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	12/04/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#2) of five residents out of 14 sample residents were treated with respect, dignity and care in a manner that promoted quality of life or recognized the residents' individuality.Specifically, the facility failed to:-Knock prior to entering Resident #2's room, introduce themselves and the care they were going to be providing; and,-Respect Resident #2's wish to have staff enter her room wearing a face mask. Findings include:I. Resident #2A. Resident statusResident #2, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), the diagnoses included bipolar disorder (mental illness), chronic respiratory failure and type 2 diabetes mellitus.The 9/3/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 12 out of 15. She was dependent on staff for activities of daily living (ADL), including eating, oral hygiene, showering, toileting and dressing.B. ObservationsDuring a continuous observation on 10/1/25, starting at 1:50 p.m. and ending at 4:28 p.m. the following was observed:At 1:50 p.m. three handwritten signs were attached to Resident #2's door which requested any staff member who entered the resident's room, except to administer medications, wore a face mask over their nose. One of the handwritten signs was written in Spanish.At 3:44 p.m. an unidentified medical supply staff member entered Resident #2's room without knocking or wearing a mask. At 3:53 p.m. certified nursing assistant (CNA) #1 entered Resident #2's room without knocking or wearing a mask.C. Resident interviewResident #2 was interviewed on 10/6/25 at 5:00 p.m. Resident #2 said it made her feel horrible when the staff entered her room without wearing a face mask. She said the facility had face masks available. She said it made her feel bad when staff entered her room without knocking or announcing themselves.D. Record reviewReview of Resident #2's care plan, initiated on 11/6/21, revealed the resident preferred to wear a mask when outside of her room. The pertinent intervention included keeping a mask on Resident #2 at all times while she was out in the community.-However, Resident #2's care plan failed to include the resident's preference for staff members to wear a mask upon entering her room.E. Staff interviewsAn unidentified CNA was interviewed on 10/6/25 at 3:15 p.m. The CNA said there was a box of face masks available in Resident #2's room for staff members who did not present to the room wearing a face covering.The nursing home administrator (NHA) was interviewed on 10/7/25 at 11:46 a.m. The NHA said staff should have knocked on the resident's doors to announce themselves and the care they would provide in order to protect the resident's dignity. She said individual resident preferences, such as Resident #2's preference for staff to put on a face mask prior to entering the resident's room, should have been communicated in the care plan in order to provide consistent care. The NHA said in this case, Resident #2's family member placed the signs on the door to communicate the resident's preference to staff. She said face masks should have been donned prior to entering the resident's room, and face masks were accessible and stored at the nursing station. The NHA said the facility should have honored all of the residents' choices.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to facilitate resident self-determination for one (#4) of five residents reviewed for choices and preferences out of 14 sample residents.Specifically, the facility failed to honor Resident #4's choice to return to his room. Findings include:I. Resident #4A. Resident statusResident #4, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI), post traumatic seizures and chronic respiratory failure.The 8/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on staff for activities of daily living (ADL), including personal hygiene, dressing, eating and mobilizing.B. ObservationsDuring a continuous observation in the dining room on 10/1/25, starting at 12:55 p.m. and ending at 2:11 p.m., the following was observed:At 1:06 p.m. Resident #4 asked an unidentified staff member to assist him back to his room. The unidentified staff member told the resident his room was being cleaned and he had to wait 15 minutes.At 1:32 p.m. an unidentified housekeeping staff member asked Resident #4 how he was doing. The resident responded by saying he would like to go to his room. The staff member walked away without responding to the resident.At 2:02 p.m. Resident #4 began shouting get me the (explicit language) out of here.At 2:06 p.m. Resident #4 asked the activities director (AD) to bring him back to his room. The AD did not respond to the resident. Resident #4 then asked an unidentified kitchen staff member to bring him back to his room. The kitchen staff member said he would find a staff member to help him. The AD said she was busy setting up for the Bingo activity.At 2:11 p.m. Resident #4 said he wanted to go home, then repeated himself and said he wanted to go to his room. -The facility failed to assist Resident #4 out of the dining room for over an hour after he requested.C. Resident interviewResident #4 was interviewed on 10/6/25 at 2:00 p.m. Resident #4 said when he wanted to go back to his room he was often required to wait long periods of time it made him feel bad. D. Staff interviewsThe nursing home administrator (NHA) was interviewed on 10/7/25 at 11:46 a.m. The NHA said the facility should have honored all of the residents' choices. She said Resident #4's experience did not occur as a result of a staffing issue. The NHA said the unidentified staff member who told Resident #4 he would have to wait just 15 minutes to return to his room probably forgot to follow up with him.

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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 observations, record review and interviews, the facility failed to ensure a dependent resident received the necessary services to maintain activities of daily living (ADL) for two (#4 and #5) of five residents out of 14 sample residents.Specifically, the facility failed to:-Ensure timely repositioning and incontinence care for Resident #4; and,-Ensure timely repositioning for Resident #5. Findings include: I. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI), post traumatic seizures and chronic respiratory failure. The 8/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on staff for ADLs, including personal hygiene, dressing, eating and mobilizing. B. Resident interview and observation During a continuous observation on 10/2/25, starting at 12:37 p.m. and ending at 2:30 p.m., the following was observed: At 12:37 p.m. Resident #4 was sitting in his geri chair (specialty wheelchair) in the dining room staring at the wall. There were no activities or engagement for the residents and only dining room staff members were present. At 12:50 p.m. Resident #4 remained in the same position. At 1:37 p.m. Resident #4 remained in the same position At 1:54 p.m. Resident #4 remained in the same position At 2:00 p.m. Resident #4 said he had been sitting in his chair for a long time and would like to go back to his room. He said it had been a long time since he had been offered incontinence care. At 2:02 p.m. the activities director (AD) entered the dining room and was notified that Resident #4 would like to be assisted back to his room and changed. The AD left the dining room and said she would find a certified nursing assistant (CNA). At 2:04 p.m. the AD returned to the dining room and said she notified CNA staff. At 2:11 p.m. no staff members had come to the dining room to assist Resident #4. The AD was walking in and out of the dining room, but did not provide further assistance to the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:14 p.m. CNA #2 arrived on shift and was asked to assist Resident #4 with incontinence care. CNA #2 assisted the resident to his room and said she was going to get the Hoyer lift (mechanical lift used to transfer residents) and would be right back. At 2:18 p.m. CNA #2 returned to Resident #4's room with the Hoyer lift. At 2:20 p.m. CNA #2 began to independently prepare the Hoyer lift to transfer Resident #4 from the geri chair to his bed when the nursing home administrator (NHA) entered the room to assist with the hoyer lift transfer. Once on his bed, Resident #4 said it felt better to lay down flat. The NHA left the room. At 2:23 p.m. Resident #4's room filled with the scent of foul urine. At 2:26 p.m. CNA #2 tossed a saturated urine brief into the trash can. The brief made a loud thud when it hit the bottom of the can. At 2:27 p.m. CNA #2 said she needed to get a new sling for the Hoyer lift because the previously used sling was wet with urine. -Resident #4 was not provided repositioning or incontinence care for two hours. Resident #4 was interviewed again on 10/6/25 at 9:30 a.m. Resident #4 said sitting in a wet incontinence brief for long periods of time made him feel bad and his skin would become irritated. D. Record review Review of Resident #4's comprehensive care plan, initiated on 8/18/25, revealed the resident had bowel and bladder incontinence. Pertinent interventions included providing perineal care after each incontinent episode, checking the resident frequently and as required for incontinence and changing the resident's clothing as needed after incontinence episodes. Review of Resident #4's electronic medical record (EMR) revealed weekly nursing assessments which document Resident #4 was incontinent of bowel and bladder. Further review of Resident #4's EMR revealed the following documentation of incontinence care on 10/2/25: Incontinence care was performed at 5:43 a.m. and again at 1:35 p.m. -However, Resident #4 was sitting in the dining room during a continuous observation between 12:37 p.m. and 2:15 p.m. and was not provided with incontinence care during that time (see observations above). E. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #2 was interviewed on 10/6/25 at 9:38 a.m. RN #2 said the staff would check the residents for incontinence with every medication pass. RN #2 said foul smells and wet clothes or linens were an indication that a resident needed to be changed, and providing incontinence care was important because sitting in urine or stool for long amounts of time could cause skin breakdown. CNA #3 was interviewed on 10/6/25 at 11:48 a.m. CNA #3 said incontinence care was scheduled to be performed at the start of the shift, every two hours after that with rounds and as needed. She said wet pants and the smell of a bowel movement indicated that incontinence care might need to be performed more frequently. CNA #3 said incontinence care was important to maintain personal hygiene, provide skin protection and ensure the residents were comfortable and dry. The NHA was interviewed on 10/7/25 at 11:46 a.m. The NHA said incontinence care should be performed every two hours. She said if the resident was not soiled, then they should be repositioned. The NHA said smells of urine or agitation could indicate the resident was in need of changing, and providing incontinence care was important in order to prevent skin breakdown. II. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included Huntington's disease, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, anxiety disorder, depression and other abnormal involuntary movements. The 8/21/25 minimum data set (MDS) assessment revealed the resident scored a zero on the brief interview for mental status (BIMS) indicating severe cognitive impairment. The MDS assessment revealed Resident #5 was dependent on staff for all ADLs. B. Observations During a continuous observation on 10/1/25, beginning at 1:47 p.m. and ending at 4:20 p.m., the following was observed: At 1:47 p.m. Resident #5 was sitting in their wheelchair at the table in the dining room. At 2:06 p.m. the AD began setting up the dining room for Bingo. The staff did not reposition Resident #5. At 3:30 p.m. Resident #5 remained in her wheelchair at the table in the same position. At 4:20 p.m. Resident #5 was sitting in her wheelchair at the dining room table in the same position waiting for dinner. -Resident #5 was not repositioned or offered repositioning for over two and a half hours. C. Record review (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan, revised on 7/15/21, indicated Resident #5 used a wheelchair and occasionally had delusions that she can walk. Pertinent interventions included positioning the resident in a wheelchair and providing assistance with repositioning as indicated. -However observations revealed the facility failed to consistently assist Resident #5 with repositioning (see observations above). D. Staff interview CNA #4 was interviewed on 10/7/25 at 10:14 a.m. CNA #4 said Resident #5 was capable of offloading her own weight. CNA #4 saidResident #5 was capable of moving herself up in the chair if Resident #5 felt she was sitting too low in the wheelchair. CNA #4 said the staff would reposition Resident #5 when they were providing toileting care. CNA #4 said that Resident #5 was good about vocalizing her needs. CNA #4 said Resident #5 did not sit for long periods of time in her wheelchair because Resident #5 did not like to. -However, Resident #5's care plan indicated the resident needed assistance with repositioning (see care plan above). it