

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Lowry Hills Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, sanitary and comfortable homelike environment for seven out of 10 rooms. Specifically, the facility failed to ensure resident room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] were in good repair. Findings include: I. Facility policy and procedure The Safe and Homelike Environment policy, dated 2025, was provided by the nursing home administrator (NHA) on 6/4/26 at 1:04 p.m. It read in pertinent part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk. II. Observations Between 5/28/26 at 9:15 a.m. and 6/1/26 at 12:46 p.m. the following observations were made: Resident room [ROOM NUMBER] was observed to have spackle on the walls and was not painted. Resident room [ROOM NUMBER] was observed to have spackle on the wall. Resident room [ROOM NUMBER] was observed to have broken blinds and were intertwined together. Resident room [ROOM NUMBER] was observed to have the lower corner of the wall eroded and damaged, exposing the steel frame by the bathroom door frame. The base vinyl around the wall by the bathroom was missing and had chipped paint above it. The wall to the right of the resident's bed had two windows. The blinds in one of the two windows had bent or were missing a blind slat. The wall was painted brown with multiple white spots about an inch in width where the brown paint had been removed in some way. Behind the resident's bed, on the wall, were butterflies and birds painted or stuck on the wall, approximately one to two inches in size. Resident room [ROOM NUMBER] was observed to have broken blinds. Resident room [ROOM NUMBER] was observed to have cracked paint and peeling around the toilet. The tile was chipped around the length of the toilet and peeling. The door frame was scratched from the floor to approximately midway up the frame. The transition piece between the room and bathroom was missing and the bare floor was exposed underneath. There were tape pieces on the door inside. Resident room [ROOM NUMBER] was observed to have the paint worn off all the walls in the room. III. Resident interviews The resident who resided in room [ROOM NUMBER] was interviewed on 5/28/26 at 3:18 p.m. The resident said no one asked him about the birds and butterflies stickers on his wall. He said those stickers were just there when he moved in the room. The resident who resided in room [ROOM NUMBER] was interviewed on 6/2/26 at 10:15 a.m. The resident said the floor in the bathroom around the toilet had been cracked for three months. He said he let the director of nursing (DON) and the maintenance director know about it, but nothing had been done about it. The resident said the cracked floor could be a breeding ground for insects. IV. Staff interviews The maintenance director was interviewed on 6/1/26 at 2:01 p.m. The maintenance (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	LPN #4 was interviewed on 6/2/26 at 4:21 p.m. LPN #4 said Resident #2 was prescribed buspirone for anxiety and sertraline for depression from the hospital. LPN #4 said Resident #2 was oriented, but scared and sometimes attempted to get out of bed. Resident #2 was agitated at times, sometimes she was drawn to herself and did not want to interact with others. LPN #4 said monitoring was not only observing for anti-anxiety and antidepressant medications adverse effects, but also monitoring for signs of anxiety and depression. The SSD was interviewed on 6/3/26 at 9:35 a.m. The SSD said Resident #2 was admitted with physician's orders for buspirone and sertraline. The SSD said Resident #2 was depressed, self-isolated, tearful, and melancholic for her past. She said Resident #2 expressed anxiety and sadness regarding the future, and wanted support. The SSD said Resident #2's target behaviors included self-isolation, low motivation to participate in activities, therapy and care. She said Resident #2 had a change in appetite and sleep pattern. She said the resident had anxiety, perseveration on things out of her control, irritability, panic attacks and refusal of activities. The SSD said she identified Resident #2's target behaviors and communicated them to the nursing staff for monitoring. She said she was not responsible for adding the identified target behaviors into residents' behavior monitoring tracking on their MARs. VI. Failed to update Resident #29's care plan with specific target behaviors and interventions for the resident's use of psychotropic medications A. Resident status Resident #29, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses 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, (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in three of six medication storage carts. Specifically, the facility failed to: -Ensure medications were labeled with the date they were opened;-Ensure medications were labeled with medication identification and resident identification; and,-Ensure expired medication were removed and discarded from the medication carts.Findings include: I. Professional reference The PharMerica (1/12/25) Abridged List of Medications with Shortened Expirations Dates, was retrieved on 6/4/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://pharmerica.com/wp-content/uploads/2025/01/PI It read in pertinent part, Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's package insert under the 'How Supplied/Storage & Handling' section. A drug product's beyond use date (BUD) is the manufacturer supplied expiration date or the shortened date after opening, whichever comes first. These in-use medications should be labeled such that the date opened is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration. The Pharmcare USA's (4/9/23) Medication Disposal Practices in Assisted Living and Long Term Care, was retrieved on 6/4/26 from https://pharmcareusa.com/education/medication-disposal-practices-in-assisted-living-ltc/. It read in pertinent part, When medications are not disposed of correctly, they can pose serious threats to both human health and the environment. Improper disposal can lead to accidental ingestions, overdose and even death. The Highlights of Prescribing Information for Fluticasone propionate and salmeterol (January 2019) nasal spray, was retrieved on 6/8/26 fromchrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/ It read in pertinent part, Safely throw away the Advair Diskus in the trash one month after you open the foil pouch or when the counter reads '0', whichever comes first.The Highlights for Prescribing Information for Xalatan (latanoprost ophthalmic solution) 0.005%, for topical ophthalmic use (December 2022), was retrieved on 6/8/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label. It read in pertinent part, Store unopened bottle(s) under refrigeration at 2 degrees celsius (C) to 8 degrees C (36 degrees fahrenheit (F) to 46 degrees F). During shipment to the patient, the bottle may be maintained at temperatures up to 40 degrees C (104 degree F) for a period not exceeding eight days. 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. The Highlights of Prescribing Information for Humalog (insulin lispro) injection (May 2025), for subcutaneous or intravenous use was retrieved on 6/8/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label. It read in pertinent part, Diluted Humalog for subcutaneous injection may be stored for 28 days when refrigerated at 41 degrees F (5 degrees C) and for 14 days at room temperature up to 86 degrees F (30 degrees C). When stored at room temperature, Humalog U-100 and U-200 can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time.The Highlights of Prescribing Information for Lantus (insulin glargine) injection (June 2023), for subcutaneous use (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(June 2023), retrieved on 6/8/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/ It read in pertinent part, Store unused Lantus in a refrigerator between 36 degrees F and 46 degrees F (2 degrees C and 8 degrees C). Do not freeze. The Lantus vial you are using should be thrown away after 28 days or if the expiration date has passed, even if it still has insulin left in it. The Highlights of Prescribing Information for Incruse Ellipta (umeclidinium inhalation powder), for oral inhalation use (December 2023), was retrieved on 6/8/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/ It read in pertinent part, Throw away Incruse Ellipta in the trash six weeks after you open the tray or when the counter reads '0', whichever comes first. Write the date you open the tray on the label on the inhaler. The Highlights of Prescribing Information for Symbicort (budesonide and formoterol fumarate dihydrate) Inhalation Aerosol, for oral inhalation use, was retrieved on 6/8/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/ It read in pertinent part, Throw away Symbicort when the counter reaches zero ('0') or three months after you take Symbicort out of its foil pouch, whichever comes first. The Highlights of Prescribing Information for Combivent Respimat (ipratropium bromide and albuterol inhalation spray), for oral inhalation use (September 2020), was retrieved on 6/8/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/ It read in pertinent part, Three months after insertion of cartridge, throw away the Combivent Respimat even if it has not been used, or when the inhaler is locked, or when it expires, whichever comes first. II. Facility policy and procedure The Medication Storage policy, undated, was received from the nursing home administrator (NHA) on 6/4/26 at 1:04 p.m. It read in pertinent part, It is the policy of this facility 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 sanitation, temperature, light, ventilation, moisture control, segregation, and security. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs policy. III. Observations On 6/1/26, the medication cart for the 200/300 hallway was observed with licensed practical nurse (LPN) #3. The following items were found: -One card of Midodrine (a blood pressure medication) 5 milligrams (mg), expired 4/13/26; -One card of Hydroxyzine (an antihistamine medication) 25 mg, expired 4/29/26; -One card of Hydroxyzine 50 mg, expired 5/21/26; -One card of Simvastatin (a cholesterol medication) 20 mg, expired 7/5/25; -One bottle of carboxymethylcellulose sodium 0.5% (lubricant eye drop), expired January 2026; -One bottle of Vitamin D3 125 micrograms (mcg) had no expiration date; -One bottle of Calcium citrate with vitamin D3 with an expiration date of February 2026; -One bottle of oyster shell calcium with vitamin D3 500 mcg with an expiration date of July 2025; -One bottle of Diphenhydramine (allergy medication) 25 mg with an expiration date of March 2026; -One bottle of Bisacodyl (stool softener medication) 5 mg with an expiration date of February 2026; -Four fluticasone propionate and salmeterol (medication to help with asthma and chronic airway conditions) 250/50 mcg inhalers were not labeled with the date they were opened; -Two opened bottles of lantaprost (eye drop for glaucoma) 0.005% eye drops were not labeled with the date they were opened; and, -One unopened bottle of latanoprost 0.005% eye drops was not stored in the refrigerator. On 6/1/26, the medication cart for the 100/200 hallway was observed with LPN #2. The following items were found: -One vial of Humalog insulin (short acting insulin) with an expiration date of 5/28/26; -One vial of Insulin glargine (long acting insulin) with an expiration date of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/28/26;-Multiple unidentified pills were in the bottom of the first drawer, second drawer and third drawer of the cart with no resident identifying information or medication label;-One bottle of Guaifenesin (mucus relieving medication) 400 mg with an expiration date of March 2026;-One vial of Humalog insulin, which was not opened and not stored properly in the refrigerator; -One vial of insulin Humalog was not labeled with the date it was opened;-One package of ipratropium bromide (bronchodilator medication) 0.2% inhalation solution with an expiration date of 4/28/26;-One Incurse ellipta 62.5 mcg (long acting medication to help relax the airway) inhaler was not labeled with the date it was opened;-One card of Sertraline (antidepressant medication) 25 mg with an expiration date of 3/22/26;-One card of Zofran (anti-nausea medication) 4 mg with no expiration date; -One bottle of Aspirin (anti-inflammatory medication) 325 mg with an expiration date of May 2026;-One bottle of Vitamin D3 50 mcg had no expiration date; -Cepacol cough drops with an expiration date of May 2026;-One box of Phenazopyridine hydrochloride (urinary tract medication) 95 mg with an expiration date of December 2025; and,-One bottle of latanoprost 0.005% eye drops was not labeled with the date it was opened. On 6/2/26, the medication cart for the 400/500 hallway was observed with LPN #5. The following items were found: -One bottle of Guaifenesin 400 mg with an expiration date of March 2026;-One bottle of Aspirin 325 mg with an expiration date of May 2026;-One bottle of Loratadine (allergy relief medication) 10 mg with an expiration date of April 2026;-One bottle of oyster shell calcium 250 mg with vitamin D with an expiration date of May 2026; -One bottle of folic acid 1 mg with an expiration date of 4/20/26;-One bottle of thiamin vitamin b12 with an expiration date of 4/2026; -One bottle of Biotin (B vitamin) 5000 mcg, with an expiration date of February 2026;-One bottle of iron 65 mg with no expiration date; -One bottle of latanoprost 0.005% eye drops was not labeled with the date it was opened; -Multiple unidentified pills were on the bottoms of the cart drawers with no resident identifying information or medication label;-Two medication cards of ondansetron (anti-nausea medication) 4 mg with an expiration date of 2/3/26; -One bottle of Potassium 10 milliequivalent (mEq) with an expiration date of 4/14/26;-Methimazole 5mg with an expiration date of 5/20/26;-One card of Zofran 4mg with an expiration date of 4/21/26; -One bottle of Refresh eye drops (polyvinyl alcohol 1.4% for dry eyes) with an expiration date of May 2026;-One vial of Humalog insulin was not labeled with the date it was opened;-One vial of Humalog insulin with an expiration date of 5/28/26;-One vial of insulin glargine with an expiration date of 5/28/26;-Five budesonide-formoterol 160 mcg/4.5 mcg inhalers were not labeled with the dates they were opened; and, -One ipratropium bromide and albuterol (long acting inhaler for chronic respiratory conditions) 20 mcg/100 mcg inhaler was not labeled with the date it was opened.IV. Staff interviews The director of nursing (DON), the NHA and the regional clinical resource were interviewed together on 6/2/26 at 3:00 p.m. The DON said the night shift supervisor was supposed to audit the medication storage one time per week. She said the nurses working on the medication carts were all responsible for checking expiration dates and discarding any expired medications. She said it was important to label medications with shortened expiration dates with an opened date in order for staff to know when the medications expired and when to discard them. She said the importance of discarding expired medications was to ensure those medications were not being administered to residents.		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to be designed or equipped to assure full visual privacy for each resident for six out of 10 rooms. Specifically, the facility failed to ensure residents had privacy curtains that provided them with full visual privacy for resident room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]. Findings include: I. Facility policy and procedure The Resident Rooms policy, dated 2026, was provided by the nursing home administrator (NHA) on 6/4/26 at 1:04 p.m. It read in pertinent part, Resident bedrooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. All resident bedrooms will be equipped to assure full visual privacy for each resident, including ceiling suspended curtains which extend around each bed in non-private bedrooms. II. Observations Between 5/28/26 at 9:15 a.m. and 6/1/26 at 12:46 p.m., the following observations were made: Resident room [ROOM NUMBER] was observed to have no privacy curtain for the bed by the room's entrance that faced the bathroom, in case the resident's roommate had to use the bathroom. Resident room [ROOM NUMBER] was observed to have no privacy curtain for the first bed by the room's entrance. Resident room [ROOM NUMBER] was observed to have no privacy curtain for the third bed. Resident room [ROOM NUMBER] was observed to have no privacy curtain. Resident room [ROOM NUMBER] was observed to have a privacy curtain, however, it was not big enough for the first bed by the room entrance. The curtain did not go around the entire bed and the resident could be seen lying in the bed. Resident room [ROOM NUMBER] was observed to have one privacy curtain between the middle resident's bed and the resident's bed by the window. There was no privacy curtain between the first resident's bed and the middle resident's bed. There was no track in the ceiling to allow for privacy curtains and no portable privacy screens were observed in the room. III. Resident interviews The resident who resided in room [ROOM NUMBER] was interviewed on 6/1/26 at 10:52 a.m. The resident said there should be a curtain for privacy. The resident wondered how staff would provide her care with privacy if they had to look at something on her skin. She said she had to go into the bathroom to get dressed or undressed. The resident said the staff had to do whatever was convenient for them to provide care. IV. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 6/1/26 at 11:11 a.m. CNA #7 said if there was a privacy curtain, she had to pull it while providing care to the residents in their rooms. CNA #7 said if the privacy curtain was not available, she would take the resident to the bathroom to provide care. She said if the resident could not walk, she would call another staff member for assistance to get the resident to the bathroom. CNA #7 said there was no privacy curtain between the first resident's bed and the middle resident's bed in room [ROOM NUMBER]. She said she provided care to one of the residents in the bathroom. CNA #7 said she asked one of the residents to step outside while providing care to the roommate. CNA #7 said sometimes the roommate would stay in the room throughout the care. CNA #7 said resident room [ROOM NUMBER] had not had a privacy curtain for over a year between the residents and she had not notified the facility's management team about it. Licensed practical nurse (LPN) #5 was interviewed on 6/1/26 at 12:12 p.m. LPN #5 said she closed the curtain and ensured the door was closed for privacy during resident care. She said if there was no privacy curtain, she would move the other resident to the bathroom for care or would ask the roommate if it was okay to step aside. LPN #5 said she knew there was no privacy curtain between the residents' beds in room [ROOM NUMBER], but never thought about reporting it to the management or maintenance. The maintenance director was interviewed on 6/1/26 at 2:01 p.m. The maintenance director said to ensure residents' (continued on next page)		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	privacy during care in their rooms, the facility installed ceiling curtains in the rooms. He said there should be three curtains separating beds for a room with three residents. The maintenance director said the privacy curtain in room [ROOM NUMBER] was caught by the bed, pulled down and ripped, damaging the ceiling. He said it happened on 5/29/26 and the facility had already ordered a new one.-However, according to the interview with CNA #7, there had been no privacy curtains in room [ROOM NUMBER] for over a year (see interview above).After realizing that there was no privacy curtain track installed in room [ROOM NUMBER] in order to hang privacy curtains, the maintenance director amended his prior statement and said he had just been made aware of the issue on 5/29/26 and was in the process of ordering a ceiling track to install the privacy curtains. The NHA was interviewed on 6/2/26 at 3:37 p.m. The NHA said she was not aware of the missing privacy curtain. The NHA said the facility ordered a portable privacy screen for temporary use. The NHA provided proof of the order documentation for the privacy screen during the interview.V. Facility follow-upOn 6/1/26 at approximately 2:30 p.m. the maintenance director provided documentation that the ceiling track for room [ROOM NUMBER]'s privacy curtains had been ordered on 6/1/26, during the survey.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure residents unable to carry out activities of daily living (ADLs) received necessary services for one (#8) of five residents reviewed for ADLs out of 51 sample residents. Specifically, the facility failed to ensure Resident #8 received timely meal assistance. Findings include: I. Facility policy and procedure The Assisted Nutrition and Hydration policy, revised 2025, was provided by the nursing home administrator (NHA) on 6/3/26 at 12:44 p.m. The policy read in pertinent part, The facility will provide nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment, recognize, evaluate, and address the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration and provide a therapeutic diet, taking into account the resident's clinical condition and preferences. II. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included severe protein-calorie malnutrition, pressure ulcer of the sacral region, stage 4, congestive heart failure, dementia and generalized muscle weakness. The 4/30/26 minimum data set (MDS) assessment revealed Resident #8 was unable to complete the brief interview for mental status (BIMS). According to the staff assessment for mental status, the resident had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The resident was dependent on staff assistance for most ADLs. She required setup or clean-up assistance for eating. B. Observations and resident interview On 6/2/26 at 8:15 a.m. Resident #8 was in her room eating breakfast by herself with a regular spoon and no staff assistance. The resident's breakfast consisted of eggs and what looked like hashbrowns. The resident's left hand was contracted and she could not open her fingers, which were curled closed. Resident #8 said she could eat by herself. On 6/2/26 at 11:40 a.m. Resident #8 was observed asleep in her room as the staff was delivering lunch room trays. Certified nurse aide (CNA) #5 delivered the residents' room tray. CNA #5 said hello to the resident, but did not ask the resident if she needed assistance with eating or offer to sit down to assist her with eating. After delivering the room tray, CNA #5 exited Resident #8's room. Resident #8 said she could not get the cover off her food plate and asked for assistance. CNA #5 was notified that the resident was having trouble and returned to the resident's room. CNA #5 uncovered Resident #8's plate and said she would help the resident eat in a moment, and then replaced the cover on the resident's plate again before exiting the room. -CNA #5 did not attempt to offer Resident #8 any bites of food prior to exiting the resident's room. At 12:11 p.m., 31 minutes after CNA #5 delivered Resident #8's room tray, the physical therapist (PT) entered the resident's room to speak with the resident. At 12:13 p.m. CNA #5 entered Resident #8's room and shut the door to the room. At 12:14 p.m. CNA #5 exited the resident's room again with Resident #8's roommate's lunch tray. At 12:22 p.m. the PT was observed doing arm exercises with Resident #8 and assisting the resident with eating. -However, Resident #8 did not receive meal assistance for over 30 minutes after her lunch tray was delivered to her room, despite the fact that documentation in the resident's electronic medical record (EMR) indicated the resident required assistance with eating (see record review below). C. Record review The ADL care plan, initiated 11/21/24, revealed Resident #8 had an ADL self-care performance deficit related to dementia, encephalopathy, decreased mobility and increased weakness to the left side. Interventions included providing the resident with finger foods when she had difficulty using utensils and assisting the resident one-to-one with meals. The 5/1/26 registered dietitian (RD) progress note revealed Resident #8 required feeding (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance/encouragement at meals as needed (PRN).-However, observations revealed staff did not offer to assist the resident with eating (see observations above).III. Staff interviewsCNA #5 was interviewed on 6/2/26 at 9:44 a.m. CNA #5 said she assisted Resident #8 with her eating. She said the resident could sometimes eat her meal herself but she generally needed assistance. -However, CNA #5 did not provide or offer meal assistance to Resident #8 after delivering her lunch tray on 6/2/26 (see observation above).CNA #3 was interviewed on 6/2/26 at 3:17 p.m. CNA #3 said Resident #8 did not need staff assistance or queuing for meals and she was able to feed herself.The director of nursing (DON) was interviewed on 6/3/26 at 11:01 a.m. The DON said that occupational therapy normally informed the staff if a resident needed assistance with eating upon admission. The DON said it varied on how much feeding assistance Resident #8 required for meals. She said CNAs should be encouraging the resident to eat and offering her help frequently during meals.		

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NAME OF PROVIDER OR SUPPLIER Lowry Hills Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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 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 review The 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 interviews The 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 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents with with limited range of motion received appropriate treatment and services to increase range of motion for one (#8) of one resident out of 51 sample residents. Specifically, the facility failed to provide passive range of motion services for Resident #8's left hand, which had a contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff and prevents normal movement of a joint or other body part). Findings include: I. Facility policy and procedure The Prevention of Decline in Range of Motion policy, revised 2025, was provided by the nursing home administrator (NHA) on 6/3/26 at 12:44 p.m. The policy read in pertinent part, The facility will utilize a systematic approach for prevention of decline in range of motion, including assessment, appropriate care planning and preventative care. Licensed nurses will assess resident's range of motion (such as current extent of movement of his/her joints and the identification of limitations) on admission/readmission, quarterly, and upon a significant change. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion. Nursing assistants will report any significant changes in range of motion, as noted during daily care activities, to the resident's nurse when any changes are noted. The assessment should include identified risks which could impact resident's range of motion including, but not limited to: -Immobilization; -Neurological conditions causing functional limitations; -Any condition where movement may result in pain, spasms or loss of movement; and, -Clinical conditions such as immobilized limbs or digits because of injury, fractures or surgical procedures including amputations. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. II. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included severe protein-calorie malnutrition, pressure ulcer of the sacral region, stage 4, congestive heart failure, dementia and generalized muscle weakness. The 4/30/26 minimum data set (MDS) assessment revealed Resident #8 was unable to complete the brief interview for mental status (BIMS). According to the staff assessment for mental status, the resident had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The resident was dependent on staff assistance for most activities of daily living (ADL). The MDS assessment indicated the resident had impairment on one side of her upper extremities with no range of motion services. B. Observations On 6/1/26 at 5:21 p.m. Resident #8 was observed to have a left hand contracture. She was unable to open her hand fully and she was unable to straighten her fingers. On 6/2/26 8:15 a.m., Resident #8 left hand was observed to be contracted and three of her fingers were curled closed. The resident was unable to open her hand fully. There was no hand splint in the resident's hand. C. Record review The 12/26/24 occupational therapy and plan of treatment revealed no documentation to indicate Resident #8's left hand contracture was being addressed by therapy. The limited range of motion care plan, initiated 11/21/24, revealed Resident #8 had limited physical mobility related to dementia, encephalopathy, decreased mobility and weakness to the left side. Interventions included occupational therapy and physical therapy referrals as needed, monitoring/documenting/reporting as needed any signs or symptoms of immobility, such as contractures forming or worsening and thrombus formation and providing supportive care and assistance with mobility as needed. -However, the care plan did not (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicate the resident was to receive passive range of motion assistance to prevent further contractures. The 4/23/26 nurse practitioner note revealed Resident #8 was transitioned to hospice for a comfort focus treatment plan and recommended the facility consider restorative care for passive range of motion (PROM) and palliative movement. The 5/1/26 nurse practitioner note recommended the facility consider restorative care for Resident #8 for PROM and palliative movement. -Review of Resident #8's Kardex (tool used to assist staff with providing consistent care of residents), as of 6/4/26, failed to reveal any documentation in regards to the resident's left hand contracture. -Review of the certified nurse aide (CNA) task section in Resident #8's electronic medical record (EMR) did not reveal any documentation related to providing range of motion to the resident's left hand. III. Staff interviews The director of rehabilitation was interviewed on 6/2/26 at 1:00 p.m. The director of rehabilitation said the facility did not have a restorative program. She said Resident #8 had not been on the therapy caseload since 2024. The director of nursing (DON) was interviewed on 6/3/26 at 11:01 a.m. The DON said if a resident had a contracture, the therapy department would be notified and a therapist would complete an evaluation to identify if a splint or range of motion program (ROM) was needed. She said Resident #8 was not receiving any range of motion services, however, physical therapy completed an evaluation on 6/2/26 for ROM exercises. The DON said the December 2024 occupational therapy notes did not indicate that therapy was assisting Resident #8 with her contracture.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for one (#29) of three residents reviewed for accident hazards out of 51 sample residents. Specifically, the facility failed to ensure Resident #29, who was an elopement risk, was assessed timely and accurately for a wander guard (wearable tags/bracelets and door sensors that automatically alert staff or lock doors near a restricted exit). Findings include: I. Facility policy and procedure The Elopements and Wandering Residents policy, dated 2025, was provided by the nursing home administrator (NHA) on 6/4/26 at 1:16 p.m. It read in pertinent part, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. II. Resident #29A. Resident status Resident #29, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included cognitive communication deficit, psychotic disorder with hallucinations due to known physiological conditions and major depressive disorder. The 3/25/26 minimum data set (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 activities of daily living (ADL). The MDS assessment indicated that the resident had not exhibited wandering behavior, had no other behaviors, and that a wander/elopement alarm was not used. -However, staff interviews and record review (see below) revealed the resident had wandering behaviors and a wander guard was used. B. Observations On 6/1/26 at 2:24 p.m. Resident #29 was observed in the hallway with a wander guard on his wrist. C. Record review Resident #29's wandering care plan, revised 4/20/26, documented that due to wandering and exit seeking behavior and with approval of the resident's representative, the facility sought secure memory care placement for the resident's safety. Pertinent interventions, initiated 1/15/25 and revised 4/20/26 included that until potential discharge, Resident #29 continued to utilize a wander guard for safety. Resident #29's wandering/exit seeking care plan, revised 2/24/26, documented the resident presented with impaired cognitive function, confusion, impulsivity and poor safety awareness, as well as hallucinations, secondary to a diagnosis of dementia with psychotic features. Resident #29 had made statements that he was going to leave and was attempting to leave the building. The resident's photograph, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description and face sheet had been placed in the facility's elopement binder and he also had a wander guard placed for safety. Pertinent interventions, revised 2/24/26, included to ensure that Resident #29 was safe by noting his location throughout the day; ensuring proper placement of the wander guard; and ensuring the wander guard was working appropriately, redirecting the resident from exits as needed and out of other residents' rooms as needed, and notifying the physician should wandering and/or exit seeking behaviors persist. The resident's photograph was placed in the elopement binder and the elopement binders were located at each nurses' station, the front desk and in the social services department. -However, a review of Resident #29's electronic medical record (EMR) revealed the resident did not have consent to have a wander guard placed until 3/14/26, a physician's order to ensure the wander guard was working properly was not placed until 5/27/26 (during the survey) and the resident was not evaluated for use of a wander guard until 5/30/26 (during the survey). A 3/14/26 nursing progress documented the facility contacted Resident #29's representative for consent of a wander guard. Education was provided and paperwork was read out loud to the resident's representative. The representative gave verbal consent to have Resident #29 on a wander guard and had no questions about the system. -However, Resident #29's care planned interventions, revised 2/24/26, documented to ensure proper placement of the resident's wander guard and to ensure the wander guard was working properly. There was no documentation that the resident had a wander guard or that it was working properly. A 3/15/26 fall risk assessment and elopement evaluation documented the resident had no falls in the last three months. The elopement evaluation documented the resident had not verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door. -However, a review of the Resident #29's progress notes documented the resident experienced a fall on 2/22/26. The resident's wandering/exit seeking care plan, revised 2/24/26 documented Resident #29 had made statements that he was going to leave and was now making attempts to leave the building. A review of Resident #29's May 2026 CPO documented a physician's order for a wander guard bracelet to be placed on the resident's left wrist (site selected by resident) for elopement risk and wandering behavior. The staff were to monitor the resident's skin under the bracelet for signs of skin breakdown and notify the physician if signs and symptoms of skin breakdown were present, ordered 5/27/26 (during the survey). -However the physician's order failed to include monitoring the placement and functionality of the wander guard bracelet. A 5/30/26 evaluation for restraint determination documented the evaluation was initiated and completed on 5/30/26 (during the survey). The evaluation revealed Resident #29 was assessed for a wander guard and documented that the wander guard ensured the resident did not wander out of the facility without staff, which put the resident at risk for harm. The evaluation additionally documented consent was completed, the care plan was updated and the order was received and entered from the provider. -However, Resident #29's representative had given consent for the wander guard to be placed on 3/14/26, over two months prior to the survey (see above) III. Staff interviews The NHA and the director of nursing (DON) were interviewed together on 6/1/26 at 2:37 p.m. The NHA said if a resident with a wander guard got close to the front door, and if the door was open, the door would alarm. The NHA said the alarms were very, very loud and you could hear each of the alarms down the hallways. The NHA said the facility had checked the wander guard system weekly and it was a scheduled task. The DON said the facility initially received consent from the resident's representative on 3/14/26 for the use of Resident #29's wander guard. The NHA said she thought it was possible the gap in the care plan (between the wander guard intervention being initiated and the placement of the wander guard) came from trying to get ahold of Resident #29's representative for consent. The NHA said it was social services staff member or nursing staff (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member who would call for consent for the wander guard. The NHA said Resident #29's wander guard order was entered into the resident's EMR on 5/27/26 and the facility had identified the order had not been entered when the wander guard bracelet had been applied during a recent audit. The NHA said the staff had started checking for the wander guard twice a day every shift and to monitor for skin breakdown. She said the facility had identified Resident #29 needed a wander guard regardless of the evaluation documenting he was at moderate risk for elopement. Certified nurse aide (CNA) #8 was interviewed on 6/1/26 at 2:06 p.m. CNA #8 said Resident #29 wandered all over the building all day long. CNA #8 said she thought the resident got the wander guard about six months ago. Licensed practical nurse (LPN) #5 was interviewed on 6/1/26 at 2:20 p.m. LPN #5 said Resident #29's wandering was frequent. LPN #5 said she thought the resident started on his wander guard in April 2026. LPN #5 said she thought the DON or the physician completed the resident assessments. CNA #9 was interviewed on 6/2/26 at 3:08 p.m. CNA #9 said it was fairly recently that Resident #29 got the wander guard bracelet but was not exactly sure when he got it. LPN #4 was interviewed on 6/2/26 at 4:58 p.m. LPN #4 said the staff did not have access to the wander guard tester and needed to ask the DON for it.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure respiratory care was provided in accordance with professional standards for one (#7) of two residents out of 51 sample residents. Specifically, the facility failed to ensure oxygen administered according to physician's orders for Resident #7. Findings include: I. Facility policy and procedure The Oxygen Administration policy, revised 2026, was provided by the nursing home administrator (NHA) on 6/3/26 at 12:44 p.m. It read in pertinent part, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician, except in the case of an emergency. In such a case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. II. Resident #7A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD - a progressive, irreversible lung disease that restricts airflow, making it difficult to breathe), congestive heart failure and chronic respiratory failure. The 5/18/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She was dependent on staff for most activities of daily living (ADL). She required substantial to maximal assistance for transfers. The assessment revealed the resident was receiving oxygen therapy. B. Resident observations and interviews On 6/2/26 4:31 PM., Resident #7 was lying in her bed with a nasal cannula in her nose. The resident's oxygen concentrator was set at 2.5 liters per minute (LPM). -However, according to the resident's care plan and physician's orders, the resident's oxygen flow rate was supposed to be 4 LPM (see record review below). Resident #7 said she had oxygen continuously. She said that at times, her oxygen was not on the correct LPM. She said that earlier in the day (on 6/2/26) she believed her oxygen was set too high as it had made her feel like electricity had been going through her body. She said her oxygen was normally set at three LPM. On 6/2/26 at 7:05 p.m. Registered nurse #2 (RN) observed that Resident #7's oxygen concentrator was set at 2.5 LPM. RN #2 said the resident's oxygen flow rate was not set according to the physician's order. Resident #2 asked the RN #2 what the physician's order was. RN #2 informed Resident #2 that the physician's order was for 4 LPM. The resident said she thought she was supposed to be on 3 LPM. RN #2 told the resident she would contact the physician to clarify what oxygen flow rate she should be receiving. C. Record review The respiratory care plan for shortness of breath, initiated 3/4/26, revealed Resident #7 had shortness of breath related to COPD. Interventions included providing oxygen via nasal cannula at 4 LPM and monitoring/documenting/reporting breathing abnormalities to the physician. Review of Resident #7's June 2026 CPO revealed the following physician's orders: Apply oxygen via nasal cannula at 4 LPM every shift, ordered 5/27/26. -However, observations revealed the resident's oxygen was set to 2.5 LPM (see observations above). III. Staff interviews RN #2 was interviewed on 6/2/26 at 7:03 p.m. RN #2 said Resident #7 was prescribed oxygen because of her COPD. She said according to the physician's order, the resident was supposed to be on 4 LPM. The director of nursing (DON) was interviewed on 6/3/26 at 11:01 a.m. The DON said she would generally expect residents' oxygen flow rates to be set to what the physician's order read. She said residents' oxygen flow rates could be 0.5 LPM more or less for special circumstances, but she said that should be documented in the resident's progress notes if it occurred.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for one resident (#1) reviewed for dialysis out of 51 sample residents. Specifically, the facility failed to:-Ensure thorough dialysis documentation was in place for Resident #1; and,-Consistently and thoroughly complete the dialysis communication forms between the facility and the dialysis center for Resident #1. Findings include:I. Facility policy and procedureThe Hemodialysis policy, dated 2025, was provided by the nursing home administrator (NHA) on 6/4/26 at 1:04 p.m. It read in pertinent part, The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility will coordinate and collaborate with the dialysis facility to assure that there is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to:-Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility;-Physician/treatment orders, laboratory values, and vital signs; and,-Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included acute kidney failure, dependence on renal dialysis (process to filter wastes from the body), and type 2 diabetes mellitus without complications.The 4/25/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. He was dependent on staff for toileting and eating. He required substantial to maximum assistance for oral hygiene.The MDS assessment indicated the resident received dialysis treatment. B. Record reviewReview of Resident #1's dialysis care plan, initiated 4/19/26, revealed the resident received dialysis related to anasarca (widespread swelling of the body caused by a buildup of fluid in the tissues). Interventions included encouraging the resident to go for the scheduled dialysis appointments, monitoring vital signs, notifying the medical director of significant abnormalities, and checking and changing the dressing daily at the access site. -However, the care plan did not include monitoring the resident's weights pre- and post-dialysis treatment. Review of Resident #1's May 2026 CPO revealed the following physician's orders related to dialysis:Obtain weight before dialysis every Monday, Wednesday, Friday and add in the electronic medical records (EMR) under weights, ordered 5/6/26.Obtain weight after dialysis in the evening every Monday, Wednesday, Friday and add in the EMR under weights, ordered 5/6/26.-However, the physician's orders were not entered into the resident's EMR until 5/6/26, even though the dialysis treatment started on 5/1/26 Resident #1's dialysis communication binder was provided by the assistant director of nursing (ADON) on 6/2/26 at 8:58 a.m. Review of Resident #1's dialysis communication forms in the binder revealed the following:-There were no dialysis communication forms for Resident #1's 5/4/26, 5/6/26, 5/8/26, 5/13/26, 5/15/26, 5/18/26 and 5/20/26 dialysis sessions. -The 5/1/26, 5/11/26, 5/13/26, 5/22/26 and 5/25/26 dialysis communication forms did not have the pre-dialysis section completed by facility staff.-The facility failed to complete the (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pre-dialysis section of the communication form for five dialysis sessions. Review of Resident #1's May 2026 treatment administration record (TAR) revealed pre- and post-dialysis weights were documented for Resident #1 on 5/8/26, 5/13/26, 5/15/26 and 5/20/26. -However, there was no documentation in the May 2026 TAR indicating pre- and post-dialysis weights were obtained for Resident #1 on 5/1/26, 5/4/26 and 5/6/26.III. Staff interviewsThe ADON was interviewed on 6/2/26 at 9:35 a.m. The ADON said staff were expected to obtain residents' vital signs and weights before the residents left for the dialysis center. She said staff should document the information in the dialysis communication form and send it to the dialysis center with the resident. The ADON said staff should obtain and document residents' weights and vital signs upon their return from the dialysis center. She said staff kept the dialysis communication forms in the binder. The ADON confirmed that a few of Resident #1's dialysis communication forms were not filled out properly. She said she was not aware of additional missing dialysis communication forms in the binder because she did not routinely work in the nursing unit.Licensed practical nurse (LPN) #4 was interviewed on 6/2/26 at 5:53 p.m. LPN #4 said staff should take the vital signs and weight before sending the residents out for dialysis. She said staff should document the information in the dialysis communication form and give it to the residents. LPN #4 said staff should check the vital signs and weights when the residents returned from the dialysis center. She said she never filled out a dialysis communication form for Resident #1 because she worked the night shift and never sent Resident #1 out for dialysis. LPN #4 said if a dialysis communication form was missing, she would contact the dialysis center and notify the director of nursing (DON). She said nurses should ensure dialysis communication forms were completed thoroughly before sending the residents out to the dialysis center.The DON was interviewed on 6/2/26 at 1:45 p.m. The DON said the nurses completed the dialysis communication forms and sent them with the residents to the dialysis center. She said the nurses reviewed the forms when the residents returned to the facility for any recommendations. The DON said she expected nurses to check Resident #1's vital signs and weights prior to sending the resident to the dialysis center and when the Resident #1 returned to the facility. She said the nurses should document weights pre- and post-dialysis in the EMR and the dialysis communication forms. The DON said Resident #1 was admitted on [DATE] and started his first dialysis session on 5/1/26. She said the dialysis center wanted the facility to call ahead to determine if Resident #1 needed a dialysis session or not. The DON said Resident #1 missed the dialysis session on 5/20/26 and he refused on 5/29/26. -The missing dialysis communication forms for Resident #2 were requested during the interview, however, the facility was unable to provide documentation of the forms at the time of the survey exit on 6/3/26.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide pharmaceutical services to meet the needs of one (#64) of five residents out of 51 sample residents. Specifically, the facility failed to ensure Resident #64's anti-anxiety medication was ordered and delivered to the facility in a timely manner. Findings include: I. Facility policy and procedure The Pharmacy Services policy, undated, was received from the nursing home administrator (NHA) on 6/4/26 at 1:04 p.m. It read in pertinent part, The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. II. Resident #64A. Resident status Resident #64, age less than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included Wernicke's encephalopathy (neurological condition caused by vitamin B1 deficiency), muscle weakness, anxiety disorder, major depressive disorder and attention deficit hyperactivity disorder (ADHD). The 4/21/26 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. She was independent with activities of daily living (ADL). B. Resident interview Resident #64 was interviewed on 5/27/26 at 2:25 p.m. Resident #64 said she missed some doses of her scheduled Wellbutrin (anti-anxiety medication) and started to feel withdrawal side effects. She said she felt increased anxiety and as if her insides were going to jump out. She said she let the director of nursing (DON) know about it. C. Record review A review of Resident #64's June 2026 CPO revealed the following physician's order: Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 milligrams (mg), give 300 mg by mouth one time a day for ADHD, ordered 4/15/26. A review of Resident #64's May 2026 medication administration record (MAR) revealed the resident's Wellbutrin medication was not administered on 5/11/26, 5/19/26, 5/20/26, 5/21/26 and 5/31/26. The reason the medication was not administered on all five dates was documented as other/see nurse notes. A review of Resident #64's nursing progress notes revealed the following: On 5/11/26 at 10:50 a.m. a nursing note documented Resident #64's Wellbutrin medication was not on hand. On 5/19/26 at 10:39 a.m. a nursing note documented Resident #64's Wellbutrin medication was not on hand. On 5/20/26 at 2:33 p.m., a nursing note documented Resident #64's Wellbutrin medication was not available, the pharmacy was contacted and delivery was pending. On 5/21/26 at 9:54 a.m. a nursing note documented Resident #64's Wellbutrin medication was on order. On 5/31/26 at 10:10 a.m. a nursing note documented Resident #64's Wellbutrin medication was unavailable and on order. -The facility failed to provide Resident #64 with her prescribed medication and contact the physician when the medication was not available, which resulted in the resident missing five doses of medication. III. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 6/1/26 at 1:02 p.m. LPN #3 said each medication card had a darker blue slot with about 10 days of medication left and when the card reached that point, she was able to reorder the medication. She said it took one to two days for the pharmacy to deliver the medication once it was ordered. She said if the physician needed to send a new prescription for the medication, she would get in contact with the physician to do so. She said if a medication was unavailable to be administered, she would notify the physician and put the medication on hold, educate the resident, and call the pharmacy to see when the medication was expected to be delivered. She said she would write a progress note to document notifying the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician, pharmacy, resident and what actions were taken. Registered nurse (RN) #3 was interviewed on 6/2/26 at 9:50 a.m. RN #3 said when there was about a week of medication doses left on a medication card, she reordered the medication on the computer. She said if the pharmacy did not send the medication in one to two days after reordering, she would fax the medication label to the pharmacy and call the pharmacy. She said if the medication needed authorization, she would get in contact with the physician or the DON. She said if medication was unavailable to administer to the resident, she would check the emergency medication kit, notify the physician and write a nursing progress note. The DON, the NHA and the regional clinical resource were interviewed together on 6/2/26 at 3:00 p.m. The DON said the nurses passing medications should always reorder the medications when they are down to the last five days of medication. She said if they got down to the last three days, the nurses should call the pharmacy. The DON said if a medication was unavailable to be administered, the nurses should check the emergency supply of medications and if still unavailable, notify the physician and the pharmacy, notify the resident and the resident's representative, place the medication order on hold and write a nursing progress note to document everything. The DON said she was made aware of Resident #64's Wellbutrin unavailability and the facility was able to get it added to the facility's emergency medication supply system on 5/28/26 (during the survey). She said all nurses had access to the facility's emergency medication supply system -However, Resident #64's Wellbutrin was again documented as unavailable on 5/31/26 for administration (see record review above).		

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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. 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 disease and infection. Specifically, the facility failed to:-Ensure enhanced barrier precautions (EBP) were followed during high contact resident care areas for Resident #9, who had an indwelling urinary catheter and Resident #3, who had a tracheostomy (airway created through the neck); and, -Ensure Resident #83 and Resident #9's urinary catheter drainage bags and catheter tubing were not dragging on the ground. Findings include: I. Failure to ensure EBP were followed during high contact resident care areas for Resident #9 and Resident #3A. Facility policy and procedureThe EBP policy and procedure, 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, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multi-resistant drug organism (MDRO) or a resident with an infection or colonization with a center of disease control (CDC)-targeted MDRO when contact precautions do not otherwise apply. Personal protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. B. Observations During an interview with Resident #9 on 5/27/26 at 4:32 p.m., licensed practical nurse (LPN) #2 came into the resident's room to administer medication. After administering the medication. She donned (put on) clean gloves and drained the urine in Resident #9's catheter bag into a container. LPN #2 measured the urine and discarded it in the bathroom. -LPN #2 failed to don a gown prior to performing catheter care. During a medication administration observation on 6/1/26 at 11:30 a.m., LPN #2 was observed preparing medication to administer to Resident #3. LPN #2 gathered a nebulizer treatment and an insulin injection. LPN #2 went into Resident #3's room. LPN #2 donned clean gloves and administered the insulin. Respiratory therapist #1 came into the room to assist with setting up the nebulizer treatment. Respiratory therapist #1 donned sterile gloves and performed a suction treatment to Resident #3's tracheostomy before the nebulizer treatment. Respiratory therapist #1 then assisted LPN #2 with setting up the nebulizer treatment. LPN #2 administered the nebulizer treatment through Resident #3's tracheostomy oxygen tubing. -LPN #2 and respiratory therapist #1 failed to don a gown prior to administering treatments and suctioning the tracheostomy for Resident #3. II. Failure to ensure Resident #83 and Resident #9's urinary catheter bags and catheter tubing were not dragging on the groundA. Facility policy and procedureThe Infection Prevention and Control Program policy and procedure, no revision date, was received from the NHA on 6/4/26 at 1:04 p.m. It documented in pertinent part, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. B. Observations During an observation on 5/27/26 at 4:03 p.m., Resident #83 was lying in bed and her urinary catheter drainage bag was lying on the floor with the wheel of the bedside table on top of it. During an observation on 5/28/26 at 5:17 p.m., Resident #9 was wheeling himself around the hallways to the dining room and his urinary catheter tubing was dragging under the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair on the ground. During an observation on 6/2/26 at 11:23 a.m., LPN #3 was notified that Resident #9 was sitting in his wheelchair moving around the hallways and his urinary catheter drainage bag was dragging on the ground. III. Staff interviewsRegistered nurse (RN) #3 was interviewed on 6/2/26 at 9:50 a.m. RN #3 said that a gown and gloves should be worn for any resident on EBP. RN #3 said this applied to any resident who had a wound, a Foley catheter, colostomy, tracheostomy or intravenous line. RN #3 said PPE should be worn by staff when they were completing any high contact care activity with residents on EBP. The pulmonary program coordinator was interviewed on 6/2/26 at 10:20 a.m. The pulmonary program coordinator said EBP should be used for any resident with an indwelling medical device. The pulmonary program coordinator said staff should be donning a gown and gloves any time a high contact care task was performed with a resident on EBP. The pulmonary program coordinator said this included suctioning a tracheostomy due to the potential for spread of infection. The infection preventionist was interviewed on 6/2/26 at 12:30 p.m. The infection preventionist said any resident with a wound or indwelling medical device should be placed on EBP. The infection preventionist said the PPE staff was required to wear included a gown and gloves any time a high contact care task was completed. The infection preventionist said the importance of utilizing EBP was to prevent the spread of infection and protect the staff and residents. The infection preventionist said catheter care and tracheostomy care required the use of EBP. The infection preventionist said that catheter tubing or the drainage bag should never be dragging on the ground because of the risk for infection. The director of nursing (DON), the NHA and the regional clinical resource were interviewed together on 6/2/26 at 3:00 p.m. The DON said a gown and gloves should be worn for residents on EBP for wounds and/or indwelling medical devices for high contact care areas. The DON said EBP should be used when emptying out a catheter and when administering breathing treatments and suctioning a tracheostomy. The DON said this was important for infection control measures. The DON said that urinary catheter drainage bags should be in a privacy bag and the bag and tubing should not be in contact with the ground.		

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and interviews, the facility failed to post, in a form and manner accessible and understandable to residents, a list of names, addresses (mailing and email) and telephone numbers of all pertinent State Agencies and advocacy groups. Specifically, the facility failed to: -Ensure the required posting contained the correct phone number for the State Agency; and, -Ensure the required posting contained contact information for other pertinent state agencies and advocacy groups. Findings include: I. Facility policy and procedure The Facility Required Postings policy and procedure, dated April 2025, was provided by the nursing home administrator (NHA) on 6/4/26 at 1:16 p.m. It revealed in pertinent part, The facility will post required postings in an area that is accessible to all staff and residents. Facility postings include the following: A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups to include but not limited to: State Survey Agency, State Licensure office, Adult Protective Services (where state law provides jurisdiction), office of the State of Long-Term Care Ombudsman, Protection and Advocacy Network, Home and Community Based Service Programs, Family and Medical Leave Act, Medicaid Fraud Control Unit, and applying for Medicare and Medicaid. II. Resident group interview The resident group interview was conducted on 6/1/26 at 10:49 a.m. with five residents (#31, #33, #55, #65 and #92) who routinely attended monthly resident council meetings and were deemed interviewable by the facility and assessment. The residents said they did not know how to file a complaint with the State Agency. Four of the residents said they only knew how to contact the ombudsman. III. Observations On 6/1/26 at 11:22 a.m. there was a posting on how to file a complaint with the State Agency observed hanging on a bulletin board in a common area of the facility. The piece of paper contained the address, a phone number and an email address for the State Agency. -However, the phone number on the piece of paper was not the correct phone number for filing a complaint with the State Agency. -Additionally, the piece of paper failed to include a list of names for other pertinent state agencies and advocacy groups and their mailing addresses, email addresses and phone numbers. IV. Staff interviews The social services director (SSD) and the social services assistant were interviewed together on 6/2/26 at 2:11 p.m. The SSD reviewed the posting of the phone number and required posting. She confirmed the posting did not have the list of names, addresses (mailing and email) and telephone numbers of all pertinent state agencies and advocacy groups.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on record review and interviews, the facility failed to ensure residents, family members and legal representatives had full access to review the results of the facility's most recent survey findings that included the survey results, certifications, complaint investigations and plans of correction in effect for the preceding three years. Specifically, the facility failed to ensure residents, family members, and legal representatives had full access to review the facility's most recent survey findings for 2025, including recertifications, complaint investigations, and plans of correction. Findings include: I. Resident group interviewThe resident group interview was conducted on 6/1/26 at 10:49 a.m. with five residents (#31, #33, #55, #65 and #92) who routinely attended monthly resident council meetings and were deemed interviewable by facility and assessment. Three residents said they were not aware they could view the federal and state survey results. The residents said they were unaware that the results of the surveys were supposed to be posted for them to be able to access and read. II. Record reviewThe survey results binder was reviewed on 6/2/26 at 3:50 p.m. The last survey on file in the survey results binder was from 9/3/24.-The survey results binder did not contain any survey results from 2025 or any plans for corrections. -The folder did not hold the 2025 survey results from the complaint surveys which occurred on 1/22/25, 3/13/25, 6/26/25, 8/18/25 and 12/22/25. III. Staff interviewsThe nursing home administrator (NHA) was interviewed on 6/2/26 at 4:28 p.m. The NHA said she had the 2025 survey results on file; however, the documentation was in a different folder in her office and was unavailable to residents and family members.		