gown, because they were too small. She said she received training on EBP from the facility when she was hired. She said the reason for a resident to have EBP was to prevent the resident from getting contaminated with bacteria and possible infection. The director of nursing (DON) was interviewed on 1/28/26 at 3:12 p.m. The DON said she had completed the CDC in infection prevention training. The DON said she would provide nursing staff with education regarding infection control protocol. The DON said she would have the nursing staff provide a return demonstration of standards of care for PPE donning. The DON said EBP and contact precautions were very different. She said if a resident were on contact precautions, the nursing staff would be required to wear gowns, gloves, mask with goggles before entering their room. The DON said gloves and gowns were required for all nursing staff engaged high-contact resident care activities if a resident was on EBP. She said all nursing staff were expected to follow all of the requirements for EBP. The DON said the nurses were trained upon hire, annually and as needed. The DON said she did infection control audits on facility staff for transmission based precautions earlier this month. The DON and the infection preventionist (IP) were interviewed together on 1/29/26 10:29 a.m. The IP said she would do training for all nursing staff on EBP beginning today. The IP said she would watch all of the nursing staff to ensure they were wearing the correct PPE. She said it was important for the nursing staff to understand the importance of adhering to EBP to protect the resident and to protect the staff as well. She said infections could spread very quickly so the key was to follow professional standards of care. III. Hand hygiene failures A. Observations Observations of Catalpa house on 1/26/26 at 11:23 a.m. CNA #1 touched the rims of six glasses with her fingers as she placed them on the table. She was not observed to wash or sanitize her hands prior to touching the rims of the six glasses. Observations of Catalpa house on 1/28/26 at 11:00 a.m. revealed CNA #1 was setting the table with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	eight place mats, cloth napkins and silverware. CNA #1 was not observed to wash or sanitize her hands prior to pre-setting the table for the lunch meal. At 12:16 p.m. Resident #30 ambulated herself with the use of her right hand, to propel to the dining table. Her right hand touched the push rim of the right wheel. Also at this time, Resident #18, with the use of a front wheeled walker, ambulated herself to the dining table. Her hands gripped the hands on the walker during ambulation. Neither resident was offered or assisted with hand sanitization at the table. B. Staff interviews CNA #2 was interviewed on 1/28/26 at 12:33 p.m. CNA #2 said she was not in the dining room when Residents #18 and #30 came to the dining table. CNA #2 said residents' hands should be sanitized at the dining table before a meal service. The registered dietitian (RD) and the dietary manager (DM)were interviewed on 1/29/26 at 7:25 a.m. They said the staff should not be touching the rims of glasses when serving. They said the staff should encourage and help residents sanitize their hands at meal times. The RD said these observations were infection control concerns. The RD said the lack of infection control procedures might result in the spread of germs and a possible outcome might be a resident becoming sick. The RD said staff were educated on infection control procedures upon hire and during yearly in-services.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, record review and interviews the facility failed to provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Specifically, the facility failed to ensure all staff that were responsible for preparing and cooking meals for the residents were fully educated on proper food handling and food preparation. Findings include:I. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 2/4/26. It read in pertinent part, Employees are properly trained in food safety, including food allergy awareness, as it relates to their assigned duties. Food allergy awareness includes describing food identified as major food allergens and the symptoms that a major food allergen could cause in a sensitive individual who has an allergic reaction. (Chapter 2-103.11)II. Facility policy and procedureThe Food Preparation and Service policy, dated 2001, was provided by the nursing home administrator (NHA) on 1/29/26 at 4:39 p.m. It read in pertinent part, Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to elders. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. III. ObservationsOn 1/27/26 at 3:15 p.m. certified nurse aide (CNA) #5 (who was an agency staff member) began putting silverware away. She did not wash her hands before putting the silverware away. On 1/28/26 at 12:15 p.m. an unidentified agency CNA put on gloves to pass out cucumber salad. The unidentified CNA did not wash his hands before donning (putting on) the gloves. On 1/28/26 at 12:44 p.m. an unidentified agency CNA put on a pair of gloves. He did not wash or sanitize his hands before putting on a new pair of gloves. He began serving plates of pizza and bowls of cucumber salad. He then went into the kitchen and grabbed a piece of pizza with his gloved hand and placed the pizza on a plate. He microwaved the pizza, did not take the temperature of the pizza and served it to a resident. IV. Resident representative interview and resident interviewResident #41's representative was interviewed on 1/26/26 at 11:15 a.m. He said the facility was having the CNAs cook and they did not have adequate training. He said some of the CNAs were good at cooking and some were not. He said the facility used to have homemakers and they would do the cooking and cleaning. The representative said now the CNAs did all of the cooking and cleaning. Resident #5 was interviewed on 1/27/26 at 9:23 a.m. He said the food varied based on who cooked the food. He said when agency staff cooked the food was usually bad. V. Staff interviewsCNA #5 was interviewed on 1/27/26 at 3:27 p.m. She said she was an agency staff member. She said she cooked for the residents from time to time. She said she did not get any training for working in the kitchen. CNA #6 was interviewed on 1/27/26 at 3:36 p.m. She said she was an agency staff member. She said she did not get any training before working in the kitchen. She said there were binders that had recipes and that there were temperature sheets in the kitchen. She said it was very difficult to cook for this population. CNA #7 was interviewed on 1/28/26 at 9:47 a.m. She said she had been working at the facility for almost two years. She said she got some training on temperatures and testing the sanitizer water during her orientation. CNA #8 was interviewed on 1/28/26 at 11:38 a.m. She said she was not trained on how to cook but was trained on temperatures and to follow the recipes. The dietary manager (DM) and the registered dietitian (RD) were interviewed together on 1/29/26 at 1:00 p.m. They said the only person who was ServSafe certified (food safety certificate) was the RD. The RD said she was also certified as a food safety instructor. They said they planned on getting all of the staff ServSafe certified this year. They said the DM did the training on food handling at orientation (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and then yearly. They said they would do one-on-one training with staff but they did not document those trainings. They said when a resident complained about a meal, it was usually when an agency staff member did the cooking. They said if it were one of the facility's staff members, they had a meeting with the staff member so coaching could be provided. They said the facility staff members should be supporting the agency staff members when they were cooking. They said if a unit only had agency staff working, there were binders that had recipes and lists on what to do in the kitchen. The NHA was interviewed on 1/29/26 at 2:15 p.m. She said the facility staff should be conducting the kitchen duties, such as cooking. The NHA said the facility staff should be supporting and guiding the agency staff while they were in the kitchen. She said the facility did not give agency staff any formal training for working in the kitchen.

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the one (#41) of six residents or their representative orally and in writing of a charge for an item out of 31 sample residents. Specifically, the facility failed to provide Resident #41 and his representative notification of an accidental charge for Narcan (medication used for reversal of opioid overdose) and how to get reimbursed for the accidental charge in a timely manner. Findings include: I. Resident #41A. Resident statusResident #41, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included cerebrovascular disease (conditions affecting the brain's blood vessels and supply), dementia, history of transient ischemic attack (stroke), anxiety disorder and muscle weakness. According to the 11/5/25 minimum data set (MDS) assessment Resident #41 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The MDS assessment indicated Resident #41 needed partial to moderate assistance with most of her activities of daily living (ADL). The MDS assessment indicated Resident #41 did have a scheduled abd as needed pain medications.B. Resident representative interviewResident #41's representative was interviewed on 1/26/26 at 12:10 p.m. He said Resident #41 was prescribed tramadol (a narcotic pain reliever) for pain as needed. He said the facility did not talk to him about the fact that Resident #41 was going to need Narcan and the facility charged him for it. Resident #41's representative was interviewed a second time on 1/29/26 at approximately 11:30 a.m. He said he wanted to know what steps he needed to take to get reimbursed for the Narcan. C. Record reviewThe January 2026 CPO revealed the following physician's orders: Tramadol 50 milligrams (mg) every six hours as needed for pain, ordered 8/5/25. Narcan nasal liquid four mg/.1 milliliter (ml) as needed for opioid overdose, ordered 11/26/25. II. Staff interviewsThe director of nursing (DON) was interviewed on 1/27/26 at 3:10 p.m. She said she thought there was a new requirement to have the medication Narcan available for each resident in the facility. She said she misinterpreted the requirement incorrectly. She said the mistake had been fixed. The DON was interviewed again on 1/29/26 at 12:30 p.m. She said Resident #41's representative should not have been billed for the Narcan. She said if the representative brought tin the bill, the facility would reimburse him. The DON was interviewed again on 1/29/26 at 12:46 p.m. She said she was unsure if Resident #41's representative was notified about bringing in the bill for the Narcan to get reimbursed. She said she had talked to him about the Narcan before she realized she had made a mistake. She said only one other family had come and talked to her about the Narcan charge. She said that family had been reimbursed. She said she was only talking to families that came and talked to her about it. She said she did not send out a notification of the mistake to all the families. She said she would talk to the nursing home administrator (NHA) about sending out a letter or email. The DON was interviewed again on 1/29/26 at 1:01 p.m. The DON said she had called Resident #41's representative and told him to bring in the bill for the Narcan. She said she notified the representative that he would be reimbursed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Findings include:I. Facility policy and procedureThe Required Training policy, reviewed on 1/9/26 was provided by the nursing home administrator (NHA) on 1/29/26 at 2:02 p.m. The policy revealed the facility would comply with State and Federal regulations and requirements as they pertain to training. Every employee was also required to complete an annual training curriculum through Care Academy (and/other sources) that would be assigned according to their job responsibilities. It was the responsibility of the employee to complete the required training to maintain employment status. The policy did not address that nursing staff were to demonstrate competency in skills and techniques necessary to care for residents on an annual basis.II. Record reviewOn 1/29/26 at 7:52 a.m. an email request was made to the NHA for the facility's annual competency assessment for CNA #1, CNA #2 and CNA #12.-The facility was unable to provide documentation to show that the three selected CNAs had the specific skill sets necessary to provide competent care for residents' needs as demonstrated in an annual skills assessment.III. Staff interviewsThe NHA was interviewed on 1/29/26 at 12:40 p.m. The NHA said she was unable to locate the annual skills competencies assessments for CNA #1, CNA #2 and CNA #12. The NHA said she called the former assistant director of nursing (ADON) and was told the facility had assessed all of the CNAs for skilled competencies and those assessments had been placed in a binder. The NHA said she was unable to locate this binder. The NHA said all CNAs should receive annual skill set competencies assessments. The NHA said the annual skill competencies assessments were necessary to ensure CNAs maintain their skills to provide adequate care of the elders. The NHA said if a CNA was lacking in their competencies, a resident might not receive the care that they required. The director of nursing (DON) was interviewed on 1/29/26 at 1:01 p.m. The DON said the facility was unable to find the nursing staff competency assessments binder. The DON said the competency assessments of CNAs was necessary to check the skills to ensure they know the basic skills of a CNA. The DON also said the assessment would help identify and allow correction of any lack in the basic skills for resident care. The DON said a lack of basic skills might diminish the quality of care for a resident.