STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A175	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walsh Healthcare Center	150 N Nevada St Walsh, CO 81090

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on staff interview and record review the facility failed to electronically submit complete and accurate direct care staffing information.Specifically, the facility failed to submit to the Center for Medicare and Medicaid Services (CMS) the Payroll Based Journal (PBJ) for the quarter (4/1/25 thru 6/30/25) due to staff errors. Findings include:I. Facility policy and procedureThe Payroll Based Journal policy, implemented 1/1/25, was provided by the nursing home administrator (NHA) on 10/16/25 at 10:27 a.m. It read in pertinent part, It is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.II. Record reviewThe CMS submission report, dated 10/9/25, revealed the facility failed to submit the required data for the quarter. III. Staff interviewThe human resource director (HRD) was interviewed on 10/16/25 at 1:15 p.m. The HRD said the facility previously had used a third party to submit the PBJ. She said she was responsible for submitting the data and was having issues submitting the report. She said she was unable to submit the report for all three quarters prior to the deadline.

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 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure adequate outside ventilation by means of windows, or mechanical ventilation. Specifically, the facility failed to ensure the exhaust fans in the shower room and resident bathrooms. Findings include:I. Professional referenceAccording to the U.S. Department of Energy's Office of Energy Efficiency and Renewable Energy, April 2021, retrieved on 10/21/25 from: https://docs.nrel.gov/docs/fy21osti/79150.pdf., Proper ventilation helps reduce the concentration of bioaerosols (bioaerosols consist of aerosols originated biologically such as metabolites, toxins, or fragments of microorganisms), which can be particularly important in nursing homes due to the presence of vulnerable adults. Good ventilation can improve the health and wellbeing of the residents by reducing infection risks and preventing respiratory issues. By ensuring proper ventilation, nursing homes can significantly enhance the safety and quality of life for their residents. II. Observations On 10/16/25 at 11:00 a.m., during a walk through of the shower rooms and resident bathrooms, the following was observed:The resident shower room had four vents. There was no air flow coming from the ventilation fans in the shower room. The resident bathroom attached to room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] had no air flow coming from the ventilation fans. III. Staff interview and observationsThe maintenance director (MTD) was interviewed on 10/16/25 at 11:26 a m. while touring the shower rooms.The MTD said the facility used a mechanical ventilation system and if the belt on the motor drive was not functioning properly, this would cause a failure in air flow though the vents. The MTD said the ventilation system in the bathrooms and shower room should be checked daily by housekeeping and cleaned monthly. He said it was important to have proper air flow in the vents to keep moisture and contaminants out of the air. After inspecting the shower room, resident bathroom [ROOM NUMBER], resident bathroom [ROOM NUMBER] and resident bathroom [ROOM NUMBER], the MTD said there was not any air flow.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to provide response, action and rationale to residents involved in group grievances. Specifically, the facility failed to effectively address, resolve and demonstrate the facility's response to grievances identified during resident council. Findings include:I. Facility policy and procedureThe Resident and Family Grievance policy, revised 10/1/25, was provided by the nursing home administrator (NHA) on 10/14/25. It read in pertinent part, In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:The date the grievance was received, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issuedII. Resident group interviewFive alert and oriented residents (#4, #2, #16, #17 and #19) who regularly attended the resident council meetings were interviewed on 10/15/25 at 9:16 a.m. The residents were identified as alert and oriented through facility and assessment.The group of residents said the facility did not follow up on grievances brought up in the resident council meetings. The residents said they did not know how to file a grievance.Resident #17 said when a grievance came up in the resident council meeting the department head tried to address it during the meeting, but the manager did not complete a grievance form. Resident #19 said if it was an individual grievance, the department head would follow-up with the individual resident. Resident #19 said if it was a group grievance a resolution was not consistently brought back to the next resident council meeting by the facility. Resident #17 said she has reported missing clothing before and was told by the staff that she would get the clothes back eventually. She said the facility was not good about completing formal grievance forms with the residents. III. Record reviewA review of a resident council meeting minutes, dated 6/30/25, revealed group grievances concerning needing more toilet tissue in shared resident bathrooms, water not being passed to residents on the weekends, the palatability of chicken and missing clothing from laundry. A review of the resident council meeting minutes, dated 7/28/25, revealed group grievances concerning some of the residents' rooms being too hot. -There was no documentation that indicated the resolutions for June 2025 grievances with the resident council. A review of the resident council meeting minutes, dated 8/25/25, revealed group grievances concerning some resident rooms being too hot and some resident rooms being too cold. -There was no documentation that indicated the resolutions for July 2025 grievances with the resident council. A review of the resident council meeting minutes, dated 9/29/25, revealed group grievances concerning needing more support staff on weekends to cover certified nurse aide (CNA) call offs. -There was no documentation that indicated the resolutions for August 2025 with the resident council. A review of the grievance forms dated 7/14/25 through 9/15/25 revealed:A grievance form, dated 7/15/25, revealed a resident had a concern for a missing shirt and the item was found in the laundry room. A grievance form, dated 7/28/25, revealed a resident had a regarding the room temperature being too hot. The resident was offered a fan and declined it. The maintenance director checked all the air conditioning units in the resident rooms to determine functionality. -However, there were no other grievance forms related to the concerns brought up in the resident council meetings in June 2025, July 2025, August 2025 and November 2025. IV. Staff interviewsA frequent visitor was interviewed on 10/15/25 at 10:14 a.m. She said she attended the facility resident council meetings. She said the facility staff did not go over resolutions of grievances during resident council and she did not know if the residents knew how to file grievances. The activities director (AD) was interviewed on 10/16/25 at 11:29 a.m. She said she was responsible for managing grievances. The AD said if a concern was brought up in the meeting and was isolated to one resident, the concern form was written as an individual grievance. She said if the (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concern brought up pertained to more than one resident, it would be written as a group concern. She said she was not aware a grievance should be written for every concern brought up during resident council and followed through the same way as an individual grievance.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, and interviews, the facility failed to ensure that its medication error rate was not greater than five percent (%).Specifically, the facility had a medication error rate of 48%, which was 12 errors out of 25 total opportunities for error. Findings include:I. Facility policy and procedureThe Medication Administration Policy, revised 6/17/25, was provided by the nursing home administrator (NHA) on 10/15/25 at 3:24 p.m. It revealed 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. Ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and the right documentation.Administer within 60 minutes before or after the scheduled time unless otherwise ordered by the physician. Medication administration timing twice a day at 8:00 a.m. and 6:00 p.m.II. ObservationsOn 10/14/25 at 1:45 p.m. licensed practical nurse (LPN) #1 was dispensing medications to Resident #6. LPN #1 prepared the following medications:loratadine (allergy medication) 10 milligrams (mg); One package of Arginaid (supplement); Metoprolol 12.5 mg; Colon Health (probiotic supplement) 1 capsule; Famotidine (anti-acid) 20 mg; TheraLITH XR (supplement) 1 tablet; Duloxetine (antianxiety) 90 mg; Oxybutynin (overactive bladder) 5 mg; Pantoprazole (reduce stomach acid) 40 mg; Baclofen (muscle relaxant) 10 mg; Trelegy inhaler saline nasal mist; Pataday eye drops; and,Iron 65 mg.At 1:45 p.m. LPN #1 gave the medicine cup with pills to Resident #6 and gave him water to drink. Resident #6 consumed the medications, and the nasal spray, inhaler and eye drops were administered. -LPN #1 administered the medications five hours after they were scheduled to be administered. -Resident #6 did not have a physician's order for iron (see record review below). III. Record reviewReview of Resident #6's October 2025 computerized physician orders (CPO) revealed the resident did not have a physician's order for Iron. Further review of Resident #6's EMR revealed the medications that were administered at 1:45 p.m., were ordered for 9:00 a.m. administration.Review of Resident #6's electronic medical record (EMR) did not reveal documentation that the physician was notified that the resident was administered his medication five hours late or that she was administered iron that was not prescribed. IV. Staff interviewsLPN #1 was interviewed on 10/14/25 at 11:00 a.m.LPN #1 said Resident #6 was asleep, so she would administer his medications later. She said he went to bed at 2:30 a.m. last night.LPN #2 was interviewed on 10/15/25 at 9:35 a.m. LPN #2 said Resident #6 did not have a physician's order for iron. LPN #2 said if a resident's medications were going to be administered late, the physician needed to be notified prior to the administration of the medication. She said the physician would then give instructions on administering the late medications. LPN #2 said she would write a progress note regarding the late medications and if the physician gave any new orders. The medical director (MD) was interviewed on 10/15/25 at 2:30 p.m. The MD said a medication should not be administered without a physician's order. The MD said Resident #6 was not ordered an iron supplement.LPN #2 was interviewed on 10/16/25 at 10:40 a.m. LPN #2 said when a medication was ordered for twice a day, it should be given 12 hours apart. She said if the medication was scheduled for 8:00 a.m., the second dose should be scheduled for 8:00 p.m. LPN #2 said some residents' medications were scheduled at 8:00 a.m. and then at 6:00 p.m. LPN #2 said the assistant director of nursing (ADON) and the director of nursing (DON) transcribed the physicians' orders into the MAR. She said the ADON and the DON decided what time the medication would be administered. LPN #2 said medications could be administered one hour prior and one hour after the scheduled administration time. LPN #2 said when she administered Resident #6's medications, she would wake him up and he would take the medications with no concerns. The DON was interviewed on 10/16/25 at 11:20 a.m. The DON said medications should be administered 30 minutes before or after the scheduled time. The DON said she was aware that LPN #1 dispensed medication that was not ordered and that the physician was notified. The DON said an incident report (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was initiated for the medication error. The DON said the nurse (LPN #1) was educated to call the physician when the medication was late, assure a physician's order was in place before administering a medication and document the interaction with the physician. The DON said the care team was in the process of establishing a more accurate medication time for Resident #6 since he liked to stay awake half of the night and sleep in till afternoon.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#7) of three residents reviewed received food and fluids prepared in a form designed to meet his or her needs out of 16 sample residents. Specifically, the facility failed to ensure Residents #7 was served a mechanically altered diet per physician's orders. Findings include:I. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and progressive neurological disorder (a condition that gradually damages and destroys parts of the nervous system). The 9/29/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. She required set up assistance for meals. The MDS assessment indicated the resident had signs and symptoms of a swallowing disorder to include coughing or choking during meals and required a mechanically altered diet. B. ObservationsDuring a continuous observation on 10/13/25, beginning at 12:00 p.m. and ending at 1:29 p.m., the following was observed:At 12:55 p.m., Resident #7 was in the dining room for lunch. The resident was served one inch sized cut up pieces of chicken breast with cream of chicken soap over the top, baked rice, whole broccoli florets, a dinner roll and a berry cobbler. Between 12:55 p.m. and 1:15 p.m. Resident #7 put food into her mouth five times before she had completed chewing and swallowing the previous bite. The resident was observed eating her meal without staff supervision or intervention. The resident's meal ticket documented she was on a ground diet. During a continuous observation on 10/14/25, beginning at 12:00 p.m. and ending at 1:30 p.m., the following was observed:At 12:30 p.m., Resident #7 was in the dining room during lunch. The resident was served a parmesan breaded pork chop, candied yams, a dinner roll and cherry chocolate cake. When the food was served, the pork chop was whole. A nursing staff member cut the pork into one inch pieces for the resident, however, some pieces had not been cut all the way through and were attached to other pieces. At 1:12 p.m. Resident #7 put two pieces of cut pork chop into her mouth that were still connected. The resident continued to chew the pork until 1:16 p.m when she put a spoonful of candied yams in her mouth before finishing chewing the pork and swallowing it. At 1:18 p.m. the resident put another spoonful of candied yams in her mouth before finishing chewing the pork and swallowing it. Between 1:03 p.m. and 1:30 p.m. the resident put food into her mouth six times before she had completed chewing and swallowing the previous bite. The resident was observed eating her meal without staff supervision or intervention. The resident's meal ticket documented she was on a ground diet.During a continuous observation on 10/15/25, beginning at 12:00 p.m. and ending at 1:30 p.m., the following was observed:At 12:15 p.m., Resident #7 was in the dining room during lunch. The resident was served a whole, uncut piece of salisbury steak, mashed potatoes and carrots. Between 12:15 p.m. and 1:15 p.m. Resident #7 put food into her mouth five times before she had completed chewing and swallowing the previous bite. The resident was eating her meal without staff supervision or intervention. The resident's meal ticket documented she was on a ground diet. At approximately 1:35 p.m., the dietary aide (DA) #2 prepared two test trays, one was requested to be mechanically soft and the other a regular texture. The meal was salisbury steak, mashed potatoes, and carrots. The two plates consisted of the same food textures. He said both plates were the same. On 10/16/25 at 1:25 p.m. Resident #7 was in the dining room during lunch eating a plate including fried chicken with bones. The resident's meal ticket documented she was on a ground diet. C. Record reviewThe October 2025 CPO revealed the following physician's orders:ST (speech therapist) two times a week for ninety days for oropharyngeal dysphagia (swallowing problems caused by impaired muscle problems in the mouth or throat), ordered on 7/28/25. Regular diet, mechanical soft texture, nectar thick liquid consistency, ordered on 9/10/25. Resident #7's nutrition care plan, revised 9/30/25, revealed the (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had nutritional deficits related to swallowing assessment results showing oropharyngeal dysphagia. Interventions included providing and serving the diet as ordered and monitoring for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, or pocketing food in the mouth. A review of Resident #7's electronic medical record (EMR) from 7/30/25 to 10/3/25 revealed the following progress notes:A dietary progress note, dated 7/30/25, revealed Resident #7 requested that her meat be ground due to her missing her lower teeth. The resident ate s with supervision and set-up help in the dining room.A quarterly nutrition progress note, dated 10/3/25, revealed the resident coughed during meals and had trouble swallowing at times. The resident received a mechanical soft texture die and nectar thick liquid consistency.A swallowing evaluation, dated 7/26/25, revealed Resident #7 had been evaluated due to coughing and choking during meals. The resident had decreased safety awareness during eating and required an altered diet texture for safety. A speech therapy note 10/8/25, revealed Resident #7 took longer than normal to move foods and liquids from the front of her mouth to then the back of her mouth to swallow, she required the size of the food presented to be smaller than a regular diet indicated, and showed excessive or prolonged chewing before she was able to swallow food. During speech therapy sessions, Resident #7 coughed while eating when the food was not mechanically altered and had to excessively chew the food before swallowing. It was recommended that Resident #7 take sips of fluid in between bites to promote taking a break in between and be provided minimal cueing to remind her to swallow before taking the next bite. A review of the menu for the week of 10/13/25 included instructions for modifying a diet to mechanical soft that included:On 10/13/25 the menu revealed the chicken should have been cut into one eighth of an inch pieces, the broccoli should have been cut into one eighth of an inch pieces, the dinner roll should have been moistened and cut into bite size pieces and the cobbler should have been softened with added milk, cut into one eighth of an inch pieces and without crumble topping. On 10/14/25 the menu revealed the chicken should have been cut into one eight of an inch pieces with a sauce to moisten and the dinner roll should have been moistened and cut into bite size pieces.On 10/15/25 the menu revealed the Salisbury steak should have been cut into one eighth of an inch pieces with a gravy sauce to moisten and the dinner roll should have been moistened and cut into bite size pieces.II. Staff interviewsDietary aide (DA) #2 was interviewed on 10/15/25 at 12:15 p.m. while preparing lunch. He said he had been trained as a dietary aide, dishwasher and cook. DA #2 said if a resident had a special diet, there were tickets on the wall indicating what diet the resident required. DA #2 showed the puree lunch meals. He said he was not able to describe what mechanically altered or ground, entailed. Certified nurse aide (CNA) #2 was interviewed on 10/15/25 at 1:38 p.m. CNA #2 said the staff did not check the meal tickets for diet orders before passing the trays to the residents. She said Resident #7 ate a regular diet, with no altered texture. -However, record review revealed Resident #7 was prescribed a mechanically altered diet (See record review above).The dietary supervisor (DS) was interviewed on 10/15/25 at 2:00 p.m. The DS said mechanical soft diets should be ground or cut into small pieces. She said she was not sure how the kitchen staff ensured the food was one eighth of an inch. She said each menu item had a recipe and at the bottom of the recipe were the instructions for how to alter the diet to mechanical soft or puree. The DS said she would expect the mechanical food items to be ground in the blender and then served to the resident. She said she cross trained all of her dietary staff how to also cook and showed them where to find the preparation on the menu to alter a diet texture. She said she had not done documented training with the dietary staff on different diet textures. The registered dietitian (RD) was interviewed on 10/15/25 at 3:50 p.m. He said it was important to follow the diet orders for the safety of the residents and to prevent choking or aspirating on food. He said he had not done documented training with the dietary staff on different diet textures. The director of nursing (DON) was interviewed on 10/16/25 at 1:13 p.m. She said if the facility noticed a resident having difficulty with a diet, the facility would involve the physician and request an order for a speech evaluation if necessary. The DON said once a diet order had been changed to an (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	altered texture, like mechanical soft, the diet was changed in the resident's EMR and care plan. She said she expected the CNA's to check the meal tickets before serving the meal to the residents. The DON said that if a resident was not getting their correct diet, there could be aspiration or death.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for two (#2 and #9) of three residents out of 16 sample residents.Specifically, the facility failed to:-Ensure clinical signs and symptoms of an infection were identified and/or culture results were obtained prior to the administration of antibiotics for Resident #9; and,-Ensure a system was in place to monitor Resident #2's prophylactic antibiotic use. Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC), The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix B, 9/10/25, was retrieved on 10/20/25 from https://www.cdc.gov/antibiotic-use/media/pdfs/Consult-pharm-11by17poster-Urinary-Tract-P.pd.Antibiotics are frequently prescribed for prolonged duration for the prevention of infection or prophylaxis in nursing homes. While antibiotic prophylaxis may reduce recurrent UTIs (urinary tract infections) in specific populations, there is no clear evidence on prevention of recurrent UTIs among nursing home residents with asymptomatic bacteriuria. Furthermore, antibiotic use carries the risk of harm to residents, including adverse drug events and increased antibiotic resistance, which argue against the use of prolonged antibiotic therapy in nursing home residents.Identify residents on prolonged antibiotic therapy for the prevention of recurrent UTI. Discuss the indications, rationale, and planned duration of prolonged antibiotic therapy with healthcare professionals to ensure that the benefits outweigh the risk of adverse drug events.II. Facility policy and procedureThe Antibiotic Stewardship program policy and procedure, revised 6/17/25, was provided by the nursing home administrator (NHA) on 10/15/25 at 3:24 p.m. It revealed in pertinent part, It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The medical director (MD) sets the standards for antibiotic prescribing practices for all healthcare providers prescribing antibiotics, oversees adherence to antibiotic prescribing practices, and reviews antibiotic use data and ensures best practices are followed.The director of nursing (DON) establish standards for nursing staff to assess, monitor and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use. The infection preventionist (IP) utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics.The program includes monitoring response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (antibiotic time-out). Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families. -The policy did not address long term (prophylactic) antibiotics.III. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included unspecified dementia, cellulitis of the right finger and peripheral vascular disease (a disorder of the blood vessels). The 7/29/25 minimum data set (MDS) assessment revealed the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A175	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walsh Healthcare Center	150 N Nevada St Walsh, CO 81090

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of three out of 15. She was dependent on staff for most of her activities of daily living (ADLs). B. Record reviewReview of the September 2025 CPO revealed the following physician's order:Cephalexin (antibiotic) oral tablet 500 mg (milligrams), give one tablet by mouth two times a day related to cellulitis of the right finger for seven days, ordered 9/19/25. The 9/19/25 daily progress note documented Resident #9 had redness and swelling to her right pointer finger. The nurse practitioner (NP) ordered an antibiotic for seven days. Review of the October 2025 CPO revealed the following physician's order:Doxycycline Hyclate (antibiotic) oral tablet 100 mg, give one tablet by mouth two times a day related to cellulitis of the right finger for 10 days, ordered 10/2/25.The 10/2/25 daily progress note documented Resident #9's right finger was getting red and swollen again. The NP ordered a second antibiotic (Doxycycline) for ten days. Bactrim DS (antibiotic) oral tablet 800-160 mg, give one tablet by mouth two times a day related to cellulitis of the right finger for seven days, ordered 10/13/25.The 10/12/25 daily progress note documented Resident #9's affected finger was pinkish in color at the tip only. The 10/13/25 daily progress note documented the NP ordered a third antibiotic (Bactrim DS), epsom salt soaks to the right index finger two times a day until the infection resolved and a culture of the right index finger. Amoxicillin (antibiotic) oral capsule 500 mg, give one capsule by mouth two times a day related to cellulitis of the right finger for seven days, ordered 10/14/25.The 10/14/25 daily progress note documented the NP discontinued the Bactrim DS and started Resident #9 on Amoxicillin after the culture results were reviewed. -However, there was no documentation in the resident's electronic medical record (EMR) to indicate a culture and sensitivity (a laboratory test which identifies bacteria type and what antibiotics are best used to effectively treat the infection) was completed prior to prescribing the first three antibiotics (Cephalexin, doxycycline and Bactrim). IV. Resident #2A. Resident statusResident #2, age less than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included urinary tract infection, peripheral vascular disease and hydronephrosis (obstruction to urine flow).The 8/11/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS of nine out of 15. She was dependent on staff for toileting hygiene and was always incontinent of urine. She received an antibiotic. B. Record reviewReview of the October 2025 CPO revealed the following physician's order:Cefadroxil (antibiotic) oral capsule 500 mg, give one capsule by mouth one time a day related to urinary tract infection, ordered 6/13/23. -Review of Resident #2's EMR did not reveal documentation that the facility was monitoring Resident #2 for adverse reactions and the effectiveness of the prophylaxis antibiotic or justification for the continued use of the prophylactic antibiotic. -Review of Resident #2's comprehensive care plan revealed the facility failed to document a care plan focus to address the need for long-term use of an antibiotic.V. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 10/15/25 at 10:51 a.m. LPN #2 said if a resident was having signs and symptoms of an infection she would call the provider with the findings. She said Resident #9's finger was red and swollen with no pain or drainage. She said her finger started getting better when she was prescribed the first antibiotic but then started getting worse again. She said Resident #9 was then started on a different antibiotic. She said when Resident #9's finger continued to be red and swollen, the NP started her on a third antibiotic and ordered a wound culture. She said when the culture results were reviewed Resident #9 was started on the fourth antibiotic. She said the facility did not use a criteria to determine if a resident needed to be treated with an antibiotic. She said she did not know if a care plan was needed for the antibiotic use. LPN #2 said Resident #2's long term antibiotic was prescribed by a urologist (specialist in urinary organs) and should have been monitored for adverse reactions and effectiveness. She said she did not know how often a long term antibiotic needed to be reassessed for continued use. The MD was interviewed on 10/15/25 at 2:32 p.m. The MD said she was not aware the facility had a policy to use a criteria to help diagnose infections. She said she had never heard of the McGeer criteria and left it up to the NP's to assess the resident and identify the need for an antibiotic. The MD said said Resident #9 had gotten a manicure which resulted in a (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	paronychia (an infection in the tissue that borders the side of the nail). She said the treatment for a paronychia was to soak the finger and a topical steroid. She said the infection did not require the use of antibiotics. She said a culture should have been collected prior to the use of an antibiotic. She said since Resident #9 had already received three different antibiotics, the culture results would not be accurate. The MD said Resident #2 was prescribed the long term antibiotic by her previous urologist. She said Resident #2 should see a urologist at least once a year to assess for continued use of the antibiotic. She said as far as she knew Resident #2 would be on the antibiotic indefinitely. The NP was interviewed on 10/15/23 at 2:44 p.m. The NP said she prescribed the initial antibiotic for Resident #9. She said when the first antibiotic was not effective she prescribed a second antibiotic. She said she was on vacation when the third antibiotic was ordered. She said when she returned from vacation she ordered a culture of the index finger and when the results were received she prescribed the fourth antibiotic. She said the culture should have been ordered prior to the use of an antibiotic. She said she had never heard of the McGeer criteria for diagnosis of infection and was not aware the facility followed any certain criteria when diagnosing an infection. She said she tried not to use long term antibiotics. The NP said said Resident #9 was prescribed the long term antibiotic by a urologist in 2023. She said as far as she knew Resident #9 had not had a follow up appointment with a urologist for the continued use of the long term antibiotic. She said the facility would have to add the use of long term antibiotics to the policy. She said the resident should have been monitored for adverse reactions and effectiveness as well as a follow up with a urologist for the continued use of the antibiotic. The IP was interviewed on 10/16/25 at 2:09 p.m. The IP said the facility followed the McGeer criteria to identify infections that may need to be treated with an antibiotic. She said the nurse called the provider and the facility followed the providers orders. She said the facility infection control plan was a team approach with herself, the providers, the pharmacist and the NHA. She said was not aware that the MD and the NP were not familiar with the Mcgeer criteria and a meeting was set up for the following day for training on the infection control program. She said a culture should have been ordered prior to the use of an antibiotic for Resident #9. She said the facility infection control policy did not address the use of long term antibiotics and a care plan with monitoring should have been initiated for Resident #2. She said the facility had not been following the facility criteria. She said going forward the facility would start at the beginning and start with the antibiotic tool kit and review it with the MD.