STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065206	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowan Community, Inc	4601 E Asbury Cir Denver, CO 80222

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on interviews and record review, the facility failed to ensure prompt action was taken to honor a request for the resident's personal and medical records by the resident and legal representative for one (#52) of one resident reviewed for medical records requests out of 33 sample residents. Specifically, the facility failed to allow Resident #52 and the resident's legal representative the right to obtain a copy of the resident's medical records or any portions of the electronically maintained record upon request and within two (2) working days of a verbal or written request for the resident's medical records. Findings include: I. Resident #52 A. Resident status Resident #52, under the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included bipolar disorder (a mental illness that causes unusual shifts in the person's behavior), anxiety disorder and cerebrovascular disorder (a condition that affects blood flow to the brain). The 3/15/24 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. The resident required extensive assistance with bathing, dressing and personal hygiene. The resident did not have any behaviors or rejection of care. B. Record review A medical durable power of attorney (MDPOA) for healthcare decisions, signed on 1/6/24 by Resident #52, read in pertinent part: I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care services or treatment, including hospitals, nursing homes, and any other facilities or treatment centers or programs to release to my agent all information or photocopies of any record which my agent may request. B. Resident and legal representative interview (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52 was interviewed on 4/22/24 at 2:30 p.m. Resident #52 said she made her sister her MDPOA and wanted her MDPOA to make all her medical decisions because she did not understand medications and medical matters and she needed help to make good decisions. Resident #52 said it made her anxious and worried when the nursing staff tried to discuss medical issues with her and asked her to make medical decisions on her own without her MDPOA present. Resident #52's MDPOA was interviewed on 4/23/24 at 10:42 a.m. The MDPOA said she had filed a couple of requests for Resident #52's medical records asking for specific information. She said it took the facility approximately 30 days to respond to the first request for medical records and she did not get all of the documents she had requested. She said, additionally, the facility did not provide an explanation of why the facility had not provided all of the requested documents. She said a grievance form was filed and the facility did not provide a written response on how they resolved the grievance. The MDPOA said the failure to provide medical records as requested was not resolved (cross-reference F585 for failure to respond to grievances). The MDPOA said, in addition to the request made on 3/5/24, she made an additional request for records on 4/21/24 and she still had not received the records. She said the facility returned the request to her because she had attached a page explaining the types of documents requested. She said the facility told her she needed to rewrite the request because the request needed to be written on one sheet of paper and if she needed more space she could write on the back of the form. The MDPOA was interviewed again on 4/24/24 at 5:12 p.m. The MDPOA said she still had not received the medical records documents she requested on 4/21/24. C. Records review A review of a grievance form dated 3/18/24 revealed Resident #52 and her MDPOA requested medical records on 3/5/24 and they had not received the requested documents by 3/18/24. When the resident's representative complained the facility requested the representative fill out a new request form. The grievance form documented that the requested medical records were sent to the MDPOA by email and the grievance was resolved. -However, the MDPOA disagreed with the grievance finding and said that she did not receive all of the requested documents. The MDPOA provided a copy of a records request sent to the facility by email on 4/22/24 at 7:18 a.m. The requested documents included documentation of resolutions for all grievances forms filed with the facility from 11/2/21 through 4/22/24, all speech therapy and any other therapy notes and evaluations from 1/1/24 through 4/22/24 and laboratory results from 4/11/24 through 4/22/24. The facility responded by email on 4/23/24 at 10:07 a.m. The email read in pertinent part, I received your request, unfortunately, I will need you to fill out another request. The dates are required to be provided on the form. If there is not enough room on the sheet, can you please provide additional information on the back of the form. -However, the facility did not permit the resident and the MDPOA the right to clarify the medical records request verbally. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interviews The nursing home administrator (NHA) was interviewed on 4/24/24 at 1:10 p.m. The NHA said the facility had some difficulty with records management and it was taking longer than usual to process records requests. The NHA said the facility had hired a new director of medical records (DMR) and a records request should take approximately 10 days to process. The NHA said they had received the records request for Resident #52 and would process the request as soon as possible. -However, the resident/ resident representative had the right to request copies of the resident's medical records verbally or in writing and receive the requested records within two working days with advance notice to the facility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on record review and interview, the facility failed to ensure two (#209 and #52) of two residents out of 33 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to: -Ensure Resident #209' s complaint about meals not being served at a palatable temperature; -Support Resident #52' s right to file any grievance (written or verbally) without the fear of feeling retaliation; -Ensure that all written grievance decisions included the date the grievance was received, a summary statement of the resident' s grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident' s concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was provided to the resident; -Ensure Resident #209 and Resident #52 received written responses to verbal and written grievances; and, -Establish a grievance policy that included all required elements per the regulations. Findings include: I. Facility policy and procedures The Grievances Policy, dated [DATE], was provided by the corporate director of clinical services (CDCS) on [DATE] at 5:13 p.m. It read in pertinent part, To provide residents and responsible party with information on the facility grievance procedure. To ensure that residents are afforded their right to file a grievance without discrimination or reprisal and that such grievance shall be responded promptly and in written form. A resident, family member, staff member or visitor may file a grievance at any time with an appropriate staff member or supervisor regardless of cognitive status, mental health diagnosis, or physical disability. There is no set time frame or minimum amount of time in which it must be filed except for those required under Elder Justice Law (see Abuse Policy). The administrator may assign the responsibility of investigating grievances and complaints to the appropriate department. Upon the receipt of a Grievance and Complaint Report or Complaint Concern form, the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Services Director or designee will begin an exploration into the allegations/concerns. The appropriate department director will be notified of the nature of the complaint and that follow up is necessary. The investigation and report will include, as each may apply the date and time the incident took place, the circumstances surrounding the incident, where the incident took place, the names of any witnesses and their account of the incident, the resident' s account of the incident, the employee' s account of the incident, accounts of any other individuals involved (employee' s supervisor) and recommendations for corrective action if not already remedied . The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten (10) working days of the filing of the grievance or complaint. -The grievance policy failed to include the resident's right to file a grievance in writing or orally, file a grievance anonymously and obtain the review in writing. II. Resident #209 A. Resident status Resident #209, age 67, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included bipolar disorder (mental illness that causes unusual shifts in the person's behavior) and generalized anxiety disorder. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was independent for eating. She required partial/moderate assistance for oral hygiene and was dependent on staff for toileting. B. Resident interviews Resident #209 was interviewed on [DATE] at 10:54 a.m. She said she had recently been admitted to the facility and had noticed the food was served cold for most meals. Resident #209 said she had filed grievances about the concern but it was never resolved and she was still receiving cold food at meals (cross-reference F804 for failure to serve food that was palatable in temperature). Resident #209 was interviewed again on [DATE] at 1:53 p.m. She said her food was still arriving cold and she had only had two fairly warm meals over the past week. C. Record review A grievance, filed by Resident #209 on [DATE], revealed she had a concern with her meals being served cold. The food and nutrition manager (FNM) documented the concern was passed on to the dietary manager (DM). The DM documented the food was being made at the proper temperature and recommended the resident eat in the dining room for faster service. -Resident #209' s preference to eat in her room was not taken into account and there was no action taken to address the resident's complaint of food being served cold and unpalatable food. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on [DATE] at 2:12 p.m. She said breakfast trays were served late that morning because there were only two CNA' s on the floor and they were providing care for a resident that required care in pairs. CNA #4 said one resident did not get her breakfast until after 9:30 a.m. and then had to order a special breakfast because the tray had sat for so long it was cold. The DM was interviewed on [DATE] at 1:29 p.m. The DM said the kitchen served the residents in the dining room first and then the room trays were sent out for delivery to residents who ate in their rooms. The DM said there were a lot of room trays so it sometimes took the kitchen staff time to plate and get all the trays for the units on the food delivery carts. The DM said the kitchen was working on fixing the room tray deliveries and it could sometimes take a long time for the trays to get delivered by the nursing staff depending on what other duties they had to complete. The DM could not provide evidence the facility had resolved Resident #209' s grievance regarding cold food in a manner that was satisfactory to the resident. 41032 III. Resident #52 A. Resident status Resident #52, under the age of 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included bipolar disorder (a mental illness that causes unusual shifts in the person's behavior), anxiety disorder and cerebrovascular disorder (a condition that affects blood flow to the brain). The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required extensive assistance with bathing, dressing and personal hygiene. The resident did not have any behaviors or rejection of care. B. Resident and resident representative interview Resident #52 was interviewed on [DATE] at 2:30 p.m. Resident #52 said she was very nervous and worried about speaking to anyone because she was worried what she said would be used against her. Resident #52 said the nursing home administrator (NHA) once told her she was a mandated reporter. The resident said she was worried that meant the NHA would use her status as a mandated reporter to stop her sister from being her legal representative and also stop her sister from visiting me if she said too much or complained. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52 said one night last month ([DATE]), she woke up and her room was very cold. Resident #52 said she asked one of the certified nurse aides (CNA) to adjust the heat and the CNA would not adjust the heat and instead piled a bunch of blankets on top of her. The CNA then told her that was good enough. Resident #52 said she complained to the facility staff about the encounter and the social services director (SSD) came to her room to talk to her about her complaint. Resident #52 said after she spoke to the SSD, the previous director of nursing (DON) came to talk to her about her grievance but did not explain how they planned to resolve the staff's refusal to honor a request like turning the heat up a couple of degrees. She said after the DON spoke to her, the NHA came to her room and told her the matter had been resolved but did not tell her how it was resolved. Resident #52 said after she voiced her grievance about the CNA's response to her request to turn up her heat, facility leadership responded by imposing care in pairs, which meant that any time a staff member came to her room there needed to be two staff present to provide any assistance so the staff had a witness for the interactions. Resident #52 said she worried that the staff would stick together and no one would believe anything she said. Resident #52 said she wanted a witness for herself. Resident #52 said that was the reason she did not want to discuss care issues or make medical decisions without her legally designated representative being present. Resident #52 said the facility's response to her grievance was upsetting and made her very anxious. She said if staff were to come in to discuss concerns with her and ask her to make decisions about her daily care she wanted her legal representative to be present. Resident #52 said the facility's leadership staff was bossy. The resident said she brought things to the facility's attention and the staff did not listen to everything she had to say. She said the leadership staff would end the conversations by saying That is all I am going to say. Resident #52 said she did not feel listened to. The resident's representative was interviewed on [DATE] at 2:30 p.m. The resident's representative said she and Resident #52 had voiced several grievances to facility staff on numerous occasions. She said most of the time the grievances were verbally communicated and the facility failed to provide a written response of actions taken to resolve the concerns. The resident's representative said most of the time she tried to talk to facility leadership privately about their concerns because talking about the grievances in front of Resident #52 was upsetting to the resident and made Resident #52 very anxious. The resident's representative said she filed a records request for the grievance action reports filed by her and Resident #52 and some other medical records information on [DATE] but had yet to receive the responses (cross-reference F573 for failure to provide residents the right to access/ purchase copies of records). The resident's representative said she and Resident #52 did not feel their grievances were resolved fully or to their satisfaction. She said the facility kept changing the way they resolved their concerns and she and Resident #52 wanted the facility's resolutions provided in writing. C. Record review (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52's grievance report dated [DATE] documented Resident #52 voiced a concern regarding the temperature of her room on the night of [DATE]. The concern form documented Resident #52 said she activated her call light and requested the CNA to turn the heat up to 75 degrees when she noticed the heat had been turned down to 73 degrees and she was freezing. The resident requested the CNA to turn up the heat. The grievance form documented the resident reported the CNA refused to turn up the heat and said she was unable to access the heater controls. The CNA got the resident extra blankets. The resident said she was unable to go back to sleep. The resident said she did not want extra blankets but instead wanted the heat turned up and she needed assistance from staff to reach and access the heater controls. The grievance form documented the action taken by the facility to ask the resident if she got someone who could help her and the resident said yes. -However, per Resident #52, the staff who came to help the resident refused to honor her request. The grievance form documented that the facility interviewed the CNA who responded to Resident #52's call light on the night she requested her heat be turned up; the CNA said she provided the resident blankets and did not adjust the heat as providing the resident with blankets would be the same as the turning the heat up. The CNA said after the staff left the room, the resident screamed for the heat to be fixed. The CNA said she explained to the resident that screaming was disruptive and Resident #52 said she did not care. The CNA said she asked Resident #52 not to speak to her that way. -The grievance report documented how the CNA made a decision to disregard the resident's request and implemented her own solution rather than work with the resident to come up with an agreeable solution. Additionally, the report failed to document how the facility planned to ensure that the resident's request would be accommodated in the future, or if it was not possible to accommodate the resident's request, how the staff would work with the resident to come up with an agreeable resolution. -According to the grievance report, the resident did not agree with the resolution and declined to sign the finalized report. The [DATE] grievance form submitted by Resident #52 revealed the resident was concerned because she signed a medical records release form on [DATE] and had received a menu instead. The resident was told she had to submit a new medical records release form. The facility's response on the form documented the facility had 30 days to get the information to the resident. The resident and her representative said the information was supposed to be provided within two days. The form documented the concern would be addressed with the NHA. The follow-up action documented an email was sent by medical records confirming the records were sent. -However, the response did not document the date the records were sent to the resident and the resident's representative. The form documented the resolution was reviewed verbally with the resident's legal representative and was resolved on [DATE]. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the resident and her representative did not feel the concern had been addressed because they had not received the medical records. III. Staff interviews The social services director (SSD) was interviewed on [DATE] at 12:16 p.m. The SSD said he was the grievance officer and managed grievances and complaints. The SSD said staff were asked to complete a grievance form when a resident voiced a concern. The SSD said, as the grievance officer, he would check and pick up all concern forms from the hallway grievance box a couple of times a day. The SSD said he also received written grievance forms directly from staff and residents. He said once a grievance form was accepted, he handed it over to the manager responsible for the area related to the concern for them to investigate and issue a resolution. He said the manager had 72 hours to respond to a resident's grievance and get the form back to the resident to see if they agreed to the resolution. The SSD said if the resident agreed and it was fully resolved, the grievance was filed in the facility's grievance binder. He said if the resident did not agree and the concern was not resolved, the grievance was turned back to the program manager to attempt another resolution. He said the grievances that came in over the weekend should be reported directly to a member of the leadership team in case it required urgent attention. The SSD said food grievances were directed to the DM. He said the facility had a lot of concerns with room trays and the facility was looking into those concerns and addressing the identified issues with leadership and the food committee monthly. The SSD said he was trending grievance concerns and it was rare to receive a concern about long call lights but most nursing related complaints were about agency staff not knowing residents' care. The facility had a few grievances about missing items that were usually located after a search. The SSD said the facility was usually able to resolve concerns quickly and when concerns were not resolved, they made a call to the ombudsman to see if the ombudsman could speak with the resident to see if they could assist with a resolution as a neutral person. The NHA was interviewed on [DATE] at 1:10 p.m. The NHA said she had many discussions with Resident #52 and her representative and had tried to resolve their concerns. The NHA said the facility had made several adjustments in the residents' care to try to meet the resident's and the resident representatives' requests but the resident's representative still had unresolved concerns that the facility continued to address. The NHA said with regard to the heater incident, the facility staff did not adjust the heat as the resident requested because the heat was already reading in the 70's and the staff did not think it needed to be turned up higher. The NHA considered that the grievance was resolved.