STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Specifically, the facility failed to maintain residents' dignity and ensure residents were provided equal access to incontinence care supplies. Findings include: I. Resident interviews Resident #1 was interviewed on 6/11/25 at 3:15 p.m. Resident #1 said he did not have briefs for four days because the facility ran out of briefs. Resident #1 said he asked a nurse manager what to use for briefs if the facility ran out and the nurse manager told him to use a towel instead. Resident #1 said he was not sure what the facility meant by using a towel but there were no briefs available. Resident #1 said the issue started on a Friday and the new briefs were delivered on a Tuesday. Resident #9 was interviewed on 6/12/25 at 9:45 a.m. Resident #9 said a certified nurse aide (CNA) told him the facility did not order briefs. Resident #9 said he only had one pair of briefs left and the facility finally got more briefs in. Resident #9 said the facility was out of briefs at the end of May 2025. Resident #1 was interviewed a second time on 6/12/25 at 10:15 a.m. Resident #1 said the staff told him they were out of briefs and the staff told him the director of nursing (DON) told the facility not to order facility supplies because it was the end of the month. Resident #10 was interviewed on 6/12/ 25 at 10:25 a.m. Resident #10 said he decided to wait to have his brief changed one night because he thought he would run out of briefs in the beginning of June 2025 because he had one brief remaining and he thought the facility was going to run out of briefs again later in the month. Resident #10 said his briefs were wet when he waited to have his briefs changed but it was only for six to seven hours. Resident #10 said when he did not have his briefs changed he did not feel discomfort because he was paraplegic. Resident #10 said he did not like to sit in his briefs too long because he did not want any open sores. Resident #10 said he could not remember who told him the facility was out of briefs but thought it was a CNA. Resident #10 said he was told by a staff member running low on briefs was a money issue and that the facility wanted to order the briefs after the first of the following month. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 was interviewed on 6/12/25 at 10:37 a.m. Resident #11 said the facility ran out of briefs at the beginning of June 2025 and staff had to use a pull-up garment for him instead. Resident #11 said the pull-up garment leaked into his bed but he did get his wet sheets changed by staff. Resident #11 said he used briefs and needed staff assistance to change his briefs. Resident #12 was interviewed on 6/12/25 at 2:13 p.m. Resident #12 said the facility was constantly running out of necessary supplies the residents needed. Resident #12 said a staff member brought him a package of incorrectly sized incontinence briefs earlier in the day (see observation below). Resident #12 said he normally wore size three extra large (3XL) briefs and the staff member brought him size two extra large (2XL). Resident #12 said the staff member performed incontinence care on him and changed him into the 2XL briefs. Resident #12 said the staff member returned to his room a short while after, with a package of 3XL briefs, and told the resident that the central supply area was full of supplies on 6/11/25 and most of them were gone by 6/12/25. An open package of 2XL briefs and a closed package of 3XL briefs were observed next to Resident #12's bed during the interview. II. Observation On 6/12/25 at 10:28 a.m. an unidentified staff member walked into Resident #12's room. The staff member was holding a package of incontinence briefs. The staff member was heard telling Resident #12 she could not find his size of briefs. The unidentified staff member asked Resident #12 if the smaller size would work and the resident replied that he guessed so. III. Grievance forms Facility grievances were provided by the DON on 6/12/25 at 9:00 a.m. A grievance, dated 6/2/25, documented Resident #1 was concerned he ran out of supplies and only had one brief left and that a night shift CNA told him he was out (of briefs). IV. Staff interviews A staff member, who wished to remain anonymous, was interviewed on 6/12/25 at 3:10 p.m. The staff member said the facility ran out of briefs at the end of May 2025/beginning of June 2025 and there were pull-up garments available, but the supply of pull-up garments was limited. The staff member said some residents were unable to wear a pull-up garment and briefs were not an option for them based on their build. The staff member said the staff took briefs from residents' rooms to use for other residents.The staff member said a nurse manager instructed the staff to put towels under the residents if the facility ran out of briefs. The staff member said a resident expressed his concerns about the limited supply of briefs to the nurse manager and the nurse manager told the resident to just use towels. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second staff member, who wished to remain anonymous was interviewed on 6/12/25 at 3:13 p.m. The second staff member said the facility ran out of briefs. The second staff member said most of the residents who were offered pull-up garments instead of briefs did not want pull-up garments and some residents did not fit in the pull-up garments. The second staff member said one resident declined to take his medicine and to have his briefs changed because he did not want to go to the bathroom in his briefs. The second staff member said a central supply staff member told the staff that the DON instructed the central supply staff member not to order supplies because the facility was over budget and the facility would probably run out of briefs. A third staff member, who wished to remain anonymous, was interviewed on 6/12/25 at 3:18 p.m. The third staff member said each unit had its own storage closet for supplies and staff would go to the central supply area or other units in the facility if the storage closet on a particular unit was out. The third staff member said they were told by another staff member that on 5/31/25, a member of management told staff to use towels as incontinence briefs for the residents. The third staff member said the staff all had an understanding that there was a lack of resident care supplies in the facility. The third staff member said they felt frustrated and hurt by not having adequate resources necessary for resident care. The nursing home administrator (NHA) and the DON were interviewed together on 6/12/25 at 4:00 p.m. The DON and the NHA said they were not aware of a member of the management telling staff to use towels underneath residents for briefs. The DON said it was not appropriate for staff to be told to use towels instead of incontinence briefs. The NHA said the facility did not run out of briefs for the residents. The DON said she did not instruct the central supply staff not to order supplies, but to order the supplies if needed.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the transfer or discharge was documented accurately in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider for one (#2) of three residents reviewed for discharge out of 12 sample residents. Specifically, for Resident #2, the facility failed to: -Ensure the resident's discharge summary included the resident's need for two transfer poles; -Ensure the resident's discharge care plan included the resident's medical equipment needs, specifically the two transfer poles -Document communication and responses from the referral sources to confirm the resident's discharge needs; and, -Ensure the resident's discharge date documented in the physician's orders was accurate and the physician's order was obtained timely. Findings include: I. Resident #2 A. Resident status Resident #2, age [AGE], was admitted on [DATE] and discharged to home on 5/21/25. According to the June 2025 computerized physician orders (CPO), diagnoses included cervical spinal stenosis (narrowing of the spinal canal in the neck), paroxysmal atrial fibrillation (irregular heart beat), need for assistance with personal care, mixed incontinence, unilateral primary osteoarthritis of unspecified hip (one-sided hip joint condition) and unsteadiness on feet. The 5/21/25 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 required partial assistance with toileting hygiene, bed mobility and transfers. He was dependent on staff for shower/tub transfers. He independently used a motorized wheelchair for locomotion. The MDS assessment documented Resident #2 was discharged from the facility, as planned, on 5/21/25 through a local contact agency. B. Resident interview (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was interviewed via phone on 6/11/25 at 1:16 p.m. Resident #2 said his apartment was incorrectly set up and his medical equipment was just beginning to be set up. Resident #2 said he was supposed to have two transfer poles in his apartment; one in his bedroom and one in his bathroom. Resident #2 said the transfer pole in his bedroom was not set up in the correct spot and a transfer pole had yet to be installed in his bathroom. During the interview with Resident #2, the resident handed the phone to the transition services agent to answer questions (see interview below). C. Record review A review of the 4/24/25 occupational therapy (OT) and physical therapy (PT) notes documented Resident #2 was waiting for approval for a home visit to install vertical transfer poles for a safe discharge to his community apartment. The nursing Discharge summary, dated [DATE] at 7:55 a.m., documented Resident #2 had completed therapy services and obtained the highest practical level in a long-term care setting. It documented Resident #2 would require assistance with toileting, bathing and functional transfers upon discharge to the community. It documented Resident #2 was independent with mobility once he was transferred to his power wheelchair. It documented home health nursing and therapy services were arranged to assist Resident #2's transition back to the community. It documented Resident #2 had physician's orders for a specialty bed and mattress and a shower chair with wheels for use at home. -Review of Resident #2's discharge summary revealed there was no documentation regarding the resident's need to have two transfer poles set up in his apartment. The discharge care plan, initiated 2/29/24 and revised 2/10/25, documented Resident #2 intended to be discharged back to the community through a local contact agency. Interventions included reviewing the resident's discharge care plan quarterly and as needed, preparing and providing Resident #2 with contact numbers for all community referrals and staff providing the resident with any needed support. -Review of the discharge care plan revealed there was no documentation addressing Resident #2's specific durable medical equipment needs for a safe discharge, including his need for two transfer poles. Review of Resident #2's May 2025 CPO revealed the following physician's order: Resident to discharge from [facility] to [apartment] on 5/22/25. Resident to discharge with all medications needed, ordered 5/23/25. -The physician's order incorrectly listed Resident #2's date of discharge as 5/22/25, instead of 5/21/25. -Additionally, the physician's order was not obtained until two days after Resident #2 was discharged home from the facility (on 5/21/25). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at approximately 3:00 p.m., a purchase order for two transfer poles was provided by the SSD. The purchase order indicated the order was placed on 4/8/25 and had not yet shipped. The purchase order was signed by Resident #2, but was not dated as to when the resident signed it. II. Staff interviews The social services director (SSD) was interviewed on 6/10/25 at 3:30 p.m. The SSD said the social services assistant (SSA) confirmed with the home health agency over the phone, on 5/20/25, that they had approved home health services for Resident #2. The SSD said the home health agency confirmed Resident #2 would be seen the day following his discharge from the facility on 5/21/25. The SSD said his understanding was that the resident's equipment in his apartment had been set up and the resident's care was successfully transitioned to the home health agency after his discharge from the facility. The director of rehabilitation (DOR) was interviewed on 6/11/25 at 11:27 a.m. The DOR said Resident #2 was assessed prior to his discharge from the facility for a bed to chair transfer with a transfer pole because that was the equipment the resident was going to use at home. The DOR said the transitions services team said Resident #2 would have a transfer pole in his bathroom at his new apartment. The SSA was interviewed on 6/11/25 at 12:07 p.m. The SSA said she spoke to the home health agency contact on 5/20/25 and she said the home health agency confirmed services for Resident #2 that would start on 5/22/25. The SSA said she did not document the conversation in which the home health agency confirmed they would be assuming care for the resident. The SSA said she verbally confirmed with the transition services team on 5/20/25 that Resident #2's two transfer poles were installed at his apartment. -However, only one transfer pole was installed at Resident #2's apartment (see interview below). The transition services agent was interviewed via phone on 6/11/25 at 1:16 p.m. The transition services agent said Resident #2 needed assistance transferring from his bed to his motorized wheelchair. The transition services agent said Resident #2 had one transfer pole installed in his bedroom. The transition services agent said the second transfer pole for Resident #2's bathroom had not been installed yet, but he said he would install the transfer pole in Resident #2's bathroom while he was there (on 6/11/25). The transition services supervisor was interviewed on 6/11/25 at 1:50 p.m. The transition services supervisor said the facility ordered the equipment based on the medical needs of the resident. The transition services supervisor said he knew there was one transfer pole for Resident #2 provided by the facility. The transition services supervisor said the facility did not give the transition team an inventory of the resident's equipment, but during the discharge meeting, via the phone on 5/20/25, the equipment Resident #2 required at discharge had been reviewed. The transition services supervisor was interviewed again on 6/11/25 at 5:45 p.m. The transition services supervisor said a second transfer pole was found in a box at Resident #2's apartment (on 6/11/25) and was going to be installed. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD was interviewed a second time on 6/12/25 at 3:37 p.m. The SSD said Resident #2's discharge date was verbalized over the phone to the home health agency but it was not documented in the resident's record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#9) of five residents reviewed for medications errors out of 12 sample residents. Specifically the facility failed to ensure Resident #9 was administered Farxiga (for chronic kidney disease and diabetes mellitus type 2) per physician's orders. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: -The right medication; -The right dose; -The right patient; -The right route; -The right time; -The right documentation; and, -The right indication. II. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, congestive heart failure, ischemic cardiomyopathy (narrowed arteries reducing blood flow) and chronic kidney disease. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/22/25 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. He required set up or clean up assistance with his activities of daily living (ADL) and supervision while bathing. B. Resident interview Resident #9 was interviewed on 6/12/25 at 9:45 a.m. Resident #9 said the facility ran out of his medications frequently. He said the facility ran out of two of his medications in May 2025 and he was told a nurse forgot to order the medications. C. Record review A review of Resident #9's June 2025 CPO revealed the resident had physician's orders for the following medication: Farxiga oral tablet (dapagliflozin propanediol) 5 milligrams (mg), give two tablets by mouth one time a day for chronic kidney disease and diabetes mellitus type 2, ordered 5/13/25. Resident #9's May 2025 medication administration record (MAR) revealed the resident did not receive the Farxiga as ordered on 5/17/25, 5/18/25 and 5/19/25. A 5/17/2025 at 7:27 a.m. medication administration note documented Resident #9's Farxiga was not administered and the facility was awaiting delivery of the medication from the pharmacy. A 5/18/25 at 9:27 a.m. medication administration note documented to administer Farxiga 5 mg; give two tablets by mouth one time a day for chronic kidney disease and diabetes mellitus type 2. -The note did not indicate why the resident's Farxiga medication was not administered. A 5/19/25 at 11:40 a.m. medication administration note documented to administer Farxiga 5 mg; give two tablets by mouth one time a day for chronic kidney disease and diabetes mellitus type 2 and the medication was on order. -However, there were no progress notes documented to indicate the pharmacy or the physician had been contacted or notified that Resident #9's Farxiga medication was not available and had not been administered to the resident on 5/17/25, 5/18/25 and 5/19/25. III. Staff interviews The consultant pharmacist was interviewed on 6/12/25 at 1:48 p.m. The consultant pharmacist said Farxiga was approved for coronary heart failure and studies had shown that it reduced mortality in residents with heart failure. She said the medication was also approved for use with chronic kidney disease. The consultant pharmacist said if the facility were out of a medication, the facility would not contact the pharmacist but should instead contact the pharmacy and could also contact the resident's physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 6/12/25 at 2:58 p.m. LPN #1 said she had had to call the pharmacy after the facility had ordered a medication and sometimes the facility had to order the medication a second time. LPN #1 said she usually documented when she called the pharmacy. LPN #1 said the facility could order medications electronically, and if a medication had to be ordered a second time, she would call the pharmacy for follow up. LPN #1 said if a medication was not available to administer, staff had to notify the physician. The clinical nurse consultant (CNC) was interviewed on 6/12/25 at 4:30 p.m. The CNC said she checked Resident #9's Farxiga medication order and the physician had ordered the medication on 5/13/25. She said the medication showed on the resident's profile but the medication was not filled by the pharmacy. She said the facility reordered the medication on 5/18/25 and it was delivered to the facility on 5/18/25. She said she was not sure why the medication was not administered on 5/19/25. IV. Facility follow-up A provider education document, dated 6/13/25, was provided by the NHA on 6/13/25 at 3:20 p.m., after the survey exit The provider education documented the physician sent an electronic prescription for Resident #9's Farxiga medication to the pharmacy on 5/13/25 and indicated the prescription was for the resident's profile only. Therefore, the pharmacy added the medication to the resident's medication list but did not fill the prescription. The physician was counseled on ensuring that the profile only was not marked on the electronic prescription submission.