STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065229	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Post Acute and Rehabilitation Center	2701 California St Pueblo, CO 81004

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide and document sufficient discharge preparation and documentation for one (#97) of two residents reviewed for a safe and orderly discharge out of 55 sample residents. Specifically, the facility failed to notify the ombudsman in writing regarding Resident #97's discharge. Findings include:I. Resident #97A. Resident statusResident #97, age less than 65, was admitted on [DATE] and discharged home on 6/18/25. According to the August 2025 computerized physician orders (CPO), diagnoses included fracture of right lower leg, asthma, type 2 diabetes mellitus and fibromyalgia (pain disorder).The 6/4/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required set-up assistance with eating, substantial to maximum assistance from staff with personal hygiene, and toileting. The MDS assessment documented Resident #97 was discharged from the facility, as planned, on 6/18/25.B. Record reviewThe discharge summary nursing progress note, dated 6/17/25 at 3:22 p.m., revealed Resident #97 was admitted to the facility for post-acute care, skilled nursing and rehabilitation services following a hospitalization after a recent fall at home. The treatments provided during her stay were physical therapy, occupational therapy and skilled nursing orthopedic aftercare.The discharge social services summary note, dated 6/18/25 at 9:36 a.m., revealed Resident #97 received a notification on 6/17/25 from her commercial insurance plan that they had determined she was no longer appropriate or needing the services of an inpatient skilled stay, and they would no longer cover her skilled services at the facility starting on 6/17/25.The social services discharge summary documented Resident #97 was assisted by the admissions coordinator and the social services director (SSD) to file an appeal on behalf of the resident. The SSD and the admissions coordinator explained to the resident that she would be able to stay at the facility for 30 days of the appeal; however, if the appeal was denied, the resident would have to pay private pay to the facility.The discharge care plan, initiated 6/5/25 and revised 7/2/25, revealed Resident #97 wished to return to her home upon completion of skilled nursing services and once regaining weight-bearing status.The discharge planning note, dated 6/18/25 at 9:36 a.m., revealed that the SSD left a voicemail notifying the local long-term care ombudsman of the resident's discharge situation and requested a return call.-A review of Resident #97's electronic medical record (EMR) did not reveal documentation to indicate the ombudsman was notified of Resident #97's discharge in writing prior to the resident's discharge from the facility.II. Staff interviewsThe SSD, the regional clinical resource (RCR), the nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 8/28/25 at 10:30 a.m. The SSD said she sent a list of discharges to the ombudsman at the beginning of each month for the previous month's discharges. The RCR said that the SSD's process did not meet the regulatory requirements. She said the ombudsman should be notified in writing before the resident's discharge from the facility.The SSD was interviewed again on 8/28/25 at 2:35 p.m. The SSD (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she was responsible for coordinating residents' discharges. She said Resident #97 was discharged before her care conference date, which was scheduled to be held on 6/20/25. The SSD said she left a voicemail for the local long-term care ombudsman about Resident #97's situation and discharge, but said she did not notify the ombudsman in writing of the resident's discharge. She said she was aware that notifying the ombudsman in writing was part of the regulatory compliance in relation to discharges. The SSD said she sent the ombudsman notification in writing at the end of the month (June 2025), after Resident #97's discharge from the facility.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide ongoing group activities designed to support the needs and preferences of the residents for two (#2 and #78) of five residents reviewed for activities out of 55 sample residents.Specifically, the facility failed to provide activities that met Resident #2 and Resident #78's preferences. Findings include:I. Facility policy and procedureThe Activity policy and procedure, revised September 2024, was received from the nursing home administrator (NHA) on 8/28/25 at 4:20 pm. It read in pertinent part, It is the policy of this facility to ensure that residents have the right to choose the types of activities and social events in which they wish to participate. Residents are encouraged to choose the types of activities and social events in which they prefer to participate. Residents who wish to meet with or participate in social or religious activities, or other community activities, at or away from the facility are encouraged to do so.II. Resident #2A. Resident statusResident #2, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnosis included cerebral palsy (abnormal brain development), schizoaffective disorder (mental illness), bipolar disorder (mental illness) and muscle weakness.The 7/22/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She was dependent on staff for assistance with toileting, personal hygiene, and required set-up assistance with eating.The assessment documented the resident's activity preferences included listening to music, being around animals, keeping up with the news, doing activities with groups of other people and going outside when the weather was good for fresh air.B. Resident interviewResident #2 was interviewed on 8/25/25 at 3:20 p.m. Resident #2 said she had lived at the facility for over two years. She said the facility obtained a new bus for group activities, however the new bus had only one spot for residents in wheelchairs. Resident #2 said she had missed several group outings because other residents had already signed up. She said it was very stressful for her not to be able to participate with her friends in any group outings because she was unable to transfer to a seat and required her wheelchair at all times. She said she really enjoyed outings outside the facility. She said since there was only one spot for a wheelchair, she had just been spending time with her sister C. Record reviewThe activities care plan, initiated on 9/13/24 and revised on 7/23/25, documented that Resident #2 enjoyed group activities such as going outside when the weather was nice, Bingo, going to the movies, shopping, community outings, karaoke and music performers. Interventions included assisting with arranging community outings with transportation and introducing the resident to other residents with similar backgrounds and interests.Review of activity log from 11/1/24 to 8/28/25 revealed that Resident #2 participated in three (11/6/24, 12/12/24 and 4/3/25) outside group trip activities and refused to participate in one event (7/16/25).III. Resident #78A. Resident statusResident #78, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included post-traumatic stress disorder (PTSD), depression, anxiety disorder, multiple sclerosis (progressive disease that affects movement) and renal insufficiency. The 10/3/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required setup help with eating, maximum assistance with transfers, dependent with showers, and toileting. She utilized a motorized wheelchair for mobility.The10/3/24 MDS assessment for Resident #78 documented that Resident #78 enjoyed group activities and going out when the weather was nice.B. Resident interviewResident #78 was interviewed on 8/25/25 at 4:35 p.m. Resident #78 said she wished she could go out on a group activity with her friends, but the facility bus could only accommodate one wheelchair, and most of the time was left behind because she could not transfer to a seat. She said she went (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to dialysis a couple of times a week. When she was available to go on an outing, the staff told her there were no spots available , She said she enjoyed being outside but had never had the opportunity to go out on a trip into the community with her friends this year. The resident said it was very frustrating that she could not join her friends because she could not walk.C. Record reviewReview of activity log from 11/1/24 to 8/28/25 revealed that Resident #78 did not participate in two outside group trip activities (11/12/24 and 11/14/24).-Review of the activity log did not show any further documentation that indicated the resident participated in group outings. IV. Staff interviewsThe activity bus driver was interviewed on 8/28/25 at 8:40 a.m. The activity bus driver said the facility bus could only accommodate one resident in a wheelchair. He said most of the residents in wheelchairs who could not be transferred to a seat were often left behind. He said several residents had expressed their concerns about the bus situation.The activity director (AD) was interviewed on 8/28/25 at 9:00 a.m. The AD said the bus could only take one wheelchair, which made it extremely difficult to include residents who were in wheelchairs and could not be transferred onto a seat to go on outside group activities. The AD said she rotated the residents who required wheelchairs to take turns. She said that the facility bus had 12 seats and one wheelchair accessible spot. The AD said outside group activities were first-come first first-served for all residents who required wheelchairs. She said most residents in wheelchairs were left behind due to the bus limitations. The NHA was interviewed on 8/28/25 at 10:15 a.m. The NHA said each resident's participation in group activities was based on their physical and cognitive abilities. She said when outside group activities required additional transportation assistance, arrangements would be made to accommodate the event. She said the activity bus driver could also make multiple trips. She said it had not been brought to her attention that residents were concerned about their inability to participate in outside group activities with their peers.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of two residents received treatment and care in accordance with professional standards of practice out of 55 sample residents. Specifically, the facility failed to ensure timely follow-up from a telehealth (virtual) pulmonology appointment to ensure Resident #1 was evaluated through a sleep study for a potential continuous positive airway pressure (CPAP) machine.Findings include:I. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physicians orders (CPO), diagnoses included chronic obstructive pulmonary disease, morbid obesity with alveolar hypoventilation (inability to breathe rapidly or deeply), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood), acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues) and sleep apnea (sleep disorder in which breathing repeatedly stops and starts).The 7/30/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff assistance for most of his mobility and toileting activities of daily living (ADL). The assessment documented the resident was on continuous oxygen. B. Resident interviewResident #1 was interviewed on 8/25/25 at 10:20 a.m. Resident #1 said he had not received his CPAP machine (a machine that delivers constant and steady air pressure to help with breathing while sleeping). He said he had had at least two appointments with his pulmonologist and still had not heard about his CPAP machine. He said his pulmonologist had filled out all of the paperwork and faxed it over to the facility. He said he had been waiting since March 2025 for his CPAP machine. Resident #1 was interviewed a second time on 8/28/25 at 12:34 p.m. Resident #1 said he was not given any paperwork after his appointments because they were telehealth appointments. He said that his pulmonologist told him that she had faxed over his paperwork for the CPAP machine to the facility. Resident #1 was interviewed a third time on 8/28/25 at 3:02 p.m. Resident #1 said he was supposed to have a sleep study, but one had not been scheduled yet. C. Record reviewThe respiratory care plan, revised 4/2/25, revealed Resident #1 had an altered respiratory status and difficulty breathing due to his diagnoses (see resident status above). Pertinent interventions included monitoring the resident for respiratory distress, shortness of breath, and maintaining a clear airway, providing oxygen and administering medications/puffers (inhalers) as ordered. -Review of Resident #1's comprehensive care plan did not reveal any care plan focus or interventions for a CPAP machine. -Review of Resident #1's physician's orders did not reveal a physician's order for a CPAP machineReview of two grievances made by Resident #1 since his March 2025 admission were reviewed and revealed the resident was concerned he had not gotten a CPAP machine yet and mentioned a sleep study and pulmonology appointments. -Review of Resident #1's electronic medical record (EMR) did not reveal any progress notes or records of his pulmonology appointments while at the facility. D. Staff interviews The regional clinical resource (RCR) was interviewed on 8/28/25 at 12:29 p.m. The RCR said she did not have any physician's orders or information from Resident #1's pulmonologist about a CPAP machine. She said she would contact the pulmonology office to get his records sent over. -However, the resident's pulmonology appointment records were not provided by the survey exit on 8/28/25.The health information manager (HIM) was interviewed on 8/28/25 at 1:09 p.m. The HIM said she did not believe Resident #1 had had any appointments with a pulmonologist while he was at the facility. She said if she did not know about the appointment, then she could not follow up to request the documentation from the appointment. The receptionist was interviewed on 8/28/25 at 1:13 p.m. The receptionist said Resident #1 had pre-existing appointments scheduled with his (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pulmonologist when he was first admitted to the facility. She said he had appointments scheduled on 4/15/25, 5/21/25 and 7/25/25 She said all of the appointments were telehealth appointments. She said when residents went out to appointments, they would let her know when they came back if there were follow-up appointments and the van driver would give the floor nurse the packet of paperwork. The director of nursing (DON) was interviewed on 8/28/25 at 1:38 p.m. The DON said normally when a resident went out for an appointment and then came back, they would come back with a packet and the packet would be given to the floor nurse. She said the floor nurse would open the packet and look to see if there were any changes that needed to be made. She said if the resident came back without any paperwork, then the appointment schedule would get pulled and the HIM would follow up with the physician's office the resident went to. She said telehealth appointments were harder to track, especially if the resident did not say anything to staff. She said she would expect the same follow-up practice to occur with telehealth appointments as it did with the other appointments. She said she was unsure if a sleep study was ever scheduled for Resident #1.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide proper contracture management services, equipment, and assistance for two (#66 and #37) of three residents reviewed for restorative services out of 55 sample residents. Specifically the facility failed to:-Ensure staff consistently applied Resident #66's wrist splint to the resident's right hand, which had a contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff); and,-Ensure Resident #37 was provided with passive range of motion (PROM) to her bilateral ankles, which had contractures.Findings include: I. Facility policy and procedure The Contracture policy, dated 2022, was provided by the nursing home administrator (NHA) on 8/26/25 at 4:20 p.m. It revealed in pertinent part, A resident with a limited range of motion or contracture shall receive appropriate treatment and services, based on the comprehensive assessment of the resident, to increase range of motion and/or to prevent further decrease. II. Resident #66 A. Resident status Resident #66, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included schizophrenia, contracture unspecified hand, unspecified injury of head subsequent encounter, age-related cognitive decline, unspecified lack of coordination, dependence of wheelchair, contracture right hand and abnormal posture. The 7/14/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She depended on staff assistance with bathing, dressing, toileting and transferring. She depended on a wheelchair. The assessment indicated that the resident wore a splint on her right wrist. B. Observations On 8/25/25 at 5:29 p.m. Resident #66 was sitting in the hallway near the television (TV). Her right hand was contracted at the wrist and she was not wearing a splint or a palm protector. Her fingers looked as if they were clutching something but her hand was empty. On 8/26/25 at 1:30 p.m. Resident #66 was sitting in her room in her wheelchair. Her right hand was contracted and she was not wearing a splint or a palm protector. On 8/27/25 at 8:42 a.m. Resident #66 was sitting in the hallway near the TV. Her right hand was contracted and her fingers were curled inward toward her palm. She was not wearing a splint or a palm protector. On 8/27/25 at 10:40 a.m. Resident #66 was in the dining room with the activities group. She was sitting in her wheelchair. Her right hand was contracted at the wrist and her fingers looked like they (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were digging into her palm. She was not wearing a splint or a palm protector. C. Record review Review of Resident #66`s musculoskeletal care plan, initiated 5/6/25, revealed that the resident had an alteration in musculoskeletal status related to a contracture of her right hand. Interventions included anticipating and meeting the resident's needs and ensuring the call light was within reach and responding promptly to all requests for assistance. -The care plan did not include an intervention for the resident's right hand splint. Review of Resident #66's self care deficit care plan, initiated 10/28/24, revealed the resident had a care deficit related to schizophrenia and a history of elevated troponin. Pertinent interventions included ensuring the resident's right hand resting splint was on in the morning and off in the evening (initiated 5/6/25). Review of a Therapy for Skilled Nursing document, undated, revealed that Resident #66 had a right elbow and hand contracture. Review of Resident #66's August 2025 CPO revealed the following physician's order: Apply splint on the right hand in the morning and remove in the afternoon, two times a day, ordered 5/6/25. Review of Resident #66`s treatment administration record (TAR) revealed that the resident's splint was documented as being applied on 8/26/25 and 8/27/25.  -However, Resident #66 was not observed wearing the splint on 8/26/25 and 8/27/25 (see observations above).  Review of Resident #66`s progress notes did not reveal documentation to indicate whether or not the splint was applied or whether Resident #66 refused to wear the splint on 8/26/25 and 8/27/25. D. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 8/27/25 at 9:50 a.m. CNA #8 said splints were necessary to keep resident's muscles relaxed which would stop Resident #66`s hands from contracting even more. She said Resident #66 often refused to wear the splint. She said the staff would attempt to apply the splint multiple times during the day if she refused. She said she would chart applying, removing, and refusal of the splint in the resident's electronic medical record (EMR). She said if Resident #66 refused the splint, CNAs were to report the refusal to the registered nurse (RN) and the RN would chart the splint refusal in the resident's progress notes. RN #4 was interviewed on 8/27/25 at 10:15 a.m. RN #4 said she would document Resident #66's right hand splint application, removal and resident refusals on the resident's treatment administration records (TAR). She said she would additionally document a progress note if the resident refused to wear the splint. The NHA was interviewed on 8/28/25 at 10:27 a.m. The NHA said that Resident #66's TAR documentation (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for 8/26/25 and 8/27/25 revealed that the splint was on the resident's right wrist. -However, observations on those dates revealed the resident did not have her splint on (see observations above). The NHA said if residents refused to let staff apply a splint, nurses should document a progress note regarding the refusal. CNA #8 was interviewed a second time on 8/28/25 at 10:34 a.m. CNA #8 said Resident #66 would let staff know at the beginning of the splint application process whether she was going to tolerate the splint or not. She said Resident #66 would not take the splint off on her own. The director of rehabilitation (DOR) was interviewed on 8/28/25 at 10:45 a.m. The DOR said hand splints were to prevent skin breakdown and to prevent contractures. She said Resident #66 would only allow certain staff members to put the splint on to her right hand. She said the splint did not have to stay on all day and it should be removed in the afternoon. She agreed that the CNAs should let the nurses know if the resident refused. She said the nurses should chart refusals of the splint in the progress notes. She said if the resident's refusal behavior continued for approximately for a week, the nurses should let her know that the therapy was not working. III. Resident #37 A. Resident status Resident #37, less than age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic cystitis with hematuria (a condition where blood is present in the urine), multiple sclerosis, epilepsy, chronic obstructive pulmonary disease (COPD), chronic systolic and diastolic congestive heart failure, contractures of the left and right ankle, anxiety disorder and major depressive disorder. The 5/15/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was impaired on both sides of her lower extremities. She required maximum assistance with transfers, bathing, and toileting, and set-up assistance with eating. The MDS assessment indicated Resident #37 was part of a restorative program, which included passive range of motion (PROM) and splint or brace assistance twice per week. B. Resident interview and observations Resident #37 was interviewed on 8/26/25 at 1:02 p.m. Resident #37 said her ankles were contracted due to her diagnosis of multiple sclerosis. She said the restorative program at the facility had been non-existent. Resident #37 said she was supposed to receive PROM two times a week; however, she barely received it two times a month. She said the restorative CNAs were often pulled to work on the floor and they did not have the time to complete their restorative duties. During a continuous observation on 8/26/25, beginning at 1:00 p.m. and ending at 4:00 p.m., the following was observed: At 1:00 p.m. Resident #37 was in bed in her room. CNA #3 went to the resident's room to assist with (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. CNA #3 left the resident's room at 1:08 p.m. -CNA #3 did not provide PROM to the resident. At 2:00 p.m., CNA #3 engaged in a short conversation with Resident #37 in her room, picked up the trash from the resident's trash can and left the resident's room. -CNA #3 did not provide PROM to the resident. -No other staff members entered Resident #37's room after CNA #3 exited the resident's room shortly after 2:00 p.m. until the continuous observation ended at 4:00 p.m. Resident #37 was not provided with PROM during the three-hour continuous observation. C. Record review Review of Resident #37's August 2025 CPO revealed the following physician's order: The restorative care plan, revised 11/21/24, documented that Resident #37 had limited physical mobility related to contractures, multiple sclerosis and weakness. Interventions included PROM of the resident's bilateral ankles, providing supportive care, assisting with mobility as needed and documenting assistance provided and ensuring the resident was wearing Multi Podus boots on both feet when she was in her wheelchair, per physical therapy recommendations for her ankle contractures. -The care plan did not include how often the resident was to receive PROM. -A review of Resident #37's electronic medical records (EMR), from 5/1/25 to 8/27/25, did not reveal documentation to indicate that the resident had received PROM. D. Staff interviews CNA #3 was interviewed on 8/26/25 at 2:05 p.m. CNA #3 said Resident #37 had contractures in both of her ankles. She said Resident #37 was Multi Podus boots on her feet. CNA #3 said the restorative CNAs provided restorative care for residents, including PROM for Resident #37. The minimum data set coordinator (MDSC) was interviewed on 8/28/25 at 10:00 a.m. MDSC said she had just been assigned the role of managing the restorative team, and she intended to review the entire restorative program together with the restorative team. The MDSC said Resident #37 was on a restorative program to receive PROM. She said staff were expected to document all restorative sessions in the resident's EMR. The MDS coordinator said there were no documented sections in the resident's EMR. The MDSC said the facility currently had one restorative CNA but she said the facility was hiring more staff to revamp the restorative department. The DOR was interviewed on 8/28/25 at 10:30 a.m. The DOR said restorative staff were provided training for any ongoing restorative programs for contracture management after therapy had completed the residents' treatment plans. She said it was important that the therapists' recommendations were followed to ensure residents' contractures did not worsen. The DOR said the rehabilitation department recommended Resident #37 be provided a PROM restorative program to her bilateral ankles every day as tolerated by the resident. She said she was not sure if (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that recommendation was being followed by the restorative staff. She said staff should provide PROM to the resident's bilateral ankles for her ankle contractures and the resident should have Multi Podus boots on her feet when she was up in her wheelchair. The DOR said there were no documentation in Resident #37's EMR that indicated the resident was receiving PROM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accident hazards for one (#5) of two residents out of 55 sample residents.Specifically, the facility failed to provide adequate supervision for Resident #5, who had a history of elopement. Findings include:I. Facility policy and procedureThe Elopement policy and procedure, revised September 2024, was provided by the nursing home administrator (NHA) on 8/28/25 at 9:47 a.m. It read in pertinent part, It is the policy of this facility to ensure that the facility provides a safe and secure atmosphere for all residents in the facility while striving to maintain the highest practicable function and the least restrictive environment. To ensure that residents at risk for elopement are properly monitored. Residents who are at risk for elopement would have an appropriate plan of care developed to address the risk.II. Resident #5A. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, major depressive disorder, anxiety disorder and dementia.The 7/22/25 minimum data set (MDS) assessment revealed Resident #5 had severe cognitive impairments with a brief interview for mental status (BIMS) score of seven out of 15. He was dependent on staff with toileting, required touch assistance with personal hygiene, and set-up assistance with eating. The assessment indicated he required a manual wheelchair for mobility and had a wander guard in place.B. ObservationsDuring a continuous observation on 8/25/25, beginning at 12:37 p.m. and ending at 2:05 p.m., the following was observed:At 12:37 p.m., Resident #5 was sitting in his wheelchair near the east side of the E-hall entrance to the smoking patio.At 12:40 p.m., Resident #5 self-propelled himself outside while other residents were entering the building from the smoking patio. He sat in his wheelchair waiting for the 1:00 p.m. supervised smoking break. There were no staff members in the smoking area.At 12:58 p.m., activity assistant (AA) #1 entered the smoking patio with a container of cigarettes and assisted the residents with smoking.At 2:05 p.m., AA #1 assisted Resident #5 back onto E-hall.On 8/26/25 at 2:33 p.m., Resident #5 self-propelled his wheelchair from the E-hall through the exit door when other residents, who smoked independently, were going out to the smoking patio to smoke. His wander guard alarm did not activate. There was no staff member in the area.At 2:55 p.m. Resident #5 sat in his wheelchair outside. An unidentified resident alerted a staff member that Resident #5 was outside at the smoking patio without staff.At 3:02 p.m. CNA #5 went out and stayed with the residents while AA #2 went to get the smoking container.On 8/27/25 at 2:15 p.m., a visual tour of the smoking area revealed there was a fence with an unsecured gate entrance leading directly to the street.C. Record reviewThe behavior and wandering care plan, revised 7/19/25, revealed Resident #5 was an elopement risk related to dementia with agitation and had a history of exit-seeking behaviors. Interventions included distracting the resident from wandering and exit seeking by offering smoke, pleasant diversions, structured activities, food, conversation, and television. The care plan indicated Resident #5 required supervision while smoking.A review of Resident #5's electronic medical record (EMR) from the admission date 7/9/25 until 8/27/25 did not reveal any episode of exit seeking.-However, interviews revealed Resident #5 had exit-seeking behaviors (see interviews below).Review of the August 2025 CPO revealed a physician's order that indicated to replace the wanderguard every 90 days, ordered 7/9/25. III. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 8/27/25 at 10:14 a.m. CNA #6 said Resident #5 had exit-seeking behaviors and required supervision at all times when he exited the building. She said the resident had a wanderguard, which was supposed to activate when Resident #5 entered the building. CNA #6 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she did not know how to ensure the wanderguard system was functioning currently.Registered nurse (RN) #5 was interviewed on 8/27/25 at 10:30 a.m. RN #5 said Resident #5 had wandering behaviors and had a wander on his ankle. RN #5 said the resident verbalized the desire to go home to live with his son. RN #5 said the staff were responsible for ensuring the resident was supervised when he was out of the building.The director of nursing (DON) was interviewed on 8/27/25 at 10:45 a.m. The DON said the facility staff were responsible for ensuring all unsafe smokers were adequately supervised. The DON said Resident #5 had exit-seeking behavior and had a wanderguard on his ankle. She said the staff were provided education on how to ensure residents with exit-seeking behaviors were monitored appropriately. The DON said she would immediately review the facility's smoking policy and provide education to all staff to ensure the safety of all residents.The NHA was interviewed on 8/28/25 at 11:30 a.m. The NHA said Resident #5 had a history of wandering and exit seeking. She said Resident #5 was admitted to the facility with the wander guard, and the facility had not completed its own assessment of the resident's wandering behavior. The NHA said the resident's wander guard program was immediately discontinued since an assessment of the resident's wandering behavior had not been completed, and there was no episode of exit seeking since admission. The NHA said Resident #5 expressed interest in living with his son; however, he had not left the building. The NHA said a physician's order was obtained to monitor for wandering and exit-seeking attempts for five days.

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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 the medication error rate was not greater than five percent (%).Specifically, the facility's medication error rate was 10.3%, or three errors out of 29 opportunities for error.Findings include:I. Facility policy and procedureThe Subcutaneous Insulin Medication Administration policy, dated January 2022, was provided by the NHA on 8/28/25 at 9:47 a.m. It read in pertinent part, Prepare syringe/pen and safety needle. Line up the needle with the pen, and keep it straight as you attach it. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle work properly and removing air bubbles. Select the priming dose by turning the dosage selector. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip.The Medication Administration policy, revised August 2024, was provided by the nursing home administrator (NHA) on 8/28/25 at 4:00 p.m. It read in pertinent part, It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Medications must be administered in accordance with the written orders of the attending physician.II. Resident #43A. ObservationsOn 8/26/25 at 3:25 p.m. licensed practical nurse (LPN) #3 prepared to administer medications to Resident #43, including a Symbicort 160-4.5 microgram per actuation (mcg/act) inhaler.At 3:28 p.m. Resident #43 self-administered the Symbicort inhaler with LPN #3's supervision.Resident #43 self-administered one puff of the Symbicort inhaler to herself.-LPN #3 failed to instruct the resident to take a second puff from the inhaler (see physician's orders below).-LPN #3 failed to instruct the resident to rinse her mouth with water and spit after Resident #43 used the inhaler (see physician's orders below).B. Record reviewReview of Resident #43's August 2025 computerized physician orders (CPO) revealed the following physician's order:Symbicort (budesonide-formoterol fumarate dihydrate) inhalation aerosol 160-4.5 mcg/act. Inhale two puffs orally two times a day for COPD (chronic obstructive pulmonary disease). Rinse and spit after inhaler use, ordered 3/18/25.C. Staff interviewLPN #3 was interviewed on 8/26/25 at 4:35 p.m. LPN #3 said she thought she saw Resident #43 administer a second puff from the inhaler to herself. After she looked up the physician's orders in Resident #43's electronic medical record (EMR), LPN #3 said the resident should have rinsed her mouth after she used the inhaler. LPN #3 said she was not positive, but she thought it was important for the resident to rinse her mouth after using the inhaler in order to prevent thrush.III. Resident #92A. ObservationsOn 8/27/25 at 3:11 p.m. registered nurse (RN) #2 prepared to administer medications to Resident #92, including a Dulera (mometasone furoate-formoterol fumarate dihydrate) inhalation aerosol 200-5 mcg/act inhaler.At 3:15 p.m. RN #2 allowed Resident #92 to self-administer the Dulera inhaler to himself.-RN #2 failed to instruct the resident to rinse his mouth with water and spit after Resident #92 used the inhaler (see physician's orders below).B. Record reviewReview of Resident #92's August 2025 CPO revealed the following physician's order:Dulera (mometasone furoate-formoterol fumarate dihydrate) inhalation aerosol 200-5 mcg/act. Inhale two puffs orally two times a day for COPD. Rinse mouth and spit after inhaler use, ordered 10/15/24.C. Staff interviewsRN #2 was interviewed on 8/27/25 at 3:35 p.m. RN #2 said Resident #92 usually self-administered the Dulera inhaler and he had been educated several times to rinse and spit after he used the inhaler. RN #2 said the resident just did what he wanted. She said she was unclear about why it was important for the resident to rinse and spit after he used the inhaler but she said she thought it prevented sores from the steroid medication in the resident's mouth.IV. Resident #99A. ObservationDuring a continuous observation on 8/27/25, beginning at 8:40 a.m. and ending at 9:10 a.m., the following was observed:At 8:40 a.m. RN #1 entered (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #99's room to check his blood glucose level and administer medications, including insulin via the resident's insulin pen injector. The resident requested his brief be changed upon RN #1's arrival.After Resident #99's brief was changed, RN #1 administered the resident's oral medications, checked his blood glucose level and prepared to administer the insulin. RN #1 turned the dosage selector on the insulin pen to 13 units.-However, RN #1 failed to prime the insulin pen injector before she administered the insulin to Resident #99's right abdomen.-Additionally, the physician's order indicated the resident was to receive 15 units of insulin (see physician's order below).At the medication cart, RN #1 self-identified that the physician's order said she should have administered 15 units of insulin. RN #1 prepared to re-enter Resident #99's room to administer the final two units of insulin.Prior to entering Resident #99's room, RN #1 turned the dosage selector on the insulin pen to two units.-However, RN #1 again failed to prime the insulin pen injector before she administered the remaining insulin dose to Resident #99's left abdomen.At 9:10 a.m. RN #1 completed Resident #99's subcutaneous insulin administration via the insulin pen injector.Cross reference F760 for failure to ensure residents were free from significant medication errors.B. Record reviewReview of Resident #99's August 2025 CPO revealed the following physician's order:Lantus (insulin glargine-yfgn) subcutaneous solution 100 units per milliliter (unit/ml). Inject 15 units subcutaneously two times a day for diabetes mellitus. Call the provider (MD) if blood sugar (BS) is less than 60 milligrams per deciliter (mg/dl) or greater than 400 mg/dl, ordered 8/25/25.C. Staff interviewsRN #1 was interviewed on 8/28/25 at 9:40 a.m. RN #1 said the insulin pen should be primed prior to administration, but she was not clear on the correct process to do so. She said she primed the pen during the first administration of insulin. She said the needle did not need to be attached to prime the insulin. She said she did not prime the pen when she returned to Resident #99's room for the final administration of insulin. RN #1 said it was important to prime the insulin pen to remove the air so the resident would receive the full dose of insulin.V. Additional interviewsThe pharmacy consultant was interviewed by telephone on 8/28/25 at 10:37 a.m. She said LPN #3 should have followed the physician's order and instructed Resident #43 to take an additional puff from the inhaler. The pharmacy consultant said that standard practice when taking corticosteroids would be to have residents rinse and spit after using the inhaler in order to prevent thrush.The pharmacy consultant said the needle was required to be attached to the insulin pen in order to prime it prior to administration. She said the insulin pen was primed by pushing the insulin to the tip of the needle prior to drawing up the physician ordered dose of insulin in order to ensure the resident received the full dose of insulin.The director of nursing (DON) was interviewed on 8/28/25 at 5:04 p.m. The DON said LPN #3 should have followed the physician's order and instructed Resident #43 to take an additional puff from her inhaler. She said it was important that the resident received the full physician ordered dose of the inhaler to ensure she had received the full effect of the medication. The DON said Resident #43 and Resident #92 should have been instructed by LPN #3 and RN #2 to rinse and spit after they used an inhaled corticosteroid in order to prevent thrush.The DON said a needle must be attached to the insulin pen in order to prime the pen. She said priming was the first step of insulin administration. She said RN #1 should have primed Resident #99's insulin pen and made sure the insulin was visible at the end of the needle prior to administering the resident's insulin to her. The DON said it was important to prime the insulin pen prior to the administration of insulin to ensure the resident received the full dose of medication.

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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 observation and interviews, the facility failed to ensure one (#99) of six residents out of 55 sample residents were free from significant medication errors.Specifically, the facility failed to ensure the insulin pen was primed in a manner consistent with professional standards of practice prior to medication administration for Resident #99. Findings include:I. Facility policy and procedureThe Subcutaneous Insulin Medication Administration policy, dated January 2022, was provided by the nursing home administrator (NHA) on 8/28/25 at 9:47 a.m. It read in pertinent part, Prepare syringe/pen and safety needle. Line up the needle with the pen, and keep it straight as you attach it. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle work properly and removing air bubbles. Select the priming dose by turning the dosage selector. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip.II. Resident #99A. Resident statusResident #99, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue, and infective myositis (an inflammation of the muscles caused by bacteria, parasites, fungi or viruses).The 8/26/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff for activities of daily living (ADLs), including bathing, toileting, dressing and repositioning. B. ObservationsDuring a continuous observation on 8/27/25, beginning at 8:40 a.m. and ending at 9:10 a.m., the following was observed:At 8:40 a.m. registered nurse (RN) #1 entered Resident #99's room to check his blood glucose level and administer medications, including insulin via the insulin pen injector. The resident requested his brief be changed upon RN #1's arrival.After Resident #99's brief was changed, RN #1 administered the resident's oral medications, checked his blood glucose level and prepared to administer the insulin. RN #1 turned the dosage selector on the insulin pen to 13 units.-RN #1 failed to prime the insulin pen injector before she administered the insulin to Resident #99's right abdomen.At the medication cart, RN #1 self-identified that the physician's order said she should have administered 15 units of insulin. RN #1 prepared to re-enter Resident #99's room to administer the final two units of insulin.Prior to entering Resident #99's room, RN #1 turned the dosage selector on the insulin pen to two units.-RN #1 failed to prime the insulin pen injector before she administered the remaining insulin dose to Resident #99's left abdomen.At 9:10 a.m. RN #1 completed Resident #99's subcutaneous insulin administration via the insulin pen injector.Cross reference F759: the facility failed to ensure the medication administration error rate was less than 5% (percent).C. Staff interviewsRN #1 was interviewed on 8/28/25 at 9:40 a.m. RN #1 said the insulin pen should be primed prior to administration, but she was not clear on the correct process to do so. She said she primed the pen during the first administration of insulin. She said the needle did not need to be attached to prime the insulin. She said she did not prime the pen when she returned to Resident #99's room for the final administration of insulin. RN #1 said it was important to prime the insulin pen to remove the air so the resident would receive the full dose of insulin. The pharmacy consultant was interviewed on 8/28/25 at 10:37 a.m. The pharmacy consultant said the needle was required to be attached to the insulin pen in order to prime it prior to administration. She said the insulin pen was primed by pushing the insulin to the tip of the needle to ensure the resident received the full dose of insulin.The director of nursing (DON) was interviewed on 8/28/25 at 5:04 p.m. The DON said a needle must be attached to the insulin pen (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in order to prime the pen. She said priming was the first step of insulin administration. She said the nurse should make sure the insulin at the end of the needle was visible. The DON said it was important to prime the insulin pen prior to the administration of insulin to ensure the resident received the full dose of medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of three medication carts and one of one medication storage rooms.Specifically, the facility failed to:-Ensure medications for discharged residents were stored in a secure manner; and,-Ensure residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened.Findings include:I. ObservationsOn 8/28/25 at 3:15 p.m. the facility's one medication storage room was observed with the regional clinical resource (RCR) and registered nurse (RN) #1. There were multiple bubble packs of medications sitting out on the counter. The medications belonged to Resident #9 and Resident #31.On 8/28/25 at 3:25 p.m. the medication cart in hallway D was observed with licensed practical nurse (LPN) #3. The following items were found:-There were two fluticasone propionate 50 micrograms (mcg) nasal spray bottles stored in appropriately labeled medication boxes; however, the individual medication bottles inside were not labelled with the resident's name or the date the medications were opened for Resident #28 and Resident #52.On 8/28/25 at 3:34 p.m. the medication cart in hallway A was observed with RN #2. The following item was found:-There was a 3 milligram (mg) semaglutide (Rybelsus) oral tablet medication stored appropriately in a labeled medication box; however, the medication container inside was not labelled with the resident's name or the date the medication was opened for Resident #16.II. Staff interviewsThe RCR was interviewed on 8/28/25 at 3:15 p.m. The RCR said that Resident #9 and Resident #31 had been discharged , and their medications should have been brought to the director of nursing's (DON) office after a resident was discharged from the facility. The RCR removed the unsecured bubble packs of medications from the medication room at that time.The RCR was interviewed a second time on 8/28/25 at 3:25 p.m. The RCR said she did not know medication containers needed to be labelled when they were stored inside their respective medication boxes, which were labeled.

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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 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 disease and infection on one of six units.Specifically, the facility failed to:-Ensure Resident #99's glucometer was cleaned according to manufacturer recommendations; and,-Ensure proper hand hygiene was conducted during medication administration. Findings include:I. Failure to clean the glucometer according to manufacturer recommendationsA. Cleaning and disinfecting guidelinesThe Assure glucometer manufacturer cleaning and disinfecting guidelines were provided by the nursing home administrator (NHA) on 8/28/25 at 9:47 a.m. It read in pertinent part, We suggest cleaning and disinfecting the meter between patient use. Cleaning and disinfecting can be completed by using a commercially-available EPA-registered (tested, approved and registered by the United States Environmental Protection Agency) disinfectant detergent or germicide wipe. To use a wipe, remove from the container and follow product label instructions to disinfect the meter.The Medline micro-kill germicidal-bleach wipes, which were EPA-registered, were utilized to clean a resident's glucometer. The Medline product label read in pertinent part, Contact time: allow surface(s) to remain visibly wet for 30-seconds to kill the bacteria and viruses on the label. A one minute contact time is required to kill Candida albicans and Trichophyton interdigitale. A two minute contact time is required to kill Candida auris. A three minute contact time is required to kill Clostridium difficile spores.B. ObservationsDuring the medication administration observation on 8/27/25 at 9:14 a.m. registered nurse (RN) #1 completed Resident #99's blood sugar check and medication administration. Before she exited the room, RN #1 pulled a cleaning wipe and wrapped it in a glove from her pocket. RN #1 spent less than ten seconds cleaning all surfaces of the glucometer. The surface of the glucometer did not become wet.-RN #1 failed to ensure the surface of the glucometer became and remained visibly wet for the minimum duration of 30-seconds to kill bacteria and viruses.C. Staff interviewsRN #1 was interviewed on 8/27/25 at 9:34 a.m. She said the facility used the Medline micro-kill germicidal-bleach wipes to clean and disinfect the glucometers. RN #1 said she was unclear on the manufacturer guidelines for cleaning the resident's glucometers. She said after she read the bleach wipes' product label, RN #1 said the cleaning time was three minutes. RN #1 said it was important to follow these instructions to kill the stuff on the glucometers.The infection preventionist (IP) was interviewed on 8/28/25 at 4:43 p.m. The IP said glucometers should be cleaned after every use with a wipe. She said the nurse should wrap the glucometer in the wipe for two minutes before letting it air dry. She said once the glucometer dried, it could be placed back into the resident's individual bag for storage inside the medication cart. The IP said it was important to ensure the glucometers were cleaned of any potential blood or bacteria. She said cleaning the glucometer prevented the spread of infection.The director of nursing (DON) was interviewed on 8/28/25 at 5:04 p.m. The DON said the glucometer must be saturated and the manufacturer's guidelines for cleaning must be followed. She said following the manufacturer's instructions to clean and disinfect the glucometer was important to ensure all potential pathogens were killed.II. Failure to ensure proper hand hygiene was conducted during medication administrationA. Facility policy and procedureThe Infection Control policy, dated October 2024, was provided by the NHA on 8/25/25 at 10:00 a.m. It read in pertinent part, Staff and patient education is done to focus on risk of infection and practices to decrease risk. Universal precautions, handwashing and aseptic practices arefollowed by personnel in performing procedures and in disinfection of equipment.B. ObservationsDuring the medication administration observation on 8/27/25 at 8:40 a.m. RN #1 started administering Resident #99's oral medications when the resident requested fresh ice water in his plastic cup. RN #1 did not remove (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065229	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Post Acute and Rehabilitation Center	2701 California St Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the gloves or perform hand hygiene before leaving the resident's room. RN #1 walked down the hallway to the ice cooler. She lifted the lid, handled the scoop, filled the resident's cup with ice, returned to Resident #99's room and filled the cup with water from the faucet with the same gloved hands. -RN #1 failed to remove her gloves, perform hand hygiene and change her gloves before she continued to administer Resident #99's oral medications.C. Staff interviewsThe IP was interviewed on 8/28/25 at 4:43 p.m. The IP said hand hygiene during medication administration was important to help prevent the spread of potential infections and bacteria. She said she provided handwashing training monthly during the all staff meeting, as well as on an as needed basis. The IP said she last conducted hand washing training on 8/21/25.The DON was interviewed on 8/28/25 at 5:04 p.m. The DON said hand hygiene should be performed when the nurse left the resident's room during medication administration. She said gloves should not be worn in the hallway and the same gloves should not be used to touch multiple surfaces and then administer the resident medications.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure resident rooms, shower rooms and hallways received necessary maintenance and repairs. Findings include:I. Observations On 8/26/25 at 10:20 a.m., observations of the facility revealed the following:In the shower room on the A hall, it was revealed that there was a missing vent, leaving a hole in the ceiling.-The ventilation system in the A Hall shower room was not working The vents on the A hall and B hall were rusty with a brown colored substance around the surfaces, and the vents were missing paint.A hole was observed in the drywall of room F-4.On Hall C, room [ROOM NUMBER] had water leaking from the ventilation system located on the ceiling towards the window in the room.On 8/27/25 at 11:15 a.m., observations of the facility revealed the following:Near the door going into the main dining room, there was water leakage from the roof of the building.Resident #1 said there was a pool of water flowing out of the ceiling the night before, causing a puddle of water to settle on the ground at the entrance to the facility.At 11:20 a.m., there was a loose handrail, and there was a light hanging from the hallway ceiling. At 11:30 a.m., the following doors to resident rooms were difficult to open:Room #A2, room #C12, room #C13, room #C16, room # C18, room #D3, room #D5, room #D6, room #D7, room #E6, room #E10, room #F1 and room #F10.II. Resident interviewsThe resident who resided in room #D 6-2 was interviewed on 8/25/25 at 1:223 p.m. The resident said her door got stuck daily and she could not open it most of the time.The resident who resided in room [ROOM NUMBER] was interviewed on 8/25/25 at 3:22 p.m. She said the door to her room was difficult to open and close. The resident said she had spoken with several certified nurse aides CNAs to complete a maintenance work order, but no one had fixed the door.The residents who resided in room # D6 were interviewed together on 8/27/25 at 11:28 a.m. One of the residents said her door to her room had been difficult to open and close since he was admitted to the facility. The other resident said he stayed in his room most of the time. He said he would prefer to have the door shut when his roommate left the room, but his roommate could not open the door when he returned. III. Staff interviews and observationsAn environmental tour was conducted on 8/27/25 at 3:18 p.m. with the maintenance director (MTD), and the above concerns were observed. The MTD said all identified concerns would be addressed immediately. The MTD said staff should be putting in work orders when they notice something is broken. He said the facility utilized an electronic work system to track needed repairs. He said the facility staff also verbally let him know what needed to be repaired. He said the maintenance staff put the work orders into the electronic work system. He said all of the maintenance staff knew how to put a work order into the electronic work system.The MTD said he would take notes on what needed to be repaired. He said work orders were completed in order to be completed when it was received, except emergency work orders, which were completed immediately.The MTD said he completed weekly audits throughout the building once a week.The MTD said he completed maintenance work orders when he noticed any issues during his weekly audits and walk-throughs and ensured that they were completed.The MTD said that when it rained the previous night, the gutters became flooded, affecting the roof, causing leakages from several areas of the building. He said the facility was in the process of replacing the roof of the building.The nursing home administrator (NHA) said that staff could place work orders in the facility's computerized healthcare software system. The NHA said the computerized healthcare software system would then generate a work order in the facility's management computerized system.The NHA said the identified concerns would be immediately taken care of. She said she would review the maintenance work order (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system to identify where the issues were and provide education.