

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: 065146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Hampden Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 14699 E Hampden Ave Aurora, CO 80014	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to provide necessary services to maintain personal hygiene for two (#10 and #11) of four residents out of 13 sample residents. Specifically, the facility failed to:-Ensure Resident #11 received timely incontinence care in accordance with professional standards and per the resident's preference; and,-Ensure Resident #10 received oral care as needed and per the resident's preference. Findings include: I. Failed to ensure Resident #11 received timely incontinence care in accordance with professional standards and per the resident's preference A. Facility policy and procedure: The Urinary Continence and Incontinence Assessment and Management policy and procedure, revised 2022, was provided by the nursing home administrator (NHA) on 7/9/26 at 6:06 p.m. It read in pertinent part, The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. For those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a check and change strategy. B. Resident #11 1. Resident status Resident #11, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses included dementia, failure to thrive and basal cell carcinoma with open wound to the right buttock. According to the 6/1/26 minimum data set (MDS) assessment, Resident #11 had severely impaired cognition with a brief interview for mental status (BIMS) score of three out of 15. The resident was dependent on staff for toileting hygiene and the ability to maintain perineal hygiene. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment revealed Resident #11 was always incontinent with no episodes of continent voiding. 2. Observation and staff interview Certified nurse aide (CNA) #3 was interviewed on 7/7/26 at 6:30 a.m. CNA #3 said Resident #11 received a bath three times per week and perineal care when the resident was incontinent. CNA #3 said she would perform incontinence care for the resident after breakfast, per Resident #11's preference. At 7:08 a.m. (prior to breakfast) Resident #11 was lying in bed. The resident removed her urine soaked incontinence brief with her bare hands and tossed it onto the floor. Observation of the incontinence brief on the floor revealed the brief was saturated with urine. 3. Record review A review of Resident #11's toileting hygiene task record, from 6/29/26 to 7/9/26, revealed that perineal hygiene was consistently not documented as being completed for a nine to 13 hour period of time throughout the day for 14 out of 14 days. The bowel and bladder incontinence care plan, revised 4/15/23, revealed Resident #11 was incontinent of bowel and bladder related to dementia and weakness. Interventions included checking as required for incontinence, washing, rinsing and drying the resident's perineum and changing the resident's clothing as needed after incontinence episodes. The skin integrity care plan, revised 10/20/25, revealed Resident #11 had actual impairment of her skin integrity related to the chronic area of cancer on her right buttock. Pertinent interventions included keeping the resident's skin clean and dry. C. Additional staff interview The staff development coordinator was interviewed on 7/8/26 at 11:00 a.m. The staff development coordinator said lying in a soiled brief put Resident #11 at risk of infections, including urinary tract and wound infections. The staff development coordinator said she would add a component of the importance of timely incontinence care to the skills education fair for nursing staff. II. Failed to ensure Resident #10 received oral care as needed and per the resident's preference A. Professional referenc According to Terech-Sk&oacute;ra S, [NAME]-[NAME] J, Leyk-Kola^czak M, [NAME] A, Piotrkowska R, M^drzycka-D^browska W, Ksi^ek J. Assessment of Oral Health in Long-Term Enteral and Parenteral Nutrition Patients: Significant Aspects of Nursing Care. International Journal of Environmental Resources Public Health, (February 2023), retrieved on 7/14/26 from https://pmc.ncbi.nlm.nih.gov/articles/PMC9967838/ (continued on next page)		

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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 observations, record review and interviews, the facility failed to ensure residents rooms were free from hazardous conditions for two (#2 and #13) of six residents out of 13 sample residents. Specifically, the facility failed to:-Ensure Resident #2's care planned fall interventions were implemented; and, -Ensure Resident #13 had a clear pathway from his bed to the bathroom and the exit doorway to the hallway that was free of his personal items so he could safely walk around.Findings include:I. Facility policy and procedure:The Incidents and Accidents policy, dated 2024, was provided by the nursing home administrator (NHA) on 7/9/26 at 6:06 p.m. It read, It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. -However, the policy did not include methods to ensure an environment free of accidents and hazards or appropriate preventative interventions.II. Resident #2A. Resident statusResident #2 age [AGE], was admitted on [DATE]. According to the computerized physicians orders (CPO), diagnoses included history of a past fracture of the fourth lumbar vertebra (spine),chronic pain and other low back pain.According to the 5/16/26 minimum data set (MDS) assessment the resident was cognitively intact with a brief interview for mental status (BIMS) score 13 out of 15. The resident had limited movement in the lower extremities (feet, hip and knees) that interfered with her daily functional abilities and put her at risk of injury. The resident was assessed to need supervision or touch assistance with verbal skills during transfers from surface to surface. The resident could walk. The assessment documented the resident used a wheelchair. The assessment indicated the resident had had two or more falls since admission with a minor injury and one major injury. B. Resident observation and interviewOn 7/6/26 at 2:20 p.m. Resident #2 was sitting in her recliner in her room. The resident stood up from the recliner. As she stood up from the recliner, she hunched over leaning forward as she stood and started to walk. The resident declined to use her walker and continued to walk in a hunched and leaning forward position heading towards the bathroom. There were no grip strips on the floor in front of her recliner (see care plan below). Resident #2 said the reason for her hunched position was due to a painful condition related to a previous surgery where hardware was placed on her spine. Said the last time she fell was three months ago. The resident said she was waiting for staff to come back to help her off the toilet but nobody came so she reached out for the grab bar and missed and fell on the bathroom floor. The resident said she hit her head in the fall and was confused for about a day after the fall. On 7/8/26 7:25 a.m. Resident #2 was asleep in bed. There was no fall mat at the bedside and the bed was not in its lowest position, as was care planned (see care plan below). There were no grip strips on the floor at the resident's bedside. There were two cloth incontinence pads placed on the floor at the bedside. Neither of the incontinence pads securely affixed to the floor and did not have any gripping type surface on the side on the floor.Resident #2 was interviewed a second time on 7/9/26 at 12:05 p.m. Resident #2 said she did not like the fall mat because it was slippery and she placed the cloth incontinence pads on the floor because the floor was cold on her bare feet. Resident #2 said no one told her the incontinence pads were unsafe or could lead to potential falls. The resident said she thought the incontinence pads were non-slip. Resident #2 said staff did not check on her very often because they thought she was independent. She said they came into her room to check on her roommate often because she was in a wheelchair, but she said she had to wait for staff when she needed assistance and that was why she fell in the bathroom a few months ago.C. Resident's (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative interview Resident #2's representative was interviewed on 7/7/26 at 1:30 p.m. The resident's representative said she was worried about Resident #2 because the resident had fallen in the facility. She said the resident told her she laid on the floor for 30 minutes after she fell. The resident's representative said Resident #2 was disabled and could not do a lot of things for herself. She said the resident could not use her hands fully due to arthritis and could not stand up straight. She said the staff did not communicate well with Resident #2. D. Record review The fall prevention care plan, revised 7/8/26 (during the survey), revealed Resident #2 was at risk for falls related to pain, muscle weakness and reduced mobility. Interventions included avoiding rearranging furniture, ensuring the call light was within reach and encouraging the resident to call for assistance as needed, ensuring the floors were free from spills and/or clutter, making sure the bed was in a low position at night and making sure the resident's personal items were within her reach. The fall care plan was revised on 7/8/26 (during the survey) to include that Resident #2 was able to transfer independently and tended to put blankets on the floor. Interventions added to the care plan on 7/8/26 included removing fall mats to reduce falls and tripping hazards, educating the resident to not place blankets on the floor due to her risk of falling and applying non-skid strips on the floor where the resident transferred. E. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 7/9/26 at 1:15 p.m. LPN #2 said yesterday (7/8/26) was the first time she had worked with Resident #2. She said it was not safe for the resident to have the incontinence pads on the floor next to her bed because they posed a fall risk, but the resident wanted her room to be like home. LPN #2 said she offered Resident #2 a new fall mat but the resident refused. LPN #3 was interviewed on 7/9/26 at 3:00 p.m. LPN #3 said the incontinence pads were still on the floor at the resident's bedside. LPN #3 said he did not know why the incontinence pads were on the floor at the resident's bedside. He said he would talk to the resident about the pads on the floor. LPN #3 was interviewed a second time on 7/9/26 at 4:30 p.m. LPN #3 said he had talked to Resident #2 and tried to tell her she could not put the incontinence pads on the floor at her bedside because it was a slipping and fall hazard but she got agitated and refused to remove them from the floor. LPN #3 said the resident was non-compliant and there was nothing he could do about it because it was her right to refuse. The director of nursing (DON), the NHA and the corporate nurse consultant were interviewed together on 7/9/26 at approximately 5:10 p.m. The DON, the NHA and the corporate nurse consultant said Resident #2 refused the floor fall mat and they were aware she was placing incontinence pads on the floor. The DON, the NHA and the corporate nurse consultant said they did not know why the resident placed the incontinence pads on the floor. The DON said Resident #2 had just moved into her current room and the staff must have forgotten to apply the grip strips in the resident's new room. The DON said they would get the grip strips installed in the appropriate place. III. Resident #13A. Resident status Resident #13, age [AGE], was admitted on [DATE]. According to the July 2026 CPO, diagnoses included rheumatoid arthritis and age-related cataracts. According to the 6/24/26 MDS assessment, Resident #13 was cognitively intact with a BIMS score of 13 out of 15. The resident was assessed to need supervision or touching assistance with surface to surface transfers and walking. The resident did not have any falls in the facility. B. Resident observations On 7/7/26 at 12:45 p.m. Resident #13's room was observed to be full of clutter. The resident was moving out of the facility and the empty boxes he had stacked up had fallen over. There were two empty oxygen portable tanks in the room and several items were randomly lying on the floor in the walk pathway between the resident's bed and the bathroom and the exit door to the hallway. The items on the floor included a drill, hangers, clothing, blankets, boxes and other miscellaneous items. On 7/8/26 at 7:29 a.m. Resident #13's room was observed to be still full of clutter, with the same items (see above) lying on the floor and around the room where they were the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous day. On 7/9/26 at 10:26 a.m. Resident #13's room was observed to be still full of clutter, with the same items (see above) lying on the floor and around the room where they were the previous day. C. Record review The fall risk care plan, revised 3/20/26, revealed Resident #13 was at risk for falls due to physical deterioration and oxygen equipment in his room. Interventions included maintaining a clear pathway, free of obstacles, avoiding rearranging furniture, educating the resident/family/caregivers about safety reminders and what to do if a fall occurred and ensuring a safe environment by keeping the floors free from spills and/or clutter. D. Staff interviews LPN #3 was interviewed on 7/9/26 at 4:00 p.m. LPN #3 said he offered and suggested to help Resident #13 picked up the items cluttering the resident's room on two different occasions, but the resident refused. He said the resident told him that he was not a child anymore, he was an adult and he did not want anyone touching his things. The DON and the NHA were interviewed together on 7/9/26 at approximately 5:15 p.m. The DON and the NHA said Resident #13 was about to move into a community placement and said he did not like staff to touch his things. The NHA said he was not aware Resident #13 had a drill on his floor. He said that was concerning and he would talk to the resident about not leaving it on the floor.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews the facility failed to ensure one (#8) of two residents received enteral feedings consistent with professional standards of practice out of 13 sample residents. Specifically, the facility failed to ensure Resident #8's enteral feeding pump was running at the correct rate per physician's orders. Findings include: I. Professional reference According to Fundamentals of Nursing version 11.2 Fundamental Principles of Medication Administration, updated 4/2/26, retrieved on 7/8/26 from www.openstax.org Nurses are responsible for ensuring patient safety during medication administration. The rights of medication administration are a set of guidelines to adhere to when administering medications in an effort to reduce adverse medication events. The five core rights of medication administration include the following: right patient, right drug, right route, right time, and right dose. The five core rights of medication administration should be confirmed at three different checkpoints during the medication administration process. These three checkpoints are when obtaining the medication, when preparing the medication and when administering the medication. At each of the checkpoints, the medication label should be compared to the medication order to confirm the right patient, right drug, right route, right time, and right dose. II. Facility policy and procedure The Enteral Tube Feeding via Continuous Pump policy, revised November 2018, was provided by the nursing home administrator (NHA) on 7/9/26 at 6:06 p.m. It read in pertinent part, Check the enteral nutrition label against the order before administration. Check the following information: resident name, ID and room number; type of formula; date and time formula was prepared; route of delivery; access site; and, method and rate of administration III. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO) diagnosis included failure to thrive, muscle wasting, dysphagia, and generalized muscle weakness. According to the 5/13/26 minimum data set (MDS) assessment, Resident #8 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The assessment indicated the resident received enteral tube feeding nutrition. The resident received 51% of her nutrition from the enteral feeding to ensure she maintained her daily caloric intake. B. Observations On 7/6/26 at 9:45 a.m. Resident #8's tube feed was infusing at a rate of 82 milliliters per hour. -However, the physician's order revealed the tube feed was ordered to infuse at 45 milliliters per hour (see record review below). At 10:00 a.m. certified nurse aide with medication aide authority (CNA-Med) #1 entered the room and discontinued the infusion. C. Record Review The July 2026 CPO revealed the following physician's order: Enteral feed, administer Isosource 1.5 at 45 milliliters per hour for 19 hours, off at 10:00 a.m. and on at 3:00 p.m., ordered on 5/27/26. The resident's nutrition risk care plan, revised 5/12/26, revealed the resident received enteral feedings. Pertinent interventions included providing the resident's diet as ordered by the physician, encouraging the resident to eat in the dining room, providing enteral tube feedings as ordered, monitoring meal intakes, registered dietitian (RD) to evaluate and make diet change recommendations, as needed, and RD to monitor ongoing nutritional status as needed related to risk of malnutrition per mini nutrition assessment. C. Staff interview The RD was interviewed on 7/8/26 at approximately 12:00 p.m. The RD said she had no concerns that the tube feed was running at the incorrect rate of 82 milliliters per hour as it did not have any adverse effect on the resident. The staff development coordinator was interviewed on 7/8/26 at approximately 12:30 p.m. The staff development coordinator said a root cause analysis was completed in response to the enteral tube feeding rate error. She said nursing (continued on next page)		

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