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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Park Forest Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7045 Stuart St Westminster, CO 80030	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#11) of three residents reviewed for feeding tube out of 22 sample residents received necessary care and services to remain free from neglect. Resident #11 was nonverbal and dependent on staff for nutrition and hydration through a gastrostomy tube (G-tube). The resident was unable to communicate needs, discomfort, or hunger and relied entirely on staff to provide ordered tube feeding. The physician's orders revealed the resident required continuous enteral feeding with scheduled water flushes to meet the resident's nutritional and hydration needs.On 1/28/26, the resident's tube feeding was not administered beginning at 4:00 p.m. until 6:00 a.m. on 1/29/26. Record review revealed no documentation that the ordered tube feeding was provided during this time period. Nursing documentation reflected that the failure to administer the tube feeding was identified after the fact, and the physician was notified on 1/29/26. The facility failed to ensure follow-up and continuity of care to meet the resident's nutritional needs during this extended period.The resident's representative said the incident caused increased fear and anxiety regarding the resident's care and said she was stressed by learning the resident's tube feeding was not provided as ordered and said that had the resident been aware, he would have been mad and would have requested transfer to another facility.Specifically, registered nurse (RN) #3 and RN #4 failed to take necessary steps to ensure Resident #11 received his enteral nutrition, which was his sole means of nutrition Finding include:Record review, observations and interviews confirmed the facility corrected the deficient practice related to Resident #11's tube feeding prior to the onsite investigation conducted on 2/3/26 to 2/9/26. The deficiency was cited as past non-compliance with a correction date of 1/29/26.I. Facility investigationThe nursing home administrator (NHA) provided an investigation on 2/4/26 at 12:49 p.m. regarding the failure to administer ordered tube feeding to Resident #11. The investigation identified RN #3 and RN #4 as the staff responsible for not administering the resident's tube feeding as ordered.An investigative report documented the initial reported incident on 1/28/26 and follow-up actions that included review of physician orders, record review, staff interviews, resident assessment, continuous education, in-servicing on tube feeding, neglect and reporting. The investigation, corrective actions, and facility wide education were completed on 1/29/26.On 1/28/26 at approximately 4:00 p.m., the resident's tube feeding orders were not administered by the assigned RN. The oncoming shift was provided inaccurate information regarding the tube feeding being on hold, and the resident did not receive tube feeding per physician orders from 4:00 p.m. on 1/28/26 until 6:00 a.m. on 1/29/26.On 1/29/26 at 9:30 a.m., the facility identified the missed tube feeding. The interdisciplinary team (IDT) reviewed Resident #11's physician's orders, the medication administration (MAR) and the treatment administration record (TAR) to verify tube feeding orders and administration. The RN #1 completed a resident assessment and noted no concerns. The facility documented the resident was not interviewable and did not observe any behavioral (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 0600 Level of Harm - Actual harm Residents Affected - Few	changes.Interviews documented the day shift (RN #3) said there was no tube feeding formula in the facility, while the assistant director of nursing (ADON) and central supply visually observed tube feeding formula in the facility. The night shift (RN #4) said the day shift nurse advised the tube feeding order was on hold and did not follow up regarding supply status.The investigation documented the resident was not interviewed due to severe cognitive impairment and inability to communicate.The investigation documented RN #3 and RN #4 were identified as the staff responsible for placing the resident's tube feeding orders on hold and not administering tube feeding as ordered on 1/28/26. Documentation and interviews reflected RN #3 placed the tube feeding orders on hold, provided inaccurate information to the oncoming shift regarding the tube feeding being on hold, and did not ensure follow-up regarding tube feeding availability. Interviews documented RN #4 was informed the tube feeding order was on hold and did not follow up to verify tube feeding supply availability or clarify physician orders.The investigation documented interviews documented the day shift RN #3 said there was no tube feeding formula available in the facility. Interviews further documented the ADON and central supply visually observed tube feeding formula available in the facility on 1/28/26.The investigation documented interviews documented the night shift RN #4 said the day shift RN #3 advised the tube feeding order was on hold and said the night shift RN #4 did not follow up regarding tube feeding supply status.The investigation documented the ADON provided a written statement and it read in pertinent part that on 1/28/26 at 6:30 a.m., the ADON informed RN #3 and licensed practical nurse (LPN) #1 that tube feeding formula was scheduled for delivery that day and that formula was available in the facility for immediate use.The DON provided a written statement on 1/29/26 that read in pertinent part, on 1/29/26 at 8:53 a.m., the DON was notified the resident did not receive ordered tube feeding overnight beginning on 1/28/26. The DON contacted RN #3 by phone and RN #3 said there was no tube feeding formula available in the building. The statement documented the ADON confirmed that at 6:30 a.m. on 1/28/26, the resident's tube feeding formula was scheduled for delivery that day and a 1000 milliliter bag of formula was available in the building for immediate use. RN #3 acknowledged the information and said she understood. -However, the resident's order for continuous feeding at 75 ml per hour for 18 hours required 1350 milliliters, therefore the 1,000 milliliter supply was not sufficient to meet the ordered amount.The investigation documented several staff members throughout the facility were interviewed on 1/29/26. All staff interviewed denied concerns related to tube feeding supply availability and identified appropriate steps to take when supplies were unavailable, including contacting the pharmacy or central supply and clarifying physician orders when tube feeding was held.II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #11The facility verified the physician's orders for tube feeding and verified tube feeding formula was available. The facility assessed Resident #11 after identifying the missed tube feeding and documented no findings noted. The facility ensured tube feeding was restarted and provided per physician's orders.B. Identification of other residentsOn 1/29/26 the facility reviewed tube feeding orders and documentation for residents receiving tube feeding to identify other residents who could be affected by the deficient practice. C. Systemic changesThe facility provided education and in-servicing on tube feeding, hydration, nutrition, neglect, and reporting requirements. On 1/29/26 the facility completed one-on-one training and competency checklist and evaluated nursing staff on tube feeding skills.D. MonitoringThe facility implemented weekly monitoring of tube feeding orders and tube feeding administration to ensure tube feeding was provided per physician orders.III. Facility policy and procedureThe Care and Treatment of Feeding Tubes Policy, implemented 12/1/25, was provided by the DON on 2/5/26 at 12:10 p.m. The policy read in pertinent part that, Feeding tubes would be utilized (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	via G-tube at 75 milliliters per hour (ml/hr) for 18 hours. Start at 6:00 a.m. and run until midnight or until total volume of 1350 ml is reached ordered 2/3/26.V. Staff interviewsLPN #1 was interviewed on 2/4/26 at 3:47 p.m. LPN #1 said he had not experienced issues with insufficient medical supplies to complete resident care tasks and said certified nurse aides (CNA) had not reported running out of supplies. LPN #1 said when supplies were unavailable, staff were expected to contact the pharmacy or obtain supplies from central supply and said in an emergency, staff could obtain needed supplies from a local store. LPN #1 said tube feedings could be held for showers or medical procedures but said a physician order was required to hold or restart tube feeding.The DON was interviewed on 2/5/26 at 11:00 a.m. She said RN #3 did not hang the tube feeding that was due at 4:00 p.m. on 1/28/26 and passed that information to RN #4. She said RN #4 followed RN #3's direction to hold the tube feeding. She said on the morning of 1/29/26 at about 8:50 a.m., while she was at the nurses' station, RN #1 informed her that Resident #11 did not receive his nutrition because RN #3 had told RN #1 the tube feeding was on hold due to no supply of formula available in the building.The DON said she had spoken with the ADON on the morning of 1/28/26 regarding running low on formula, however, there was still 1,000 ml of formula in the building and staff were directed how to obtain it. She said after the event they took measures to ensure the resident maintained adequate nutritional intake, including obtaining a new order for an alternate formula that was available at the facility. She said if staff believed tube feeding cannot be administered due to lack of supplies, they are expected to notify the supply coordinator and the DON. She said the supply coordinator typically placed orders on Monday with expected delivery the next day on Tuesday, however, that week the supplies were not received until Wednesday for an unknown reason.The DON said the required process for handoff communication between shifts was for the nurse giving report to verbally communicated to the next shift and ensured orders were in place. She said she would never tell staff to hold orders and would ensure alternate orders were obtained to maintain continuity of care. She said when tube feeding was not administered as ordered, the physician and power of attorney would be notified.The DON said after the event they ordered laboratory tests for monitoring and results were within normal limits. She said they notified the physician and the physician was not concerned and did not give new orders. She said the laboratory results drawn on 1/29/26 were similar to those obtained on 1/6/26. She said the resident remained at baseline after the event and did not observe distress or behaviors.The DON said it was important for the resident to receive his tube feeding without lapse because he was nothing by mouth and received his nutrition and fluids through tube feeding and if he did not receive it, it could lead to dehydration or weight loss. She said a performance improvement plan was implemented in which a nurse manager audited and ensured supplies were available daily and on Fridays verified there were adequate supplies for the weekend and notified the DON if supplies were low. She said only the physician could hold a tube feeding and she expected the nurses to know this.The supply coordinator was interviewed on 2/5/26 at 12:05 p.m. She said she had worked at the facility for a little over one month. She said her first day of training was on 12/27/25 and she began working as a full time employee the first week of January 2026. She said she prepared the supply orders on 1/26/26 at 12:30 p.m. and the NHA submitted the order on 1/26/26.The supply coordinator said to avoid running out of tube feeding supplies, contingency plans were in place when scheduled deliveries were delayed, such as ordering extra supplies or borrowing from sister facilities. She said staff notified her either verbally or by leaving notes when they were running low on supplies, and she reviewed those daily and would place an order immediately. She said as long as the order was placed before 12:30 p.m., they expect delivery the next business day.The NHA was interviewed on 2/5/26 at 12:50 p.m. She said that Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	1/28/26.The NHA said the vendor dropped off the facility's order at the front of the building and with the housekeeping department. She said she thought the facility's central supply staff was notified of the delivery.The ADON said she told the nurses in the morning on 1/28/26 that the tube feeding formula would be delivered that day.The DON said Resident #11 had a 4:00 p.m. start on the day the order was placed on hold. The DON said she spoke to the nurses who worked on the women's side of the facility. She said the nurses confirmed the tube feeding formula was available but was stored in the basement. She said the nurses went to the basement and retrieved the formula.The DON said once the LPN #2, who started at 6:00 a.m., received notification, LPN #2 called the physician to restart the tube feeding so the resident could receive nutrition. She said the physician provided orders for laboratory tests and to obtain the resident's weight. The DON said that even a late start for a tube feeding was better than not starting the tube feeding at all. The DON said she spoke with the resident's wife and updated her on the resident's tube feeding status.

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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 two (#5 and #2) of seven residents reviewed for accidents out of 22 sample residents received adequate supervision to prevent accidents. Resident #5 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, vascular dementia, unspecified severity, with other behavioral disturbance and unspecified symptoms and signs involving cognitive functions and awareness.Resident #5 was identified as a high fall risk. On 12/25/25, Resident #5 sustained an unwitnessed fall. On 12/29/25, the resident sustained an additional unwitnessed fall. The facility recommended implementing a communication board due to the resident's difficult communication. However, observations during the survey revealed the staff did not utilize the communication board. Resident #5 sustained an additional fall on 1/1/26, where she hit the back of her head. The resident was transferred to the hospital and received five stitches to the back of her head. Upon return from the hospital, the physician documented the staff were ordering a low bed to help prevent falls. However, observations revealed the resident's bed was not in the low position. The resident sustained an additional fall on 1/19/26.Specifically, the facility failed to:-Ensure person centered fall interventions were consistently implemented for Resident #5, who sustained multiple falls;-Ensure person centered fall interventions were implemented for Resident #2. Findings include: I. Facility policy and procedure The Fall prevention program policy, dated 12/1/25, was provided by the nursing home administrator (NHA) on 2/5/26 at 2:38 p.m. It revealed in pertinent part, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The facility utilizes a standardized risk assessment for determining a resident's fall risk. a. The risk assessment categorizes residents according to low, moderate, or high risk. b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling,including, but not limited to: i. A clear pathway to the bathroom and bedroom doors. ii. The bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. iii.Call light and frequently used items are within reach. iv. Adequate lighting. v. Wheelchairs and assistive devices are in good repair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. Implement routine rounding schedule. c. Monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. d.Encourage residents to wear shoes or slippers with non-slip soles when ambulating. e.Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. f.Monitor vital signs in accordance with facility policy. g.Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. High Risk Protocols: a. The resident will be placed on the facility's Fall Prevention Program. i. Indicate fall risk on care plan. b. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. d. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assistive devices ii. Increased frequency of rounds iii. Sitter, if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii.Scheduled ambulation or toileting assistance viii.Family/caregiver or resident education ix. Therapy services referral Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify the physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. II. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, vascular dementia, unspecified severity, with other behavioral disturbance, and unspecified symptoms and signs involving cognitive functions and awareness. The 2/2/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for a mental status score of zero out of 15. She required partial/moderate assistance with activities of daily living (ADL). The MDS assessment revealed the resident exhibited wandering behaviors on one to three days during the assessment look-back period. The MDS assessment revealed the resident had two or more falls without injury and one fall with injury since her time of admission to the facility. B. Observations During a continuous observation on 2/5/26, starting at 12:15 p.m. and ending at 1:02 p.m., the following were observed: At 12:15 p.m. Resident #5 was assisted to her room from lunch, and assisted to her bed. Resident #5 was left sitting on the side of her bed with her call light in reach.Resident #5 was not wearing a helmet during the observation. At 12:22 p.m. Resident #5 began to stand up and reach out for the blanket that was in her (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchair. Resident #5 sat back down on the edge of the bed and placed the blanket on her bed. Resident #5 stood back up from the bed and reached out for her bedside table that was not within reach of her. Resident #5 sat back down on the edge of the bed and began to unlock the brakes on her wheelchair that was placed in front of her. Resident #5 stood up from the bed and placed one hand on her transfer pole while using her free hand to continue to unlock the wheelchair. Resident #5 was unstable on her feet. At 12:25 p.m. licensed practical nurse (LPN) #4 was prompted that Resident #5 was walking without assistance. LPN #4 entered Resident #5's room and assisted her to the bathroom. LPN #4 placed Resident #5's wheelchair in the doorway of the bathroom and told Resident #5 to call when she was done on the toilet. LPN #4 exited the room and did not return. Facility staff congregated in the hall near the nurses station, however no one came back to check on Resident #5. At 12:32 p.m. Resident #5 did not push her call light for assistance Resident #5 self transferred from the toilet to her wheelchair and began backing herself out of the bathroom getting her wheelchair stuck on the transfer pole in her room. At 12:46 p.m. Resident #5 self propelled to the bathroom and self transferred from the wheelchair to the toilet. Facility staff were sitting at the nurses' station and talking with each other in the hallway. At 12:54 p.m. Resident #5 self transferred from the toilet back to her wheelchair and continued to self propel out into the hallway. At 1:02 p.m. Resident #5 was assisted back to her room, where staff left Resident #5 sitting in the middle of her room. Resident #5 self propelled back out into the hallway. On 2/9/26 at 9:32 a.m. Resident #5 was sitting in her wheelchair in the hallway by the nurses' station. Resident #5 began to stand up from her wheelchair. LPN #3 intervened and asked Resident #5 if she would like to take a shower. Resident #5 agreed to the shower and attended activities after. C. Record review 1. Care plan The fall care plan, revised on 11/27/24, identified Resident #5 was a high risk for falls related to a history of frequent falls, impaired safety awareness, left sided weakness secondary to history of a cerebrovascular accident (stroke), seizure disorder and medication use. Pertinent interventions (revised on 12/1/25) included placing anti-rollbacks to the resident's wheelchair, applying anti tippers to the resident's wheelchair, applying grip tape and bright pink reflective tape to restroom floor, apply grip tape next to bed to help prevent falls/injuries, assisting Resident #5 with toileting every two hours for fall prevention, giving Resident #5 a soft touch call light to make it easier for her to call for assistance, ordering a helmet to try and prevent injury with future falls and moving the resident's room closer to nurses' station to increase line of sight. The fall care plan, revised on 11/27/24, identified Resident #5 had sustained multiple falls prior to her long term care stay and during her stay related to poor safety awareness, unsteady gait, impulsivity, and poor cognition. The care plan documented Resident #5 falls were unavoidable. Pertinent interventions (revised on 1/2/26) included placing belongings within reach of Resident #5. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
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F 0689 Level of Harm - Actual harm Residents Affected - Few	-However during observations revealed person centered fall interventions were not consistently implemented for Resident #5 (see observations above). 2. Fall on 12/25/25 - unwitnessed The 12/25/25 nursing progress note documented at 10:50 a.m. revealed Resident #5 had an unwitnessed fall. Staff heard a noise from Resident #5's room and immediately responded. Resident #5 was found on the floor next to her bedside and wheelchair. Resident #5 was assessed and assisted from the floor. No injuries noted. 3. Falls on 12/29/25 - unwitnessed The 12/29/25 nursing progress note documented at 12:11 p.m. revealed the nurse was notified that Resident #5 had fallen in the bathroom while brushing her hair. The note documented no injuries were noted. The 12/29/25 nursing progress note documented at 6:03 p.m. revealed the nurse made aware that Resident #5 was found by a certified nurse aide (CNA). Resident #5's wheelchair was at the door of the bathroom. Resident #5 was on the floor at the sink on her left side attempting to get up independently. No injuries were noted. The 12/30/25 interdisciplinary team (IDT) progress note was documented at 10:04 a.m. revealed the IDT met to discuss Resident #5's fall on 12/29/25. A new intervention was put in place to use a communication board to aide in providing care for Resident #5's basic needs in attempt to decrease Resident #5's frustration while trying to communicate her needs. Resident #5 became angry when staff was unable to understand Resident #5. The note documented Resident #5 would get up out of her wheelchair and attempt to ambulate while being unsteady. Resident #5's care plan was reviewed and updated. -However during observations made on 2/5/26 staff were not observed using a communication board with Resident #5 (see observations above). 4. Fall on 1/1/26 - unwitnessed The 1/1/26 nursing progress noted documented at 6:31 a.m. revealed Resident #5 was found sitting on the floor in her room at 4:30 a.m. Resident #5 was attempting to get out of bed for a drink of water and slipped. Resident #5 was wearing regular socks. The note documented the resident may need non-skid footwear while in bed. Resident #5's tray table was moved closer to Resident #5's bedside. Resident #5 was kept in the common area for better visualization until she requested to go back to bed. The 1/2/26 nursing progress note documented at 1:10 a.m. was struck out in error but revealed Resident #5 had an unwitnessed fall with injury. Staff heard a loud noise coming from Resident #5's room. Resident #5 was found on her hands and knees in front of the bathroom door. Resident #5 was wearing proper footwear. The note documented the resident was transferring without her wheelchair and without staff assistance. The note documented blood was observed dripping from Resident #5's chin. A laceration was identified on the right backside of Resident #5's head. The registered nurse (RN) was notified to perform an assessment and emergency services were notified. The 1/2/26 nursing progress note documented at 3:20 a.m. revealed Resident #5 returned to the facility from the hospital after receiving five stitches to the laceration. Resident #5 was alert and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	oriented to the room. The 1/2/26 hospital summary revealed Resident #5 was treated for head injury involving a laceration that required stitches or staples. The 1/7/26 physician's progress note documented Resident #5 had repeated falls. The note documented the staff were ordering the resident a low bed. The resident denied pain. The note documented the staff reported agitation and most of the resident's falls occurred when she was attempting to use the bathroom. The note documented the hospice nurse indicated the resident was constipated and a laxative was ordered. -However, observations revealed the resident's bed was not in a low position (see observations above). 5. Fall on 1/19/26 - unwitnessed The 1/19/26 nursing progress note documented at 12:06 a.m. revealed the nurse heard a loud thud and found Resident #5 sitting on the floor in her room next to the bed and her wheelchair. Resident #5 got herself into her wheelchair and declined to be assessed. Resident #5 continued to assist herself to the bathroom. The nurse provided a stand by assist while Resident #5 toileted. Resident #5 continued to deny the physical assessment. No injuries were observed. Neurological checks were implemented. D. Staff interviews CNA #4 was interviewed on 2/9/26 at 9:45 a.m. CNA #4 said she used the Kardex (staff directive tool) to determine if a resident was at risk for falls. CNA #4 said fall interventions were also included on the Kardex. CNA #4 said good practice in general for anyone who was at a high fall risk was to ensure she was rounding timely. CNA #4 said she typically rounded every hour unless specified. CNA #4 said if she found a resident on the floor she would ensure the resident was safe and then notify the nurse immediately. CNA #4 said they then began 15-minute vital sign checks and documented them. CNA #4 said if the vital signs were not within normal limits, she would notify the nurse immediately. LPN #3 was interviewed on 2/9/26 at 10:30 a.m. LPN #3 said she gave Resident #5 activities to do, including a fidget board that she can play with or watching movies in her room. LPN #3 said Resident #5 could tell the staff what movie she wanted to watch. LPN #3 said Resident #5 also attended activities and the hospice staff came every other day. LPN #3 said hospice staff would l provide one-to-one with Resident #3 for up to three hours. LPN #3 said Resident #5 also enjoyed taking showers. LPN #3 said the showers helped relax Resident #5, however LPN #3 said Resident #5 was a private person so she also did not like to be watched especially when she was in the bathroom. LPN #3 said Resident #5 was capable of standing on her own, but was not stable enough to walk. LPN #3 said Resident #5 could show signs of aggression by reaching for the staff's ID badge or reaching for the staff's hair. LPN #3 said when a resident fell, the nurse would assess the resident and then notify family, provider. She said since Resident #5, she would also contact the hospice staff to inform them of the fall. LPN #3 said she would assess the residents vital signs and if the fall was unwitnessed she would begin a neurological assessments. The director of nursing (DON) was interviewed on 2/9/26 at 12:33 p.m. The DON said the facility would implement a plan to ensure Resident #5 was not left alone while toileting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The NHA and the DON were interviewed together on 2/9/26 at 3:04 p.m. The NHA said the staff needed to do more training on purposeful rounding. She said purposeful rounding would be beneficial in regards to the high amount of falls in the facility. The DON said getting ahead of the residents' needs before they tried to do things on their own would help reduce the amount of falls. The DON said in order to tell if an intervention was successful the DON said a big portion would be through feedback from the nursing staff. The NHA said they also discussed falls during their team leadership rounds, after morning meetings, and during each shift change a huddle at each nurses' station to be able to provide training. III. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia, protein-calorie malnutrition and a history of falling. The 1/15/26 MDS assessment documented the resident was severely cognitively impaired with a BIMS score of zero out of 15. The resident required substantial/maximum assistance for chair to bed or bed to chair transfers, partial/moderate assistance for dressing including footwear, hygiene and bed mobility, and set up assistance at meals. The assessment documented the resident had a fall with injury and did not refuse care. B. Observations On 2/4/26 a continuous observation was conducted from 2:36 p.m. to 3:40 p.m. At 2:36 p.m. Resident #2 was in bed in her room. The resident's wheelchair was next to her bed. The resident remained in bed until 3:40 p.m. A fall mat was not placed next to the bed while the resident was in bed and the bed was not in the lowest position. The fall mat was folded in half next to the wall in the residents's room. On 2/5/26 Resident at 11:15 a.m. Resident #2 was observed in her room in her wheelchair sitting next to her bed. Resident #2 self transferred from her wheelchair into her bed, leaving the wheelchair at her bedside. The resident's red locking pedal under the bed was up and the green pedal was down. On 2/5/26 at 11:30 p.m. the resident remained in bed. A fall mat was not on the floor next to the resident's bed. On 2/5/26 at 11:54 p.m. the resident remained in bed. A fall mat was not on the floor next to the resident's bed. On 2/5/26 at 12:13 p.m. an unidentified staff member entered Resident #2's room. The unidentified staff member looked at Resident #2, asked where the resident's roommate was and then exited the room. The unidentified staff member did not place a fall mat next to the resident's bed, or ensure the resident's bed was in a locked position (see CNA #2 interview below). On 2/5/26 at 12:30 p.m. Resident #2 remained in her bed. There was no fall mat on the floor by the bed and the bed remained in an unlocked position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/9/26 at 10:17 a.m. Resident #2 was observed sitting in her wheelchair in her room. The resident had on regular socks and no shoes. The resident's red locking pedal under the bed was up and the green pedal was down. (see CNA #2 interview below). C. Record review Resident #2's care plan, revised 1/15/25, documented the resident was at moderate risk for falls as related to her poor safety awareness secondary to dementia disease progression. Pertinent interventions included to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed and the resident needed prompt response to all requests for assistance (10/18/23); provide the resident with tennis shoes to help with ambulation (12/18/23); provide the resident wheelchair education to lock brakes prior to self transfer (revised 12/01/25); the resident was able to transfer independently, however, benefited from contact guard assist (CGA) to promote safety as she allowed (revised 12/01/25). Additional fall interventions added after the resident's fall on 12/31/26 included to ensure the resident had proper footwear (1/2/26), a fall mat to be placed when the resident was in bed (1/12/26) and for the bed to be in the lowest position (1/20/26). -The resident's care plan did not document the resident refused care planned interventions for falls. A review of the resident's progress notes revealed the resident's sustained falls on 12/28/25, 12/31/25, 1/10/26 and 1/20/26: A 12/28/25 nursing progress note documented at 4:20 a.m. the nurse was notified at 4:15 a.m. that the resident stated that she had fallen. The resident claimed to have fallen on her bottom after returning to her bed from using the restroom. The resident stated that she had used the walker to transfer herself, and the resident was noted to be wearing non-slip socks. The resident stated she had pain in her left leg. A 12/29/25 nursing note at documented 7:08 a.m the resident had Xrays that showed moderately displaced fractures of the right superior and inferior pubic rami (pelvis). No dislocation was identified. There were moderate degenerative changes and bones were osteopenic. The physician was notified and orders were placed to send the resident to the ED. A 12/29/25 nursing progress note documented at 3:41 p.m. the facility received a call from the hospital that stated the resident received pelvis imaging and only found old fractures, no new fractures were identified. A 12/31/25 nursing progress note documented at 11:50 a.m. that the resident was found on the floor. A post-fall assessment was completed. There were no obvious deformities noted to any extremities. A neurological assessment was performed and the resident noted to be at her baseline. When asked if she struck her head, the resident shook her head no. The resident was observed yelling out in pain and guarding right hip and the nurse practitioner (NP) at the resident's bedside to complete an assessment. New orders were received to transfer the resident to the emergency department for further evaluation and to rule out an injury to the right hip. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A 1/1/26 nursing progress note documented at 12:19 a.m. that the resident returned from the hospital at 6:35 p.m. via a stretcher with a diagnosis of hypokalemia, a stable pelvic fracture and weight bearing as tolerated. A 1/10/26 nursing progress note documented at 2:20 a.m. the resident was assessed for a fall with head involvement. The resident was observed while still on the floor and her baseline physical and cognitive function was intact. There were no new limb deformities, bruising or bleeding. A small hematoma was noted at the back of the head. No spinal tenderness was noted but the resident endorsed pain. A 1/10/26 nursing progress note documented at 2:30 a.m. that a CNA opened the door to the residents room to answer a call light at 2:15 a.m. and observed the resident fall out of bed onto her head. A RN assessed the resident. A hematoma was noted to the back of the resident's head, and her right shin had a small skin tear with bruising. The nurse practitioner (NP) was notified with a recommendation to follow up with imaging later in the morning as the resident declined to go to the hospital. A 1/10/26 nursing progress note documented 4:35 a.m. an intervention was implemented to place a fall mat at the resident's bedside while the resident was in bed. A 1/10/26 nursing progress note documented at 11:40 p.m. the nurse assessed the resident and the resident's pupil response was non-reactive and the resident was unable to follow commands. The resident was observed to have altered mental status, the physician was notified and an order was placed to have the resident sent to the emergency department for further evaluation. -The nursing progress notes failed to document the date the resident returned to the facility or results of the emergency department evaluation. A 1/20/26 nurses note documented at 3:14 a.m. the staff heard the resident calling out and observed the resident sitting on her bottom on a fall mat next to her bed. The resident reported she was trying to roll over and get into a better position and rolled out of bed. The resident denied hitting her head and denied pain. The resident was assessed by an RN. An immediate intervention to replace the resident's bed with a high/low bed that lowered to the floor was implemented. D. Staff interviews CNA #2 was interviewed on 2/9/26 at 10:18 a.m. CNA #2 said when the green pedal on a resident's bed was pushed down the bed was not locked. CNA #2 said Resident #2's bed should be locked. -CNA #2 then used her food to push down on the red pedal under the bed to lock the bed. The DON, the NHA and regional clinical resource #2 were interviewed together on 2/9/26 at 3:05 p.m. The DON said Resident #2 could answer yes and no questions and was able to state her needs. The DON said the resident had a fall mat added to her care plan but did not know the resident self transferred and did not remember the self transfers being part of the facility's IDT discussion for Resident #2's falls. Regional clinical resource #2 said the facility did review Resident #2's falls and her care plan including her fall mat intervention and talked further on 2/9/26 about Resident #2. (continued on next page)

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	06A172	A. Building B. Wing	02/09/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The NHA said she did not know if the Resident #2's bed was checked and locked at the time of the resident's fall (on 12/31/25). Regional clinical resource #2 said the facility staff checked all the beds in the facility on 2/9/26 to ensure the beds were locked. She said the ordered a new bed from hospice for Resident #2 that included a specialty mattress and a remote control. She said the staff assisted Resident #2 in putting on non-skid socks in the morning (2/9/26 after the resident was observed without appropriate footwear per the resident's care planned interventions). She said Resident #2 used contact guard assist in her care plan to assist and was able to transfer by herself. The DON said when the facility did fall investigations, if the staff were unable to gather the needed information from the fall reports they further discussed the resident's falls with the staff during their daily meetings. The DON said the facility had provided education to the staff on purposeful rounding of the residents with the staff to look for improvement on getting ahead of residents needs before the residents tried to do things on their own. The DON said staff feedback was a good portion of the fall interventions and they discussed as a team if a fall intervention was not working.

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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 two (#1 and #10) of four residents reviewed, out of a total sample of 22 residents, remained free of significant medication errors. Specifically, the facility failed to:-Ensure staff timely and accurately updated Resident #1's Methadone dose and indicated use in his electronic medical record (EMR) per external provider orders; -Ensure staff accurately administered and documented the dose of Methadone Resident #1 received in his medication administration record (MAR); -Ensure staff implemented and documented care interventions to identify, assess, monitor, or treat Resident #1's specific triggering/craving behaviors related to his documented history of substance use disorder (SUD); -Ensure staff obtained a standing order to administer Narcan to Resident #1, who had a history of SUD and was currently prescribed opioid medications; and,-Ensure Resident #10's antibiotic was administered per the provider's order.Cross-reference F842: the facility failed to ensure staff maintained a complete and accurate medical record. Findings include: I. Facility policy and procedure The Medication Administration policy and procedure, revised 11/6/25, was provided by the nursing home administrator (NHA) on 2/5/26 at 3:07 p.m. It read in pertinent part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The Medication Orders policy and procedure, dated 12/1/25, was provided by the NHA on 2/5/26 at 3:07 p.m. It read in pertinent part, Medications should be administered only upon the signed order of a person lawfully authorized to prescribe. Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the physician, on the next visit to the facility (See Verbal Orders Policy). Documentation of Medication Orders: -Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR). -Clarify the order. -Enter the order on the medication order and receipt record. -If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions and facility policy. -Call or fax the medication order to the provider pharmacy. -Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing DC'd and the date, or discontinue the order as per the electronic software instructions and retype the new order. -Enter the new order on the MAR or ensure the new order is in the electronic MAR. -Notify resident's sponsor/family of new medication order. II. Methadone failures A. Resident #1 status Resident #1, age less than [AGE] years old, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), the diagnoses included displaced fracture of fifth cervical (neck) vertebrae, functional quadriplegia (paralysis), post traumatic stress disorder (PTSD), schizophrenia, chronic pain due to trauma, and neuromuscular dysfunction of bladder. The 11/18/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. He required partial assistance with bed mobility and transfers, and required substantial assistance with sit to stand transfers and toileting. The resident did not exhibit verbal or physical behaviors toward others during the assessment period. He did not have any episodes of rejecting care. B. Record review A 12/18/25 addiction provider visit note was provided by the NHA on 2/4/26 at 1:28 p.m. It documented Resident #1 reported still experiencing cravings while taking Methadone 40 milligrams (mg) daily. It documented the treatment plan for Resident #1's relapse prevention was increasing his Methadone dose to 50mg daily. A review of Resident #1's December 2025, January 2026 and February 2026 CPO revealed the following physician orders: Methadone oral concentrate 10 mg per 10 milliliters (mL). Give 40 mg by mouth in the morning for pain. Start date 9/19/25. Discontinue date 1/20/26. Methadone oral concentrate 10mg/mL. Give 50 mg by mouth in the morning for pain. Start date 1/20/26. Discontinue date 2/2/26. Monitor for nausea, constipation, itchiness, drowsiness, slowed breathing, or euphoria every shift for opioid/narcotic medication use. Start date 8/21/25. -However, a review of Resident #1's addiction provider's note (see above) documented Resident #1's Methadone dose was increased to 50 mg orally daily after his visit on 12/18/25, over one month before the dose was updated in Resident #1's EMR. -Additionally, the 12/18/25 provider's note (see above) documented the indicated use for Resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's Methadone was relapse prevention. However, a review of Resident #1's December 2025, January 2026, or February 2026 CPO revealed pain was the indicated use documented for Resident #1's Methadone. -Review of Resident #1's February 2026 CPO revealed no documented orders to identify/monitor/assess/document the resident's triggers and/or cravings related to his history of SUD or relapse prevention. -A review of Resident #1's February 2026 CPOs revealed no documented diagnoses addressing the resident's history of SUD. Resident #1's Methadone narcotic count sheets, dated from 12/26/25 to 1/23/26, were provided by the NHA on 2/3/26 at 3:46 p.m. and revealed the following: The narcotic count sheet, dated 12/26/25 to 1/2/26, documented the facility received seven bottles of Methadone on 12/26/25. The count sheet contained handwritten documentation, including the resident's name, the medication, and the administration route. It documented Resident #1 was administered Methadone orally on 12/27/25, 12/28/25, 12/29/25, 12/30/25, 12/31/25, 1/1/26, and 1/2/26. -Review of the 12/26/25 to 1/2/26 narcotic count sheet revealed facility staff failed to document the strength of Methadone received from the pharmacy for Resident #1. Additionally, Resident #1's December 2025 and January 2026 MAR documented the resident was administered Methadone 40 mg on 12/27/25, 12/28/25, 12/29/25, 12/30/25, and 12/31/25, 1/1/26, and 1/2/26. This was against Resident #1's addiction provider's order to administer Methadone 50 mg daily (see provider note above). The narcotic count sheet, dated 1/2/26 to 1/9/26, documented the facility received seven bottles of Methadone on 1/2/26. The count sheet included the following sections to be filled out by facility staff: resident name, room number, medication name, dose and route of administration, prescribing physician, starting count, and signature of nurse receiving the medication. The count sheet documented Resident #1's name, room number, medication name, route of administration, starting count, and the signature of the nurse receiving the medication. The count sheet documented Resident #1 was administered Methadone on 1/3/26, 1/4/26, 1/5/26, 1/6/26, 1/7/26, 1/8/26, and 1/9/26. -Review of the 1/2/26 to 1/9/26 narcotic count sheet revealed facility staff failed to document the strength of Methadone received from the pharmacy for Resident #1, as the count sheet indicated. Additionally, Resident #1's January 2026 MAR documented the resident was administered Methadone 40mg on 1/3/26, 1/4/26, 1/5/26, 1/6/26, 1/7/26, 1/8/26, and 1/9/26. This was against Resident #1's addiction provider's order to administer Methadone 50 mg daily (see provider note above). The narcotic count sheet, dated 1/10/26 to 1/16/26, documented the facility received seven bottles of Methadone 50 mg on 1/10/26. The count sheet documented Resident #1 was administered Methadone 50 mg on 1/10/26, 1/11/26, 1/12/26, 1/13/26, 1/14/26, 1/15/26, and 1/16/26. -However, Resident #1's January 2026 MAR documented the resident received Methadone 40 mg orally on 1/10/26, 1/11/26, 1/12/26, 1/13/26, 1/14/26, 1/15/26, and 1/16/26. This was against Resident #1's addiction provider's order to administer Methadone 50 mg daily (see provider note above). The narcotic count sheet, dated 1/16/26 to 1/23/26, documented the facility received seven bottles of Methadone 50mg on 1/16/26. The count sheet documented Resident #1 was administered Methadone 50mg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER: Park Forest Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 7045 Stuart St, Westminster, CO 80030	

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

on 1/17/26, 1/18/26, 1/19/26, 1/20/26, 1/21/26, 1/22/26, and 1/23/26.

-However, review of Resident #1's January 2026 MAR documented the resident received Methadone 40 mg orally on 1/17/26, 1/18/26, 1/19/26, and 1/20/26. This was against Resident #1's addiction provider's order to administer Methadone 50 mg daily (see provider note above).

-Additionally, a review of Resident #1's January 2026 CPO revealed orders to discontinue Methadone 40 mg daily and start Methadone 50 mg daily, both entered on 1/20/26 (see above). This was over one month after Resident #1's addiction provider visit on 12/18/25 (see provider note above), where his Methadone dose was increased to 50mg daily.

The substance abuse care plan, revised 11/27/25, documented Resident #1 had a history of methamphetamine substance abuse. Interventions included: encouraging the resident to discuss his feelings and concerns (initiated 8/19/25), inviting the resident to activities to divert attention (initiated 8/19/25), and offering the resident mental health services (initiated 8/19/25).

The psychosocial care plan, revised 11/27/25, documented Resident #1 had a psychosocial well-being problem related to previous homelessness, dependent behavior, pain in his back and legs, and a history of alcohol and substance abuse. Interventions included: allowing the resident time to answer questions and verbalize feelings (revised 12/1/25), increasing communication between resident/family/caregivers about care and living environment (initiated 8/20/25), and providing opportunities for the resident and family to participate in care (initiated 8/20/25).

-A review of Resident #1's care plan revealed no documented care interventions to identify/address/monitor/document the resident's Methadone use, or his triggers/cravings related to his history of SUD.

III. Narcan failures

A. Record review

A nurse note, dated 1/26/26 at 8:09 p.m., documented at approximately 5:00 p.m. Resident #1 was found unresponsive. It documented that upon assessment, Resident #1's respiratory rate was 11 breaths per minute. It documented the nurse administered one spray of Narcan into each of Resident #1's nostrils with immediate results. It documented emergency medical services (EMS) were activated, and Resident #1 was transferred to the hospital. It documented Resident #1's provider was notified.

A nurse note, dated 1/26/26 at 9:09 p.m., documented Resident #1's addiction clinic was contacted to schedule an appointment for increased lethargy, disorientation, and sedation after the resident's Methadone dose was increased. It documented a meeting was requested to discuss lowering Resident #1's Methadone dose from 50 mg back to 40 mg daily per the resident's primary provider's recommendation. It documented staff were awaiting a call back from Resident #1's addiction provider.

-A review of Resident #1's progress notes revealed no documentation the resident was experiencing increased lethargy, disorientation, or sedation before the incident on 1/26/26, when he was administered Narcan.

A review of Resident #1's January 2026 CPO revealed a physician's orders for Narcan nasal liquid 4 milligram (mg) per 0.1 milliliters (mL). Spray one spray to alternating nostrils as needed for

(continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opioid overdose. May Repeat in five minutes if needed up to one dose. Start date 1/30/26. -However, review of the resident's CPO revealed no documented orders to administer Narcan to Resident #1 on 1/26/26, or standing orders to administer Narcan to Resident #1 as needed for potential opioid overdose before 1/30/26 (four days after the resident was administered Narcan without a physician's order). Additionally, a review of Resident #1's January 2026 MAR revealed no documented administration of Narcan to Resident #1 on 1/26/26. D. Staff interviews Licensed practical nurse (LPN #1) was interviewed on 2/3/26 at 4:27 p.m. LPN #1 reviewed Resident #1's EMR and said the resident's Methadone dose was increased to 50 mg on 1/20/26. LPN #1 said he was unsure why the resident's dose was increased. LPN #1 said Resident #1's Methadone dose was managed and adjusted by an external provider. LPN #1 said a few days before the incident on 1/26/26, Resident #1 was exhibiting increased lethargy and difficulty arousing. LPN #1 said he reported this to Resident #1's primary provider, who advised staff to notify Resident #1's pain provider. -However, review of Resident #1's progress notes revealed no documentation of Resident #1's symptoms or provider notification before the incident involving Narcan administration on 1/26/26. LPN #1 said on 1/26/26 at approximately 5:00 p.m., he was alerted that Resident #1 was unresponsive. LPN #1 said upon initial assessment, Resident #1's respiratory rate was 12 breaths per minute. LPN #1 said he reported Resident #1's change in condition to the director of nursing (DON), and was advised to contact the resident's provider and prepare to administer Narcan. LPN #1 said upon returning to Resident #1's side, he observed the resident's respiratory rate to be 10 breaths per minute. LPN #1 said he administered Narcan to Resident #1, and the resident's eyes opened immediately. LPN #1 said he was unsure why Resident #1 did not have a standing order for Narcan on file before the incident on 1/26/26. LPN #1 said he spoke with Resident #1's nurse practitioner about not having an order, which prompted the Narcan order entered on 1/30/26. -However, the standing order to administer Narcan to Resident #1 as needed was entered four days after Resident #1 required Narcan administration on 1/26/26. Additionally, the facility failed to have a standing order for Narcan in place for Resident #1, who had a known history of SUD, and orders for Methadone and Oxycodone. The DON was interviewed on 2/4/26 at 11:05 a.m. The DON said upon being alerted of Resident #1's change in condition, she went to the resident's side. The DON said she performed a sternal rub, and Resident #1 moved. The DON said she advised LPN #1 to notify Resident #1's provider due to her concern the resident needed a higher level of care and/or Narcan. The DON said she was not present when LPN #1 administered Narcan to Resident #1. The DON said Resident #1's provider was notified before LPN #1 administered Narcan to the resident. The DON said LPN #1 would need to confirm the medication order and dose with the resident's provider to ensure accurate medication administration. The DON said she was unsure why Resident #1's Methadone dose was increased or when his increased lethargy symptoms started. The DON said if a resident's external provider changed any orders, facility staff should fill out a physician communication form, review the orders with the resident's primary provider, and update the resident's EMR as needed. The DON said the facility's health information manager ceased working at the facility on 1/26/26. The DON said she was unsure what the complete process was for reviewing external provider notes and updating the resident's EMR. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON was interviewed on 2/4/26 at 11:14 a.m. The ADON said when residents returned from external provider visits, transportation staff would hand a copy of the physician communication form to the resident's floor nurse, unit manager (UM), or ADON. The ADON said the resident's nurse or nurse managers were responsible for reviewing the orders and updating them in the EMR. LPN #1 was interviewed a second time on 2/4/26 at 11:33 a.m. LPN #1 confirmed he spoke with the DON regarding the resident's change in condition on 1/26/26 and then returned to Resident #1's side. LPN #1 said he observed Resident #1's respiratory rate to be 10 breaths per minute. LPN #1 said because of Resident #1's lowered respiratory rate, he took the initiative and administered Narcan to the resident. LPN #1 said he did not have a chance to notify the provider and obtain an order before he administered the Narcan to Resident #1. LPN #1 confirmed he did not document the Narcan administration in Resident #1's MAR. The DON and regional clinical resource #1 were interviewed on 2/5/26 at 11:05 a.m. The DON said no emergency medications were kept in the facility's emergency response cart, and the facility did not have standing orders to administer Narcan to residents as needed. The DON said she was unsure why Resident #1 did not have a standing order for Narcan. The DON said if a resident experienced a change in condition, the nurse should gather information, notify the resident's provider, and implement orders received. The DON said for any new treatments, the nurse needed to obtain an order from the physician before performing a treatment to ensure accurate ordering and resident safety. The DON said all treatments and medication administrations should be documented in the MAR. The DON said she was unaware LPN #1 did not contact Resident #1's provider, obtain an order before administering Narcan to the resident, or document the Narcan administration in the resident's MAR. The DON said after reviewing any external provider orders and updating the resident's EMR, the nursing staff should place communication forms into the medical records box to be uploaded into the resident's EMR. The DON said she was unsure if there was a backlog of resident records needing to be uploaded and/or how long one had been present. The DON said it was important to maintain an accurate medical record to ensure accurate treatment and continuity of care. The DON said a potential risk of not maintaining accurate medical records was the potential for untimely updates to resident care orders, which could lead to adverse resident care outcomes. The DON confirmed Resident #1 was taking Methadone due to his history of SUD. The DON also confirmed, as per Resident #1's February 2026 CPOs, that the documented indicated use for Methadone was pain. The RCR said Resident #1's pain provider note documented the indicated reason for Methadone use was pain. -However, [NAME] clinical resource #1 was unable to confirm whether Resident #1 was being seen by his addiction provider for pain management or his history of SUD and cravings management. The DON confirmed Resident #1's indicated use for Methadone should be SUD and cravings management, not specifically pain relief, based on a review of Resident #1's 12/18/25 visit note. The DON said the communication form was not received from his addiction provider on 12/18/25, which led to the delay in his Methadone dose being updated in Resident #1's EMR. The DON said it was important for Resident #1's methadone use and his substance use triggers and cravings to be identified on the care plan to assist staff in monitoring for signs and symptoms of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adverse effects, effectiveness of interventions, and any potential change in condition related to the resident's Methadone use. Resident #1's primary care physician (PCP) was interviewed on 2/9/26 at 1:39 p.m. The PCP said Resident #1 was vague about his history of SUD. The PCP said Resident #1 would admit to having a history of SUD, however, the PCP was unsure what specific substances the resident had taken in the past. The PCP said he assumed Resident #1's substance abuse history was related to narcotic and/or opioid pain medication use. The PCP said Resident #1's Methadone dose was increased approximately two to three weeks before, and he was unsure why the resident's dose was increased. The PCP said he was not aware Resident #1 was administered Narcan on 1/26/26. The PCP said he saw Resident #1 on 1/26/26, and the resident was lethargic but responsive. The PCP said he had exited the building before Resident #1's change in condition on 1/26/26, and after hours calls were answered by an on-call answering service. The PCP said facility staff contacted him recently regarding Narcan orders, however, he was unable to specify the date. The PCP said it was his understanding that the facility was asking for a standing Narcan order for any resident receiving Methadone or opioid pain medication, not specifically for Resident #1. The PCP said he expected facility staff to notify him if a resident experienced a change in condition. The PCP said it was important because a delay in notification could lead to critical results or consequences to the resident. -In a follow-up message received from the PCP on 2/9/26 at 2:28 p.m., the PCP said he went through the on-call notes for 1/26/26 and found a note reporting the incident and administration of Narcan. However, there was no mention an order to administer Narcan being given before the administration to Resident #1 on 1/26/26. A. Resident #10 status Resident #10, age less than 65, was admitted on [DATE]. According to the February 2026 CPO, the diagnoses included neuronal ceroid lipofuscinosis (the accumulation of auto fluorescent lipopigment in neurons, leading to vision loss, seizures, cognitive decline, motor skill loss, and frequently, a shortened lifespan), pervasive developmental disorder unspecified, acute respiratory failure with hypoxia, and personal history of pneumonia (recurrent). The 10/30/25 MDS assessment revealed the resident had short term and long term memory impairment and had moderate impairment in making daily decisions. The resident was unable to recall the current season, staff's names or faces, or where her room was located. She was completely dependent on staff for all activities of daily living (ADLs). B. Record review The December 2025 MAR revealed the physician ordered Doxycycline Hyclate tablet 100 mg by mouth two times a day for an infection. Ordered on 12/24/25 and discontinued on 12/31/25. However, blanks on the MAR revealed Resident #10 did not receive the medication on the evening shift on 12/24/25 and the morning shift on 12/25/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The evening shift on 12/25/25 documented a 9, which indicated there was a corresponding progress note. -However the resident's EMR did not include a progress note to provide an explanation as to why Resident #10 was not administered the medication The 12/26/25 nursing progress note documented at 1:12 a.m. revealed the antibiotic had not arrived from the pharmacy, however the MAR documented the medication was administered even though it had not arrived from the pharmacy. The 12/26/25 nursing progress note documented at 4:48 p.m. revealed Resident #10 was on continued monitoring for the start of doxycycline. C. Staff interviews LPN #3 was interviewed on 2/4/26 at 12:47 p.m. LPN #3 said the administration of medications was documented on the MAR. She said she was unsure if blank boxes on the MAR meant the resident was not administered a medication. The DON was interviewed on 2/4/25 at 1:13 p.m. The DON said the blank spaces on the MAR indicated that the medication was not administered to the resident. She confirmed Resident #10 was not administered doxycycline on the days which had a corresponding black space on the December 2025 MAR. The DON said Resident #10's medical record did not contain a progress note on the evening shift on 12/25/25 indicating the reason the resident was not administered doxycycline. The DON said the medication was delivered from the pharmacy on 12/26/25 and was administered on 12/26/25. She confirmed Resident #10 did not receive three doses of doxycycline.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain accurate and complete medical records for one resident (#1), of four residents reviewed out of a sample of 22 residents. Specifically, the facility failed to ensure Resident #1's addiction provider notes were obtained and uploaded into the resident's electronic medical record (EMR). Findings include:I. Facility policy and procedureThe Documentation In Medical Record policy and procedure, dated 12/1/25, was provided by the nursing home administrator (NHA) on 2/5/26 at 3:07 p.m. It read in pertinent part: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.II. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), the diagnoses included displaced fracture of fifth cervical (neck) vertebrae, functional quadriplegia (paralysis), post traumatic stress disorder (PTSD), schizophrenia, chronic pain due to trauma, and neuromuscular dysfunction of bladder.The 11/18/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. He required partial assistance with bed mobility and transfers. He required substantial assistance with sit to stand and toileting. transfers. B. Record reviewA review of Resident #1's February 2026 electronic medical record (EMR) revealed no documentation regarding the resident's visits to the addiction provider visit notes since the resident's admission to the facility on 8/18/25. Upon request, the NHA obtained and provided addiction provider visit notes for Resident #1, on 2/4/26 at 1:28 p.m., for the dates 9/18/25, 12/18/25, and 1/27/26. The provider visit notes documented the following:The 9/18/25 addiction provider note documented Resident #1 was seen for methadone dose optimization. It documented Resident #1 was currently taking methadone 30 milligram (mg) daily. It documented Resident #1 reported intense cravings and drug dreams. It documented the treatment plan was to increase Resident #1's methadone to 40 mg daily.The 12/18/25 addiction provider note documented Resident #1 was seen for a dose adjustment of his methadone. It documented Resident #1 reported continued cravings while taking methadone 40 mg daily. It documented the treatment plan was to increase Resident #1's methadone to 50 mg daily. The 1/27/26 addiction provider note documented Resident #1 was seen for a dose adjustment of his methadone. It documented Resident #1 reported sedation while taking Methadone 50 mg. It documented Resident #1 requested a dose decrease. It documented the treatment plan was to decrease Resident #1's Methadone from 50 mg to 40 mg daily. Cross-referenced to F760 failure to prevent significant medication errors. III. Staff interviewsThe director of nursing (DON) was interviewed on 2/4/26 at 11:05 a.m. The DON said if a resident's external provider changed any orders, facility staff should fill out a physician communication form, review the orders with the resident's primary provider, and update the resident's EMR as needed. The DON said the facility's health information manager ceased working at the facility on 1/26/26. The DON said she was unsure what the complete process was for reviewing external provider notes and updating the resident's EMR.The assistant director of nursing (ADON) was interviewed on 2/4/26 at 11:14 a.m. The ADON said when residents returned from external provider visits, transportation staff would hand a copy of the physician communication form to the resident's floor nurse, unit manager, or ADON. The ADON said the resident's nurse or nurse managers were responsible for reviewing the orders and updating them in the EMR. The DON was interviewed on 2/5/26 at 11:05 a.m. The DON said after reviewing any external provider orders and updating the resident's EMR, the nursing staff should place communication forms into the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical records box to be uploaded in the resident's EMR. The DON said she was unsure if there was a backlog of resident records needing to be uploaded and/or how long one had been present. The DON said it was important to maintain an accurate medical record to ensure accurate treatment and continuity of care. The DON said a potential risk of not maintaining accurate medical records was the potential for untimely updates to resident care orders, which could lead to adverse resident care outcomes.