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	06/03/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the comprehensive care plan was reviewed and revised timely to include the instructions needed to provide effective and personalized care for six (#9, #83, #104, #41, #2 and #29) of 10 residents out of 51 sample residents. Specifically, the facility failed to: -Ensure Resident #9's and Resident #83's care plans were updated with catheter care interventions;-Ensure Resident #104's care plan was updated with skin integrity/pressure wound interventions and feeding precaution interventions; -Ensure Resident #41's dementia and behavioral care plan was updated with all appropriate non-pharmacological interventions for psychotropic medications;-Ensure Resident #2's care plan was updated with specific target behaviors and interventions for the resident's use of psychotropic medications; and,-Ensure Resident #29's care plan was updated with specific target behaviors and interventions for the resident's use of psychotropic medications. Findings include: I. Facility policy and procedure The Comprehensive Care Plans policy, no revision date, was received from the nursing home administrator (NHA) on 6/4/26 at 1:04 p.m. It documented in pertinent part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe, at a minimum, the following: -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment; -Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of Pre-admission Screening and Resident Review (PASRR) recommendations; -The resident's goals for admission, desired outcomes, and preferences for future discharge; (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Discharge plans, as appropriate; -Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate; and, -Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. II. Failed to update Resident #9 and Resident #83's care plans with catheter care interventions A. Resident #9 1. Resident status Resident #9, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included acute on chronic heart failure, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (enlarged prostate causing urinary tract symptoms) and obstructive and reflux uropathy (blockage causing difficulty with urination). The 1/8/26 minimum data set (MDS) assessment revealed Resident #9 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #9 required substantial assistance with toileting and with transfers. The assessment revealed Resident #9 had an indwelling urinary catheter. 2. Record review The indwelling catheter related to BPH and obstructive uropathy care plan, revised 12/26/25, revealed the goal for Resident #9 was to remain free from catheter-related trauma through the review date of 8/10/26. Interventions (revised 4/13/26) included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door, enhanced barrier precautions, monitoring for signs and symptoms of discomfort on urination and frequency, monitoring for pain/discomfort due to the catheter and monitoring/recording/reporting to the physician for signs and symptoms of a urinary tract infection (UTI). -However, the care plan for Resident #9's catheter failed to include anything related to hygiene of the catheter. A review of Resident #9's June 2026 CPO revealed the following physician's order: Indwelling urinary catheter care: cleanse site with soap and water and rinse, then pat dry every shift, ordered 6/2/26 (during the survey). The 5/27/26 at 7:08 a.m. nurse progress note documented that Resident #9 had returned from the hospital the evening prior at approximately 10:38 p.m. The resident's test revealed a UTI and a foley (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheter had been inserted. B. Resident #83 1. Resident status Resident #83, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included emphysema, chronic obstructive pulmonary disease and neuromuscular dysfunction of the bladder. The 4/30/26 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 12 out of 15. Resident #83 was dependent on staff assistance with toileting and transfers. The assessment revealed the resident had an indwelling urinary catheter. 2. Record review The indwelling catheter care plan, initiated 8/29/25 and revised 9/10/25, revealed Resident #83 was admitted with a Foley catheter. The goal was for Resident #83 was to remain free from catheter-related trauma through the review date of 6/29/26. Interventions included checking the catheter for kinks, monitoring for signs and symptoms of discomfort on urination and frequency, monitoring and documenting intake and output as per facility policy, monitoring for pain/discomfort due to the catheter and monitoring/recording/reporting to the physician for signs and symptoms of a urinary tract infection (UTI). -However, the care plan for Resident #83's catheter failed to include anything related to hygiene of the catheter. A review of Resident #83's June 2026 CPO revealed the following physician's order: Indwelling urinary catheter care: cleanse site with soap and water and rinse, then pat dry every shift, ordered 5/14/26. C. Staff interviews Registered nurse (RN) #1 was interviewed on 6/3/26 at 9:20 a.m. RN #1 said she was responsible for communicating information and updates about residents to the nursing management team and they updated the residents' care plans. She said the nurses were responsible for catheter care, including cleaning the catheters and flushing the catheter if needed. She said the nurses and certified nurse aides (CNA) were responsible for emptying out the catheter drainage bags and documenting the output. She said catheter care and cleaning catheters should be on the care plan, including how to clean it and how often. Licensed practical nurse (LPN) #1 was interviewed on 6/3/26 at 9:30 a.m. LPN #1 said the director of nursing (DON) implemented and updated care plans. She said she was responsible for letting the DON know about any concerns with the residents. She said the nurses were responsible for cleaning catheter tubing and it should be on the care plan. She said there should additionally be a physician's order for cleaning the catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON, the NHA, and the regional clinical resource were interviewed together on 6/2/26 at 3:00 p.m. The DON said residents with catheters should have a care plan and physician's orders that included the size of the catheter, the size of the catheter balloon, catheter cleaning every shift, the drainage bag to be replaced monthly, irrigation if necessary, securing the catheter to the stat lock (a medical securement device used to hold catheters in place), changing the catheter if leaking, pulled out or clogged and enhanced barrier precautions. She said there should be a task created for CNAs to empty and document the output of urine. The DON said Resident #9's catheter had been put back in recently and the resident's physician orders and care plan had not been updated. III. Failed to update Resident #104's care plan with with skin integrity/pressure wound interventions and feeding precaution interventions A. Resident status Resident #104, age greater than 65, was admitted on [DATE] and discharged to the hospital on 4/22/26. According to the April 2026 CPO, diagnoses included traumatic subdural hemorrhage without loss of consciousness, need for assistance with personal care, presence of left artificial hip joint, displaced trimalleolar fracture of the right lower leg and dementia. The 4/22/26 MDS assessment revealed the resident had a memory problem and was moderately cognitively impaired. The MDS assessment revealed the resident was dependent on assistance from staff for all activities of daily living (ADL). B. Record review The impairment to skin care plan, initiated 4/19/26, documented Resident #104 had impairment to her skin integrity upon admission that included right lower extremity surgical incision, left lateral thigh surgical incision, left medial distal foot wound and right heel. Pertinent interventions, initiated 4/19/26, included to encourage good nutrition and hydration in order to promote healthier skin and to monitor/document the location, size and treatment of the skin injury; report abnormalities, failure to heal, signs and symptoms of infection, and maceration (breakdown) to the physician and weekly treatment documentation to include the measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid) and any other notable changes or observations. -The care plan did not specify what the sin concern was on the resident's right heel. A review of Resident #104's 4/15/26 skin note revealed the resident had a scab on her right heel that was present upon the resident's admission to the facility. A review of the resident's 4/21/26 wound note revealed the resident had a right heel pressure ulcer after debridement (removal of tissue). -However, the care plan failed to include that the resident had a right heel scab present upon admission and failed to update the care plan accordingly after development of a right heel stage 4 pressure ulcer on 4/21/26. The nutrition care plan, initiated 4/14/26, revealed Resident #104 had potential and/or was at risk for (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an inability to maintain her nutrition due to a history of falls, a right lower leg fracture, severe protein-calorie malnutrition, dementia, a history of metastatic cancer, malignant neoplasm of the bone, traumatic subdural hemorrhage and femur fracture. Pertinent interventions, revised 4/17/26, included to provide and serve the diet as ordered: a regular diet, regular texture with thin liquids and feeding assistance as needed; monitor and record intake every meal and provide food in a form that was acceptable and culturally acceptable. The registered dietitian (RD) was to evaluate and make nutritional recommendations as needed. A review of Resident #104's April 2026 CPO revealed the resident's diet was changed from regular texture to mince and moist level five on 4/19/26, and from mince and moist level 5 to puree level four on 4/20/26. The speech therapy evaluation and plan of treatment, starting 4/20/26, documented Resident #104's overall presentation was consistent with suspected moderate/severe oropharyngeal (middle of the throat behind the mouth) dysphagia (difficulty swallowing) and the resident remained at an elevated risk of aspiration. A FEES instrumental assessment (fiberoptic endoscopic evaluation of swallowing) was recommended as clinically appropriate to guide diet recommendations and plan of care. Speech therapy recommended the resident be downgraded to puree solids and thin liquids with adherence to safe swallow strategies during one-to-one feeding that included small bites/sips, a slow rate of intake, sitting upright for all oral intake and liquid wash. -However, the resident's care plan failed to include the resident's elevated risk of aspiration, new diet texture orders on 4/19/26 and 4/20/26 and safe swallowing strategies as recommended by speech therapy (see care plan above). C. Staff interviews The DON was interviewed on 6/3/26 at 11:52am. The DON said the interdisciplinary team (IDT) reviewed care plans at least quarterly to update the care plans for established residents. She said the care plans should be updated in real time as changes with residents occurred. The DON said the IDT reviewed any changes in condition or hospitalization and updated the care plans during that time. The DON said Resident #104's care plan should have included the updated recommendations from speech therapy. The DON said the resident should have had a more personalized care plan for her pressure ulcer that included details about the wound and more personalized interventions. IV. Failed to update Resident #41's dementia and behavioral care plan with all appropriate non-pharmacological interventions for psychotropic medications A. Resident status Resident #41, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included severe vascular dementia with behavioral disturbance, major depressive disorder, and stage 3 chronic kidney disease. The 2/17/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of two out of 15. She was legally blind, and required partial to moderate assistance with transfers and hygiene tasks. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review Review of Resident #41's June 2026 CPO revealed the following physician's orders: Sertraline (Zoloft) oral tablet. Give 50 milligrams (mg) by mouth one time a day related to adjustment disorder with mixed anxiety and depressed mood, ordered 10/23/25. Quetiapine fumarate oral tablet 25 mg. Give one tablet by mouth three times a day related to severe vascular dementia with behavioral disturbance, ordered 3/4/26. The behavioral and dementia care plan, revised 4/19/24, revealed that Resident #41 had the following behaviors: frequent crying, refusing to stay in the facility, and pacing while feeling anxious. Interventions included administering medications as ordered, monitoring medication side effects and effectiveness, assisting the resident to develop more appropriate methods of coping and interacting, encouraging the resident to express feelings appropriately, providing reassurance and reorientation, explaining all procedures to the resident before starting and allowing the resident time to adjust to changes. Review of Resident #41's May 2025 medication administration record (MAR) revealed the staff were to be monitoring the resident for episodes of dementia, delusional thinking, hallucinations, and episodes of confusion causing emotional distress. Non-pharmacological interventions included offering emotional support, providing a quiet environment, allowing the resident to express feelings, and offering a snack. -However, the interventions were not added to the behavioral and dementia care plan (see care plan above). Further review of Resident #41's May 2025 MAR revealed the staff were to be monitoring the resident for the number of episodes of self-isolation and crying. Non-pharmacological interventions included redirection, repositioning, offering a snack, offering fluids, distraction, and offering activity. -However, the interventions were not added to the behavioral and dementia care plan (see care plan above). C. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/2/26 at 1:53 p.m. CNA #1 said Resident #41 was usually confused and moved around in her wheelchair. CNA #1 said she did not see the resident being aggressive with others, crying, trying to harm herself or saying she wanted to leave the facility. CNA #5 was interviewed on 6/3/26 at 10:29 a.m. CNA #5 said she saw Resident #41 being a little verbally aggressive toward staff members, but it did not happen too often. CNA #5 said Resident #41 did not try to hit anybody when she was mad. CNA #41 said she never saw Resident #41 crying or hallucinating. The social services director (SSD) was interviewed on 6/3/26 at 9:30 a.m. The SSD said social services was responsible for identifying depression symptoms and target behaviors and shared this information with nursing staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included cognitive communication deficit, psychotic disorder with hallucinations due to known physiological conditions and major depressive disorder. The 3/25/26 MDS assessment revealed the resident had both short and long term memory impairments and the resident's decision making skills were moderately impaired. The resident was independent with ADLs. The assessment indicated the resident was receiving antidepressant and antipsychotic medications. B. Record review Review of Resident #29's June 2026 CPO revealed the following physician's orders: Zoloft (antidepressant medication) 100 mg by mouth one time a day, ordered 3/4/26. Risperidone (antipsychotic medication) 1 mg by mouth in the evening for dementia with psychotic disturbance, ordered 5/8/26. Review of the psychotropic medication care plan, initiated 1/13/25 and revised 7/1/25, revealed Resident #29 used psychotropic medications related to psychotic disorder with hallucinations and dementia. Interventions included administering psychotropic medications as ordered by the physician, monitoring for side effects and effectiveness every shift, consulting with the pharmacy and the physician to consider dosage reduction when clinically appropriate, at least quarterly, monitoring and recording occurrences of target behavior symptoms and documenting per facility protocol. -However, the specific target behaviors associated with the use of the psychotropic medications were not included on the care plan. Review of Resident #29's May 2026 MAR revealed staff were to monitor the resident for hallucinations. Interventions documented on the MAR included offering the resident activities of choice, offering emotional support, redirecting the resident, providing the resident with a quiet environment, allowing the resident to express his feelings and offering a snack. -However the care plan failed to include the specific target behaviors and interventions which were on the MAR (see care plan above). C. Staff interview The SSD was interviewed on 6/3/26 at 9:25 a.m. The SSD said Resident #29 received psychotropic medications for psychiatric disturbances. She said he was paranoid about dogs and was distrustful of staff. She said he was also paranoid that his brother was stealing his money. The SSD said the social services department developed the specific target behaviors and interventions for addressing residents' behaviors. She said she and the social services assistant would update the resident's care plans for the use of the psychotropic medications. The SSD said she was aware some of the residents' care plans were not specific to the individual target behaviors of each resident. She said she was working on a performance improvement plan to ensure the residents were reviewed in the psychotropic medication meetings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (#104) of five residents out of 51 sample residents reviewed for skin assessments.Specifically, the facility failed to assess and obtain orders for the care of Resident #104's controlled ankle motion (CAM - a device that provides protection after orthopedic procedures and assists in offloading pressure) boot for her right leg.Findings include:I. Resident #104A. Resident statusResident #104, age greater than 65, was admitted on [DATE] and discharged to the hospital on 4/22/26. According to the April 2026 computerized physician orders (CPO), diagnoses included traumatic subdural hemorrhage without loss of consciousness, need for assistance with personal care, presence of left artificial hip joint, displaced trimalleolar fracture of the right lower leg and dementia.The 4/22/26 minimum data set (MDS) assessment revealed the resident had a memory problem and was moderately cognitively impaired. The MDS assessment revealed the resident was dependent on assistance from staff for all activities of daily living (ADL).The assessment documented the resident had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device.B. Record reviewThe ADL care plan, initiated 4/19/26, documented Resident #104 had an ADL self-care performance deficit related to limited mobility, impaired balance, deconditioning, dementia, a history of falls, left femur fracture - hemiarthroplasty (partial joint replacement), right ankle fracture with open reduction and internal fixation (ORIF - a common orthopedic surgical procedure used to repair severely broken or displaced bones), subdural hematoma and subarachnoid hemorrhage (bleeding on the brain), breast cancer with metastases to the bone, psychotropic medication use, incontinence and cognitive loss. Pertinent interventions, initiated 4/19/26, included a CAM boot to the resident's lower right leg.The 4/13/26 admission note documented Resident #104 was admitted after undergoing significant orthopedic interventions in the hospital, including a left hip cemented hemiarthroplasty and a right ankle ORIF with a hindfoot nail (rod inserted through the heel). The note documented the resident's baseline dementia/intermittent delirium required a high level of care and necessitated one-on-one staff supervision on arrival to the facility. The resident had a CAM boot on her right leg and was a high fall risk.A 4/15/26 skin and wound note documented Resident #104 had an external device. The external device was a CAM boot that was present to the resident's right lower extremity. The external device was removed and the site was inspected. The staff were to observe for any discoloration on the device/cast that may indicate drainage under the device. Resident #104 was to use the CAM boot when out of bed.A review of Resident #104's April 2026 CPO revealed the following physician's orders:Weight bearing as tolerated for stand and pivot transfers every shift for the right lower extremity in the CAM boot, ordered 4/14/26 and discontinued 4/14/26. Weight bearing as tolerated for stand and pivot transfers every shift for the right lower extremity ordered 4/14/26.-The second weight bearing order did not include the resident's CAM boot.A 4/21/26 occupational therapy note documented a certified nurse aide (CNA) was educated that Resident #104 needed to wear the CAM boot for transfers and when out of bed. -Review of Resident #104's electronic medical record (EMR) did not reveal physician's orders for the resident to wear the CAM boot for transfers and when out of bed, or physician's orders for monitoring the resident's skin underneath the CAM boot.II. Staff interviewsThe regional clinical resource and the wound care nurse were interviewed together on 6/3/26 at 10:06 a.m. The wound care nurse said Resident #104 had a CAM boot on her right heel upon admission to the facility and the CAM boot came up to just below the resident's knee. The wound care nurse said the resident's heel was covered under the boot and her toes were exposed. The wound care nurse said the resident had surgery on her right ankle prior to her admission to the facility.The regional clinical resource said Resident #104 had surgery and a CAM boot was placed on the resident's right heel prior to her admission to the facility. The regional clinical resource said it did not (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	06/03/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	look like the admitting nurse actually removed the CAM boot to assess the resident's heel upon her admission. She said a complete head-to-toe assessment of the resident should be completed upon admission to the facility.The regional clinical resource said the hospital discharging physician's order was for Resident #104 to have the CAM boot on for transfers when the resident was out of bed. The regional clinical resource said the resident was to have the boot removed at her follow up appointment on 4/23/26.The regional clinical resource said the therapy staff were getting Resident #104 up and out of bed and utilizing the CAM boot but the physician's order for the boot was not entered into the resident's EMR so it was not clear to all staff that the resident was to wear the boot. The regional clinical resource said a physician's order should have been placed upon admission for the boot because the resident was admitted with the boot.