STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A173	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedgwick County Memorial Nursing Home	901 Cedar St Julesburg, CO 80737

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 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 record review and interviews, the facility failed to ensure one (#7) of four residents reviewed for accidents out of 18 sample residents remained free of accidents.Resident #7, who was identified as a high fall risk, sustained a fall on 2/27/25 resulting in bruising to her forehead. The facility failed to review the resident's care plan after the fall to determine if the resident's fall interventions were effective or if new interventions were needed to prevent further falls. Additionally, documentation failed to indicate the resident was assessed by a registered nurse (RN) following the fall.On 5/31/25, Resident #7 sustained another fall which resulted in a hospitalization for a hip fracture. Again, documentation failed to indicate the resident was assessed by a RN following the fall. Upon Resident #7's return to the facility on 6/18/25, the facility again failed to review the resident's care plan after the fall to determine if the resident's fall interventions were effective or if new interventions were needed to prevent further falls.Specifically, the facility failed to:-Review Resident #7's fall interventions for effectiveness and implement new fall interventions if needed following the resident's falls in order to prevent a fall with major injury; and,-Ensure Resident #7 was assessed by a RN following her falls on 2/27/25 and 5/31/25.Findings include:I. Facility policy and procedureThe Fall policy and procedure, undated, was provided by the director of nursing (DON) on 9/10/25 at 8:55 a.m. It read in pertinent part, The purpose of this policy is to ensure the facility has a process to make appropriate care decisions for persons that have fallen and may have obtained an injury. The policy will be followed to ensure processes are set up upon admission to prevent harm from falls.Each resident will be evaluated on their fall risk level upon admission and have appropriate interventions implemented and reassessed quarterly and with changes in status. Assessment for elimination or alternate interventions to prevent falls and injuries from falls will be conducted quarterly and with changes. The risk assessment will be completed by a nurse or designee on admission and at the time of any new fall and quarterly thereafter. Update the care plan, communicate interventions and initiate neurological assessments.II. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included unspecified dementia, age related osteoporosis (increased risk of fracture), chronic respiratory failure with hypoxia (low oxygen), chronic fatigue and urinary incontinence. The 6/18/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. She used a walker and a wheelchair. She was dependent on staff assistance for bathing, upper/lower body dressing, putting on/off footwear and personal hygiene. She required maximal assistance with toileting hygiene, oral hygiene, sit to stand, chair to chair transfers, toilet transfers and shower transfers. She was always incontinent of urine. The assessment indicated the resident had a fall prior to admission and a fracture related fall at the facility. B. Record reviewResident #7's fall care plan, initiated 4/10/23 and revised 7/1/25, revealed the resident was at a high risk for falls related to gait imbalance, poor safety awareness and history of fracture. The interventions included determining and addressing causative factors of falls (initiated 9/24/24), keeping walkways free of clutter (initiated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	2/7/25), providing activities that promoted exercise and strength building where possible (initiated 10/13/23), encouraging participation in group exercise (initiated 10/13/23) and encouraging ambulation (initiated 10/23/23).-There was no documentation to indicate the facility reviewed Resident #7's fall care plan after the resident's falls on 2/27/25 and 5/31/25 (which resulted in a fracture) in order to determine if the fall interventions were effective or if new fall interventions were needed in order to prevent further falls for the resident.A nursing progress note, dated 2/27/25 at 9:36 a.m., revealed Resident #7 had a fall which was reported from the prior shift and bruising was noted on the resident's forehead. The resident complained of dizziness when standing, which had resolved. The unwitnessed fall incident report, dated 2/27/25 and documented by a licensed practical nurse (LPN), revealed a staff member entered Resident #7's room and she was sitting in her recliner. The resident told the certified nurse aide (CNA) that the chair moved on her and that she hit her head on the bed frame. Resident #7 was observed by the CNA to have swelling and a mark to the right side of her forehead. The CNA immediately informed the nurse. The resident's walker was noted to be directly in front of her dresser. She denied having to get up from the floor and she was unsure what happened. The bed frame was at approximately waist height on the resident. No injuries were noted to the resident other than the right side of her forehead, which had an approximate 2.5 centimeter (cm) area of redness and swelling.-The incident report failed to include documentation to indicate that the resident was assessed by a RN after the fall. -Additionally, the incident report failed to document if new fall interventions were implemented to prevent further falls for the resident.A nursing progress note, dated 6/4/25 at 11:18 p.m., revealed the note was a late entry documentation for a fall that occurred on 5/31/25 at 5:00 a.m. The note documented Resident #7 had an unwitnessed fall with injury to her right hip area and a small skin tear with a lime-sized bruise/hematoma above her pinky finger. The nurse was walking past the resident's room and heard a thud on the other side of the door. The resident was found sitting on the floor facing away from the door with her right leg bent at the knee and her right ankle under her left leg. She was unable to perform range of motion and expressed extreme pain in her right hip. Emergency medical services (EMS) were notified and the resident was transported to the hospital. A 6/5/25 hospital note revealed Resident #7 required surgical repair of a closed right hip fracture.The unwitnessed fall incident report, dated 5/31/25 at 4:05 a.m. and documented by a LPN, revealed Resident #7 was unable to give a description of the fall. The nurse documented the resident had an unwitnessed fall with injury to her right hip area and a small skin tear with a lime-sized bruise/hematoma above her pinky finger. The nurse was walking past the resident's room and heard a thud on the other side of the door. The resident was found sitting on the floor facing away from the door with her right leg bent at the knee and her right ankle under her left leg. She was unable to perform range of motion and expressed extreme pain in her right hip. EMS were notified and the resident was transported to the hospital. The predisposing physiological factors included confusion, incontinence and gait imbalance. The resident was ambulating without assistance with a walker. -The incident report failed to include documentation to indicate that the resident was assessed by a RN after the fall.-Additionally, the incident report failed to document if new fall interventions were implemented to prevent further falls for the resident.III. Staff interviewsCNA #1 was interviewed on 9/8/25 at 4:38 p.m. CNA #1 said when a resident had a fall she would notify the nurse. She said the nurse would complete the assessment and if there was no injury, the staff would get the resident up and check on them frequently. She said residents who were a high fall risk had a green leaf on the door frame to identify they were a fall risk. She said she did not know what interventions were put into place to prevent Resident #7 from falling. She said she would just remind the resident to use her call light. LPN #2 was interviewed on 9/8/25 at 4:41 p.m. LPN #2 said if a resident had a fall the nurse would assess the resident for injuries, range of motion and take their vital signs. She said if the nurse suspected any kind of injury, an ambulance was called to transport the resident to the hospital. She said if the resident did not have an injury, the staff would get the resident up off the floor and contact the DON, the physician and the resident's representative. She (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	said there were not many RNs that worked in the facility so the LPNs would assess the resident after a fall. She said she was not aware that a RN was required to assess residents after a fall. She said Resident #7 did not have any new fall interventions initiated after her last two falls (on 2/27/25 and 5/31/25). The DON was interviewed on 9/8/25 at 4:51 p.m. The DON said if she was in the facility at the time of a resident fall, she would accompany the LPN to assess the resident for injuries. She said on the night shift, the LPNs assessed the resident after a fall and if there were no injuries, the LPN would text her to let her know about the fall. She said if the resident sustained an injury, the LPN would call the physician and the physician would make the decision of what treatment needed to be ordered. She said she was not aware that a RN was required to assess a resident after a fall.Cross reference F727 for failure to have a RN in the facility for at least eight consecutive hours, seven days a week. The DON said following a fall, she and the social services director (SSD) would meet and try to put interventions in place after each fall and track the interventions. However, Resident #7's previous interventions were not tracked for their effectiveness. The DON said Resident #7 was not a frequent faller, but when she did fall, she sustained injuries. She said she was not sure why the facility did not put interventions in place after the resident's falls on 2/27/25 and 5/31/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week.Specifically, the facility failed to use the services of a RN for at least eight consecutive hours a day for seven days a week.Findings include: I. Facility policy and procedure The Staffing policy, undated, was received from the director of nursing (DON) on 9/10/25. It documented in pertinent part, It is the policy of this facility to employ appropriately qualified staff that shall consist of registered nurses (RN) and licensed practical nurses (LPN), who maintain current licensure or certification in the state of Colorado, and also certified nurse aides. Adequate coverage shall be determined by routine staffing schedules with additional staffing needs to be determined at the discretion of the charge nurse, the DON or the nursing home administrator (NHA).II. Record review A review of the facility's April 2025, May 2025 and June 2025 nursing schedules revealed there was not a RN scheduled in the facility on for 4/12/25, 4/13/25, 4/27/25, 5/11/25, 5/25/25, 5/26/25, 6/17/25, 6/21/25, 6/22/25, 6/28/25 and 6/29/25.On 9/9/25 a review of emails sent back and forth from the facility's chief executive officer (CEO) to The Center for Medicare and Medicaid (CMS) revealed the facility had made attempts to reach out for a federal staffing waiver and failed to get a response from CMS on how to obtain a waiver. III. Staff interviews The DON was interviewed on 9/9/25 at 2:45 p.m. The DON said there was no RN in the building on the dates of 4/12/25, 4/13/25, 4/27/25, 5/11/25, 5/25/25, 5/26/25, 6/17/25, 6/21/25, 6/22/25, 6/28/25 and 6/29/25. The DON said she was on-call for those dates and there was also an on-call physician a block away from the facility, at the hospital. She said if a resident required an assessment to be completed by a RN, she was available over the phone to assist the LPN who was present in the building. The chief executive officer (CEO) and the DON were interviewed together on 9/10/25 at 10:30 a.m. The CEO said for as long as he was aware of, there had been no RN coverage seven days a week for eight consecutive hours each day at the facility. The CEO said the facility was actively trying to recruit and hire RNs to work at the facility. He said they had the job posted on several online job sites, had an advertisement on social media and in the local newspaper. He said the facility offered sign-on bonuses, they covered 80% of health insurance premiums and offered shift differentials for pay to try to get RNs hired. The CEO said agency RNs required up to 100 dollars/hour to cover shifts at the facility and if the facility were to rely on agency RNs, the facility would be at risk of closing. The CEO said the facility was not aware the state staffing waiver they were approved for did not cover the federal regulations until last year. He said since then, the facility had actively been seeking out a way to obtain a federal staffing waiver but that the federal agency (CMS) had not been able to offer a solution to them.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide nursing services according to accepted professional standards of clinical practice for two (#17 and #18) out of 18 residents reviewed out of 18 sample residents. Specifically, the facility: -Failed to transcribe physician's orders into the electronic medical record (EMR) correctly for Resident #17 and Resident #18; and,-Failed to notify a provider when Resident #17 had a change in condition and obtain a physician's order to hold a routinely scheduled medication Findings include: I. Failure to transcribe physician's orders into the EMR correctly A. Professional reference According to the National Institutes of Health (NIH), National Library of Medicine, Hypoglycemia (Nursing) (12/26/22), retrieved on 9/16/25 from https://www.ncbi.nlm.nih.gov/books/NBK568695/#:~:text=It%20is%20the%20nurse's%20responsibility,possibl Hypoglycemia is often defined by a plasma glucose concentration below 70 milligram (mg)/ deciliter (dl); however, signs and symptoms may not occur until plasma glucose concentrations drop below 55 mg/dl. It is the nurse's responsibility to assess for signs and symptoms of hypoglycemia and to report any abnormal findings. It is also the nurse's responsibility to assess that medications are taken as prescribed and report any possible side effects of hypoglycemia.B. Resident #171. Resident status Resident #17, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (autoimmune disease that affects the central nervous systems), type 1 diabetes and neuromuscular dysfunction of the bladder. The 6/30/25 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) score of three out of 15. 2. Observations and interviews On 9/8/25 at 11:40 a.m. licensed practical nurse (LPN) #1 was preparing Resident #17's medications for administration. LPN #1 checked Resident #17's blood sugar while he was in the dining room eating lunch. LPN #1 said the resident's blood sugar was 316 milligrams per deciliter (mg/dl).LPN #1 checked the physician's orders for sliding scale insulin and realized the physician's order did not reflect a blood sugar of 316 mg/dl. LPN #1 said Resident #17 came back from the hospital yesterday (9/7/25) with a new physician's order for Humalog and she had not transcribed it into the EMR correctly. She notified the director of nursing (DON) of the error and called the provider on call to clarify the order. 3. Record review A review of Resident #17's September 2025 CPO revealed the following physician's order: Humalog Kwikpen Solution pen-injector 100 units/milliliter (ml), inject as per sliding scale: if 136-180 mg/dl = 2 units, 181-225 mg/dl = 4 units, 226-270 mg/dl = 6 units, 271-315 mg/dl = 8 units, 321-360 mg/dl = 10 units. Blood sugar 50-70 mg/dl: give four ounces of juice or one cup of milk. Notify the on-call physician if the blood sugar is above 400 mg/dl, subcutaneously with meals for type 1 diabetes mellitus with other diabetic neurological complications, ordered 9/7/25 and discontinued 9/8/25.-The physician's order failed to include a blood sugar ranging from 316-320 mg/dl. C. Resident 18A. Resident status Resident #18, age less than 65, was admitted on [DATE] and discharged on 6/7/25. According to the June 2025 CPO, diagnoses included malignant neoplasm of the uterus (uterine cancer), acute kidney failure and hypertension (high blood pressure).The 5/27/25 MDS assessment documented the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. B. Record review A review of Resident #18's September 2025 CPO revealed the following physician's orders: Morphine sulfate oral solution 100 mg/5 milliliters (ml), give 0.25 ml by mouth every four hours as needed for pain/restlessness, ordered 6/4/25 and discontinued 6/6/25. Morphine sulfate oral solution 100mg/5ml, give 2.5 ml by mouth every two hours as needed for pain/restlessness, ordered 6/6/25 and discontinued 6/9/25. -LPN #1 entered the order for Morphine as 2.5 ml instead of 0.25 ml (see interviews below).C. Staff interviews The DON and the chief executive officer (CEO) were interviewed together on 9/10/25 at 10:30 a.m. The DON said LPN #1 came to her when entering the morphine order into the computer. The DON said that LPN #1 did not check off the final check mark to complete an order to be able to push it through (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and make it an active order. The DON said she checked off the final checkmark in the order to make it an active order without double checking the order. She said the order should have been morphine sulfate, 0.25 ml every two hours, but instead was transcribed to 2.5 ml every two hours. The DON said every nurse checking off a physician's order should double check that the order matched exactly what was prescribed. The DON said there was an automated note that came after she signed off on the incorrect order that she did not see saying that the order was outside the recommended dose. The DON said that the next nurse on night shift brought it to the DON's attention, saying the order was incorrect. The DON said that the nurse confirmed she was going to correct the order. The DON said the order never was corrected and she did not know where the breakdown came from. The DON said she reviewed the controlled substance count sheet and confirmed that the dose of 0.25 ml was given each time. The DON said she confirmed the final count of the medication left was the correct amount. III. Failure to notify a physician when Resident #17 had a change in condition and obtain a physician's order to hold a routinely scheduled medicationA. Resident #171. Record review The 6/21/25 nursing progress note documented Resident #17's fasting blood sugar was low today. It was 53 mg/dl at breakfast and the nurse did not give Lantus. The blood sugar was within normal limits at lunch of 91mg/dl. This was on the provider note (see interview below). A review of Resident #17's September 2025 CPO revealed the following physician's order: Lantus subcutaneous solution, 100 units/ml (long acting insulin), inject 18 units subcutaneously in the morning related to type one diabetes mellitus with other neurological complications, ordered 1/24/25 and discontinued 6/24/25. 2. Staff interviews The DON and the CEO were interviewed together on 9/10/25 at 10:30 a.m. The DON said if a resident's blood sugar was outside of the normal limits, she would expect the provider on call to be notified right away. She said the provider note that the nurse was referring to in the progress note was a once daily note that was sent to the provider from the DON. The DON said this was a list of non-urgent items such as needing a stool softener. The DON said blood sugars outside of the normal limits should not be put on this list and should instead be called into the provider right away. LPN #2 was interviewed on 9/10/25 at 3:00 p.m. She said she would always notify the provider, the DON and the medical power of attorney (POA) right away if a resident experienced a change in condition. She said if she had a scheduled medication due and was unable to administer it to the resident, she would notify the DON and the provider.

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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 observations, record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#17) of one resident reviewed for significant medication errors out of 18 sample residents. Specifically, the facility failed to ensure that Resident #17 was administered the correct dose of insulin by properly priming the insulin pen before insulin administration. Findings include: I. Facility policy and procedureThe Medication Administration policy and procedure, revised 3/1/19, was received from the director of nursing (DON) on 9/10/25 at 8:55 a.m. It documented in pertinent part, The purpose of this policy is to administer medication as ordered by the resident's physician in a timely manner and with the highest degree of efficiency and safety to the resident.II. Manufacturer's recommendationsAccording to the Humalog (insulin lispro, which is a prefilled quick acting insulin pen) medication package insert (2022), retrieved on 9/15/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/ Humalog KwikPen is a disposable single-patient-use prefilled pen containing 300 units of Humalog. You can give yourself more than one dose from the pen. Each turn (click) of the dose knob dials one unit of insulin. Pull the pen cap straight off. Wipe the rubber seal with an alcohol swab. Check the liquid in the pen. Humalog should look clear and colorless. Do not use it if it is cloudy, colored, or has particles or clumps in it. Push the capped needle straight onto the pen and twist the needle on until it is tight. Pull off the outer needle shield. Do not throw it away. Pull off the inner needle shield and throw it away. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming, no more than four times.III. Resident #17A. Resident status Resident #17, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (autoimmune disease that affects the central nervous systems), type 1 diabetes and neuromuscular dysfunction of the bladder. The 6/30/25 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) score of three out of 15. The MDS assessment indicated the resident was on daily injection medication for diabetes. B. Observation and interview On 9/8/25 at 11:40 a.m. licensed practical nurse (LPN) #1 was preparing Resident #17's medications for administration. LPN #1 checked Resident #17's blood sugar while he was in the dining room eating lunch. LPN #1 said the resident's blood sugar was 316 milligrams per deciliter (mg/dl). LPN #1 removed Resident #17's Humalog insulin pen from the medication cart. She attached a needle to the end of the rubber stopper. She dialed the pen to 10 units of insulin. She went to Resident #17 in the dining room, wiped his left upper arm with an alcohol swab and administered the insulin to Resident #17. -LPN #1 failed to prime the Lantus insulin pen prior to drawing up the 10 units of insulin.LPN #1 said she was told by another nurse when she received orientation that the only time insulin pens were primed at the facility was when they were opened for the first time. She said she had been a nurse at other facilities and they always primed the insulin pens prior to each administration of insulin. LPN #1 said she had not clarified the information she received from the other nurse regarding priming insulin pens with the DON. C. Record review A review of Resident #17's September 2025 CPO revealed the following physician's order: Humalog Kwikpen Solution pen-injector 100 units/milliliter (ml), inject as per sliding scale: if 136180 mg/dl = 2 units, 181-225 mg/dl= 4 units, 226-270 mg/dl = 6 units, 271-315 mg/dl = 8 units, 316-360 mg/dl = 10 units. Blood sugar 50-70 mg/dl: give four ounces of juice or one cup of milk. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the on-call physician if the blood sugar is above 400 mg/dl, subcutaneously with meals for type 1 diabetes mellitus with other diabetic neurological complications, ordered 9/8/25.IV. Additional staff interviewThe DON was interviewed on 9/8/25 at 1:32 p.m. The DON said she had not worked on the floor in a while but she knew that insulin pens had to be primed to one or two units prior to dialing up the insulin dose on the pen and administering the dose of insulin. She said it was important to prime insulin pens to ensure the resident was administered the full correct dose of insulin. She said she was not aware of any nurses at the facility who were not priming the insulin pens prior to administration.-However, LPN #1 failed to prime Resident #17's insulin prior to administering the resident's insulin (see observation above).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper storage of medications in one of one medication carts and one of one medication storage rooms. Specifically, the facility failed to: -Ensure medications were labeled with the date they were opened; and,-Ensure expired medications were removed and discarded from medication carts.Findings include: I. Professional referencePharMerica (1/12/25) Abridged List of Medications with Shortened Expirations Dates, was retrieved on 9/15/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://pharmerica.com/wp-content/uploads/2025/01/PM it revealed in pertinent part, Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's package insert under the ?How Supplied/Storage & Handling' section. A drug product's beyond use date (BUD) is the manufacturer supplied expiration date or the shortened date after opening whichever comes first.These in-use medications should be labeled such that the date opened is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration.The Pharmcare USA's (4/9/23) Medication Disposal Practices in Assisted Living and Long Term Care, was retrieved on 9/15/25 from https://pharmcareusa.com/education/medication-disposal-practices-in-assisted-living-ltc/#:~:text=As%20an%2 It revealed in pertinent part, When medications are not disposed of correctly, they can pose serious threats to both human health and the environment. Improper disposal can lead to accidental ingestions, overdose and even death.II. Failed to ensure medications were labeled with the date they were openedA. Observations and staff interviews On 9/9/25 at 9:15 a.m., the Main medication cart was observed with licensed practical nurse (LPN) #2. The following items were found: -An open inhaler of Trelegy 200 micrograms (mcg)/62.5 mcg/25 mcg (long term maintenance inhaler for asthma and chronic obstructive pulmonary disease) was labeled with a resident's name and dosage information, but no open date. -An open inhaler of Advair Diskus (long term maintenance inhaler for asthma and chronic obstructive pulmonary disease) 250 mcg/50 mcg was labeled with a resident's name, but no open date. LPN #2 said she thought the resident the Trelegy inhaler was prescribed for was admitted from assisted living and the medication came with her unlabeled. LPN #2 said she would dispose of the Trelegy inhaler and the Advair Diskus and ensure the residents who used them had a new one. III. Failed to ensure expired medications were removed and discarded from medication cartsA. Observations and staff interviews On 9/9/25 at 9:15 a.m., the Main medication cart was observed with LPN #2. The following items were found: -An open bottle of house stock Ibuprofen tablets 200 milligrams (mg) had an expiration date, verified with LPN #2, of August 2025. -An open bottle of house stock Senokot tablets 8.6 mg had an expiration date, verified with LPN #2, of August 2025.-A bag containing Bisacodyl rectal suppositories 10 mg, labeled with a specific resident's name, had an expiration date, verified with LPN #2, of 3/19/25. -An open bottle of Loteprednol-Tobramycin eye drops 0.5-0.3%, labeled with a specific resident's name, had an open date of 6/24/25 and expired 30 days after opening, verified with LPN #2. LPN #2 said she would dispose of the expired medications. She said night shift nurses were responsible for disposing of expired medications when they did medication change over with the pharmacy every two weeks. IV. Additional staff interview The director of nursing (DON) was interviewed on 9/9/25 at 10:30 a.m. The DON said the pharmacist conducted a monthly audit of the medication cart and the medication storage room. She said the night shift nurses were expected to audit the medication cart every two weeks when they changed over the medications with the pharmacy. The DON said labeling medications with the date the medication was (continued on next page)

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	06A173	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedgwick County Memorial Nursing Home	901 Cedar St Julesburg, CO 80737

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened was important so the nurses knew when medications should be disposed of. The DON said the importance of discarding expired medications was to ensure the residents were not receiving expired medications that could be too potent or not potent enough.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and interviews the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one of one units. Specifically the facility failed to:-Ensure an effective process to identify residents who required enhanced barrier precautions (EBP); -Ensure staff were aware of which residents required EBP; -Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing direct care to residents who required EBP; and,-Ensure staff sanitized the rubber stop on an insulin pen before administering to Resident #17. Findings include: I. EBP failures A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 9/12/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs (multidrug resistant organisms). The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy, revised March 2024, was received from the director of nursing (DON) on 9/10/25 at 9:36 a.m. The policy read in pertinent part, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms in the facility. Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition and residents with wounds or indwelling medical devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All staff received training on enhanced barrier precautions upon hire, annually, PRN (as needed) and are expected to comply with all designated precautions. All staff received training on high-risk activities and common organisms that require enhanced barrier precautions. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required PPE, and the high-contact resident care activities that require the use of gown and gloves. An order for enhanced barrier precautions will be obtained for residents with any of the following wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers); and, indwelling medical devices (central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, medical device care and use and wound care of any skin opening requiring a dressing. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. C. Observations On 9/8/25 at 10:26 a.m. Resident #5 was sitting in a recliner in her room. Licensed practical nurse (LPN) #1 washed her hands and put gloves on. LPN #1 disconnected Resident #5's tubing from the feeding tube. LPN #1 removed her gloves, used alcohol based hand rub (ABHR) and exited the resident's room. She returned to the resident's room with a drainage sponge and tape. She put on gloves and placed the drain sponge around the feeding tube insertion site. She taped the sponge in place. She retrieved water from the sink, filled the syringe with water, inserted the syringe into the feeding tube and flushed Resident #5's feeding tube with 30 ml (milliliters) of water. She removed her gloves and washed her hands. -The facility failed to identify Resident #5 required EBP and LPN #1 failed to put on PPE prior to providing care to Resident #5, who required EBP. On 9/9/25 at 8:21 a.m. LPN #2 was observed during medication administration. She entered Resident #5's room which had a EBP sign posted on the door and a PPE cart next to the entry of the door. LPN #2 washed her hands and put gloves on. She used a feeding syringe to push air into the feeding tube to check for placement. She flushed the feeding tube with 30 ml of water. She hung the feeding bag up and poured a carton of the resident's nutrition formula into the bag. She hooked the feeding bag tubing to the resident's feeding tube and opened the clamp to allow the formula to flow into the feeding tube. She washed her hands and put on clean gloves. She performed oral care for the resident. The feeding bag ran empty and LPN #2 poured water into the bag to flush the tubing and feeding tube. -LPN #2 failed to put on a gown. D. Staff interviews LPN #1 was interviewed on 9/8/25 at 10:40 a.m. LPN #1 said she did not know what EBP was or when a resident was required to be on EBP. She said she was not aware that PPE needed to be worn when giving care to a resident with a feeding tube. She said she never wore PPE when proving cares (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to Resident #5. LPN #2 was interviewed on 9/9/25 at 8:40 a.m. LPN #2 said Resident #5 was on EBP since she had a feeding tube. She said a gown and gloves were only required when performing incontinence care. She said she was not aware she needed to put on a PPE for device (feeding tube) care. She said she did not know during what care areas the PPE was required. LPN #2 was interviewed a second time on 9/9/25 at 4:41 p.m. LPN #2 said she was not aware that Resident #5 needed to be on EBP prior to her shift on the day of the interview. She said she had never heard of EBP. She said the DON provided education to her at the start of her shift. The DON was interviewed on 9/9/25 at 4:51 p.m. The DON said EBP had completely slipped her mind. She said residents who had any medical devices or openings to the body required EBP to protect the resident and staff from transmission of infectious organisms. She said once LPN #1 questioned her about EBP during the survey, she reached out to the medical director and initiated EBP for the resident. The DON and the chief executive officer (CEO) were interviewed together on 9/10/25 at 12:30 p.m. The DON said any resident with an indwelling medical device or chronic wound would require EBP. The DON said the personal protective equipment worn for residents on EBP was a gown, gloves and a face shield if there was risk for splashing. The DON said when staff performed any high risk care area they should be wearing PPE for residents on EBP. She said residents on EBP should have a physician's order for it and have it in their care plan. The DON said there were three residents currently on EBP in the building and they had implemented EBP in the building on 9/9/25. The DON said this was because it was recently identified that the facility needed to implement EBP. The DON said when it was identified that the building needed to implement EBP, she sent out a video to all staff and a quiz to complete, as well as a binder with a powerpoint of information located at the nurses desk. II. Failure to sanitize the rubber seal on an insulin pen A. Manufacturer's recommendations According to the Humalog (insulin lispro, which is a prefilled quick acting insulin pen) medication package insert (2022), retrieved on 9/16/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/ Humalog KwikPen is a disposable single-patient-use prefilled pen containing 300 units of Humalog. You can give yourself more than one dose from the pen. Each turn (click) of the dose knob dials one unit of insulin. Pull the pen cap straight off. Wipe the rubber seal with an alcohol swab. Check the liquid in the pen. Humalog should look clear and colorless. Do not use it if it is cloudy, colored, or has particles or clumps in it. Push the capped needle straight onto the pen and twist the needle on until it is tight. Pull off the outer needle shield. Do not throw it away. Pull off the inner needle shield and throw it away. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should see insulin at the tip of the needle. If you do not see insulin, repeat priming, no more than four times. B. Observation and interview On 9/8/25 at 11:40 a.m. LPN #1 was preparing Resident #17's medications for administration. LPN #1 removed Resident #17's Humalog insulin pen from the medication cart. She attached a needle to the end of the rubber seal. She dialed the pen to 10 units of insulin. She went to Resident #17 in the dining room, wiped his left upper arm with an alcohol swab and administered the insulin to Resident #17. -LPN #1 failed to sanitize the rubber seal on the end of the insulin pen prior to attaching the needle to it. LPN #1 said she was told by another nurse when she received orientation that the only time insulin pens were primed at the facility was when they were opened for the first time. She said she had been a nurse at other facilities and they always primed the insulin pens prior to each administration of insulin. LPN #1 said she had not clarified the information she received from the other nurse regarding priming insulin pens with the DON. C. Additional staff interviews The DON was interviewed on 9/8/25 at 1:32 p.m. The DON said while preparing to administer an insulin pen, the nurse should wipe the rubber seal with an alcohol wipe, prime the pen, and then prepare to administer it to the resident. The DON said the importance of sanitizing the rubber seal is to ensure the nurse was not putting a clean needle onto a dirty surface, causing risk for infection.