STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents had the right to a dignified existence for four (#3, #28, #72 and #73) of 24 residents out of 36 sample residents reviewed. Specifically, the facility failed to:-Speak with Resident #3, Resident #28, Resident #72 and Resident #73 respectfully while providing care to the residents; and,-Ensure residents were not discussed by staff in areas where the conversations could be overheard by others.Findings include:I. Facility policy and procedureThe Dignity policy and procedure, revised August 2009, was provided by the nursing home administrator (NHA) on 8/21/25 at 12:30 pm. It revealed in pertinent part, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be informed about what rights and responsibilities he or she has; privacy and confidentiality and voice grievances and have the facility respond to those grievances.II. Resident #3A. Resident statusResident #3, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included epilepsy, cerebral infarction (stroke), left-sided hemiplegia (paralysis of the left side of the body), depression, anxiety and insomnia. The 8/4/25 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. She was dependent on staff assistance with repositioning, transfers, toileting, dressing, hygiene and showering.B. Resident interviewResident #3 was interviewed on 8/20/25 at 12:53 p.m. Resident #3 said during the evening of 8/15/25, she tried to use her call light to call for assistance but the call light was out of reach of Resident #3's right side. Resident #3 said she called the facility using her cell phone in order to ask a staff member for help. Resident #3 said she called multiple times from 8:45 p.m. until 9:15 p.m. Resident #3 said registered nurse (RN) #5 answered the phone, spoke rudely to Resident #3 and told her to stop calling. Resident #3 said she did not file a grievance and did not notify the NHA or the director of nursing (DON) because she did not know that she could file a grievance. III. Resident #28A. Resident statusResident #28, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic kidney disease stage 3, osteoarthritis of the left knee, alcohol use with withdrawal delirium, polyneuropathy, anxiety and insomnia. The 8/17/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #28 required touching assistance with bathing and when ambulating with a walker.B. Resident interviewResident #28 was interviewed on 8/18/25 at 12:06 p.m. Resident #28 said she was waiting for RN #5 to bring her as needed medication for her pain on 8/16/25 at approximately 8:00 p.m. Resident #28 said she heard RN #5 talking loudly in the hallway calling somebody a drug addict. Resident #28 said she asked RN #5 if she was referring to Resident #28 when she said drug addict. Resident #28 said RN #5 replied to her that she was not talking to Resident #28 when she made that statement and RN #5 said she had a hallway full of drug addicts. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28 said RN #5 was rude and dismissive when administering her medication.Resident #28 was tearful recalling the events of the evening (8/16/25) during the interview. Resident #28 said she reported the statements made by RN #5 to the DON on the morning of 8/17/25. Resident #28 said she thought the facility was looking into her concern, but she was not sure. IV. Resident #72A. Resident statusResident #72, age greater than 65, was admitted on [DATE] and discharged from the facility on 6/17/25. According to the June 2025 CPO, diagnoses included heart disease, diabetes type 2, chronic kidney disease stage 2, unspecified falls and syncope (fainting). The 5/29/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #72 required partial assistance with bathing, hygiene, dressing and footwear.B. Record reviewResident grievances were provided by the NHA on 8/21/25 at approximately 08:00 a.m. The resident grievances revealed Resident #72 filed a grievance to the DON on 6/2/25. The grievance revealed an unidentified nurse was argumentative with Resident #72 when discontinuing her intravenous (IV) infusion. When Resident #72 asked the nurse to clean her central IV line with alcohol instead of chlorhexidine (a potent, broad-spectrum antiseptic and disinfectant used to kill bacteria and other microorganisms). The grievance revealed Resident #72 said the nurse told her I'm a nurse and I know what I'm doing. The grievance revealed Resident #72 suffered blisters around the site of her central line after the use of chlorhexidine. The grievance documented the resolution to Resident #72's grievance was that the staff nurse was not to touch any intravenous infusions until additional education was completed and intravenous competency was demonstrated. -However, the grievance did not indicate if the inappropriate way the RN spoke to Resident #72 was addressed by the facility.V. Resident #73A. Resident statusResident #73, age greater than 65, was admitted on [DATE] and discharged from the facility on 7/10/25. According to the July 2025 CPO, diagnoses included wedge compression fractures of the T9 to T12 (thoracic) vertebra with routine healing, lower back pain, difficulty walking, unspecified lack of coordination, depression and insomnia. The 6/17/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. Resident #73 required substantial assistance with bathing, lower body dressing, footwear and toileting. Resident #73 required moderate assistance with hygiene, upper body dressing, repositioning and ambulating less than 10 feet.B. Record reviewResident grievances were provided by the NHA on 8/21/25 at approximately 08:00 a.m. The resident grievances revealed Resident #73 filed a grievance about the way a staff member spoke to her. The grievance revealed Resident #73 asked an unidentified certified nurse aide (CNA) to go slower when transferring from her wheelchair to the toilet and back to bed due to pain. The grievance revealed Resident #73 also asked for a second staff member to help with the transfer. The grievance revealed the unidentified CNA told Resident #73 other staff would not come down to help because Resident #73 was too difficult to work with. The grievance revealed the resolution for the grievance was to have the CNA work in a different hall. -However, the grievance did not indicate if the inappropriate way the CNA spoke to Resident #73 was addressed by the facility.VI. Staff interviewsThe DON and the regional director of clinical services were interviewed together on 8/20/25 at 1:48 p.m. The DON said she was aware of the allegations made by Resident #28. She said an investigation of the incident was being conducted. The DON said she interviewed Resident #28 and Resident #28 told her the care she received from RN #5 was rude but she was not tearful during the initial interview. The DON said she was not aware of the additional allegation regarding RN #5 from Resident #3. The DON said she planned to start an additional investigation and to ask all other residents to see if additional residents were affected by RN #5.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen.Specifically, the facility failed to:-Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross-contamination; and, -Ensure safe and appropriate storage of food items in the main kitchen walk-in refrigerator. Findings include:I. Failed to ensure ready-to-eat foods were handled in a sanitary mannerA. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 8/25/25. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (3-301.11)B. Facility policy and procedureThe Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy and procedure was received from the nursing home administrator (NHA) on 8/21/25 at 1:16 p.m. It read in pertinent part, Gloves are considered single-use items and must be discarded after completing the task for which they are used. Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness.C. ObservationsDuring a continuous observation of the lunch meal service on 8/20/25, beginning at 11:05 a.m. and ending at 12:09 p.m. the following was observed:At 11:44 a.m. cook (CK) #1 was preparing two grilled cheese sandwiches on the griddle. With gloved hands, CK #1 used one hand to stabilize the sandwiches on top of the spatula as he transferred them from the griddle to a cutting board. With the same gloved hands, CK #1 grabbed the handle of the dish heater and pulled out two plates. CK #1 used his gloved hand to stabilize the sandwiches as he cut them on the cutting board, then picked the sandwiches up with his gloved hands and placed them onto each plate.At 11:52 a.m. CK #2 was wearing a set of gloves. CK #2 used his gloved hand to adjust a piece of toast on a plate to make room for spaghetti noodles. CK #2 had previously handled meal tickets and serving utensils with the same gloved hands.-CK #2 did this two more times throughout meal service.At 11:58 a.m. CK #1 donned (put on) a pair of gloves and began preparing a cheeseburger. CK #1 retrieved a plastic bag of hamburger buns, opened the bag, and grabbed a bun using his gloved hand before placing it on a plate. CK #1 opened the walk-in refrigerator and retrieved a plastic package of cheese slices and two pieces of lettuce, holding the lettuce with the same gloved hand. CK #1 placed the lettuce leaves onto the hamburger bun, opened the plastic packaging for the cheese and retrieved a slice of cheese using his gloved hand.At 11:59 a.m. CK #2 was ladling spaghetti sauce onto a plate of noodles and got some of the sauce on the side of his hand. CK #2 wiped the sauce off of his glove onto the inner rim of the steam table bin containing spaghetti sauce. CK #2 had previously been handling meal tickets and serving utensils with the same gloved hands.At 12:02 p.m. CK #2 used his gloved hands to place the top bun of the cheeseburger onto the rest of the burger. CK #2 then used his gloved hand to stabilize the cheeseburger as he cut it in half. CK #2 was previously handling meal tickets and serving utensils with the same gloved hands.D. Staff interviewThe dietary manager (DM) was interviewed on 8/21/25 at 8:45 a.m. The DM said gloves should be changed from one job to the next with hand hygiene performed between glove changes. The DM said ready-to-eat foods should be handled with utensils and should not be handled by hand. II. Failure to safely and appropriately store food itemsA. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 8/25/25. It revealed in pertinent part, Food shall be protected from contamination by storing (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the food in a clean, dry location where it is not exposed to splash, dust, or other contamination. (3-305.11)B. Facility policy and procedureThe Kitchen Sanitization policy and procedure was received from the NHA on 8/21/25 at 1:16 p.m. It read in pertinent part, All counters, shelves and equipment are kept clean and maintained in good repair.C. ObservationsA tour of the main kitchen was conducted on 8/17/25 at 1:15 p.m. In the walk-in refrigerator, there was a patch of green-grey mold on the floor next to the door to the freezer, approximately six inches square. Two baking sheets, which held plastic containers of cheese shreds and packages of sliced cheese, had small scattered spots of mold along their inner edges and corners.On 8/20/25 at 11:15 a.m., during a second tour of the main kitchen, the baking sheets holding the cheese products had been cleaned. The patch of mold on the floor of the refrigerator was still present.On 8/21/25 at 8:40 a.m., during a final tour of the main kitchen, the patch of mold on the floor in the walk-in refrigerator was still present and unchanged.D. Staff interviewsThe DM was interviewed on 8/20/25 at 11:20 a.m. The DM said she had not seen the mold on the floor or on the baking sheets in the walk-in refrigerator. The DM said the dietary staff deep-cleaned the refrigerators once a month, during which time they took out all of the shelves and scrubbed the refrigerator floor. The DM said the staff were a bit late on cleaning that month because they had been short-staffed. The DM said she had experienced some issues with mold but the maintenance staff were working on trying to fix the fans in the refrigerator. The DM said she was not sure if maybe the issue was trapped deeper within the tubing and components of the refrigerator fans. The DM said their freezer had recently broken down and the ice had melted, so she thought the mold on the floor may have been from the ice melt in the freezer. The DM said she would work with the dietary staff that evening and scrub the floors in the fridge.-However, the patch of mold on the refrigerator floor was observed the following day (see observations above).The DM was interviewed a second time on 8/21/25 at 8:45 a.m. The DM said the issues with buildup on the floor were caused from the freezer breaking down. The DM said she thought the baking sheets on the shelves in the refrigerator were disrupting airflow and therefore causing buildup, so she said she was thinking of removing them and storing food directly on the shelves.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure accurate medical records were kept for one (#28) of five residents out of 36 sample residents reviewed. Specifically, the facility failed to maintain accurate records for Resident #28 of pain reassessments and foley catheter care in the electronic medical record (EMR). Findings include:I. Professional referenceAccording to [NAME], P.A. and [NAME], A.G. et.al., (2021), Fundamentals of Nursing, 10 edition, pp 261 and 1067. Assessment is a continuous process that occurs each time you interact with a patient. It involves the collection of new data. Reassessment is not the same as evaluating care or determining a patient's response to an intervention. Instead, it is the gathering of additional information to ensure that the plan of care is still complete, current, and appropriate. Analgesics should be initiated at the lowest effective dose and titrated to achieve pain control with minimal adverse effects; this requires frequent reassessment of patients for pain relief and side effects as doses are adjusted.II. Resident #28A. Resident statusResident #28, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included chronic kidney disease stage 3, osteoarthritis of the left knee, alcohol use with withdrawal delirium, polyneuropathy, anxiety and insomnia. The 8/17/25 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. Resident #28 required touching assistance with bathing and when ambulating with a walker.B. ObservationsDuring a continuous observation on /19/25, beginning at 8:16 a.m. and ending at 12:09 p.m., the following was observed:At 8:16 a.m. Resident #28's medication administration record (MAR) and treatment administration record (TAR) were incomplete. The documentation for indwelling catheter care was blank at the start of the observation. At 8:38 a.m. RN #2 administered as needed pain medication per the residents request. RN #2 asked Resident #28 to rate their pain on a scale of 1 to10 during the medication administration.At 11:16 a.m. Resident #28's MAR had completed documentation for the pain reassessment score after the as needed pain medication and Resident #28's TAR had completed documentation for indwelling catheter care.-However RN #2 had not returned to Resident #28's room since the time of the pain medication administration and no staff entered the resident's room to provide catheter care. C. Resident interviewResident #28 was interviewed on 8/19/25 at 11:39 a.m. Resident #28 said nobody cleaned her indwelling catheter that morning (8/19/25). Resident #28 said she did not remember seeing RN #2 after RN #2 administered her pain medication this morning and nobody asked her to reassess her pain after taking the pain medication. Resident #28 said the staff reassessed her pain about half of the time she received as needed pain medication. D. Record reviewThe progress note, dated 8/19/25 at 9:35 a.m. documented Resident #28 rated her pain as a 3 out of 10on follow up assessment.-However, based on observations and the interview with Resident #28, this assessment did not occur.E. Staff interviewsThe director of nursing (DON) and the regional director of clinical services were interviewed together on 8/21/25 at 10:59 a.m. The DON said accurate medical records inform staff of the effectiveness of the current interventions in the plan of care. The DON said the time the indwelling catheter care was documented in the TAR was 8:47 a.m. The DON said the time the task was marked as completed in the TAR did not necessarily reflect the time the care occurred. The DON said the nursing staff had to provide multiple avenues of care and may not have documented care at the specific time it was completed. The DON said staff were encouraged to document care as accurately as possible. The DON said in regards to the pain medication reassessment, the DON said she planned to provide individual education to RN #2.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of two units. Specifically, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) when providing direct care for Resident #65, Resident #62 and Resident #29, who were on enhanced barrier precautions (EBP).Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 8/25/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent part,Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing.I. Observations On 8/18/25 at 10:30 a.m. there was a sign on Resident #65's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care.On 8/18/25 at 10:50 a.m. Resident #65, who had an indwelling urinary catheter was being assisted in the bathroom with transfer assistance and catheter care by registered nurse (RN) #1, certified nurse aide (CNA) #1 and CNA #3. RN #1 was wearing a protective gown and gloves. CNA #1 and CNA #3 were wearing gloves but were not wearing gowns.-CNA #1 and CNA #3 failed to don (put on) a protective gown prior to providing direct care for Resident #65. On 8/18/25 at 11:35 a.m. there was a sign on Resident #62's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care.On 8/18/25 at 11:38 a.m. an unidentified nursing staff member and physical therapy assistant (PTA) #1 were assisting Resident #62, who had a surgical wound with staples on her left hip, with her clothing change and transfer to her wheelchair. The unidentified nursing staff member was wearing gloves but did not have a gown on. PTA #1 was not wearing a gown or gloves.-The unidentified nursing staff member failed to don a protective gown and PTA #1 failed to don gloves or a gown prior to providing direct care for Resident #62. On 8/19/25 at 9:00 a.m. there was a sign on Resident #29's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care.On 8/19/25 at (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adhered to EBP to prevent any potential infections. The DON said it was important for all staff to adhere to the designated resident-specific precaution recommendations because the facility wanted to keep the residents safe from developing preventable infections. She said the facility did not want to be the cause of any infection. She said the potential negative outcome to the facility staff of not adhering to EBP could be the resident contracting MDROs and there was a high potential of spreading the infection to another resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement policies and procedures related to COVID-19 immunizations for two (#29 and #62) of five residents reviewed for immunizations out of 36 sample residents.Specifically, the facility failed to offer Resident #29 and Resident #62 the COVID-19 vaccination. Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC), COVID-19 guidelines (revised 1/7/25), retrieved on 8/25/25 from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html. Everyone ages six months and older should get a 2024-2025 COVID-19 vaccine. The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death. It is especially important to get your 2024-2025 COVID-19 vaccine if you are age [AGE] and older, are at risk for severe COVID-19, or have never received a COVID-19 vaccine. Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine.II. Resident #29 A. Resident status Resident #29, age less than 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician's orders (CPO), diagnoses included traumatic brain injury, chronic pain, open wound of the right hand, fracture of the left arm and fracture of the pelvis.The 8/1/25 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. He required substantial/maximal assistance with shower and bath, supervision/touch assistance with lower body dressing, and dependent with toileting hygiene. He required setup assistance with eating.The assessment did not indicate that the resident was ever offered the COVID-19 vaccine. B. Resident interviewResident #29 was interviewed on 8/19/25 at 9:05 a.m. He said he was admitted to the facility after a motorcycle accident. He said he did not remember being offered a COVID-19 vaccination from the facility and was unsure of his vaccination status.C. Record reviewReview of Resident #29's electronic medical record (EMR) on 8/21/25 did not reveal documentation that the COVID-19 vaccine was offered or administered to the resident. III. Resident #62A. Resident statusResident #62, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included fracture of the right femur, joint replacement surgery, anemia, dementia, generalized weakness and cognitive communication deficit.The 8/19/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. She was dependent on staff for eating, toileting hygiene, showers/baths and upper body dressing. She required partial/moderate assistance with oral hygiene. The assessment did not indicate that the resident was offered the COVID-19 vaccine. C. Record reviewReview of Resident #62's EMR on 8/21/25 did not reveal documentation that the COVID-19 vaccine was offered or administered to the resident. D. Staff interviewsThe director of nursing (DON) and the infection preventionist (IP) was interviewed together on 8/21/25 at 10:30 a.m. The DON said the facility monitored and tracked the residents' immunizations status in the EMR. She said the facility offered and provided education to the residents regarding the COVID-19 vaccinations upon admission after review of their vaccination history. The DON said she did not have documentation indicating Resident #29 or Resident #62 were offered and declined the COVID-19 vaccination She said it was the admitting nurses responsibility to document in the resident's EMR if the resident refused the vaccination.