STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065001	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lowry Hills Care and Rehabilitation	10201 E 3rd Ave Aurora, CO 80010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to ensure one (#3) of three residents were free from abuse out of seven sample residents. Specifically, the facility failed to protect Resident #3 from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation policy, revised 1/5/25, was provided by the director of nursing (DON) on 3/13/25. It read in pertinent part, The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. II. Facility investigations A. Incident of physical abuse by Resident #2 towards Resident #3 on 2/8/25 The facility's investigation documented an incident occurred on 2/8/25 between Resident #2 and Resident #3. Another resident reported to the staff that Resident #2 had pulled Resident #3's hair in the lunchroom. It was not determined the reason Resident #2 pulled Resident #3's hair. Resident #3 denied feeling unsafe and Resident #2 denied recollection of the event. Resident #2 was put on one-on-one supervision. Through the facility's investigation, they were unable to find any witnesses, as the reporting resident later stated she was not sure what she had seen. The facility unsubstantiated the abuse due to no injuries occurring and no intent to harm. The facility was unable to determine the reason the abuse occurred due to Resident #2 stating she had no recollection of her behavior or the event. B. Incident of physical abuse by Resident #2 towards Resident #3 on 2/19/25 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation documented an incident occurred on 2/19/25 between Resident #2 and Resident #3. Resident #2 and Resident #3 were in the lunchroom in line to get coffee. Resident #3 reported to the staff that Resident #2 had cut in front of him in line and he asked her to move. Resident #2 then turned around and splashed her coffee in his direction and it hit him in the face. Resident #3 denied feeling unsafe and Resident #2 denied recollection of the event. Resident #2 was put on one-on-one supervision. Through the facility's investigation, they were unable to find any witnesses and Resident #2 could not recall the event. The facility unsubstantiated the abuse due to no injuries occurring and no intent to harm. The abuse occurred as a result of Resident #3 verbalizing displeasure to Resident #2's cutting in line and Resident #2's reaction to his verbalization of displeasure. III. Resident #3 (victim) A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included anxiety, depression, traumatic brain injury and stroke. The 1/24/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. He required staff supervision with bathing, bed mobility, dressing, eating, toileting and transfers. The resident used a wheelchair for ambulation. B. Resident interview Resident #3 was interviewed on 3/13/25 at 2:45 p.m. Resident #3 said he did not remember the incidents with Resident #2. C. Record review Resident #3's trauma care plan, initiated 2/24/25, revealed the resident had been involved in two resident-to-resident altercations with the same resident, where Resident #3 was the victim. Interventions included encouraging Resident #3 to either move away from that resident's (Resident #2) vicinity or to notify staff to redirect the resident away from the vicinity, providing the resident with validation when he was emotionally distressed, providing active listening and notifying social services and the resident's psychologist of emotional distress. The change of condition nursing note, dated 2/8/25, revealed Resident #3 was involved in a resident-to-resident incident. Neurological checks, skin checks and vital signs were all within normal range. The physician was notified of the incident. The change of condition nursing note, dated 2/19/25, revealed Resident #3 was involved in a resident-to-resident incident. Neurological checks, skin checks and vital signs were all within normal range. The physician was notified of the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The alert note, dated 2/19/25, revealed Resident #3 reported to staff there was no precepting reason for the incident. Resident #3 wanted to file a police report and denied injuries or feeling unsafe. IV. Resident #2 (assailant) A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included neoplasm of cerebellum (brain tumor), unspecified psychosis and a delusional disorder. The 1/20/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of two out of 15. She was independent in her bathing, eating, toileting, dressing and transferring. The resident used a wheelchair for ambulation. The MDS assessment indicated she had delusions and had physical and verbal aggressive behaviors directed towards others. B. Resident interview Resident #2 was interviewed on 3/12/25 at 2:09 p.m. Resident #2 said there was a horrible man in a white shirt (Resident #3) that ran his wheelchair over her foot because she was taking too long to fix her coffee in the dining room. Resident #2 said because of this, she splashed her cold cup of coffee in his face. Resident #2 said on another occasion, she pulled Resident 3's hair because she believed he wanted to rape and murder her. C. Record review Resident #2's behavior care plan, initiated 2/24/25, revealed the resident displayed fluctuations in cognition due to a mental illness and a brain tumor. She presented with episodes of delusional thinking and paranoia causing her to display verbal and physical aggression. She had been involved in multiple incidents. Interventions included one-on-one monitoring, providing psychological support, redirection and validating her feelings. Additional interventions included providing the resident space alone, music and conversations regarding her favorite topics (sports such as soccer) could be used as redirection. V. Staff interviews The regional clinical consultant (RCC) and the DON were interviewed together on 3/13/25 at 10:35 a.m. The DON said she had done one-on-one verbal training with the staff on person-centered approaches for Resident #2 but she did not document the training. The DON said Resident #2 had deteriorated due to her brain tumor and had refused to take medications or attend oncology appointments. The DON said during Resident #2's last hospital stay, a palliative assessment was recommended. The DON said she did not know the status of the palliative assessment. The DON said the current interventions for Resident #2 included a one-on-one staff member outside of her room and to explore options on how to implement a guardian for Resident #2 to assist with decision making. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said Resident #2 had behaviors of self-isolation, refusals of care and aggression. She said the resident had displayed physical and verbal aggression towards the nurses and the certified nurse aides (CNA), which included pushing, kicking, hitting and threats. The DON said Resident #2 suffered from delusions that consisted of the other residents wanting to rape and murder her. The DON said due to the inconsistency of Resident #2's cognition, creating an intervention to address the resident's behavior had been challenging. The DON said the facility implemented a one-on-one caregiver to sit outside of Resident #2's room from 2/8/25 to 2/11/25. She said after the second incident on 2/19/25, the one-on-one caregiver was restarted. The DON said Resident #2's behaviors of delusions and aggression should be monitored in the treatment administration record (TAR) or in the progress notes. She said the behavior monitoring should include non-pharmological interventions and effectiveness of interventions. The DON was unaware Resident #2 did not have an order for behavior monitoring. CNA #2 was interviewed on 3/13/25 at 12:01 p.m. CNA #2 said today (3/13/25) was her first shift as the one-on-one caregiver for Resident #2. She said she helped Resident #2 with her meals and monitored her behaviors when she left her room. CNA #2 said Resident #2 required a one-on-one caregiver because she had displayed physical aggression towards other residents. CNA #2 said she did not know if Resident #2 had altercations with staff. CNA #2 said the management did not tell her what the resident's triggers were. She said she knew she was supposed to de-escalate Resident #2, but she had not been trained on how to de-escalate Resident #2 specifically, only general training for all residents. CNA #1 was interviewed on 3/13/25 at 12:15 p.m. CNA #1 said she had only worked on Resident #2's hallway for four days and did not know her very well. She said she was given information on Resident #2's behaviors from the other CNAs, not from management. CNA #1 said she was was told by other CNAs that Resident #2 had behaviors of yelling out and wandering. CNA #1 said she did not know the resident's behavior triggers, diagnoses, or past incidents with staff and other residents. The social services assistant (SSA) and the social services director (SSD) were interviewed together on 3/13/25 at 1:15 p.m. The SSD said she worked at a sister facility and was working in the facility to assist the SSA until a permanent SSD was hired. The SSA said regarding Resident #2's behaviors, her role was to conduct investigations and provide psychosocial support to residents. Licensed practical nurse (LPN) #1 was interviewed on 3/13/25 at 2:30 p.m. LPN #1 said Resident #2 had behaviors of refusing care, refusing medications, and verbal and physical aggression towards staff and other residents. LPN #1 said the interventions the staff used with her were to leave her alone and give her space when she was agitated. LPN #1 said the nurses documented her behaviors on the TAR according to the behavior tracking order on the March 2025 CPO. LPN #1 said she was able to locate the behavior tracking order for Resident #2's verbally and physically aggressive behaviors and she initiated it on 3/12/25 (during the survey).