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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** III. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE] and discharged home on [DATE]. According to the [DATE] CPO, diagnoses included multiple sclerosis (a disease that damages nerves and affects muscle control), muscle weakness and autistic disorder (developmental disorder). The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required substantial assistance with ADLs. The MDS assessment revealed the resident was going to stay at the facility for long term care. B. Resident #1's representative interview Resident #1's representative was interviewed on [DATE] at 10:30 a.m. The representative said Resident #1 discharged from the facility to home (on [DATE]). The representative said the facility did not set up any home health services for the resident when he was discharged home. She said there was no discharge planning and discussion of plans until a few days prior to discharge. The representative said while Resident #1 was at the facility, he spoke frequently about returning to his apartment, which he had. She said when he was living on his own, prior to living at the facility, he had a voucher for housing and he received home health services daily. She said for him to return to the community, a waiver for the Medicaid services needed to be completed. She said the facility failed to complete the waiver and did not start working on attempting to get the waiver completed until a few days prior to discharge. The representative said the resident disenrolled from hospice services that he was receiving at the facility so he could return to the community with the waiver. The representative said when Resident #1 was discharged to his apartment, the facility reassured them that there would be home health care starting the same day. She said when the home health services company contacted her, she was told the home health company would not be able to provide the services because the resident did not have a funding source. She said Resident #1 required two people a day to care for him, which included ADLs, meals and medications. She said she provided care to the resident for more than three days, giving care from the time he returned home until he was discharged again to another facility. (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

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	C. Record review A review of the comprehensive care plan, initiated on [DATE], revealed there was not a care plan to address the resident's discharge goals and needs. The [DATE] social services evaluation revealed Resident #1 was unable to live independently due to physical limitations and it was anticipated that the resident was going to stay at the facility for long term care. The [DATE] progress note, documented by the NP, revealed Resident #1 had put a call out to the Physician Assisted Dying Program. The note documented that the resident was coordinating qualifications, criteria and initial evaluations through their services. The note documented the facility was coordinating with the DON so the resident understood he must discharge from the facility before proceeding with the program. The note also documented the staff needed to discuss logistics for how far along he needed to be in the program before discharge would be required. -However, review of Resident #1's EMR failed to reveal further documentation that the facility staff discussed the logistics of how far along he needed to be in the program. The [DATE] nursing progress note documented that the nurse, the NHA, the SSD and the hospice team completed a care conference with the resident and his friend regarding his discharge to his apartment. The [DATE] interdisciplinary team (IDT) note documented that Resident #1 frequently spoke about wanting to go home to live with his dogs. The meeting note revealed Resident #1 was dependent on staff for six out of six ADLs, required maximum two-person assistance or Hoyer lift transfers and was primarily bed-bound. The note revealed the resident wished to be discharged home. -The [DATE] IDT note did not include a plan addressing how extensive care needs would be met in the community or how services such as home and community-based services would be arranged. The [DATE] progress note documented nursing staff were informed Resident #1 would be discharged home that day and described the resident as alert and oriented, stable and refused to take his medications with him. It documented the nursing staff attempted to coordinate home health care and home and community-based services but confirmed the resident's waiver was inactive and the services could not be initiated on the day of discharge. It documented the resident and his representative still requested discharge and nursing staff and the NHA assisted the resident with packing, arranged final calls to coordinate services and ensured the resident left the facility with his belongings. The [DATE] discharge summary instructions revealed the facility had ongoing conversations with Resident #1 and the ombudsman about discharge to the community. -The [DATE] discharge summary did not include documentation of a complete plan or confirmation that needed supports were in place before discharge. The [DATE] IDT note revealed Resident #1 stopped hospice care in order to pursue discharge to the community with home health care. (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	-The [DATE] IDT note did not include documentation of a completed plan addressing how necessary services, including home services would be arranged to meet the resident's high care needs after discharge. -A review of Resident #1's EMR did not reveal a documented plan for follow-up monitoring or contingency actions if planned services could not be started immediately. D. Staff interviews The SSD was interviewed on [DATE] at 11:36 a.m. The SSD said the facility's baseline care plan was completed within 24 hours of admission and care conferences occurred within 72 hours. She said discharge planning began on the first day of admission depending on whether the resident planned to remain long-term or return to the community. She said if the resident planned to return to the community then referrals were made for home health services and durable medical equipment. She said she called to confirm the receiving agencies could accommodate the resident's needs. She said confirmation was sometimes verbal and sometimes written. The SSD said that discharge planning was not always documented because staff became busy. The SSD was interviewed again on [DATE] at 2:04 p.m. The SSD said Resident #1 was admitted for long-term care on hospice services. The SSD said Resident #1 completed paperwork for the medical assistance in dying program in mid-[DATE] but stopped the process on [DATE] after the medical assistance in dying program notified him that he did not qualify. The SSD said a care conference was held on [DATE] with Resident #1, his representative, the SSD, the DON, the NHA and the hospice team to discuss discharge. The SSD said Resident #1 planned to return to his apartment with around the clock in-home care. The SSD said Resident #1 and his representative understood that he could not receive skilled home health and hospice services simultaneously. The SSD said hospice agreed to continue providing services, to order all needed durable medical equipment and medications for home use. The SSD said she spoke with Resident #1 and his representative on multiple occasions between [DATE] and [DATE] about discharge planning, safety concerns and the elderly blind and disabled waiver, which could not be activated until Resident #1 left the facility. The SSD said the uniform long-term care assessment was completed but the elderly blind and disabled waiver was not finalized. She said the case management agency was to meet Resident #1 at his apartment on [DATE]. The SSD said Resident #1 ultimately discharged on [DATE] but left the facility with no confirmed services in place, despite documentation indicating services would begin that day. The SSD said there was no formal discharge care plan documented for Resident #1, no documentation of IDT involvement at discharge, and no record showing Resident #1 or his representative was informed of the final discharge plan or offered the option to return if services were not in place. The SSD said the facility had identified this issue previously and did not implement a plan of correction due to scheduling conflicts but she said the facility would create a solid procedure moving forward. The DON was interviewed on [DATE] at 2:36 p.m. The DON said the IDT met daily to review pending discharges, needed services and medical equipment. She said social services sent referrals for services such as home health or medical equipment. She said once services were arranged, the resident picked a discharge date . She said nursing staff prepared the discharge summary, medication list and orders, reviewed these with the resident or representative and scanned signed copies into the record. (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	The DON said the team tried to ensure home health services began within 24 hours after discharge. She said regarding Resident #1, the case management agency confirmed they would complete an assessment and start services on [DATE], but Medicaid was inactive and the waiver process could not be completed. The DON said Resident #1 insisted on discharging without services fully in place despite staff informing him of the risks. E. Facility follow-up On [DATE] at 9:52 a.m., the following documentation was received from the NHA: An email documented Resident #1 was seen for home health services on [DATE], [DATE] and [DATE]. He was then discharged to the hospital. -However, Resident #1 needed around the clock services to meet his needs (see record review above). Based on record review and interviews, the facility failed to ensure two (#5 and #1) of three residents were provided the care and services necessary to ensure a safe discharge from the facility to the community out of 13 sample residents. Resident #5 was initially admitted to the facility on [DATE] for long term care with diagnoses of complete C5-C7 (cervical vertebrae) quadriplegia (no movement of all four limbs), cervical fusion of spine, left ischium stage 4 pressure injury, unspecified convulsions, major depressive disorder, post-traumatic stress disorder (PTSD), and blood hypotension (low blood pressure). Resident #5 desired to discharge home with care and services. Resident #5 was dependent on staff for all activities of daily living (ADL). Upon discharge, the facility failed to provide the resident and his representative with information on taking his prescribed medications, which included two anti-seizure medications. Three days after discharge (on [DATE]), Resident #5 began having a seizure. Resident #5's representative said she initiated cardio-pulmonary resuscitation (CPR) and called emergency services (EMS). Resident #5 was transferred to the hospital. Additionally, the facility failed to ensure a thorough discharge plan was created and documented for Resident #1. Specifically, the facility failed to ensure Resident #5 and Resident #1 had a person-centered discharge plan that ensured the residents received the necessary care and services needed upon discharge from the facility. Findings include: I. Facility policy and procedure (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	The Discharge Planning Process policy, revised 2025, was provided by the nursing home administrator (NHA) on [DATE] at 8:24 a.m. It read in pertinent part, Discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community. The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record. II. Resident #5 A. Resident status Resident #5, age less than 65, was admitted on [DATE], readmitted on [DATE] and discharged home on [DATE]. According to [DATE] computerized physician orders (CPO), diagnoses included complete C5-C7 quadriplegia, cervical fusion of spine, left ischium stage 4 pressure injury, unspecified convulsions, major depressive disorder, post-traumatic stress disorder, and hypotension. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required maximum assistance from two staff members using a Hoyer lift (mechanical lift) for repositioning and he was dependent on staff for all ADLs. The MDS assessment indicated there was an active discharge plan in place for the resident to return to the community. The MDS assessment indicated that there had been a referral made to the local contact agency. B. Resident #5's representative interview Resident #5's representative was interviewed on [DATE] at 1:30 p.m. The representative said Resident #5 had expressed a desire to come home since [DATE], but the facility had taken little action regarding it. She said the social services director (SSD) assured her that the resident would receive home services upon discharge, and these services would start on the day he came home. She said the facility had not completed the waiver services application, which was why there were no services. She said Resident #5 went home without a primary physician and they had to find one. (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	Resident #5's representative said they received a bag of medication at discharge from the facility. She said they were not given a medication list or orders on when to take the medications. She said they were not provided any further discharge information. Resident #5's representative said that on [DATE], after Resident #5 discharged home, he had a seizure and stopped breathing. She said she performed CPR and called EMS. She said the resident was admitted to the hospital. She said this happened because they did not know the resident was supposed to take seizure medications. C. Record review The discharge care plan, dated [DATE], revealed Resident #5 desired to return to his home in the community. Pertinent interventions included encouraging the resident and caregiver to participate in discharge planning, meeting with the resident and caregiver to outline discharge goals and revising if needed with progression, providing discharge information and reconciling medications with the resident and caregiver prior to discharge. -The care plan had not been updated with the ongoing discharge process to outline the resident's needs at the time of discharge. The [DATE] social services progress note documented Resident #5 planned to discharge on Monday ([DATE]). The note documented the resident was denied by two home health agencies due to his advanced care needs. The [DATE] nurse practitioner (NP) discharge summary note documented the resident had multiple comorbidities requiring medication management that necessitated frequent clinical evaluations. The note documented that without regular monitoring and management, the resident was at moderate to high risk of symptom exacerbation and complications resulting in hospitalization or death. The note documented that the staff was unaware of any discharge plan. -However, Resident #5 discharged to the community on [DATE]. -Review of Resident #5's electronic medical record (EMR) did not reveal any further documentation regarding the resident's needs at time of discharge or the facility's attempt at setting up care and services for when Resident #5 discharged to the community. The [DATE] discharge summary instructions documented Resident #5 was discharged to home with family assistance. The special instructions were that the resident needed assistance in all areas of living 24 hours a day and seven days a week. The summary documented that home health was not ordered. The instructions revealed follow-up appointments and listed a physician's office (not a name) as the following physician. The discharge summary documented a verbal signature from the resident was received. -However, there was no phone number or address provided for the physician's office on the discharge summary instructions. (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	-The discharge summary instructions did not indicate the resident needed wound care, what medications the resident was taking, catheter care plan, or instructions on what to do when seizures were present. The [DATE] hospital transcription report documented that Resident #5 was admitted to the emergency department (ED) for seizures. The note documented that day (/16/25), the resident said he had been out of his anti-seizure medications (carbamazepine and topiramate). The hospital staff gave this medication to him. The report documented the resident was recently discharged from a rehabilitation facility. The note documented Resident #5 said the facility staff did not tell him how or when to take his seizure medications when he was discharged from the facility. The resident said he was unsure if he had been taking the medications correctly. Review of Resident #5's [DATE] CPO revealed the following physician's orders: Carbamazepine (seizure medication) 200 milligrams (mg). Give two tablets by mouth three times a day, ordered [DATE]. Topiramate (medication used to treat seizure disorder) 25 mg. Give one tablet two times a day for convulsions treatment and prevention, ordered [DATE]. Eliquis (blood thinner) 5 mg. Give one tablet two times a day, ordered [DATE]. Wound care plan (suprapubic catheter, left lateral shin, and left ischium stage 4 pressure injury. Physical therapy. Magnetic resonance imaging (MRI) of left ischium for suspected osteomyelitis. Psychiatric and psychological evaluations. D. Staff interviews The SSD and the social services director from another facility were interviewed together on [DATE] at 11:37 a.m. The SSD said the facility typically held a care conference when a resident decided they wanted to discharge from the facility. (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	The SSD was interviewed a second time on [DATE] at 2:20 p.m. The SSD said after Resident #5 was admitted , he wanted to be transferred to a different city. The SSD said the facility sent referrals to other agencies and looked for wound care programs. The SSD said the resident was denied because of lack of services, the resident required advanced care or because the facility did not accept Medicaid. She said she confirmed the home health care would provide physical therapy, occupational therapy and nursing services to Resident #5 upon discharge. She said the home health agency could not visit daily to check his wounds. The SSD said due to the situation, Resident #5's representative received wound care training on [DATE]. The SSD said the facility arranged a physician along with the home health care services. The SSD said she did not receive confirmation that these services were in place prior to Resident #5 discharging. She said the resident's representative had an interest in becoming a certified nurse aide (CNA). The SSD said she did not do any follow up with the resident after he was discharged home. The SSD said the discharging nurse was responsible for reviewing the discharge summary and medications with the resident and his representative. The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on [DATE] at 2:39 p.m. The DON said she reviewed Resident #5's EMR and confirmed there was no documentation in regards to his discharge. She said a discharge note should have been written by the discharging nurse. She said the note should document if medications were sent, prescriptions were sent and that the resident and representative were educated. She said a list of the medications and discharge summary instructions were to be sent with the resident and representative. She said there was no record that the forms were sent with Resident #5. The ADON said Resident #5's representative called the day after discharge as she had not received any discharge instructions or a list of medications. The ADON said she sent the list to the representative the next day, however, she did not document it and did not follow up with the representative. The DON confirmed Resident #5 had epilepsy and that he received medications to prevent seizures. She said she did not have any record of what medications were sent home with the resident. She said the social service department was responsible for setting up home health care services. E. Facility follow-up On [DATE] at 9:52 a.m., the following documentation was received from the NHA: A signed paper from the licensed nurse who completed the discharge with Resident #5. The signed paper, dated [DATE], documented the list of medications and instructions were reviewed with the resident. The medications, list of medications, facesheet and discharge summary were sent with the resident on [DATE]. -However, review of Resident #5's EMR did not reveal documentation indicating the nurse who discharged Resident #5 provided the resident or his representative with a list of medications or instructions on taking the medications (see record review above). A written statement, dated [DATE], documented the social services director from another facility was present during the discharge. The statement documented she observed Resident #5 and the resident's family member received the medication list, medications and the discharge summary. (continued on next page)

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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	-However, review of Resident #5's EMR did not reveal documentation indicating the social services director from the other facility was present during the discharge, nor was there documentation to indicate that the resident received information regarding his medications at the time of discharge (see record review above).

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	06/26/2025

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 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 one (#6) of three residents reviewed for ADLs out of 13 sample residents. Specifically, the facility failed to provide Resident #6, who had cognitive impairments, incontinence care in a timely manner. Findings include: I. Facility policy and procedure The Incontinence policy and procedure, dated August 2024, was provided by the nursing home administrator (NHA) on 6/26/25 at 8:27 a.m. It revealed in pertinent part, Based on the resident's comprehensive assessment, all incontinent residents will receive appropriate treatment and services. II. Resident #6 A. Resident status Resident #6, age [AGE], admitted on [DATE]. According to the June 2025 computerized physician's orders (CPO), diagnoses included dementia, glaucoma (high eye pressure) and chronic kidney disease. The 6/10/25 minimum data set (MDS) assessment revealed the resident had memory impairment in making decisions regarding tasks of daily life, per the staff assessment for mental status. He required moderate assistance with oral care, personal hygiene, toileting, bathing, dressing and transferring. B. Observations During a continuous observation on 6/25/25, beginning at 2:01 p.m. and ending at 6:10 p.m., the following was observed: At 2:01 p.m. Resident #6 was napping in his wheelchair in the dining room. At 2:23 p.m. an unidentified certified nurse aide (CNA) attempted to wake Resident #6, but the resident continued to sleep. At 3:03 p.m. CNA #4 checked on Resident #6 by touching his head, but the resident did not wake up. At 3:34 p.m. an unidentified CNA tried to speak with Resident #6 and Resident #6 said he wanted to stay in his wheelchair in the dining room. At 4:11 p.m. CNA #1 assisted Resident #6 to his room. CNA #1 did not offer or provide incontinence care. (continued on next page)

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	06/26/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 4:35 p.m. CNA #1 and CNA #2 attempted to transfer Resident #6 from his wheelchair to his bed using a Hoyer lift. Resident #6 refused and said he wanted to remain in his wheelchair. Both CNA #1 and CNA #2 asked Resident #6 again if he wanted to be transferred to the bed to nap, but Resident #6 did not want to be transferred. CNA #1 said she would come back later. -The resident was not checked for incontinence or offered toileting assistance. At 5:01 p.m. CNA #1 checked on Resident #6 and asked if he needed anything, and Resident #6 said he did not need help. At 5:16 p.m. CNA #1 brought Resident #6's dinner tray and set it up for him while he remained in his wheelchair. At 6:33 p.m. after survey staff informed registered nurse (RN) #1, CNA #1 provided incontinence care for Resident #6. CNA #1 changed Resident #6's brief, which was observed to be soiled and saturated. -Resident #6 was not provided incontinence for over four and a half hours. C. Record review The ADL care plan, revised 3/1/25, documented Resident #6 had bowel and bladder incontinence related to poor sphincter control, minimal mobility and progression of dementia. Pertinent interventions included checking Resident #6 every two hours and assisting with toileting as needed, observing the pattern of incontinence and initiating a toileting schedule if indicated. According to the CNA task documentation for bladder incontinence, Resident #6 received incontinence care on 5/25/25 at 2:03 p.m. -However, a continuous observation of the resident conducted at that same time revealed the resident was in the dining room napping (see observations above). III. Staff interviews RN #1 was interviewed on 6/25/25 at 6:15 p.m. She said the staff were expected to offer and provide incontinence care for Resident #6 every two hours because he was incontinent of bladder and bowel. She said Resident #6 was also at risk for pressure injury if he was not changed every two hours. CNA #3 was interviewed on 6/26/25 at 12:30 p.m. CNA #3 said Resident #6 becomes combative when incontinence care was provided and fights the staff. CNA #3 said the staff used two people to change Resident #5 because he kicked and punched the staff. The director of nursing (DON) was interviewed on 6/26/25 at 2:36 p.m. The DON said all residents who were incontinent must be provided with incontinence care every two hours and staff should check if the resident was soiled. The DON said if a resident refused care, the staff should check again in 15 to 20 minutes and address refusals as best they could.

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	06/26/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide an ongoing program to support residents in their choice activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two (#1 and #6) of three residents reviewed for activities programming out of 10 sample residents. Specifically the facility failed to: -Offer and provide personalized activity programs for Resident #1 and Resident #6 as documented in their care plans; -Ensure Resident #1 and Resident #6 were invited and encouraged to attend activities of their preference; and, -Ensure Resident #6 was meaningfully engaged during activities. Findings include: I. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE] and discharged on 5/28/25 to the community. According to the May 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (a disease that damages nerves and affects muscle control), muscle weakness and autistic disorder. The 3/31/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed it was very important for the resident to have books, newspapers, and magazines to read, be around animals such as pets, engage in favorite activities, go outside to get fresh air when the weather was good, participate in religious services or practices, and somewhat important to the resident to listen to music. B. Resident representative interview Resident #1's representative was interviewed on 6/25/25 at p.m. The representative said Resident #1 had complained about not having anything to do. She said the resident was not invited to the activities. The representative said Resident #1 always enjoyed going outside, however he was not assisted outside by the staff. C. Record review (continued on next page)

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	06/26/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities care plan, initiated 3/24/25 and revised 6/5/25, identified that Resident #1 enjoyed writing books, listening to music, had published nine books and four recorded albums, enjoyed pet visits, being creative, computer time, and outside time when the weather was nice and he needed materials for in-room use as desired. He needed reminders and encouragement to attend group activities he may enjoy, and he had a strong spiritual faith which was important to him. Interventions included assisting and encouraging Resident #1 in meeting other peers who may share similar interests, inviting, assisting, and encouraging Resident #1 to attend group activities he may enjoy or be interested in, honor his wishes to decline activities as he chose, providing Resident #1 with a monthly activities calendar and providing Resident #1 with materials for in-room use as desired. The activity participation log, reviewed from 4/30/25 to 5/31/25, revealed Resident #1 had not received opportunities to spend time outside, have pet visits, or participate in spiritual faith activities. II. Resident #6 A. Resident status Resident #6, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included dementia, glaucoma and chronic kidney disease. The 6/10/25 MDS assessment revealed the resident had memory impairment in making decisions regarding tasks of daily life, per the staff assessment for mental status. He required moderate assistance with activities of daily living (ADL). The 9/8/24 MDS assessment revealed, per staff assessment, the resident enjoyed listening to music and keeping up with the news. B. Resident representative interview Resident #6's representative was interviewed on 6/26/25 at 10:25 a.m. The representative said staff tended to leave Resident #6 in his room without much interaction or engagement. The representative said he lived out of state and visited Resident #6 once every few months. The representative said he often saw Resident #6 sitting in his wheelchair without much engagement or participation and said that in the past, Resident #6 had been much more engaged compared to now. The representative said Resident #6 enjoyed listening to music, listening to the news, and interacting with other residents and staff. C. Observations On 6/25/25 during a continuous observation, beginning at 2:01 p.m. and ending at 5:16 p.m., the following was observed: At 2:01 p.m. Resident #6 was napping in his wheelchair in the dining room where a karaoke activity was taking place. At 2:23 p.m. an unidentified certified nurse aide (CNA) attempted to wake Resident #6, but the resident continued to sleep. (continued on next page)

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	06/26/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:03 p.m. CNA #1 checked on Resident #6 by touching his head, but the resident did not wake up. At 3:34 p.m., once the karaoke activity was over, an unidentified staff member spoke to Resident #6, and Resident #6 said he wanted to stay in his wheelchair in the dining room. -The unidentified staff member did not offer the resident any meaningful engagement or purposeful activity. At 4:11 p.m. Resident #6 was taken to his room. A compact disc (CD) player was on the resident's nightstand; however, it was not playing any music and CNA #1 did not offer to turn it on for him. Resident #6's roommate's television was turned on with no other stimulation in the room for Resident #6. At 4:35 p.m. CNA #1 and CNA #2 attempted to transfer Resident #6 from his wheelchair to his bed using a Hoyer lift (mechanical lift) so he could nap, but Resident #6 refused and said he wanted to remain in his wheelchair. Both CNA #1 and #2 asked Resident #6 again if he wanted to be transferred to the bed to nap, but Resident #6 did not want to be transferred. CNA #1 said she would come back later. -The CNAs did not offer other engagement, social interaction, or activities to provide stimulation or meet his psychosocial needs. At 5:01 p.m. CNA #1 checked on Resident #6 and asked if he needed anything, and Resident #6 said he did not need help. -CNA #1 did not offer Resident #6 any meaningful interaction or opportunities for engagement. At 5:16 p.m. CNA #1 brought Resident #6's dinner tray to his room and set it up for him while he remained in his wheelchair. On 6/26/25 the following was observed: At 8:41 a.m. Resident #6 was in his room in his wheelchair listening to his roommate's television without any other stimulation. At 9:34 a.m., Resident #6 was lying in his bed sleeping, with no stimulation or interaction offered. There was no music playing in the resident's room. At 9:52 a.m., CNA #3 offered Resident #6 water, but she did not provide additional engagement or meaningful activity. At 10:00 a.m., an activity of news and coffee was taking place in the dining room; however, Resident #6 was not invited to the activity and remained in his room sleeping. At 11:14 a.m., Resident #6 was observed still in bed sleeping. There was no music playing in the resident's room. At 11:58 a.m., Resident #6 remained in bed sleeping. (continued on next page)

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	06/26/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Throughout the observations on 6/25/25 and 6/26/25, staff did not offer activities connected to Resident #6's known interests, such as keeping up with the news, listening to music, coffee time, hand massage, religious reading, or short stories. D. Record review The activities care plan, revised 12/6/24, identified that Resident #6 liked keeping up with the news. Resident #6's favorite activities included listening to music, including soul music, rock, Motown, and jazz and he loved music, day and night. Resident #6 had a CD player that he listened to regularly. Resident #6 declined invitations to attend group programs and preferred resting, keeping to himself, and coffee time. Resident #6 enjoyed hand massages, religious reading time, and short stories. Resident #6 was blind and required assistance due to vision deficiency. Pertinent interventions included cueing and reminders for activities. Staff would provide one-on-one visits with Resident #6 and offer social visits, music time, coffee time, and activities he might enjoy. Staff would remind Resident #6 when Bible study, music entertainers, resident socials, and religious services were offered and escort him to the activity if he wished to attend. III. Staff interviews The activities director (AD) was interviewed on 6/26/25 at 3:43 p.m. The AD said that upon admission, residents were asked about their activity preferences and were provided with an activity calendar to keep in their rooms. The AD said staff were expected to inform residents daily about planned activities and offer reminders. The AD said that staff often learned residents' preferences over time but said some residents, including Resident #6, may not always be offered invitations or reminders to join group activities. The AD said Resident #6 enjoyed listening to music and owned a CD player. She said the CNAs may need reminders to assist with playing music for him, despite this being part of his care plan. The AD said CNAs likely needed re-education to ensure residents were consistently invited to activities and received meaningful engagement according to their care plans and preferences.

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	06/26/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide food and drinks that accommodated resident allergies, intolerances and preferences for one (#4) of four residents out of 13 sample residents. Specifically, the facility failed to ensure Resident #4 was provided a vegetarian diet per her preference. Findings include: I. Facility policy and procedure The Resident Food Preferences, revised July 2017, was received from the nursing home administrator (NHA) on 6/26/25 at 5:23 p.m. The policy read in pertinent part, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Nursing staff will document the resident's food and eating preference in the careplan. II. Resident #4 A. Resident status Resident #4, age [AGE], was initially admitted on [DATE] and readmitted on [DATE]. According to the June 2025 computerized physician orders (CPO) diagnoses included multiple sclerosis (disease that affects the nerves), dementia and shortness of breath. According to the 5/5/25 minimum data set (MDS) the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. The resident was independent in eating. B. Resident interview Resident #4 was interviewed on 6/25/25 at 12:15 p.m. Resident #4 said she was a vegetarian. She said at lunch today (6/25/25) she was served a pork chop. She said another resident told her that there was fish on the menu. She said she was not offered a vegetarian diet while residing at the facility. She said that her food choices were repetitive. Resident #4 was interviewed a second time on 6/25/25 at 5:04 p.m. Resident #4 said she received a grilled cheese sandwich, corn and refried beans for dinner tonight (6/25/25). She said she also received chocolate cake and she could not have chocolate cake because she had a colonoscopy procedure years ago and the doctor had told her to avoid it. C. Observations On 6/25/25 at 5:04 p.m. the resident had a piece of marble cake which had chocolate. (continued on next page)

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	06/26/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Record review The June 2025 CPO revealed a physician's order indicating the resident was prescribed a vegetarian diet. The resident's meal ticket indicated the resident was prescribed a vegetarian diet. The care plan, revised on 5/5/25, identified the resident had a risk for inability to maintain nutrition due to hypertension (high blood pressure), falls, cerebral ischemia (stroke), dementia, epilepsy (seizure disorder) and vitamin D deficiency. Pertinent interventions included providing the resident's prescribed diet as ordered. -However, the care plan failed to identify that the resident preferred to eat a vegetarian diet and was unable to eat chocolate cake. The dietary manager provided a paper which was titled Resident #4's menu. The paper read -Soup: tomato and vegetable with crackers; -Rice; -Fish; -Poatoes: fried, baked mashed; and, -Chef Salad (no meat). III. Staff interviews The registered dietitian (RD) and the dietary manager (DM) were interviewed together on 6/26/25 at 1:39 p. m. The RD said the facility did have a menu extension for vegetarian diet, however, it was not utilized. The DM said she had met with the resident a year ago and reviewed her preferences and had developed the menu based on her preferences. She said the resident would tell the kitchen what she wanted to eat, but did not use a specific vegetarian spread sheet extension. The RD said she had learned a few weeks ago that Resident #4 did not want to have chocolate. She confirmed the marble cake on the menu had chocolate.