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	05/07/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on interviews and record review, the facility failed to ensure consent was obtained for the use of psychotropic medications for three (#46, #25 and #47) of five residents reviewed for unnecessary medications out of 34 sample residents. Specifically, the facility failed to ensure informed consents, which included the risks associated with taking a psychotropic medication, were obtained for Resident #46, Resident #25 and Resident #47. Findings include: I. Facility policy and procedure The Use of Psychotropic Medications policy and procedure, revised 4/12/24 was provided by the nursing home administrator (NHA) on 5/7/24 at 12:47 p.m. It read in pertinent part, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the residents response to medications. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatment/non-pharmacological interventions. II. Resident #46 A. Resident status Resident #46, age greater than 65, admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included atrophy of the kidney (decrease in size and functional ability of the kidney), cerebral infarction (disrupted blood flow to the brain), osteomyelitis of lumbar vertebra (infection of the spine), dementia with psychotic disturbances, and hypertension (high blood pressure). (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/8/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview of mental status (BIMS) score of nine out of 15. Resident #46 received antipsychotic medications. B. Record review The May 2024 CPO revealed the following physician's orders: Zyprexa (antipsychotic) 5 milligram (mg) at bedtime related to unspecified dementia, moderate with psychotic disturbances. Ordered on 8/23/23. Resident #46's care plan, dated 2/14/24 revealed Resident #46 used psychotropic medications related to behaviors associated with the progression of dementia with psychosis. Interventions were to discuss with the medical doctor and family regarding the ongoing need for use of the medication (initiated on 10/9/23). A review of Resident #46's electronic medical record (EMR) failed to reveal an informed consent, which included the risks associated with taking the medication, had been obtained from the resident or the resident's representative for the administration of the Zyprexa. A 5/8/23 progress note written by the admitting physician revealed the resident was noted to be lacking decision making capabilities. Guardianship was completed on 5/5/23. On 5/6/24 at 9:01 a.m. the NHA provided a document of informed consent for Resident #46's Zyprexa. -The informed consent was signed by the resident but failed to have a date of when it was signed. -Additionally, the resident had a court ordered guardianship in place as he was unable to make decisions. -Review of the EMR failed to reveal the resident's guardian had signed an informed consent for Resident #46's Zyprexa medication. C. Staff interviews Registered nurse (RN) #3 was interviewed on 5/7/24 at 9:38 a.m. RN #3 said an informed consent must be obtained when a psychotropic medication was ordered. RN #3 said a consent must be signed prior to the initial medication administration so the resident or resident's representative was aware of the side effects of the medication. RN #3 said if a resident could sign for themselves, they could give consent, even if the resident had a guardian in place. Licensed practical nurse (LPN) #1 was interviewed on 5/7/24 at 9:47 a.m. LPN #1 said the family could sign an informed consent if the family member was the resident's legal representative, or the resident could sign as long as the resident was able to make their own decisions. LPN #1 said informed consent for psychotropic medications should be obtained prior to the first administration of the medication. LPN #1 said if a resident had a guardian in place, the guardian must be contacted for consent. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 said Resident #46 was unable to sign an informed consent because he was confused due to his medical diagnoses. The director of nursing (DON) was interviewed on 5/7/24 at 9:55 a.m. The DON said informed consent for psychotropic medications should be obtained before the first dose of the medication was administered. The DON said the resident had the right to know about side effects of the medication. The DON said if a resident was cognitive with a BIMs score of eight or higher and could make their needs known, they were able to sign an informed consent. The DON said if there was a guardian or legal representative set up for a resident the consent needed to come from the guardian/legal representative. -The DON was unable to determine the date when Resident #46 signed his consent for the Zyprexa (See record review above). The social service director (SSD) was interviewed on 5/07/24 at 11:18 a.m. The SSD said she started at the facility on 4/1/24. The SSD said she touched base with nursing because they were responsible for getting the informed consents. The SSD said informed consents should be signed before a medication was administered. The SSD said the facility had a psychotropic/pharmacological meeting monthly and would start discussing new medications started or changes made to medications. The SSD said the facility would make sure informed consents were in place for residents prior to them starting a psychotropic medication. The SSD said it was important for the resident to know the side effects of medications and what medications they were prescribed. The SSD said if a resident had a guardian, the guardian must sign the informed consent. 47151 III. Resident #25 A. Resident status Resident #25, age 84, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included type II diabetes mellitus, heart disease, depression, and mood disorders. The 4/19/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He was independent with hygiene, eating, toileting, and dressing and needed supervision with bathing and transfers. The MDS assessment documented Resident #25 was taking an antipsychotic medication and antidepressant medication. B. Record review Resident #25's 8/22/23 physician's order note documented an olanzapine (antipsychotic medication)oral tablet 2.5 mg was to be administered to Resident #25 by mouth at bedtime for his diagnosis of persistent mood disorders. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress note further documented possible interactions with other medications Resident #25 was taking, including an interaction with mirtazapine (the resident's antidepressant medication) which could enhance adverse effects of the olanzapine medication resulting in a serious drug reaction. -There was no documentation in the resident's EMR to indicate Resident #25 was informed of the possible interactions of olanzapine with his other medications. Resident #25's psychotropic medication care plan, initiated 10/4/23, revealed the resident received psychotropic medication for behavior management. Pertinent interventions included to administer psychotropic medications according to the physician's order and monitor for side effects and effectiveness every shift. The 4/11/24 medication regimen review documented Resident #25 had been taking the antipsychotic medication olanzapine 2.5 mg since 8/2/23. -There was no documentation in the resident's EMR to indicate Resident #25 was informed of the possible interactions of olanzapine with his other medications. The medication review was completed with Resident #25 on 5/3/24 (during the survey). The medication review documented Resident #25's psychotropic medications were reviewed, both current and a historical data review. The resident was his own decision maker. The resident reported being aware of receiving psychotropic medications while at the facility. Resident #25 reported being in agreement with the psychotropic medications he received while a resident at the facility. The medication review was signed by the interviewer and the resident on 5/3/24 (during the survey). -The medication review did not document Resident #25 was specifically informed of the risks of taking the olanzapine medication. -The facility was unable to provide documentation of an informed consent to indicate Resident #25 was informed of the risks versus benefits of his psychotropic medications prior to the medication being administered. C. Staff interviews The DON was interviewed on 5/7/24 10:02 a.m. The DON said nursing staff should obtain informed consents for psychotropic medication use upon the resident's arrival at the facility. The DON said the floor nurses should obtain the resident's consent for the antipsychotic medication if a new medication order was placed after the resident's admission to the facility. The DON said, going forward, antipsychotic medication informed consent forms should be at the nurses station. 40960 IV. Resident #47 A. Resident status Resident #47, age younger than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included generalized anxiety disorder and bipolar depression. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/28/24 MDS assessment revealed the resident was cognitively intact with a BIMS of 15 out of 15. She had no behaviors and did not reject care. She had impairment to both lower extremities. The MDS assessment documented the resident received antipsychotic and antidepressant medications daily. B. Record review The May 2024 CPO documented the following physician's orders: Seroquel (antipsychotic) oral tablet 100 mg. Give 150 mg by mouth one time a day for bipolar. Start date 11/22/23. Seroquel oral tablet give 300 mg by mouth at bedtime for bipolar disorder. Start date 11/21/23. Zoloft (antidepressant) oral tablet 50 mg give three tablets by mouth one time a day for depression. Start date 3/13/24. The psychotropic medication care plan, revised 4/22/24, revealed Resident #47 used psychotropic medications related to bipolar disorder. Interventions included education of the resident about the risks, benefits and the side effects and/or toxic symptoms. The antidepressant medication care plan, revised 4/5/24, revealed Resident #47 used an antidepressant medication related to depression. The interventions included educating the resident/family/caregivers about the risks, benefits, and the side effects and/or toxic symptoms of the drugs being given. -Review of Resident #47's EMR revealed an informed consent for Seroquel and Zoloft were both signed on 5/3/24 (during the survey). Staff interviews LPN #2 was interviewed on 5/7/24 at 9:38 a.m. LPN #2 said informed consents should be signed by the resident or the resident's representative prior to the administration of a psychotropic medication. She said it was important to educate the resident/family on the possible side effects and what medications the resident was prescribed. The DON was interviewed on 5/7/24 at 9:54 a.m. The DON said informed consents should be signed prior to the administration of a psychotropic medication. She said discussing the medication and signing the consent helped to ensure everyone understood the risks of the medication. The DON said the informed consent included black box warnings (a label that alerts individuals to serious medication safety risks), side effects and the medication prescribed. She said nursing was responsible for getting the informed consents signed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and interviews, the facility failed to ensure a Level II preadmission and resident review (PASRR) was completed for one (#33) of three residents out of 34 sample residents reviewed for PASRR to gain and maintain their highest practical medical, emotional, and psychosocial well-being. Specifically, the facility failed to ensure a Level II PASRR was in place for Resident #33. Findings include: I. Facility policy and procedure The Behavioral Health policy, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/6/24 at 3:13 p.m. It read in pertinent part, It is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching their highest level of mental and psychosocial functioning. II. Resident status Resident #33, age younger than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included mild neurocognitive disorder due to unknown physiological condition with behavioral disturbance, nonpsychotic mental disorder and major depressive disorder. The 2/28/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. He had no behaviors and did not reject care. He required setup assistance with eating and showering. He was independent with all other activities of daily living (ADL). III. Record review Review of Resident #33's Level I PASRR revealed the resident was recommended to be evaluated for a Level II PASRR. -Record review revealed no evidence a Level II PASRR had been completed. The behavior care plan, revised 4/8/24, documented the resident was resistive to care related to major depression. The interventions included to allow the resident to make decisions about his treatment regimen to provide control and to praise the resident when behavior was appropriate. IV. Staff interviews The social services director (SSD) was interviewed on 5/2/24 at 11:45 a.m. The SSD said a Level II PASRR was recommended for Resident #33. However, she said it was not completed. She said she would immediately submit a request for a Level II assessment for Resident #33. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/7/24 at 10:11 a.m. The DON said a Level I PASRR should be completed on admission and if the Level I recommended a Level II assessment, the Level II assessment should be completed. She said it was important to complete a Level II assessment to ensure any triggers for behaviors were documented and to determine the level of care the resident needed. The SSD was interviewed a second time on 5/7/24 at 11:18 a.m. The SSD said she completed an audit on all Level I PASRRs to ensure a Level II assessment was completed if recommended. She said she would continue to work with the PASRR agency to ensure all Level II PASRR assessments were in place for residents who triggered for an assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 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 to maintain good grooming and personal hygiene for two (#69 and #35) of three residents reviewed out of 34 sample residents. Specifically, the facility failed to ensure Resident #69 and Resident #35, who were dependent on staff for bathing, received their scheduled showers. Findings include: I. Facility policy and procedure The Resident Shower policy, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/9/24 at 10:48 a.m. It read in pertinent part, It is the practice of the facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues. The Activity of Daily Living policy, revised 4/12/24, was provided by the NHA on 5/6/24 at 3:13 p.m. It read in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities: -Bathing, dressing, grooming and oral care; -Transfer and ambulation; -Toileting; Eating to include meals and snacks; and -Using speech, language or other functional communication systems. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral care. II. Resident #69 A. Resident status Resident #69, age younger than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included chronic kidney disease, congestive heart failure, traumatic brain injury (TBI), transient ischemic attack, acquired absence of left toe, anxiety disorder and depressive episode. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/24/24 MDS revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He used a wheelchair and was dependent on staff for bathing. He was occasionally incontinent of urine and always continent of bowel. B. Resident interview Resident #69 was interviewed on 5/2/24 at 3:51 p.m. during the group interview. Resident #69 said his last shower on 5/6/24 was the first shower he had in three weeks. He said he was scheduled to receive two showers a week on Wednesdays and Saturday. C. Record review The ADL care plan, revised on 10/12/23, revealed Resident #69 had an ADL self-care performance deficit related to weakness and cognitive deficits resulting from a TBI. Interventions included supervision/touching assistance of one staff member with showering/bathing. Review of the February 2024 through May 2024 shower logs revealed Resident #69 had not received two showers in February 2024, four showers in March 2024, four showers in April 2024 and one shower in May 2024. III. Resident #35 A. Resident status Resident #35, age 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included Guillain-Barre syndrome (the immune system attacks the nerves), contracture (shortening of the muscle causing a deformity), difficulty in walking, muscle weakness, morbid obesity and bilateral primary osteoarthritis of the knees. The 4/8/24 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 had impairment to both of his lower extremities. He used a wheelchair and was dependent on staff for bathing. He was occasionally incontinent of urine and frequently incontinent of bowel. B. Resident interview Resident #35 was interviewed on 5/1/24 at 1:08 p.m. Resident #35 said he did not receive his bed baths as scheduled. He said he was scheduled to have two showers a week on Tuesdays and Fridays. C. Record review Review of the February 2024 through April 2024 shower logs revealed Resident #35 had not received two bed baths in February 2024 and one bed bath in April 2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADL care plan, revised on 1/25/24, revealed Resident #35 had an ADL self-care performance deficit related to Guillain Barre syndrome, transient ischemic attack (TIA) (a mini stroke), contracture and muscle weakness. Interventions included providing a sponge bath when a full bath or shower could not be tolerated and the resident preferred them on Mondays and Fridays. The resident required assistance twice weekly and as necessary. The resident was bed fast most of the time. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/7/24 at 9:33 a.m. CNA #1 said residents were given at least two showers a week and they were documented in the electronic medical record (EMR). She said it was important for the residents to receive their scheduled showers for hygiene, nail care and odors. She said if a shower was refused, the CNAs would make three attempts to reoffer the shower on the scheduled day. She said if the three attempts did not work, the CNA would offer a shower the following day. Licensed practical nurse (LPN) #2 was interviewed on 5/7/24 at 9:38 a.m. LPN #2 said the CNAs were responsible for giving the residents a shower on their scheduled day. She said if a shower was refused, the CNAs would report it to the nurse and a shower sheet, as well as a progress note, would be completed. She said it was important for the residents to receive their showers for hygiene and skin integrity. She said each resident should receive two showers weekly. The director of nursing (DON) was interviewed on 5/7/24 at 9:51 a.m. The DON said Resident #69 and Resident #35 were scheduled to receive their showers on Mondays and Fridays. She said it was important for the residents to receive their scheduled showers twice a week for hygiene, skin integrity and wounds. She said she was not sure why the showers were missed and would complete a full house audit.

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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** 47151 Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two (#60 and #58) of six residents out of 34 sample residents reviewed for nutrition status. Specifically, the facility failed to obtain weekly weights per the physician's orders for Resident #60 and Resident #58. Findings include: I. Facility policy and procedure The Weight Monitoring policy, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/7/24 at 4:00 p.m. The policy read in pertinent part, Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended weight loss over a period of time) may indicate a nutritional problem. A weight monitoring schedule will be developed upon admission for all residents: Weights should be recorded at the time obtained. Newly admitted residents and residents with weight loss will have weight monitored weekly for four weeks. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate. II. Resident #60 A. Resident status Resident #60, age less than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included bacterial infection, sickle cell anemia (disorder that causes red blood cells to be misshapen), weakness, heart failure, and severe protein-calorie malnutrition. The 2/10//24 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 needed supervision while bathing and was independent with all other activities of daily living. The MDS assessment documented Resident #60 had not refused care. B. Resident interview Resident #60 was interviewed on 5/1/24 at 2:19 p.m. and said he was concerned about his recent weight. C. Record review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/19/24 nutrition evaluation documented in the recommendation/plan section to monitor routine weights and weekly weights were needed to closely monitor Resident #60 as his body mass index (BMI) was 15.3 (underweight status). Resident #60 had a physician's order for weekly weights for four weeks and then to reevaluate, ordered on 2/26/24. A review of Resident #60's electronic medical record (EMR) documented he weighed 97.7 pounds (lbs) on 2/3/24. -Resident #60 was not weighed until 4/1/24 where he weighed 93.4 lbs. -The facility failed to monitor and record any weights for Resident #60 between 2/3/24 and 4/1/24 per the physician's order. -Between 2/3/24 and 4/1/24, Resident #60 lost 4.3 lbs, or 4.4% of his body weight, which was not significant. III. Resident #58 A. Resident status Resident #58, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included dementia, heart disease, anxiety, type II diabetes mellitus, high blood pressure, mild-protein calorie malnutrition and adult failure to thrive. The 4/11/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of five out of 15. She needed moderate assistance with bathing and personal and toileting hygiene, and supervision with lower body dressing and footwear, transfers and walking throughout the unit. She needed set up assistance with eating, oral hygiene and upper body dressing. The MDS assessment documented Resident #58 occasionally rejected care. B. Record review A review of Resident #58's EMR documented her weight upon admission on 4/3/24 was 125.4 lbs. A physician's order for weekly weights for four weeks and then to reevaluate was ordered on 4/17/24. -A review of Resident #58's EMR revealed the resident's weight was not obtained after her initial admission weight was acquired on 4/3/24. The following responses were recorded in the resident's EMR when her weight was to be obtained: -4/15/24: Not applicable; -4/22/24: Resident not available; and, -4/29/24: Not applicable. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #58's physician's order was updated on 5/6/24 (during the survey) to weigh Resident #58 every Tuesday for four weeks. C. Facility follow up The facility provided additional information on 5/8/24 that, per Resident #58's shower sheet, she refused to be weighed on 4/25/24. -However, Resident #58 was admitted on [DATE] and weekly weights were not obtained or documented as refused by Resident #58 on any additional days after her admission to the facility. IV. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 5/7/24 at 10:00 a.m. CNA #2 said residents were weighed the first day they were admitted to the facility if possible. She said residents were weighed every two weeks and then once a month following their admission. CNA #2 said residents could be weighed more frequently than once a month if requested. CNA #2 said staff documented residents' refusal of weights in the residents' EMR, and staff attempted to obtain a resident's weight three times before marking it as refused. CNA #2 said after the third attempt to obtain a resident's weight she notified a nurse and the nurse would follow-up with the resident. Licensed practical nurse (LPN) #1 was interviewed on 5/7/24 at 10:30 a.m. LPN #1 said the CNAs obtained the residents' weights. LPN #1 said if a resident refused to be weighed a CNA should let a nurse know and the nurse would try to offer to weigh the resident. LPN #1 said if the resident refused to be weighed, the resident's refusal was documented in the EMR. The director of nursing (DON) was interviewed on 5/7/24 at 1:20 p.m. The DON said staff should obtain residents' weights per the facility policy. The DON said CNAs should notify the nurse if a resident refused to be weighed or staff should reattempt to obtain the resident's weight and document the additional attempts and refusals.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 40960 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five (#1, #4, #5, #6 and #7) of five certified nurse aides. Specifically, the facility had not completed annual performance reviews for certified nurse aide (CNA) #1, #4, #5, #6 and #7 in order to determine potential training needs. Findings include: I. Facility policy and procedure The Evaluation Process policy, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/6/24 at 3:13 p.m. It read in pertinent part, It is the policy of our facility to review the work performance of employees with a formal written evaluation. Factors that will be considered in making decisions include job performance, achieving goals, attendance record and adherence to workplace policies. II. Record review Annual performance reviews were requested on 5/6/24 at 1:59 p.m for CNAs #1, #4, #5, #6 and #7. The facility was unable to provide annual performance evaluations for 2023 for all five CNAs. -The director of nursing (DON) said CNAs #1, #4, #5, #6 and #7 did not have annual performance reviews and had not completed annual in-service education based on the outcome of their reviews. Cross-reference F947 for failure to ensure CNAs received annual training as required. III. Staff interviews The director of nursing (DON) was interviewed on 5/7/24 at 10:51 a.m. The DON said the annual performance reviews were to be completed by the DON/nurse management. She said she had only been employed at the facility the week of the survey (5/1/24 to 5/7/24). She said she did not know which employees a performance review had been completed for by the previous DON and would complete a full audit to determine which employees needed their performance evaluation completed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for one (#46) of five residents reviewed for unnecessary medications out of 34 sampled residents. Specifically the facility failed to ensure: -Acetaminophen (pain medication) administered to Resident #46 did not exceed the recommended 3 grams (gm) in a 24-hour period; and, -As needed (PRN) medication was administered per physician's orders. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Facility policy and procedure The Medication Administration policy and procedure, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/7/24 at 12:47 p.m. It revealed in pertinent part, Obtain and record vital signs, when applicable or per physician order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example guidelines for medication administration (unless otherwise ordered by physician), this list is not all-inclusive: -Medications requiring vital signs prior to administration of antihypertensives. III. Resident status Resident #46, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included atrophy of the kidney, cerebral infarction (stroke), osteomyelitis of lumbar vertebra (infection of the spine), dementia with psychotic disturbances (abnormal thought process), and hypertension (high blood pressure). The 2/8/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He was dependent on staff for transfers, dressing, and toileting. He needed substantial assistance with personal hygiene and set up with eating. The assessment revealed the resident received scheduled pain medications. IV. Record review 1. Acetaminophen Resident #46's May 2024 CPO revealed the following physician's orders: Acetaminophen (pain and fever reducer) 500 milligrams (mg) two tablets three times a day for pain, ordered on 4/11/24. -The routine physician's order total dosage equaled the recommended maximum dose of 3 gm of acetaminophen in 24 hours. Acetaminophen 325 mg two tablets every six hours as needed for pain (PRN) level of 1 to 4 on a pain scale of 1-10. Not to exceed 3 grams (gm) of acetaminophen in 24 hours,ordered on 2/22/24. -Administering the PRN acetaminophen dose would result in Resident #46 receiving 650 mg over the recommended maximum dose of 3 gm of acetaminophen each time the PRN medication was administered. The April 2024 medication administration record (MAR) revealed the following: On 4/13/24, Resident #46 received one dose of PRN acetaminophen. -Resident #46 received 650 mg of acetaminophen over the maximum recommended dose of 3 gm of acetaminophen in 24 hours. On 4/17/24, Resident #46 received one dose of PRN acetaminophen. -Resident #46 received 650 mg of acetaminophen over the maximum recommended dose of 3 gm of acetaminophen in 24 hours. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #46's progress notes failed to document that a physician was notified on 4/13/24 and 4/17/24 for acetaminophen exceeding the recommended maximum dose of 3 grams of acetaminophen in 24 hours. 2. Hydralazine Resident #46's April 2024 CPO revealed the following physician's orders: Hydralazine (anti hypertensive medication) 25 mg give one tablet every six hours as needed for systolic blood pressure over 160 millimeters of mercury (mmHg), ordered on 5/13/23. The April 2024 MAR revealed the following: On 4/3/24, during the day shift, Resident #46's blood pressure was 164/87 mmHg. -The resident was not administered Hydralazine for a systolic blood pressure over 160 mmHg per the physician's order. On 4/13/24, during the day shift, Resident #46's blood pressure was 162/80 mmHg. -The resident was not administered Hydralazine for a systolic blood pressure over 160 mmHg per the physician's order -Resident #46's progress notes for 4/3/24 and 4/13/24 failed to document that the physician was notified that Hydralazine was not administered. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/6/24 at 2:41 p.m. LPN #1 said she was unaware Resident #46 had an as needed order for Hydralazine since she had never had to administer Resident #46's Hydralazine. LPN #1 said if a resident did not get an antihypertensive medication it could lead to risk of stroke because the resident's blood pressure could get too high. LPN #1 said Resident #46 had scheduled acetaminophen and as needed pain acetaminophen. LPN #1 said if a resident was administered more acetaminophen than a recommended dose it could lead to liver issues. Resident #46's primary care physician (PCP) was interviewed on 4/7/24 at 8:56 a.m. The PCP said if a resident did not get an antihypertensive medication administered as physician ordered, it could lead to stroke due to the resident's blood pressure not being controlled. The PCP said too much acetaminophen could lead to liver complications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/7/24 at 10:18 a.m. The DON said nurses should check blood pressure prior to administering any antihypertensive medications. The DON said, based on Resident #46's physician's orders, if the blood pressure reading was above 160 mmHg systolic, nurses were to administer a dose of Hydralazine. The DON said not administering an antihypertensive medication placed the resident at risk of a hypertensive crisis (medical emergency when blood pressure is too high). The DON said if a resident was administered acetaminophen over the recommended 3 grams of acetaminophen in 24 hours it could place strain on the resident's liver. The DON said the nurse should contact the resident's physician to inform the physician of the excessive dose and ask if there would be any special monitoring needed. The DON said the nurse should write a progress note to indicate the physician was notified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47064 Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly according to professional standards in one of three medication carts and one of two medication storage rooms. Specifically the facility failed to: -Ensure expired medications and vaccines were disposed of timely; -Ensure insulin pens (medication used for glucose control) were labeled with open dates; and, -Ensure Tubersol (used to test for tuberculosis) vials were labeled with open dates. Findings include: I. Professional references According to the Lantus glargine insulin package insert, retrieved on 4/29/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/021081s076lbl.pdf, When not in use store in refrigerated temperatures of 36 to 46 degrees fahrenheit (F). When in use, can be kept at room temperature for up to 28 days. According to the Novolog insulin package insert, retrieved on 5/8/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020986s082lbl.pdf After initial use a vial may be kept at temperatures below 30 degrees celsius (C) (86 degrees F) for up to 28 days, but should not be exposed to excessive heat or light. According to the Tubersol package insert, retrieved on 5/8/24 from https://www.fda.gov/media/74866/download, A vial of Tubersol which has been entered and in use for 30 days should be discarded. According to the Latanoprost package insert, retrieved on 5/8/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf, Store unopened bottle(s) under refrigeration at two to eight degrees C (36 to 46 degrees F). Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees C (77 degrees F) for six weeks. II. Facility policy and procedure The Medication Storage policy and procedure, revised on 4/12/24, was provided by the nursing home administrator (NHA) on 5/7/24 at 12:47 p.m. It revealed in pertinent part, Policy of this facility is to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitization, temperature, light, ventilation, moisture control, segregation and security. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unused medications: the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications. III. Observations and staff interviews On 5/2/24 at 2:25 p.m. the main nurses medication room was observed with registered nurse (RN) #2. The following items were found: One Lantus insulin pen that had a manufacturer's expiration date of February 2024. -The medication was over one month past the manufacturer's expiration date. One opened Lantus insulin pen with no open date. One opened vial of Tubersol with no open date. One opened vial of Tubersol with an open date of 3/5/24. -The medication was 27 days past the recommended date of open use (see manufacturer's recommendation above). One Spivax Covid-19 vaccine that expired on 4/24/24. -The medication was six days past the expiration date. One opened Novolog insulin vial with an open date of 9/29/23. -The medication was six months past the recommended use by date after opening (see manufacturer's recommendation above). Two intravenous (IV) bags of Daptomycin (antibiotic) 600 milligrams (mg) in 50 milliliters (ml) that expired on 4/3/24. -The medication was 30 days past the expiration date. RN #2 said the expired medications should have been removed from the refrigerator to help prevent a nurse from administering the medications or vaccines to a resident. RN #2 said if a resident were to receive a medication that was expired or used past the recommended use by date, the resident might not get the expected response from the medications. RN #2 took the expired medications to the director of nursing's (DON) office for destruction at 2:39 p.m. On 5/2/24 at 2:51 p.m. the 400 hall medication cart was observed with RN #1. The following items were found: One bottle of Latanoprost 0.005% eye drops that was opened on 1/25/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Latanoprost eye drops were 10 weeks past the recommended use by open date (see manufacturer recommendation above). One bottle of Latanoprost 0.005% eye drops that was opened on 2/2/24. -The Latanoprost eye drops were eight weeks past the recommended use by open date (see manufacturer recommendation e above). -One vial of Lantus insulin with no open date was stored in a box of Timolol (prescription eye drops) in the top drawer of the medication cart. RN #1 said it was the responsibility of the nurses to remove expired medications from the medication carts or refrigerators. RN #1 said expired medications increased the risk of the medications being less effective. RN #1 said eye drop bottles could grow bacteria and lead to infection if used past the recommended dates. RN #1 said bottles of Latanoprost eye drops were good for four weeks after opening the bottle, then the bottle should be discarded and a new bottle should be used. IV. Additional staff interviews The DON was interviewed on 5/7/24 at 10:03 a.m. The DON said insulin medications were only good for 30 days once they were opened. The DON said labeling the medications with open dates was important so staff know when the medications expired. The DON said Latanoprost eye drops were good for 30 days once opened. -However, according to the manufacturer's guidelines, Novolog and Lantus were only good for 28 days once they were opened (see professional references above). -However, the manufacturer guidelines revealed Latanoprost eye drops were good for six weeks after opening (see professional references above). The DON said it was the responsibility of the nurses to ensure expired and discontinued medications were removed from the medication carts and medication refrigerators. The DON said if an expired medication was given it would not be as effective for the resident.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47151 Based on observations, record review and interviews, the facility failed to ensure residents received food and fluids prepared in a form designed to meet his or her needs. Specifically, the facility failed to ensure residents who were prescribed mechanical soft diets had food prepared according to their diet orders of mechanical soft as indicated on their meal tray cards. Findings include: I. Facility policy and procedure The Therapeutic Diet Orders policy and procedure, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/6/24 at 3:00 p.m. The policy read in pertinent part, The facility provides all residents with foods in the appropriate form and/or the the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat and thickened liquids. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. II. Record review The mechanical soft diet description from the facility diet manual was provided by the NHA on 5/6/24 at 9:30 a.m. The diet manual documented the following modifications for the mechanically altered food items served during lunch meal service on 5/2/24: Bread was to be served slurried using a commercial thickener combined with liquid and bread or commercially prepared pureed bread products. Whole corn was restricted. Instead the cooks were to utilize commercially prepared pureed corn and pea products that were smooth and did not present a choking hazard to the resident. Casseroles that contained restricted items such as whole rice grains were to be served pureed. The diet menu for the mechanical soft diets was provided by the NHA on 5/6/24 at 4:30 p.m. The mechanical soft diet menu documented the following mechanical soft modifications for menu items served during the lunch meal on 5/2/24: -The stuffed pepper was to be served as a pureed stuffed pepper; -The corn was to be served pureed; (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The wheat roll needed to be slurried; and, -The mocha fudge marble cake needed to be served as a slurried mocha fudge marble cake. -The facility failed to ensure the resident's who were prescribed a mechanical soft diet received foods that were altered to the correct texture for the lunch meal on 5/2/24. II. Meal service observation and staff interviews During a continuous observation of the lunch meal service on 5/2/24, beginning at 11:15 a.m. and ending at 12:25 p.m., the following was observed: -The posted menu in the dining room documented the lunch meal consisted of stuffed bell peppers, wheat roll, buttered corn, and mocha fudge marble cake. -At 11:15 a.m. the mechanically altered items were in the hot food holding steam table. The mechanically altered menu items held in the hot food holding table were reviewed with cook (CK) #1. CK #1 said the following foods in the steam table were mechanical soft foods: a pan of creamed corn (with visible chunks of corn) and a pan of ground beef mixed with individually cooked whole grains of rice. -According to the dietary manual (see above), the mechanical soft diet restricted whole kernels of corn. The dietary manual indicated a commercially prepared pureed (smooth with no lumps) corn product was to be served instead. The commercially prepared puree corn products were smooth and did not present a choking hazard to the residents. Casseroles with restricted food items, such as rice, were to be pureed for the residents on mechanical soft diets. At 11:30 a.m. service for the lunch meal began. Between 11:30 a.m. and 12:15 p.m., five lunch meal plates, for residents who were prescribed a mechanical soft diet per their dietary meal tickets, were assembled and placed in the meal delivery carts for delivery to the resident's rooms. -The five meal plates included the ground beef and rice CK #1 had identified as the mechanical soft entree (see CK #1's interview and observation above) and a regular dinner roll, which was not modified with a slurry. -Three of the five plates included the creamed corn (not the commercially prepared pureed corn that was indicated should be served per the dietary manual). -The facility failed to puree the rice item served as part of the mechanically altered stuffed pepper, failed to serve a slurried roll and failed to serve a puree corn or mechanically appropriate vegetable for residents on the mechanical soft diets and according to the recommendations in the dietary manual and mechanically altered menus. -At 12:15 p.m., during lunch service, CK #2 was interviewed. CK #2 said she was the evening cook. CK #2 said mechanically altered menus for the meals were not available for guidance in the kitchen when the cooks were preparing and serving the meals, but the dietary manager (DM) might have the mechanically altered diet menus. IV. Additional staff interviews (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DM was interviewed on 5/2/24 at 12:20 p.m The DM said she used the dietary manual as a guideline for preparing and serving mechanically altered diets at the facility instead of utilizing the mechanically altered menus. On 5/2/24 at 12:25 p.m. the mechanically altered menus were requested from the NHA. The NHA said he would print and provide the mechanically altered menus. The NHA said he was not sure if the DM knew how to print the mechanically altered menus and the facility used the level two national dysphagia diet for mechanical soft meal modifications. The NHA said the dietary manager was new to the facility and the facility's menu program so a staff member who was trained to use the menu program would train the DM on the program. Certified nurse aide (CNA) #2 was interviewed on 5/7/24 at 10:00 a.m. CNA #2 said she had not received training on mechanically altered diets or how to recognize if a modified texture diet was prepared incorrectly in order to identify an error prior to the resident being served a meal tray. CNA #2 said if a resident ordered a menu item she thought was not part of the resident's prescribed diet, she would notify the DM. She said the DM could talk to and educate the resident about the resident's diet. The DM and NHA were interviewed together on 5/7/24 at 11:30 a.m. The DM said she was not aware the stuffed peppers served during the 5/2/24 lunch meal were to be served pureed for residents on a mechanical soft diet. The DM said she did not slurry the wheat rolls and mocha fudge cakes prior to the lunch meal being served to residents on the mechanical soft diets. The DM said she knew the items needed to be soft to decrease the risk of the resident choking. The NHA said if a resident requested an item not recommended on their prescribed diet, the facility would provide education to the resident, contact the physician and the facility could consider a speech evaluation to upgrade a resident's diet texture if it was appropriate. The NHA said the dietary staff used the mechanical soft diet menus for meals after the lunch meal service on 5/2/24. The NHA said the facility planned to transition to the International Dysphagia (difficulty swallowing) Diet Standardization Initiative (IDDSI) (a tool to standardize mechanically altered diets and liquids) and speech therapists at the facility would assist with training facility staff during the transition. The NHA said CNAs were all previously trained on recognizing appropriate items for modified textures during meal time. The NHA said the CNAs were scheduled to have additional training on mechanically altered diets during their upcoming skills fair.

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Lowry Hills Care and Rehabilitation	10201 E 3rd Ave Aurora, CO 80010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in a sanitary manner. Specifically, the facility failed to: -Ensure staff performed hand hygiene appropriately while washing dishes and handling clean dishes; and, -Ensure food was labeled, dated and disposed of timely in the nourishment refrigerator. Findings include: I. Ensure staff performed hand hygiene appropriately while washing dishes and handling clean and sanitized dishes A. Professional reference The Colorado Retail Food Regulations, ([DATE]), retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations, The regulations read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. After handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; when switching between working with raw food and working with ready-to-eat food; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. B. Facility policy and procedure The Food Safety Requirements policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 10:00 a.m. The policy read in pertinent part, All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. Clean dishes shall be kept separate from dirty dishes. Staff shall wash hands prior to handling clean dishes, and shall handle them by outside surfaces or touch only the handles of utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. Staff shall wash hands according to facility procedures. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas. Gloves will be worn when directly touching ready-to-eat foods and when serving residents who are on transmission-based precautions. However, staff do not need to wear gloves when distributing foods to residents at the dining table(s) or when assisting residents to dine unless touching ready-to-eat food. C. Observations During a continuous observation during the lunch meal service on [DATE], beginning at 11:15 a.m. and ending at 12:25 p.m., the following was observed: -At 11:36 a.m. dietary aide (DA) #1 lifted the dish machine door on the soiled side of the machine where soiled dishes were placed, pushed a rack of dishes into the dish machine and closed the dish machine door which automatically started the dishwashing cycle. DA #1 moved to the clean side of the dish machine and removed a pair of tongs from the clean and sanitized dish rack, carried the tongs to the three compartment sink, turned on the faucet with one hand, rinsed off the tongs in her other hand, turned off the faucet, shook the tongs and placed the tongs with the clean and sanitized dishes. DA #1 failed to perform hand hygiene before handling clean and sanitized dishes and placing them back with clean dishes used for food production. -At 11:38 a.m. DA #1 placed three full size baking sheets on the soiled side of the dish machine. DA #1 then placed a soiled pot and serving utensil on a dish rack. DA #1 walked to the clean side of the dish machine, used her hand to open the dish machine door and pulled the dish rack that contained clean out of the machine. DA #1 pushed another dish rack with soiled dishes into the dish machine, closed the dish machine door to start an automatic dishwashing cycle.Without performing hand hygiene, DA #1 then picked up a clean and sanitized six inch deep full size food steam table pan and placed the pan on a shelf with other clean and sanitized pans used for food production. DA #1 opened the dish machine door on the clean side of the dish machine and pulled the clean and sanitized dish rack onto the dish table. -At 11:40 a.m. DA #1 lifted two buckets on the shelf above the three compartment sink. She also turned on the water faucet in the three compartment sink. Without performing hand hygiene, DA #1 walked to the clean side of the dish area and began putting away clean dishes. -At 11:42 a.m. DA #1 opened the dish machine door on the soiled side and pushed a rack into the dish machine to be washed and closed the door to the dish machine. DA #1 walked to the three compartment sink, picked up an orange towel and wiped the table and sinks that were on the soiled and clean side of the dish machine. Without performing hand hygiene, DA #1 picked up clean dishes and put them away. DA #1 walked back to the three compartment sink, turned off the faucet with her hands, lifted a dirty item from inside the sink, walked over to a trash bin, lifted the trash can lid with her left hand and placed the item in the trash bin with her right hand. DA #1 walked back to the three compartment sink a second time, lifted a dirty item from inside the sink, walked back to the trash can, lifted the trash can lid with her left hand and placed something in the trash bin with her right hand. -At 11:44 a.m. without performing hand hygiene, DA #1 picked up a clean sauce pot and put it away with the clean dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:49 a.m. DA #1 put on single use disposable gloves. DA #1 began scraping food off dirty plates and bowls into the trash bin while wearing the single use gloves. A staff member approached DA #1 and asked for a coffee cup. While still wearing the same gloves, DA #1 picked up a clean coffee cup and gave the cup to a staff member. The staff member then filled the cup with coffee, walked into the dining room and handed the cup of coffee to a resident. D. Interviews The director of housekeeping (DOH), the dietary manager (DM) and the NHA were interviewed together on [DATE] at 11:30 a.m. The DOH said the previous infection preventionist (IP) had provided hand hygiene in-services to the kitchen staff which included education on performing hand hygiene after handling dirty dishes and before handling clean dishes. The NHA said handwashing education was provided to the kitchen staff during the survey. He said the education covered proper hand hygiene while washing dishes. He said he would include the information in the upcoming staff skills fair. The DM said DA #1 had been provided hand hygiene education prior to the survey. DA #1 was interviewed on [DATE] at 1:00 p.m. DA #1 said she typically washed and put away dishes as needed. DA #1 said if she wore disposable gloves to wash dishes, she needed to remove her gloves and clean her hands before handling clean dishes. DA #1 said she knew to wash her hands for 15 seconds during the hand washing process. She said she knew her hands needed to be washed after touching an unclean item and prior to touching a clean item. DA #1 said she had not been provided handwashing education until [DATE] (during the survey). DA #1 said she believed she received handwashing training upon hire two years ago. The IP was interviewed on [DATE] at 4:00 p.m. The IP said she provided hand hygiene education to the dietary staff on [DATE] (during the survey). She said the education included teaching staff hand hygiene needed to be performed after handling soiled dishes and before touching clean dishes. The IP said she tracked staff education with a spreadsheet and all staff signed off verifying the education was provided. The IP said she provided hand hygiene education to the facility staff at an all staff meeting prior to the survey. The director of nursing (DON) was interviewed on [DATE] at 4:00 p.m. The DON said hand hygiene audits would be in place for all departments including staff who worked in the kitchen. II. Ensure food was labeled and dated and disposed of timely in the main kitchen and nourishment refrigerator A. Professional reference The Colorado Retail Food Regulations, ([DATE]), retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. The regulation read in pertinent part, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A date marking system may include marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; and using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authority upon request. B. Facility policy and procedure The Food Safety Requirements policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 10:00 a.m. The policy read in pertinent part, Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage. Practices to maintain safe refrigerated storage include: Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation; labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and keeping foods covered or in tight containers. C. Observations On [DATE] at 2:00 p.m. the following items were observed in the nourishment room refrigerator: -A stack of three plastic food containers. The top container had a resident's name and the date [DATE] was written on a label on the container. The middle had a name written on the label but did not have a date written on the container. The bottom container had no label or date. -A local fast food restaurant sandwich bag with the date [DATE] written on the bag. -A sandwich on the bottom shelf of the refrigerator in a clear sandwich bag with 'PBJ' and [DATE] written on the clear sandwich bag. -One 32 ounce (oz) container of carrot juice. The container was half full with a name written on the bottle. An open date was not written on the bottle. -An open four oz container of yogurt.The yogurt container was half full and did not have a name or open date and was not rewrapped to seal the yogurt. -There were two individual portion cups that did not have a name, date or label to indicate what was in the cups. -A paper bag containing food items was in the freezer. The bag was not labeled with a name and the date [DATE] was on the bag. The nourishment refrigerator was observed again on [DATE] at 10:30 a.m. The following items were observed in the nourishment room refrigerator: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The stack of three plastic food containers remained in the refrigerator. The top container had a resident's name and the date [DATE] was written on a label on the container. The middle had a name written on the label but did not have a date written on the container. The bottom container had no label or date. -The fast food restaurant sandwich bag with the date [DATE] written on the bag was still in the refrigerator. -The sandwich on the bottom shelf of the refrigerator in a clear sandwich bag with 'PBJ' and [DATE] written on the clear sandwich bag was still in the refrigerator. -Two individual portion cups that did not have a name, date or label to indicate what was in the cups remained in the refrigerator. -A reusable ceramic drink cup with a lid that did not have a name or date on the cup. D. Staff interviews The NHA was interviewed on [DATE] at 10:45 a.m. The NHA said the DM was responsible for monitoring the contents of the refrigerator and removing expired items. Certified nurse aide (CNA) #4 was interviewed on [DATE] at 10:00 a.m. CNA #4 said the dietary staff removed expired food from the nourishment refrigerator but the other staff could also throw away expired food. CNA #4 said she was trained to write a resident's name on the food items brought by the family or resident and put the resident's room number on the item. CNA #4 said she was unsure of an appropriate expiration date for the food items brought by residents or their family. The DM was interviewed with the NHA on [DATE] at 11:30 a.m. The DM said a dietary aide checked the nourishment refrigerator daily and she would check the refrigerator also. The DM said dietary staff should clean out the expired food products. The DM said families brought in food for the residents. The DM said food made at the facility and placed in the nourishment refrigerator should be used within three days or discarded. The DM said sandwiches made at the facility were usually placed in a different smaller refrigerator instead of the larger refrigerator the expired food was found in. The NHA said the sandwiches might have been placed in the wrong refrigerator and should have been placed in the smaller refrigerator.The NHA said the large refrigerator was labeled as a resident refrigerator only and staff should not put their drinks in the larger refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48113 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on two of six units. Specifically, the facility failed to: -Ensure housekeeping staff followed proper cleaning techniques for cleaning and disinfecting resident rooms and high frequency touched areas (call lights, door handles and handrails); -Ensure housekeeping staff were trained appropriately on housekeeping procedures; -Ensure housekeeping staff used the correct surface disinfectant products; and, -Ensure surface disinfectant times were adhered to. Finding include: I. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 5/9/24. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 5/9/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. II. Facility policy and procedure The Housekeeping Services policy and procedure, revised on 4/12/24, was provided by the director of nursing (DON) on 5/7/24 at 3:17 p.m. It read in pertinent part, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in resident rooms and common areas. Cleaning considerations include, but are not limited to, the following: clean from top to bottom (bring dirt from high levels down to floor levels) and clean from back to front areas. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to: toilet flush handles, bed rails, tray tables, call buttons, television remote, telephones, toilet seats, monitor control panels, touch screens and cables, resident chairs, IV (intravenous) poles, blood pressure cuffs, sinks and faucets, light switches and door knobs and levers. The disinfectant solution will be prepared fresh daily and changed frequently in order to ensure effectiveness. Housekeeping staff should follow manufacturer recommendations for dilution and frequency of changing of disinfectant solution. Housekeeping staff should follow manufacturer recommendations regarding appropriate contact times to ensure adequate disinfection. The director of housekeeping (DOH) provided the surface cleaner instructions on 5/2/24 at 3:45 p.m. it read The surface cleaner used in the facility is Spray Kleen Multi-Surface Neutral Cleaner. The guidelines read: Spray Kleen Multi-Surface Neutral Cleaner is a superior multi-purpose cleaner specifically designed to safely clean most kitchen surfaces. Spray Kleen multi-surface neutral cleaner is perfect for kitchen floors and is economical to use. The product picks up grease, cleans out grout and leaves surfaces clean and film free. The product is ideal for cleaning floors, walls, terrazzo and [NAME] tile. III. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 5/6/24, beginning at 12:30 p.m. and ending at 12:59 p.m., housekeeper (HSKP) #1 was observed cleaning room [ROOM NUMBER] and #204 -HSKP #1 used a surface cleaner (see above) not a disinfectant to clean the surfaces in the room. HSKP #1 used a cleaner agent soaked cloth and wiped the horizontal surfaces in the rooms (night stands and tray tables). HSKP #1 wiped the surfaces in the rooms with the cleaning agent soaked cloth for four seconds per surface. HSKP #1 used the same cleaning agent soaked cloth to clean the nightstands and tray tables for all three residents in room [ROOM NUMBER] and used a different cleaning agent soaked cloth to clean the nightstands and tray tables for all three residents in room [ROOM NUMBER]. -HSKP #1 did not use a separate rag for each resident's nightstand and tray table in the two rooms. -HSKP #1 did not sanitize or clean the high frequency touch areas (call lights, door knobs, light switches, closet handles, bathroom grab bars and bed remote) in room [ROOM NUMBER] or room [ROOM NUMBER]. The bathroom in each room had a safety rail which was shared by the three residents who resided in the room. -HSKP #1 did not disinfect the bathroom safety rails in room [ROOM NUMBER] or room [ROOM NUMBER] During a continuous observation on 5/6/24, beginning at 1:15 p.m. and ending at 1:30 p.m., HSKP #2 was observed cleaning room [ROOM NUMBER]. -HSKP #2 used a surface cleaner (see above) not a disinfectant to clean the surfaces in the room. HSKP #2 used a cleaning agent soaked cloth and wiped horizontal surfaces in the room (night stands and tray tables). HSKP #2 wiped the surfaces in the room for four seconds per surface and the surface. HSKP #2 sprayed the cleaning agent inside the toilet bowl and used a brush to clean the inside of the toilet. HSKP #2 used the same toilet brush to clean the outside of the toilet bowl and the flushing handle. -HSKP #2 did not sanitize or clean the high frequency touch areas (call lights, door knobs, light switches, closet handles, bathroom grab bars and bed remote). IV. Staff interviews HSKP #1 was interviewed on 5/6/24 at 1:07 p.m. HSKP #1 said she used the Spray Kleen Multi-Surface Cleaner to clean the residents' rooms. She said she did not disinfect the room with an approved disinfectant product. She said she did not clean all of the high frequency touch areas in rooms #203 and #204. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HSKP #2 was interviewed on 5/6/24 at 1:31 p.m. HSKP #2 said she used the Spray Kleen Multi-Surface Cleaner to clean the residents' rooms. She said she did not disinfect the room with an approved disinfectant product. HSKP #2 said she was not trained in housekeeping properly and she was recently hired. She said she did not know what high frequency touch areas were. The DOH was interviewed on 5/7/24 at 2:15 p.m. The DOH said there were areas of opportunity to improve on related to housekeeping and routine room cleaning procedures. The DOH said housekeeping staff did not clean the residents' rooms according to the facility's procedure. The DOH said the facility disinfectant needed to be used when cleaning the resident rooms. He said the high frequency touch areas needed to be disinfected as well. He said the rooms should never be cleaned with only a cleaning agent. The DOH said he needed to provide training to all housekeeping staff. He said he needed to revise the current training program to cover using the correct surface disinfectant, not mixing chemicals, proper hand hygiene, surface disinfectant dwell times, room cleaning procedures and high frequency touch areas and he would have to audit housekeeping staff when they were cleaning residents' rooms to determine if they needed additional training. The director of nursing (DON) and infection preventionist (IP) were interviewed together on 5/7/24 at 2:23 p. m. The DON and the IP said surface disinfectant times should be adhered to in order to ensure surfaces were properly disinfected and all pathogens were destroyed. The DON and the IP said high frequency touch areas should be disinfected and only approved facility disinfectant products should be used. The DON and the IP said housekeeping staff should change cleaning cloths and gloves and complete hand hygiene appropriately between different areas of cleaning the resident rooms, between the A, B and C side of the rooms and between the bathroom and room. The DON and the IP said a toilet brush should never be used to clean the outside of the toilet bowl after cleaning the inside of the toilet bowl.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48113 Based on observations and interviews, the facility failed to maintain an environment for residents, staff and the public that is safe, functional, sanitary and comfortable for one of two shower rooms at the facility. Specifically, the facility failed to ensure the shower room was sanitary and safe for residents to use. Finding include: I. Facility policy and procedure The Housekeeping Services policy and procedure, revised on 4/12/24, was provided by the director of nursing (DON) on 5/7/24 at 3:17 p.m. It read in pertinent part, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. II. Observations On 5/7/24 at 2:30 p.m. the shower room between unit 100 and 200 was observed. The following was observed: The shower room had two wooden fabric woven chairs used for residents besides the shower. Both chairs were damp to touch and had visible brown stains on them. The shower curtain divider that hung between both sides of the shower had brown and black stains on it. Approximately 12 inches of the curtain was touching the ground. The corner wall by the shower entrance had a hole in the wall with jagged tile edges that was approximately six inches from the ground. There was another hole in the wall on the west wall near the entry from the 200 hall. The hole in the wall was approximately two inches in diameter and was approximately 12 inches from the ground. The grout in the shower room around the corners and in the shower had white, brown and black hardened debris that protruded approximately half an inch. There were five missing floor tiles by the shower entrance. The floor of the shower room by the shower entrance had a bottle of shampoo and body lotion stored on the ground next to a soiled adult brief. There was a razor that was on the floor next to used paper towels. (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	05/07/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The sharps container (a container used to dispose of needles and other sharp medical waste) was full. There was a bottle of glass cleaner by the shower room entrance on the floor, however, there were no other disinfectant products visible in the shower room for the certified nurse aides (CNA) to disinfect surfaces between residents. III. Staff interviews Housekeeper (HSKP) #1 was interviewed on 5/7/24 at 2:45 p.m. HSKP #1 said she did not know she needed to clean the shower room between unit 100 and 200. The director of housekeeping (DOH) was interviewed on 5/7/24 at 2:50 p.m. The DOH said there were areas of opportunity related to housekeeping and shower room cleaning procedures they could improve on. The DOH said housekeeping staff were not cleaning the shower room according to the facility's procedure. The DOH said the approved facility disinfectant should be used when cleaning the shower rooms and housekeeping staff should clean the shower room at least once daily. The DOH said the shower room needed to be deep cleaned to ensure the grout was clean without any accumulation of debris. He said the missing tiles and holes in the wall needed to be repaired before staff or residents used the room for safety purposes. The DOH said he needed to replace the shower divider with the appropriate length one. He said he needed to ensure it was cleaned and did not hang on the floor for infection control purposes. The DOH said personal hygiene items, trash and razors should not be stored on the ground as it was unsanitary and posed a potential safety risk. The DOH said the chairs used in the shower room were not appropriate to be used as shower chairs since the surfaces were not cleanable. He said water and other materials would soak into the fabric and the wood would rot over time since it was damp and wet in the shower room. The DOH said he needed to provide training and education to all housekeeping staff related to their responsibilities, cleaning procedures and he needed to audit the shower room weekly to ensure the room was safe, sanitized, cleaned and free of damage. The director of nursing (DON) and infection preventionist (IP) were interviewed together on 5/7/24 at 3:05 p.m.The DON and the IP said the shower chairs were not cleanable and should have never been used as they collected bacteria due to the porous surface of the fabric chair. They said the wood would rot and the chairs might not be able to withstand a person's weight. The DON and the IP said all items should be picked up off the floor including the shower divider and no trash should be left on the floor. The DON and the IP said all sharps should be disposed of in the appropriate sharps receptacle and all surfaces should be cleanable. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and the IP said loose and/or broken tiles and holes in the wall should be repaired to prevent pathogens from developing and to ensure black mold would not develop from the lack of cleaning in addition to the moist environment. The DON and the IP said they needed to work closely with housekeeping and all nursing care staff to provide education and training related to infection control practices related to the observed areas of opportunity in the shower room.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40960 Based on record review and interviews, the facility failed to ensure five (#1, #4, #5, #6 and #7) of five certified nurse aides (CNA) received the required 12 hours of annual in-service training for continued competence. Specifically, the facility failed to ensure CNA #1, #4, #5, #6 and #7 received 12 hours of training annually. Findings include: I. Facility policy and procedure The Nurse Aide Training Program policy, revised 4/12/24, was provided by the nursing home administrator (NHA) on 5/6/24 at 3:13 p.m. It read in pertinent part, The facility maintains an appropriate and effective nurse aide in-service training program for the purpose of ensuring the continuing competence of nurse aides. The staff development coordinator (SDC), with oversight from the director of nursing (DON), shall be responsible for the coordination and/or provision of nurse aide education. Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date, not calendar year. II. Training review A review of all five CNAs annual training was reviewed on 5/6/24 at 1:59 p.m. It revealed that documentation of annual training was not maintained. -The SDC was unable to provide documentation of the required 12 hour continued education units (CEU). III. Staff interviews The SDC was interviewed on 5/7/24 at 10:37 a.m. The SDC said the facility did not have a process to track the required 12 hour annual CEUs for the CNAs. She said she had put binders together in March 2024 and was currently working on a tracking form to document the CNAs completed in-service training. She said the facility had a planned skills fair for June 2024. She said she was putting a new employee packet together for training and competencies.