STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065417	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Resort of Colorado Springs, The	2818 Grand Vista Cir Colorado Springs, CO 80904

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on record review and interviews, the facility failed to honor resident choices for residents residing on three of four units of the facility. Specifically, the facility failed to ensure residents could choose to eat in the dining room at dinner time and on the weekends. Findings include: I. Facility policy and procedure The Promoting/Maintaining Resident Self-Determinations policy and procedure, revised December 2024, was provided by the director of nursing (DON) on 6/26/25 at 1:29 p.m. It read in pertinent part, Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Each resident has the right to interact with members of the community and participate in community activities both inside and outside of the facility. The facility will accommodate the resident preferences to the extent possible. II. Resident interviews and observations On 6/23/25 at 4:30 p.m. Resident #60 was sitting next to a round table close to the north hall nursing station, accompanied by an unidentified resident. Resident #60 said she was waiting for a staff member to bring her dinner. Resident #60 said she preferred going down to the dining room for meals, but the dining room was only open for breakfast and lunch. She said the dining room was closed for dinner on weekdays and on the weekends. Resident #60 said the dining room had always been closed for dinner and wished that the facility would consider opening it for the resident since she enjoyed dining there with her peers. Resident #17 was interviewed on 6/24/25 at 5:18 p.m. Resident #17 said she did not know the dining room was open again. Resident #17 said the dining room had been closed for a long time. Resident #17 said she did not know if any of the facility staff had ever invited her to the dining room. Resident #76 was interviewed on 6/24/25 at 9:16 a.m. Resident #76 said she liked to eat in the dining room. Resident #76 said she wished the dining room was open for dinner, but that it was closed (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during dinner and for all meals on the weekend. Resident #76 said the facility staff members told her they were trying to get approval to have the dining room open for dinner and on the weekends. Resident #76 said she had to eat in her room otherwise. Resident #76 said she preferred to be in the dining room to help her socialize, enjoy the company of other people and get her food faster. Resident #76 said she did not have fun eating in her room alone. Resident #76 said at home she had her husband to sit and eat with. III. Observations On 6/23/25 at 12:02 p.m. two unidentified residents were talking in the dining room during the lunch meal service. One resident told the other that dinner was only served in the residents' rooms. The resident told the other resident only breakfast and lunch were served in the dining room. On 6/24/25 at 4:46 p.m. Resident #76 was not in the main dining room for dinner. Resident #76 was sitting in her room sitting in her wheelchair. Resident #76 said she was waiting for her dinner. On 6/24/25 at 4:48 p.m., during the scheduled dinner service, no residents were present in the dining room. On 6/25/25 at 4:05 p.m. Resident #66's representative came out of her room and to the nurse's station. Resident #66's representative told licensed practical nurse (LPN) #4 that he would like to take Resident #66 to the dining room for dinner. LPN #4 said the dining room was not open because there was no one available to supervise them. Resident #66's representative went back to the resident's room with a disappointed look on his face. On 6/25/25 at 5:15 p.m. an unidentified resident and her representatives walked into the dining room. One of the resident's representatives told the other representative they could eat in the dining room at breakfast and lunch, but it was closed for dinner and on the weekends. IV. Record review A facility all-staff inservice, dated 3/10/25 at 2:15 p.m., was provided by the regional dietary consultant (RDC) on 6/26/25 at 1:38 p.m. It revealed staff were educated on the main dining room being reopened. The inservice documented the dining room would be reopened on 3/11/25. The inservice documented the facility certified nurse aides (CNA) would be primarily responsible with helping residents get to the dining room and would be present in the dining room during meals. An undated flyer was provided by the RDC on 6/26/25 at 1:38 p.m. It revealed the dining room was reopened on 3/10/25. Meal times were listed and included dinner starting at 4:30 p.m. An undated performance improvement plan was provided by the RDC on 6/26/25 at 11:42 a.m. It revealed the dining room and meal times were an identified concern. The plan documented dining was slow to resume after the COVID-19 pandemic and the facility was working on opening the dining room. The plan documented there were concerns that not all facility staff members were aware of the open-dining processes. Corrective actions included a soft opening of the dining room, completed 3/11/25, a grand opening of the dining room in April 2025 and education with staff on the dining room processes, completed 3/11/25. Additional corrective actions completed during the survey process included reeducation to staff on the open, completed 6/25/25 (during the survey process), and reeducation and announcing to residents to advise them of the open dining and meal times, completed 6/26/25 (during the survey (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	process). V. Staff interviews CNA #3 was interviewed on 6/25/25 at 2:38 p.m. CNA #3 said the nursing staff invited the residents to go to the dining room for breakfast and lunch. CNA #3 said the facility's restorative aide did restorative dining and monitored the dining room for breakfast and lunch. CNA #3 said the CNAs also helped in the dining room as needed. CNA #3 said the restorative aide left work after lunch, so the facility did not have dinner in their main dining room. CNA #3 said the residents at the facility wanted to eat in the dining room for dinner but they did not have the staff to do so. CNA #3 said if residents wanted to eat in the dining room for dinner, the nursing staff brought them to the tables near the nurse's stations to eat. LPN #1 was interviewed on 6/25/25 at 4:13 p.m. LPN #1 said the nursing and facility staff invited residents to eat in the dining room. LPN #1 said residents only went to the dining room for breakfast and lunch but did not go to the dining room for dinner. LPN #1 said she did not know if any of the residents wanted to go to the dining room for dinner, as she had not asked any of them if they wanted to eat in the dining room at dinner time. The dietary manager (DM) and the RDC were interviewed together on 6/26/25 at 9:54 a.m. The DM said the facility's restorative aide went around the facility and asked residents if they wanted to eat in the dining room. The RDC and the DM said residents should have been invited to the dining room at dinner time. The RDC said she heard a staff member say the dining room was not open at dinner so she provided them with education. The RDC said the facility did a grand reopening of their dining room in March 2025 and had been doing reeducation with the facility staff since then. The DM said the dining room was also open on the weekends. The RDC said she thought more education needed to be done with the facility staff. The RDC was interviewed a second time on 6/26/25 at 2:02 p.m. The RDC said the admission binder had a page with the meal times and noted it said each meal was available in the dining room or in the resident's room. The RDC said the facility staff went around that day (6/26/25) to each of the long-term residents to educate them that the dining room was open, as it had been a while since they received their admission binder. The RDC said she knew the process of the facility reopening their dining room had been slow-going. The RDC said the facility had tried to reopen the dining room, had a COVID-19 outbreak, opened the dining room again and had a norovirus outbreak. CNA #5 was interviewed on 6/26/25 at 11:19 a.m. CNA #5 said the facility recently had a resident council meeting to discuss meal times and remind residents to go to the dining room. CNA #5 said she knew with certainty the dining room was open for breakfast and lunch. CNA #5 said she was not sure if the dining room was open for dinner on the weekends because she did not work that shift. The DON, the assistant director of nursing (ADON) and the regional clinical resource (RCR) were interviewed together on 6/26/25 at 11:52 a.m. The ADON said the main dining room was open for all meals every day of the week. The DON and the RCR said the dining room was open each meal every day of the week. The ADON said the facility had been trying to do education on it being open with both the facility staff and the residents. The ADON said the facility did a grand reopening of the dining room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services and assistance for bathing for two (#144 and #146) of three residents reviewed for ADLs out of 39 sample residents. Specifically, the facility failed to: -Provide bathing for Resident #144 to maintain the resident's personal hygiene; and, -Provide the necessary shower assistance for Resident #146, according to the resident's care plan. Findings include: I. Facility policy and procedure The Activities of Daily Living/Maintain Abilities policy and procedure, reviewed December of 2024, was provided by the director of nursing (DON) on 6/26/25 at 9:09 a.m. It read in pertinent part, It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services or support from staff to maintain. ADL documentation will be maintained in the electronic medical record (EMR) under tasks, care plan, assessments, and therapy documentation. ADLs will be care planned to reflect the residents' specific needs. II. Resident #144 A. Resident status Resident #144, age less than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included quadriplegia, C5-C7 (cervical vertebrae) complete (paralysis of all a person's limbs and body from the neck down), muscle wasting and atrophy and pressure ulcer of left buttocks unstageable. The 6/6/25 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. He was dependent on staff assistance for toileting hygiene, upper and lower body dressing, rolling, sitting to lying and lying to sitting, chair to bed transfers and toilet transfers. The resident was non ambulatory and was dependent on the use of a manual highback wheelchair. The MDS indicated the resident required substantial/maximal assistance with shower/bathing, however shower/bathing transfers were not attempted during the assessment look back period. B. Resident interview and observations Resident #144 was interviewed on 6/23/25 at 3:46 p.m. Resident #144 was seated in an electric wheelchair. The resident had facial stubble on his face. Resident #144 said he did not get very many showers. Resident #144 said he thought it was because the facility did not have a shower chair that would work for him because he needed a high back shower chair with side support. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #144's bathroom during the interview revealed the resident had a fold down shower bench in the shower. Resident #144 said he had a shower chair at home that his wife might be able to bring into the facility for him to use, but he said that would be difficult. On 6/25/25 at 11:03 a.m. the spa shower rooms on C-Hall and A-Hall were observed. The shower room on C-Hall was being utilized by the facility as the activities office with desks inside and activities supplies stored inside the room. The A-Hall shower room was being used as another office space with a desk and other medical equipment and supplies stored inside. C. Record review Resident #144's ADL self-care performance deficit care plan, initiated 6/6/25, revealed the resident had self-care performance deficits related to showers/bathing due to quadriplegia. Interventions included providing the resident with substantial/maximal assistance for bathing. Review of Resident #144's shower preference sheet revealed the resident was to receive a bed bath, twice weekly. The visual/bedside Kardex (a tool utilized by staff to provide consistent care for residents) report, dated 6/25/25, revealed Resident #144 needed substantial/maximal assistance with bathing and preferred bed baths on Tuesday/Friday evenings. -However, Resident #144 said he had a shower chair that he utilized at home (see resident interview above). Resident #144's bathing task records were reviewed from 6/5/25 (admission) to 6/25/25. The record revealed the resident was scheduled to bathe on Tuesday/Friday evenings and preferred bed baths. -The bathing task records revealed no documentation to indicate Resident #144 had received a bath or a shower from 6/5/25 to 6/25/25 (a period of 20 days). III. Resident #146 A. Resident status Resident #146, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included fracture of right femur neck (hip), fall and difficulty in walking. The 6/20/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required supervision or touching assistance with upper and lower body dressing, personal hygiene, bed mobility, transfers, walking with a walker and shower/bathing. B. Resident interview and observation Resident #146 was interviewed on 6/23/25 at 2:54 p.m. Resident #146 said she had to ask twice for a shower because the staff never offered her a shower. Resident #146 said on the third day she was at the facility she asked for a shower and the CNA said yes and got her a towel and then left the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. Resident #146 said she did the shower herself totally unsupervised by a staff member and then got herself dressed. Resident #146 said she was surprised the staff left her to take the shower by herself because she had come to the facility for care after a fall with a hip fracture at home and the staff had told her since admission that she should always ring her bell for assistance for walking into the bathroom using her walker. Resident #146 said the staff did not go over a bathing plan with her when she first admitted but she preferred a shower twice per week, and wanted the showers to be offered to her on her shower days. Resident #146 pointed at the instructions written on her white board in her room which said weight bear as tolerated, two wheeled walker, walk resident to the bathroom. Resident #146 said one CNA told her to take her shower and then she would be back, but the resident said the CNA never came back. C. Record review Resident #146's ADL self-care performance deficit care plan, initiated 6/15/25, revealed the resident had self-care performance deficits related to right hip pain, right femur/hip fracture, fall and difficulty in walking. Bathing interventions revealed the resident required supervision or touching assistance with bathing. Review of Resident #146's shower preference sheet revealed Resident #146 preferred a shower from female staff only on Tuesdays and Fridays during the day time. The visual/bedside Kardex report, dated 6/24/25, revealed Resident #146 needed supervision or touching assistance with bathing and her bathing preference was Tuesday/Friday day shift. Resident #146's bathing task records were reviewed from 6/14/25 (admission) to 6/24/25. The record revealed the resident was scheduled to bathe Tuesday/Fridays day shift. The bathing task records indicated Resident #146 had received three showers from 6/14/25 to 6/24/25. -However, the amount of assistance documented in the resident's bathing records revealed the staff only provided setup assistance, not the required supervision or touching assistance with bathing the resident was supposed to receive, according to the resident's care plan and Kardex (see above). IV. Staff interviews CNA #7 was interviewed on 6/25/25 at 11:19 a.m. CNA #7 said she worked at the facility as needed (PRN). CNA #7 said she knew how much assistance a resident required for ADLs by looking at the paper report sheet at the nurses' station because sometimes physical therapy had not done their evaluation yet. CNA #7 said there also was a white board in each of the residents' rooms that had notes about the assistance each resident needed. CNA #7 said the CNAs were responsible for completing the residents showers and after giving the showers she would document the shower in the resident's EMR in the task section. CNA #7 said the CNAs would ask the residents their shower preferences upon admission and fill out the resident's preference sheet. CNA #7 said she had not tried a shower or bath with Resident #144 but he probably required a hoyer lift or he got a bed bath. CNA #7 said if a resident could not sit steadily on the fold down shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bench in their rooms then they would give the resident a bed bath. CNA #7 said residents only had the shower bench available for showers because the spa rooms were not available for bathing use. CNA #7 said Resident #146 was just set up assistance for showers and she would let the CNAs know when she wanted a shower. -However, according to the care plan, the resident required supervision or touching assistance with showers (see record review above). CNA #6 was interviewed on 6/25/25 at 11:29 a.m. CNA #6 said she had worked at the facility fulltime for four years. CNA #6 said she knew how much assistance a resident needed with ADLs by looking at the Kardex in the computer and there was a communication board in the resident's room. CNA #6 said the CNAs completed the showers and documented them in the shower task section of the resident's EMR. CNA #6 said the spa rooms were offices so they only used the showers in the residents' rooms. CNA #6 said the CNAs filled out the residents' shower preference sheets when they were admitted to the facility. CNA #6 said that Resident #144 wanted an evening shower and he required a hoyer lift into the shower chair or he could have a bed bath. CNA #6 said she would chart Resident #144's showers/bed baths in the EMR however she had not personally given him any showers or baths. CNA #6 said she had given Resident #146 a shower and she required set up assistance. CNA #6 said she had given Resident #146 a shower three or four times and she only required a set up. -However, according to the care plan, the resident required supervision or touching assistance with showers (see record review above). Registered nurse (RN) #1 was interviewed on 6/25/25 at 11:39 a.m. RN #1 said the CNAs knew how much assistance a resident needs for ADLs by looking at the Kardex in the EMR. RN #1 said there was also a daily report sheet at the nurses' station that the CNAs had access to and the nurses would pass information regarding the residents down to the CNAs. RN #1 said she additionally used the white boards in the residents' rooms for communication and the white boards were updated daily. RN #1 said the shower preferences were obtained by the CNAs during the initial assessment of residents upon admission and put in the residents' hard paper charts. RN #1 said the CNAs completed the showers in the residents' own bathrooms because the spa bathrooms were not available for use. She said the CNAs charted in the residents' EMRs. RN #1 looked at the printed report sheet for Resident #144 and said the facility did have an appropriate shower chair for him but she was pretty sure he got a bed bath. RN #1 said Resident #144 would require maximal assistance with a hoyer lift using a shower chair or he would have maximal assistance with a bed bath. RN #1 said she was not sure how much assistance Resident #146 required because she did not usually work in that hall. RN #1 looked at the printed report sheet on the nurses' station and said Resident #146 required stand by assistance. -However, per the resident and CNA documentation, staff was not providing the resident with stand by assistance for showers (see above). (continued on next page)

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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 ensure one (#76) of three residents reviewed for activities out of 39 sample residents received an ongoing program of activities designed to meet the needs and interests, and promote physical, medical and psychosocial well-being. Specifically, the facility failed to ensure group were available for Resident #76 on the weekends per her preference. Findings include: I. Facility policy and procedure The Activities policy and procedure, revised December 2024, was received from the director of nursing (DON) on 6/26/25 at 1:29 p.m. It revealed 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 in. Daily activities, including those on weekends and holidays, are provided, as well as scheduled religious and social activities. However, residents are free to choose whether or not they wish to attend any activity or other scheduled event(s). II. Resident #76 A. Resident status Resident #76, age less than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included fracture of the left lower leg, hypertension (high blood pressure), depression and hypothyroidism (abnormal thyroid function). The 5/14/25 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 required moderate staff assistance with dressing, toileting, and transfers. She was independent with eating and personal hygiene. The MDS assessment revealed it was very important for her to do things with groups of people. B. Resident interview Resident #76 was interviewed on 6/24/25 at 9:21 a.m. She said there were no activities on the weekends that had group interactions. Resident #76 said she had to have her husband bring in a compact disc (CD) player from home as it was too quiet on weekends with nothing to do. Resident #76 said she preferred to do activities with other people to socialize and she was not getting much socialization from others on weekends. Resident #76 said other than the staff coming to her room for therapy or other needs, and if her husband came to visit she was in her room. Resident (continued on next page)

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Healthcare Resort of Colorado Springs, The	2818 Grand Vista Cir Colorado Springs, CO 80904

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#76 said she felt isolated in her room. Resident #76 said she did have an activities calendar in her room. The calendar indicated there was coffee and news on the weekend and she said no one attended it if they had it. Resident #76 said the other activities were listed as independent activities and she had to collect the supplies from the cabinet on her own. C. Record review The activities comprehensive care plan, revised 5/12/25, revealed Resident #76 enjoyed being with a group of people. It was very important to Resident #76 to do her favorite activities such as bingo, bible study, socializing, arts and crafts. On 6/26/25 at 9:29 a.m. the DON provided a copy of the facility June 2025 monthly activity calendar. It revealed the following activities for all Sundays for June 2025: -9:30 a.m. non denominational church; -10:30 front desk newspaper and coffee; and, -Coloring contest in dining room (independent activity) It revealed the following activities for all Saturdays for June 2025: -10:00 a.m. Individual bible study; -2:00 p.m. Main dining room brain teaser on activity cabinet; and, -3:00 p.m. Journaling (individual activity). III. Staff interviews The activities director (AD) was interviewed on 6/26/25 at 10:54 a.m. She said she was the only activities staff member. She said she worked Monday through Friday. The AD said they had two group activities every day during the week. The AD said on Sundays the activity schedule had a non-denominational church service in the multipurpose room where services were streamed in. The AD said coffee and news was completed by the receptionist or the manager on duty for the weekend. The AD said the last scheduled activity on Sunday was a coloring contest, an individual activity where residents could obtain materials from the cabinet in the main dining room. The AD said on Saturdays residents were able to do independent Bible study, brain teasers on the activity cabinet and journaling. The AD said these were all individual activities. The AD said beside coffee and news and church all activities on the weekend were considered independent. The social services consultant (SSC) was interviewed on 6/26/25 at 11:00 a.m. The SSC said the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager on duty should be assisting with activities on the weekend. The SSC said she would review the manager on duty check list to see if it was on their schedule to help with. The receptionist was interviewed on 6/26/25 at 11:15 a.m. She said she was responsible for answering the phone, managing packages/mail and assisting visitors. The receptionist said she did not assist with activities. IV. Facility follow up On 2/26/25 at 2:19 p.m. the SSC provided the manager on duty check list that had been modified (during the survey) to show the manager on duty was to assist with weekend activities.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for two (#60 and #74) of three residents reviewed for respiratory care out of 39 sample residents. Specifically, the facility failed to ensure that Resident #60 and Resident #74 received oxygen therapy in accordance with their physician's orders. Findings include: I. Facility policy and procedure The Oxygen Administration, Storage, and Handling policy, revised December 2024, was provided by the director of nursing (DON) on 6/26/25 at 9:28 a.m. It read in pertinent part, The purpose of this policy is to educate staff on the safety guidelines and usage requirements for medical gases and their cylinders. Upon orientation and annually thereafter, all staff shall be trained on the following: Oxygen therapy should be administered by the licensed nurse as ordered by the physician or as a nursing measure and as an emergency measure until the order can be obtained, proper use of oxygen tanks in the facility, and proper handling of oxygen tanks in the facility. II. Resident #60 A. Resident status Resident #60, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia, hyperlipidemia, anxiety disorder and depression. The 5/3/25 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 required set-up assistance with eating, moderate assistance with personal hygiene, maximum assistance with transfers, and toileting. The assessment revealed the resident was receiving oxygen therapy. B. Observations On 6/23/25 at 10:56 a.m. Resident #60's nasal cannula (tubing device that supplies oxygen through the nose) was in her nose, connected to a room oxygen concentrator with a setting of 5 liters per minute (LPM) of oxygen. On 6/24/25 at 3:15 p.m. Resident #60 was sitting in her recliner in her room. The nasal cannula was in the resident's nose and the oxygen concentrator was on and set at 5 LPM of oxygen. On 6/25/25 at 10:34 a.m. Resident #60 was sitting in a recliner in her room. The resident was connected to the oxygen concentrator via a nasal cannula in her nose, and the concentrator was set at 5 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPM of oxygen. C. Resident interview Resident #60 was interviewed on 6/24/25 at 3:16 p.m. Resident #60 said she used oxygen continuously at all times. She said she was on 4 LPM of oxygen but she did not know what oxygen setting her oxygen concentrator was currently set on. D. Record review The oxygen therapy care plan, initiated 4/30/24 and revised 5/4/24, revealed Resident #60 required oxygen related to ineffective gas exchange, coronary artery disease, and COPD. Interventions included providing oxygen therapy as ordered by the physician, monitoring for difficulty breathing, oxygen settings via nasal cannula up to 4 LPM continuously to keep oxygen saturations (level of oxygen in the blood) at or above 90 percent (%). -A review of Resident #60's electronic medical record (EMR) revealed no documentation to indicate how many LPM of oxygen the resident was receiving. Review of Resident #60's June 2025 CPO revealed a physician's order for oxygen up to 4 LPM via nasal cannula continuously to keep the resident's oxygen saturation levels at or above 90%, ordered on 4/17/25. -However, observations on 6/23/25, 6/24/25 and 6/25/25 revealed Resident #60 was receiving 5 LPM of oxygen, not 4 LPM as was ordered by the physician (see observations above). III. Resident #74 A. Resident status Resident #74, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included COPD, acute and chronic respiratory failure with hypoxia (deficiency for oxygen reaching the brain), anxiety, depression, muscle weakness and acute systolic heart failure. The 5/7/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. She required maximum assistance from staff with personal hygiene, and was dependent on staff assistance for mobility, transfers and toileting. The assessment revealed the resident was receiving oxygen therapy. B. Observations On 6/23/25 at 11:05 a.m. Resident #74 was lying in her bed watching a television show with an oxygen mask attached to her nose. The oxygen concentrator was on and attached to the oxygen mask. The resident's oxygen concentrator was set to 6 LPM of oxygen. On 6/24/25 at 3:25 p.m. Resident #74 was in bed with her eyes closed and her oxygen mask on. The oxygen concentrator was set at 6 LPM of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 10:45 a.m. Resident #74 was awake, lying in bed with her oxygen mask on and her oxygen concentrator was set at 6 LPM of oxygen. C. Resident interview Resident #74 was interviewed on 6/25/25 at 10:46 a.m. Resident #74 said she required oxygen at all times due to her diagnosis of COPD. She said her oxygen order was for 5 LPM of oxygen and she believed that was what the oxygen concentrator was set on. Resident #74 said the staff checked her oxygen saturation levels in the morning. D. Record review The oxygen therapy care plan, initiated 5/1/25, revealed Resident #74 had oxygen therapy related to ineffective gas exchange and COPD. Interventions included providing oxygen therapy as ordered by the physician, head of bed to be elevated (semi-Fowler's to Fowler's position or resident out of bed upright in a chair during episodes of difficulty breathing, and monitoring for signs and symptoms of acute respiratory insufficiency. The care plan oxygen settings documented to apply oxygen via high flow nasal cannula (HFNC) up to 10 LPM. Care plan revised on 5/5/25. -However, a review of the physician's order revealed Resident #74 had a physician's order for up to 5 LPM of oxygen continuously to keep oxygen saturations at or above 90%, order date 5/18/25. A review of the resident's EMR revealed Resident #74's oxygen saturation levels ranged between 91% to 99%. IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/25/25 at 12:00 p.m. CNA #1 said the unit nurse would communicate a change of the resident's oxygen liter flow to the CNAs for monitoring purposes. She said CNAs were not permitted to change the oxygen liter flow of residents' oxygen concentrators. CNA #1 said she did not check Resident #60's oxygen concentrator when getting the resident up in the morning (6/25/25). She said she forgot to and would try to remember the next time. Licensed practical nurse (LPN) #2 was interviewed on 6/25/25 at 11:54 a.m. LPN #2 said Resident #60's physician's order indicated the resident was to receive up to 4 LPM of oxygen , and Resident #74 physician's order indicated the resident was to receive up to 5 LPM flow of oxygen. The LPN confirmed that Resident #60 and #74 were both on an incorrect LPM of oxygen. LPN #2 said she did not check the liter flows of oxygen for Resident #60 or Resident #74 during her morning rounds. LPN #2said it was important to follow the physician's order because oxygen was considered a form of medication. The DON was interviewed on 6/25/25 at 2:14 p.m. The DON said a physician's order was to be followed because oxygen was a form of medication. She said it was the facility's policy for staff to ensure all oxygen orders were followed. The DON said only nurses were able to change the liter flow of oxygen if necessary and informed the physician of changes in times of emergencies. The DON said receiving too much or too little oxygen could result in medical complications for residents. She said she would immediately conduct facility-wide oxygen audits and provide education to all nursing staff to ensure all residents' oxygen physician's orders were followed appropriately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%). Specifically, the facility had a medication error rate of 7.14%, which was two errors out of 28 opportunities for error. Findings include I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. According to the Voltaren gel package insert, retrieved on 6/30/25, from https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/022122s006lbl.pdf, The proper amount of Voltaren Gel should be measured using the dosing card supplied in the drug product carton. The dosing card is made of polypropylene, like the tube cap containing Voltaren Gel, but without the white colorant. The dosing card should be used for each application of a drug product. The gel should be applied within the oblong area of the dosing card up to the 2 gram (g) or 4 gram line (2 g for each elbow, wrist, or hand, and 4 g for each knee, ankle, or foot). The dosing card containing Voltaren Gel can be used to apply the gel. The hands should then be used to gently rub the gel into the skin. After using the dosing card, hold with fingertips, rinse, and dry. II. Facility policy and procedure (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration policy and procedure, revised December of 2024, was received from the director of nursing (DON) on 6/26/25 at 1:29 p.m. It revealed 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. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR). III. Observations and staff interviews On 6/24/25 at 9:01 a.m. licensed practical nurse (LPN) #3 was preparing and administering medications to Resident #194. LPN #3 dispensed a 7.5 milligram (mg) tablet of meloxicam (non-steroidal anti-inflammatory). The physician's order read Meloxicam 7.5 mg tablet, give 0.5 tablet by mouth one time a day for osteoarthritis. Cut the pill in half for a 3.75 mg dose. LPN #3 was prompted to review the medication she had dispensed prior to medications being administered to Resident #194. LPN #3 then identified she should have cut the meloxicam tablet in half to acquire the correct dose ordered. LPN #3 took the tablet and cut it in half using a tablet cutter. LPN #3 said the correct dose of a medication was part of the rights of medication administration. -LPN #3 failed to correctly dispense the correct dose of meloxicam without prompting. On 6/24/25 at 3:27 p.m. certified nurse aide with medication aide authority (CNA-Med) #1 was preparing medications for Resident #47. CNA-Med #1 dispensed Voltaren gel directly from the tube into a 30 milliliter (ml) medication cup. The physician's order read Voltaren External Gel 1 %, apply 2 grams (gm) to shoulders topically four times a day for pain ordered on 6/13/25. Observation of the medication cup revealed the medication filled the medication cup to just below the 2.5 ml line, which was the smallest measurement on the cup. CNA-Med #1 said 2 ml was equal to 2 gm. CNA-Med #1 said she dispensed less than 2.5 ml based on observation of medication in the cup so it was the correct amount per the order. CNA-Med #1 said the Voltaren gel was a house stock item and was used for multiple residents, which was why she dispensed it into the medication cup. CNA-Med #1 said she was not sure of the manufacturer's dispensing methods (see professional reference above) to ensure proper dose was administered. CNA-Med #1 dispensed the Voltaren gel using the manufacturer's dispensing card to the two gram mark and placed it into a new medication cup. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The two medication cups were observed side by side. The medication with the correct dose had less medication in the cup compared to the medication cup that was incorrectly dispensed. -CNA-Med #1 failed to accurately dispense the Voltaren gel according to manufacturer's guidelines and physician's order. III. Additional staff interviews The DON was interviewed on 6/24/25 at 4:10 p.m. She said anyone who was administering medications were to follow the seven rights of medication administration; right patient, medication, dose, time, route, documentation and diagnosis. The DON said the rights were important to ensure residents were getting the correct medication ordered by the physician and to prevent medication errors. The DON said Voltaren gel needed to be dispensed onto a strip to measure out the correct dose. The DON said the facility provided paper strips for Voltaren gel to be dispensed onto for the nurses to utilize for individual resident use. The pharmacist was interviewed on 6/26/25 at 1:00 p.m. She said meloxicam was a non steroidal anti-inflammatory drug that could cause an increase of a gastrointestinal bleeding if too much was given. The pharmacist said Voltaren gel should be measured using the dosing card that came in each box to ensure the correct dose was administered. The pharmacist stated that too much Voltaren gel could cause an increase in gastrointestinal bleeding.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly according to professional standards in two of four medications carts and one of one vaccine storage refrigerators. Specifically, the facility failed to: -Ensure vaccinations were not stored in dormitory style refrigerator; -Ensure expired vaccines were removed from refrigerators; -Ensure Tubersol (used to test for tuberculosis) vials were dated upon opening; -Ensure medication carts were clean from loose pills; and, -Ensure medications were stored according to route. Findings include: I. Professional reference According to the Vaccine Storage and Handling Tool-kit, dated 3/29/24, retrieved on 6/30/25, from https://www.cdc.gov/vaccines/hcp/downloads/storage-handling-toolkit.pdf, it revealed in pertinent part, Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances. These units have a single exterior door and an evaporator plate/cooling coil, usually located in an icemaker/freezer compartment. These units pose a significant risk of freezing vaccines even when used for temporary storage. According to the Tuberculin Purified Protein Derivative Tubersol package insert, retrieved on 6/30/25 from https://www.fda.gov/media/74866/download It revealed in pertinent part A vial of Tubersol which has been entered and in use for 30 days should be discarded. II. Facility policy and procedure The Storage of Medications policy and procedure, dated 10/1/23, was received from the director of nursing (DON) on 6/26/25 at 1:29 p.m. It revealed in pertinent part Medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. All medications dispensed by the pharmacy were stored in the container with the pharmacy label. Orally administered medications were kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products. Eye medications were stored separately per facility policy. Except for those requiring refrigeration or freezing, medications intended for internal use were stored in a medication cart or other designated area. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were immediately removed from inventory, disposed of according to procedures for medication disposal. Medication storage areas were kept clean, well-lit, and free of clutter and extreme temperatures and humidity. Medication storage conditions were monitored on a monthly basis by the consultant pharmacist and corrective action taken if problems were identified. Refrigerated medications were kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods such as employee lunches and activity department refreshments were not stored in this refrigerator. Medications requiring refrigeration were kept in a refrigerator at temperatures between 36 degrees fahrenheit (F) and 46 F were refrigerated unless otherwise directed on the label. The facility should maintain a temperature log in the storage area to record temperatures at least once a day. The facility should check the refrigerator or freezer in which vaccines were stored, at least two times a day, per CDC (Centers for Disease Control and Prevention) guidelines. III. Vaccine storage A. Observations On 6/26/25 at 10:38 a.m. the vaccine refrigerator was observed with the infection preventionist (IP) and the DON. There was no thermometer in the refrigerator upon opening. The vaccine fridge constrained the following: -Two COVID-19 vaccine comirnaty that expired on 4/17/25; -Two vials of Prevnar 20 0.5 milliliter (ml) that expired in February 2025; -Four boxes (10 vials each) totaling 40 doses of Influenza Vaccine FLUAD (Influenza Vaccine, Adjuvanted) which expired on 4/19/25; -One vial of Tubersol with no open date; and, -Three boxes (ten vials each) of Afluria flu vaccine totalling 30 doses. -The facility failed to monitor temperatures of vaccines stored and failed to remove expired medications timely. The vaccine refrigerator was also observed to be a dormitory style refrigerator (see professional reference above). -The facility failed to store vaccines in a refrigerator approved for vaccine storage. B. Staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and the IP were interviewed on 6/26/25 at approximately 10:40 a.m. during observation of the vaccine refrigerator. She said temperature monitoring was important to ensure vaccines were kept at appropriate temperatures. The IP said storage was important to help ensure the effectiveness of a vaccine. The IP was unaware that vaccines were not to be stored in a dormitory style refrigerator. The IP said the Tubersol should have been dated upon opening to ensure it was not used past the use by date once opening. The IP said she was unaware how many days it was good for once the vial of Tubersol was opened. The DON said she was unaware the IP stored vaccines in her office. The DON said she was unaware vaccines could not be stored in a dormitory style refrigerator. The DON said they would get a thermometer placed in the refrigerator immediately. The DON took all expired vaccines and the open Tubersol with her for disposal. IV. Medication cart A. Observations On 6/25/25 at 4:47 pm the Granada medication cart was observed with licensed practical nurse (LPN) #1. The medication cart had three boxes of Estradiol vaginal cream 0.1 (milligram/ per gram (mg/gm) stored in the same compartment as inhalers and nasal sprays. There were three tubes of clobetasol propriate (used to treat skin irritations) 0.05% cream stored next to inhalers and nasal sprays. -The facility failed to ensure creams were not stored with inhalers/nasal sprays. The Granada cart also had six tablets and two capsules loose within the medication drawers. -The facility failed to keep the medication cart clean. On 6/25/25 at 5:10 p.m. the Oasis medication cart was observed with LPN #2. The cart had two open Aspercream cream 4 % lidocaine (topical pain relief) patches open in the box (no longer in original manufactured foil packaging). -The facility failed to ensure medications were kept in original packaging. B. Staff interviews LPN #1 was interviewed on 6/25/25 at 4:47 p.m. during observations of the [NAME] medication cart. She said medications should be stored according to their route to prevent contamination of medications or the exposure of one route to another route a medication was not used for. LPN #1 said it was the responsibility of all staff administering medications to keep the medication cart clean. LPN #2 was interviewed on 6/25/25 at 5:10 p.m. during observation of the Oasis medication cart. She said medications were to be stored in the original packaging till ready to administer. LPN #2 said the Aspercream 4% lidocaine patches were no longer in their original packaging and they should have been disposed of when not used. V. Additional staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pharmacist was interviewed on 6/26/25 at 1:00 p.m. She said vaccines should be stored in a refrigerator between 37 to 47 degrees F and temperature monitoring should occur 1 one to two times a day. The pharmacist said expired medications or vaccines should be removed as soon as possible to prevent administration of an expired medication. The pharmacist said medications should be stored according to the route of administration to ensure there was no cross contamination and to prevent medication from being administered incorrectly. The pharmacist said all medications should be stored in original packaging to ensure effectiveness. The pharmacist said Aspercream patches were sticky and if not stored properly would be less effective in sticking to the resident and it would affect the delivery of medication. The pharmacist said vials should be dated when open as medications were only good for so many days once opened. The pharmacist said using a medication passed its best use by date decreases the effectiveness of the medication.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure physician ordered laboratory services were provided in a timely manner for one (#12) of two residents reviewed for laboratory services out of 39 sample residents. Specifically, the facility failed to ensure timely follow-up for Resident #12's urine sample, which was sent to the laboratory (lab) without being labeled with the resident's identifying information. Findings include: I. Facility policy and procedure The Laboratory Services and Reporting policy and procedure, revised December 2024, was provided by the director of nursing (DON) on 6/26/25 at 1:37 p.m. It read in pertinent part, The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the timeliness of the [laboratory] services. II. Resident #12 A. Resident status Resident #12, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included diabetes, chronic obstructive pulmonary disease (COPD) and benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland) without lower urinary tract symptoms. The 5/15/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented the resident was dependent for toileting hygiene and independent for most other activities of daily living (ADL). The assessment documented the resident was occasionally incontinent of both bowel and bladder. B. Record review The incontinence care plan, revised 9/25/24, revealed Resident #12 was occasionally incontinent of bladder and always incontinent of bowel. Pertinent interventions included assisting with toileting as needed, checking as required for incontinence and monitoring/documenting any signs or symptoms of a urinary tract infection (UTI). Review of Resident #12's June 2025 CPO revealed the following physician's orders: Urinalysis with culture and sensitivity, if indicated, for dysuria, ordered 6/19/25 at 4:17 p.m. Ciprofloxacin (antibiotic medication) 500 milligram (mg) tablets, give one tablet by mouth every 12 hours for UTI for five days, ordered 6/25/25 at 11:40 a.m. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 6/20/25 at 8:47 a.m., revealed Resident #12 complained of burning with urination. Resident #12's urine was yellow and cloudy and the nursing staff were unable to tell if the urine had a foul odor. An order for a urinalysis was noted from Resident #12's physician. Review of Resident #12's June 2025 treatment administration record (TAR) revealed the urinalysis with culture if indicated was marked as completed on 6/20/25 at 1:57 p.m. A lab result report, dated 6/21/25 at 1:17 a.m., revealed the facility's outside laboratory received a urine sample from the facility for Resident #12 on 6/21/25 at 1:03 a.m. The report documented the urine sample was collected from Resident #12 on 6/20/25 at 9:46 a.m. with a physician's order for a urinalysis with culture and sensitivity. The report documented the urine sample was not labeled with Resident #12's information. The report did not indicate that the urine sample had been run for a urinalysis with culture and sensitivity A progress note, dated 6/20/25 at 3:57 p.m., revealed Resident #12 requested oxycodone (pain medication) for pain related to a UTI. A progress note, dated 6/23/25 at 4:14 p.m., revealed Resident #12 requested oxycodone for bladder and penis pain. A progress note, dated 6/24/25 at 6:33 a.m., revealed Resident #12 requested oxycodone for bladder and penis pain. A progress note, dated 6/24/25 at 5:04 p.m., revealed Resident #12 requested Tylenol Extra Strength (pain medication) for bladder and penis pain. A progress note, dated 6/24/25 at 5:05 p.m., revealed Resident #12 requested oxycodone for bladder and penis pain. A change in condition note, dated 6/25/25 at 10:32 a.m., revealed Resident #12 had a change in condition due to dysuria (pain or discomfort during urination), cloudy urine and urinary frequency. Resident #12's physician and representative were notified of the resident's change in condition at that time. An infection surveillance assessment, dated 6/25/25 at 12:31 p.m., revealed Resident #12 had an onset of symptoms including acute dysuria, cloudy urine and increased urinary frequency on 6/24/25. The assessment documented Resident #12's physician was notified on 6/24/25 and a urinalysis was ordered at that time. The urinalysis results returned on 6/25/25 and revealed multiple out of range findings. The culture and sensitivity report results were still pending. The resident's physician was contacted and ordered antibiotic therapy for Resident #12 for a UTI. Not all criteria were met for antibiotic usage, but the order was clarified with the physician who said to continue with the order for antibiotic therapy. -However, Resident #12's UTI symptom onset was documented earlier in the progress notes (on 6/20/25), and a urinalysis was initially ordered on 6/19/25 and documented as obtained on 6/20/25 (see physician's orders and progress note above). -Review of the progress notes did not reveal documentation to indicate the reason that a second urinalysis was ordered on 6/24/25 or that an initial urinalysis had already been collected on 6/20/25. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 6/21/25 (a Saturday). LPN #1 was interviewed a second time on 6/25/25 at 4:13 p.m. LPN #1 said she spoke with Resident #12's physician and he wanted to start antibiotics as soon as possible. LPN #1 said she initiated a change of condition for Resident #12 and administered his first dose of antibiotic. LPN #1 said Resident #1 had multiple urinary symptoms including dysuria and urinary frequency. LPN #1 said Resident #12 reported he was having shooting pain in his legs from the UTI and had pain medication orders already. LPN #1 said it was important to get lab results back as soon as possible so they could start treatment if needed. LPN #1 said she had spoken with the DON who told her some of Resident #12's urine samples were contaminated so the facility had to recollect the urine sample. The assistant director of nursing (ADON) was interviewed on 6/25/25 at 9:57 a.m. The ADON said she spoke with Resident #12 and he reported the facility collected two urine samples. The ADON said Resident #12 first gave a urine sample on 6/20/25 and another one on 6/24/25. The ADON said the urine sample recollection occurred because the urine sample collected on 6/20/25 had sat too long before being tested. The DON, the ADON and the regional clinical resource (RCR) were interviewed together on 6/26/25 at 11:30 a.m. The DON said it was impossible to get an uncontaminated free catch urine sample from Resident #12 due to his anatomy, so part of the issue was the urine samples being contaminated. The DON said Resident #12 had mild discomfort noted in his EMR. The DON said she spoke with the ADON and the ADON said the original sample was contaminated. The DON said Resident #12 went out of the facility often during the day. The DON said Resident #12 would frequently go out of the facility and that was the only reason she could think of for the delay between the first urine sample being collected on 6/20/25 and the second one collected on 6/24/25. The RCR asked the DON and the ADON if anyone from the facility had contacted the lab to follow-up on the fax received by the facility on 6/21/25, however neither the DON nor the ADON verbalized a response. The DON and the RCR were interviewed together again on 6/26/25 at 12:57 p.m. The RCR said Resident #12's first urine sample (from 6/20/25) was contaminated, but Resident #12 kept signing out of the facility so they had to attempt to recollect the sample multiple times. The RCR said there was no documentation in the resident's medical record of any other attempts to recollect the resident's urine sample. The RCR said whenever the facility received a fax from the outside lab they typically gave it to the facility's lab technician. The DON said she did not know if anyone from the facility contacted the lab after the fax on 6/20/25 regarding the unlabeled urine sample for Resident #12 was sent to them. The DON said she did not know if there was a set timeframe for when the facility needed to respond to a fax from the lab.

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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: -Thaw meat in a safe manner; and, -Ensure jewelry was not worn during food preparation and meal service. Findings include: I. Failed to thaw meat in a safe manner A. Professional reference The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 6/30/25. It read in pertinent part, Time/temperature control for safety food shall be thawed completely submerged under running water with sufficient water velocity to agitate and float off loose particles in an overflow. (3-501.13) B. Facility policy and procedure The Safe Thawing Practices policy and procedure, revised September 2017, was received from the regional dietary consultant (RDC) on 6/26/25 at 11:42 a.m. It read in pertinent part, Thaw items in clean water. When water is running, it should be running fast enough to agitate any loose particles. C. Observations During a continuous observation of the lunch meal service on 6/25/25, beginning at 10:13 a.m. and ending at 12:48 p.m. the following was observed: At 10:15 a.m. three bags of raw frozen chicken cutlets were submerged in water in the kitchen sink. The faucet was not on and the bags of chicken were not under running water. All of the chicken cutlets were in their original plastic packaging. At 10:57 a.m. the dietary manager (DM) turned the sink faucet on and adjusted the flow of water and the drain opening. At 11:08 a.m. the three bags of chicken cutlets were in the kitchen sink and the water in the sink had completely drained. A slow trickle of water came out of the sink faucet and hit one corner of one of the bags of cutlets. At 11:18 a.m. the DM turned the sink faucet so the water flowed faster and pressed on the bags of chicken several times. At 11:23 a.m. the sink was filled with water but the bags of chicken cutlets were not completely (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	submerged by the water. The faucet had a steady flow of water flowing onto one of the bags of chicken. The top side of each of the bags (approximately eight inches by 11 inches of surface area) of chicken cutlets was not covered by water. At 11:26 a.m. the kitchen sink was overflowing with water and spilling onto the floor. Dietary aide (DA) #1 adjusted the sink drain. At 11:45 a.m. the three bags of chicken cutlets were sitting completely submerged in water in the sink. No water was running from the faucet. At 11:47 a.m. the RDC turned on the faucet for the sink containing the chicken cutlets. At 11:50 a.m. the RDC told the DM they may need to thaw the chicken cutlets in a different manner. The DM told the RDC the chicken cutlets were for dinner that night. The DM removed the bags of chicken cutlets from the sink, placed them into a plastic bin and placed them in the walk-in refrigerator. D. Staff interviews The RDC and the DM were interviewed together on 6/26/25 at 9:54 a.m. The DM said when meat was thawing in the sink it should be under running water. The RDC said meat thawed in the sink could be in its original packaging under running water. The RDC said the chicken cutlets were in the walk-in cooler but were frozen solid, so the dietary staff placed it under running water. The RDC said someone had shut the water off, so she turned it back on. The RDC said the dietary staff ideally did not thaw meat in the sink, but she provided education on thawing practices for the dietary staff. The RDC said meat thawed in the sink did not need to be completely submerged in water but needed to maintain a constant water flow. II. Failure to ensure jewelry was not worn during food preparation and service A. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 6/30/25. It read in pertinent part, Except for a plain ring such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. (2-303.11) B. Facility policy and procedure The Sanitary Standards Dietary Personnel policy and procedure, revised July 2016, was received by the RDC on 6/26/25 at 11:42 a.m. It read in pertinent part, Dietary personnel are not permitted to wear costume jewelry, large dangling earrings or rings with stones while on duty. Jewelry may include a wristwatch, wedding band, and post earrings. B. Observations During a continuous observation of the lunch meal service on 6/25/25, beginning at 10:13 a.m. and ending at 12:48 p.m. the following was observed: At 10:13 a.m. cook (CK) #1 was wearing a watch and a fashion dangly chain bracelet on his left (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wrist, a plain band ring on his right index finger and a plain band ring on his left ring finger. At 11:34 a.m. CK #1 began plating meals for the lunch service. CK #1 was still wearing the items of jewelry above. At 12:08 p.m. CK #1 used hand sanitizer to perform hand hygiene. While rubbing his hands with the sanitizer, CK #1's ring fell off of his index finger and onto the tray line near one of the steam table bins of food. CK #1 picked the ring up and placed it into his pocket before continuing to plate food. C. Staff interviews The RDC and the DM were interviewed together on 6/26/25 at 9:54 a.m. The DM said the dietary staff should not wear any jewelry aside from a small wedding band. The RDC said a wedding band was appropriate to wear, and a watch was fine. The RDC said the dietary staff tried to avoid wearing excess jewelry while on duty. The RDC said she and the DM both saw CK #1 was wearing a bracelet during lunch service the day prior. The RDC said CK #1's bracelet did not come off and was not able to be removed. The RDC said she provided education on the topic of jewelry with the dietary staff the day prior (6/25/25). The DM said he and the RDC were going to get together to figure out what education to give CK #1 since his bracelet could not be removed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** IV. Resident #60 A. Resident status Resident #60, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia, hyperlipidemia, anxiety disorder and depression. The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required set-up assistance with eating, moderate assistance with personal hygiene, maximum assistance with transfers, and toileting. The resident was receiving oxygen therapy. The assessment indicated the resident was not receiving hospice services. B. Record review Review of the [DATE] CPO revealed Resident #60 was admitted to hospice services related to her diagnosis of COPD on [DATE]. -Review of Resident #60's comprehensive care plan, revised on [DATE], revealed the care plan did not indicate the resident was receiving hospice services. The care plan did not include a delineation of care between the facility and the hospice company. C. Staff interviews CNA #1 was interviewed on [DATE] at 12:23 p.m. CNA #1 said she knew Resident #60 was receiving hospice care. She said when a resident received hospice services, a care plan should be implemented. CNA #1 said when a resident was on hospice services, there was typically a hospice binder. She said she did not know where the hospice binder for Resident #60 was located. CNA #1 said she provided basic care for Resident #60, such as repositioning, turning the resident, assisted with transfers out of bed, and basic hygiene. She said the hospice staff came in frequently, but she did not remember the days the hospice team came in to visit the resident. LPN #2 was interviewed on [DATE] at 12:35 p.m. LPN #2 said anytime a resident was placed on hospice care, a care plan should be implemented. She said when a resident was admitted to hospice services, she initiated a care plan revision. She said the minimum data set coordinator (MDSC) also updated the care plan. She said she did not know what Resident #60's goals were for care and treatment at the end of life. She said she was not aware that a care plan was not initiated for Resident #60 and did not know why. The regional clinical resource (RCR) was interviewed on [DATE] at 11:48 a.m. The RCR said a hospice care plan should have been developed detailing what care the facility would provide and the role of hospice. She said the facility staff should have been educated on their role and also on where to find information related to hospice care. The RCR said the resident's care plan was not updated when she was admitted to hospice services. She said she would ensure the care plan was updated. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on [DATE] at 2:14 p.m. The DON said Resident #60 had been on hospice care since [DATE] and should have had a hospice care plan implemented. She said the resident should have a hospice-initiated care plan and a facility-initiated care plan. She said she knew Resident #60 was receiving hospice services. She said she did not know that a care plan for the resident's hospice services was not implemented, and it was an issue that she was looking forward to establishing a better communication link with outside agencies to improve the services the facility provides. She said the MDSC and nursing staff were responsible for updating the care plans. The DON said she would ensure the resident's care plan was updated immediately. MDSC #1 and MDSC #2 were interviewed together on [DATE] at 12:12 p.m. MDSC #1 said they were responsible for updating the comprehensive care plans when there was a significant change of condition of a resident. She said she would look at the physician's orders and go by them to determine what needed to be updated on the residents' care plan. MDSC #1 and MDSC #2 said they knew Resident #60 was placed on hospice services from their morning team meeting and should have followed up with the hospice service to determine their role and update the resident's care plan. They said they would ensure the updates were completed immediately. Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for two (#24 and #60) of two residents reviewed for hospice services out of 39 sample residents. Specifically, the facility failed to: -Ensure the hospice agency notes regarding Resident #24's care were easily accessible to the facility staff in an attempt to effectively coordinate care with the hospice agency; and, -Ensure the comprehensive care plan for Resident #60 was updated in a timely manner for a resident who was admitted to hospice services. Findings include: I. Facility policy and procedure The End of Life Care policy and procedure, revised [DATE], was received from the director of nursing (DON) on [DATE] at 1:29 p.m. It read in pertinent part, On admission of a resident with a terminal diagnosis, or when a change in diagnosis or prognosis indicates a terminal condition, a palliative care assessment will be conducted by the interdisciplinary team. A care plan will be developed based on the individualized assessments, the desires of the resident/surrogate decision-maker, and the physician's orders. Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan. Collaboration with hospice will include processes for orienting staff to facility policies and procedures which may include documentation and record-keeping requirements. The MDS (minimum data set assessment) will be updated per regulations. Significant change in status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065417	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Resort of Colorado Springs, The	2818 Grand Vista Cir Colorado Springs, CO 80904

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments may be deferred once identification of end-stage disease status is made unless the significant change is unrelated to the terminal illness. II. Facility-Hospice contract The contract between the facility and the hospice services company, dated [DATE] was provided by the DON on [DATE] at 8:51 a.m. It read in pertinent part, Facility shall provide orientation on the policies and procedures of the facility including record-keeping requirements to hospice staff furnishing care to hospice patients. The hospice and facility agree to develop a plan of communication for each hospice patient and further agree as required by state or federal regulations, to enter all necessary information into the patients' medical chart. III. Resident #24 A. Resident status Resident #24, age greater than 65, was admitted on [DATE] and expired on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included sepsis, dementia and polyneuropathy. The [DATE] minimum data set (MDS) assessment documented 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 most activities of daily living (ADL). The MDS assessment documented the resident was not receiving hospice services. -However, record review revealed the resident admitted to hospice services on [DATE] (see record review below). B. Record review The [DATE] CPO revealed a physician's order for Resident #24 indicating the resident was admitted to hospice services on [DATE] due to his diagnosis of senile degeneration of the brain. The hospice care plan, revised [DATE], revealed Resident #24 was admitted to hospice due to a terminal prognosis from senile degeneration of the brain. Pertinent interventions included having hospice certified nurse aides (CNAs) and registered nurses (RNs) come in twice per week and the hospice chaplain come in as needed, and to work cooperatively with Resident #24's hospice team to ensure his spiritual, emotional, intellectual, physical and social needs were met. A hospice notebook was provided by licensed practical nurse (LPN) #5 on [DATE] at 1:20 p.m. Review of the notebook revealed a hospice staff sign-in page with one visit from the hospice social worker, dated [DATE]. -However, the notebook did not reveal any documentation from the hospice nursing staff regarding their visits and the care they provided. A progress note, dated [DATE] at 2:58 p.m., revealed hospice staff were at the facility to admit (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24. A progress note, dated [DATE] at 9:15 a.m., revealed Resident #24 did not want to take his prescribed morphine (pain medication) as it caused him to itch. Resident #24's hospice nurse had discussed getting an order for hydroxyzine (anti-itch medication) for itching the week prior. The facility had not received a prescription at that time. Resident #24 also requested an order for naproxen (pain medication). The facility staff member called Resident #24's on-call provider regarding morphine and naproxen. A progress note, dated [DATE] at 9:50 a.m., revealed Resident #24 requested morphine for pain after a hospice staff member gave him a bed bath. -Review of Resident #24's electronic medical record (EMR) failed to reveal any other progress notes from the hospice services provider. C. Staff interviews CNA #2 was interviewed on [DATE] at 2:26 p.m. CNA #2 said the hospice nurses and CNAs came in to visit Resident #24 twice per week. CNA #2 said the hospice staff bathed Resident #24 and attended to more acute issues like adjusting his wedge positioning pillows. CNA #2 said the hospice staff verbally briefed the nurse on the unit or the CNAs of what care they provided Resident #24 as they were leaving. CNA #2 said there was not any written documentation of what care the hospice staff provided Resident #24 during their visits. LPN #5 was interviewed on [DATE] at 3:21 p.m. LPN #5 said the hospice CNAs had visited and bathed Resident #24 that morning ([DATE]) and his nurse had come in the day prior. LPN #5 said a hospice staff member visited Resident #24 every other day. LPN #5 said the hospice staff told the facility's nursing staff what care they provided at the end of their visit. LPN #5 said she signed documents for the hospice staff confirming the care they provided at each visit, and that the hospice staff kept documentation of what care they provided. -However, documentation of what care was provided by the hospice staff for Resident #24 was not in the resident's EMR (see record review above). LPN #1 was interviewed on [DATE] at 9:13 a.m. LPN #1 said any documentation by the hospice CNAs or nurses would be kept in Resident #24's hospice binder. LPN #1 reviewed Resident #24's hospice binder and said the hospice nursing staff signed in on the sign-in sheet. LPN #1 said she knew the hospice staff had visited Resident #24 more than what was recorded on the sign-in sheet (see record review above). LPN #1 said the hospice nursing staff gave a verbal report of what care they provided Resident #24 before they left, and the nurse on duty needed to document any showers that were given in the resident's EMR so the next nursing shift would know. CNA #3 was interviewed on [DATE] at 2:38 p.m. CNA #3 said the hospice staff bathed Resident #24, washed his hair and shaved his face as needed. CNA #3 said she thought the hospice staff kept their own documentation and told the facility nurse what care they provided Resident #24, but the facility staff charted any baths the resident received in his EMR. The executive director (ED) of the hospice provider was interviewed on [DATE] at 4:58 p.m. The ED said Resident #24 received two visits from a hospice CNA and one visit from a hospice nurse each (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	week. The ED said a hospice chaplain and a social worker visited Resident #24 once per month. The ED said she had spoken with the nurse who worked with Resident #24, and was told the nurse checked in verbally with one of the facility nurses or the facility social worker before leaving. The ED said there were no forms or documents filled out for the facility that she was aware of. The ED said the facility's processes of communication were a grey area. The DON was interviewed on [DATE] at 11:30 a.m. The DON said she had looked through her emails to see if she had received any documentation or communication from the hospice provider but could not find any. The DON said she had recently talked with a liaison from the hospice provider about how to improve communication. The DON said there was verbal communication between the hospice nursing staff and the facility nursing staff, and new orders were added to Resident #24's hospice binder. The DON said in the past they had a process where the hospice company would email any notes to the facility's medical records department who would then upload the documents to the resident's EMR. The DON said the hospice notes were needed to implement interdisciplinary care for the residents. -However, review of Resident #24's EMR and hospice binder did not contain any hospice visits or any documentation aside from the hospice social worker visit (see record review above). The assistant director of nursing (ADON) was interviewed on [DATE] at 11:52 a.m. The ADON said she had noticed the previous Friday ([DATE]) that the facility was having communication issues with their hospice providers. The ADON said she met with the hospice provider earlier that day to improve their communication. The ADON said the hospice providers were not signing in when they came to the facility. The ADON said the facility currently had verbal communication between the hospice providers and the facility nursing staff. The ADON said she would prefer to have all of the care information written in the resident's medical record so the facility could track whether the residents'showers were being given, if any orders had changed, or to see if the resident had any changes in health.