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	12/18/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents and their representatives had a right to participate in the development and implementation of their person-centered plan of care for two (#10 and #15) of 12 residents out of 19 sample residents.Specifically, the facility failed to ensure residents' representatives had the opportunity to attend quarterly care conferences for Resident #10 and Resident #15. I. Resident #10 A. Resident statusResident #10, age [AGE], was admitted on [DATE]. According to the December 2025 CPO, diagnoses included dementia with behavioral disturbance, transient ischemic attack (TIA - a temporary blockage of blood to the brain), cerebral infarction (blood clot blocks blood to the artery), chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus with hyperglycemia (high blood sugar), anxiety disorder and depression. The 7/21/25 MDS assessment revealed the resident was cognitively impaired with a BIMS score of zero out of 15. The resident required maximal assistance with oral hygiene, toileting, dressing and personal hygiene. B. Resident's representative interviewResident #10's representative was interviewed on 12/17/25 at 1:39 p.m. The representative said she was invited to and participated in one care conference when Resident #10 was first admitted to the facility. The representative said she had not been invited to a care conference since July 2025. The representative said she recently had a voicemail from someone in social services to schedule a care conference and she called social services back but had not scheduled a care conference. The representative said it was frustrating not being able to have a care conference since July 2025 because there was a lot of miscommunication between nursing and social services. C. Record review The 7/25/25 interdisciplinary team (IDT) care planning review and conference assessment revealed Resident #10's representative attended the care conference. -A review of Resident #10's electronic medical record (EMR) revealed there was no documentation to indicate another care conference had taken place between 7/25/25 to 12/18/25. The 12/11/25 social services note revealed a call was placed (during the survey) to Resident #10's representative and a voicemail was left. II. Resident #15A. Resident statusResident #15, age [AGE], was admitted on [DATE]. According to the December 2025 CPO, diagnoses included epileptic syndromes with seizures, catatonic schizophrenia (schizophrenia with extreme motor disturbances) and personality and behavioral disorder. According to the 9/30/25 MDS assessment, the resident was cognitively impaired with a BIMS score of zero out of 15. The resident required maximal assistance with dressing and personal hygiene. The resident required moderate assistance with oral hygiene and was dependent on toileting and showering. B. Resident's representative interviewResident #15's representative was interviewed on 12/16/25 at 2:55 p.m. The representative said the facility made it difficult to schedule a care conference and she did not remember the last time there was a care conference for Resident #15. The representative said it was frustrating because Resident #15 had a lot going on with his healthcare and she wanted a care conference so everyone could be on the same page. C. Record review The 8/12/25 care planning review and care conference assessment revealed Resident #15's representative did not attend the care conference. The reason documented for the representative not attending was that the facility had been unable to contact the representative. -A review of Resident #15's EMR revealed there was no documentation to indicate a care conference had taken place between 8/12/25 to 12/18/25. III. Staff interviews The nursing home administrator (NHA) was interviewed on 12/18/25 at 5:52 p.m. The NHA said the social services director (SSD) and the designated social services assistant for the unit was responsible for coordinating care conferences. She said the first care conference should be completed within 72 hours from the date of admission. The NHA said everyone from the IDT participated in the care conference. The NHA said sometimes the ombudsman and hospice staff attended the care conferences. The NHA said the residents and their representatives attended the care conferences. The NHA said the residents' representatives were contacted by their preferred contact method including phone, email and text. The NHA said social services should document their attempts to contact the residents' representatives as a progress note. The NHA said she knew social services was behind in care conferences by about a quarter for all residents including Resident #10 and Resident #15. She said both the residents' initial care conference and quarterly conferences were behind schedule.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident's representative when there was a significant change in the resident's condition for one (#10) of four residents out of 19 sample residents. Specifically, the facility failed to notify the designated representative for Resident #10 when he had swelling on his face, was seen by a dentist emergently, had edema in his legs, loose stools and bruising on his knee. Findings include: I. Facility policy and procedureThe Change of Condition Reporting policy and procedure, revised October 2020, was provided by the nursing home administrator (NHA) on 12/18/25 at 7:01 p.m. It revealed in pertinent part, The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. Symptoms and unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life-threatening. All attempts to reach the physician and the responsible party will be documented in the nursing progress notes. Documentation will include time and response.II. Resident #10 A. Resident statusResident #10, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, transient ischemic attack (TIA - a temporary blockage of blood to the brain), cerebral infarction (blood clot blocks blood to the artery), chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus with hyperglycemia (high blood sugar), anxiety disorder and depression. The 7/21/25 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. The resident required maximal assistance with oral hygiene, toileting, dressing and personal hygiene. B. Resident representative interview Resident #10's representative was interviewed on 12/17/25 at 1:39 p.m. The representative said the facility did not notify her when Resident #10's legs were swollen. She said she thought a physician would see it and come up with a plan. She said there was a time Resident #10 had another visitor who asked the representative when Resident #10 got a black eye and what caused it. Resident #10's representative said the facility did not tell her about the black eye until she asked about it. Resident #10's representative was interviewed again on 12/18/25 at 2:32 p.m. The representative said Resident #10 did not see the dentist. She said she knew his lip was swollen but she was not told about him seeing a dentist. Resident #10 representative said she never heard anything about either of Resident #10's knees. Resident #10's representative said Resident #10 had loose stools when he was first admitted to the facility and she had not heard of any loose stools since then. She said it was important for her to know what was going on with Resident #10 because he could not speak for himself and he could not tell her how he was feeling. She said since Resident #10 could not communicate his needs and his wants, it was her place to be his eyes and ears to advocate for him. C. Record review The 10/28/25 weekly skin assessment revealed there were no skin issues to note. The 10/29/25 nurse progress note revealed a physician assessed Resident #10's left knee regarding resident antalgic gait (a painful limp). There were no signs or symptoms of swelling to the left knee. There was no bruising noted. There was slight discoloration to the left knee. The resident denied pain at the time. There was a new order for two view Xray. The director of nursing (DON) called the physician to place the order for the routine Xray. The facility would continue with the current plan of care. -A review of Resident #10's electronic medical record (EMR) revealed there was no documentation to indicate the resident's representative was notified of the swelling to the resident's left knee or that an order for an Xray of the left knee was obtained. The 10/29/25 physician note revealed Resident #10 was seen walking down the hall with a physical therapist who noticed the resident was limping on the left leg with mild bruising on the left knee and complained of pain in the knee joint. There were no recent falls. Nursing reported the resident had increased agitation over the last several days but was calm and cooperative in the morning. On exam, the resident's lower lip was slightly edematous and his bottom left teeth had purulent drainage. An urgent dental referral was sent. The 10/30/25 dental note revealed the nurses reported the resident was in severe pain the day before and had facial swelling. The nurse reported antibiotics were given the day before. There was no pain during the appointment. The clinical exam revealed no facial swelling. The 11/6/25 physician note revealed Resident #10 was seen by the dentist on 10/29/25. According to the dentist, the resident did not have an oral infection but had diffuse gingivitis. The resident had right periorbital ecchymosis (discoloration) and mild visible facial trauma. -A review of Resident #10's EMR revealed there was no documentation to indicate the resident's representative was

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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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in three of five units.Specifically, the facility failed to:-Ensure common hallways were free from odors and clutter;-Maintain clean floors in the residents' rooms, hallways and secure unit dining room; and, -Ensure resident rooms and common hallways were in good repair. Findings include:I. Facility policy and procedure The Safe and Homelike Environment policy and procedure, revised January 2025, was provided by the nursing home administrator (NHA) on 12/18/25 at 7:01 p.m. It revealed in pertinent part, Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. The facility will provide and maintain bed linens that are in good condition. The facility will provide and maintain adequate and comfortable light levels in all areas, minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to the housekeeping department.II. Resident group interviewFour residents (#16, #17, #18 and #19), who were cognitively intact and deemed interviewable by the facility and assessment were interviewed on 12/17/25 at 2:00 p.m. The residents said the facility often had odors of urine and feces. Resident #17 said the facility frequently smelled like feces when he walked through the 400 and 700 units. Resident #18 said the facility often had odors, which made her cover her mouth and nose with the palm of her hand.III. Resident representative interviewsResident #10's representative was interviewed on 12/17/25 at 1:39 p.m. The representative said she visited Resident #10 at least weekly and she said when she entered the 500 unit, it always smelled like feces and food. She said she did not like that the blinds were not in working order and the light above Resident #10's sink in his room was missing. She said she noticed that there were areas on the floor in the 500 unit that were sticky. The representative said social services handled the broken blinds but Resident #10 still did not have a light above his sink. Resident #14's representative was interviewed on 12/16/25 at 2:33 p.m. The representative said she had visited Resident #14 three times since she was admitted on [DATE]. The representative said she noticed the smell of urine and feces in the 500 unit and in Resident #14's room. The representative said she bought body spray for Resident #14 so her room would not smell. IV. Observations The following was observed throughout the facility on 12/16/25:At 10:08 a.m. room [ROOM NUMBER] was observed to have multiple stained footprints at the foot of the bed for bed A. At 10:09 a.m. the entrance to the secure unit had a strong smell of urine.At 10:14 a.m. the 700 unit had a strong smell of feces.At 10:17 a.m. the 700 unit's handrails were observed to have multiple paint chips on the right and left side of the hallway. The carpet throughout the unit was observed to have multiple stains. At 11:57 a.m. the entrance of the 500 unit was observed to have the smell of urine. At 11:59 a.m. the hallway next to room [ROOM NUMBER] was observed to have the smell of urine. At 12:09 p.m. prior to lunch being served, two of the four dining tables in the common area had multiple crumbs underneath the table. One of the four tables had dry stains underneath the table. In the adjacent common area with one dining table, there was a dry stain. At 12:25 p.m. there was a used water pitcher that had been filled with a thick, brown liquid on the round table in the sitting area at the end of the 200 unit. There were also used, crumpled linens found on the striped sofa and the green chair in the sitting area.At 12:30 p.m. certified nurse aide (CNA) #8 went into room [ROOM NUMBER] and walked out at 12:31 p.m. CNA #8 left the room's door open and the floor was observed to be wet. At 12:38 p.m. room [ROOM NUMBER] was observed to be sticky in the middle of the room and there was a crack below the sink. At 12:41 p.m. room [ROOM NUMBER] was observed to have dried feces next to the bed and the resident's walker. The bed sheet was stained with feces and the resident who resided in room [ROOM NUMBER] was lying in bed. The floor had a spill near the dried feces on the floor that was running towards the entrance of the room. The floor was sticky throughout the room. At 12:43 p.m. room [ROOM NUMBER] was observed to have a hairline crack on the right side of the bed. At 12:46 p.m. room [ROOM NUMBER] was observed to have a hairline crack on the wall behind the bed. At 12:50 p.m. the hallway next to room [ROOM NUMBER] was observed to have the smell of feces. At 1:43 p. m. the used water pitcher and linens were still found in the sitting area at the end of the 200 unit. At 3:32 p.m. room [ROOM NUMBER] was observed to still have dried feces and a spill next to the resident's bed. On 12/17/25 during a continuous observation from 11:13 a.m. to 12:30 p.m., the following was observed. At 11:13 a.m. the entrance of the 500 unit was observed to have the smell of urine. At 11:20 a.m. two of the four dining tables in the common area had multiple crumbs underneath the table. At 11:27 a.m. room [ROOM

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure two (#1 and #8) of five residents out of 19 sample residents received treatment and care in accordance with professional standards of practice.Specifically, the facility failed to administer medications in a timely manner per the physician orders for Resident #1 and Resident #8.Findings include:I. Professional referenceAccording 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: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Resident #1A. Resident status Resident #1, age [AGE], was admitted to the facility on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included fibromyalgia (a long-term condition that causes pain and tenderness throughout the body), hereditary and idiopathic neuropathy, diaphragmatic hernia without obstruction or gangrene and personal history of healed traumatic fracture.The 11/18/25 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. She required set up assistance with eating and oral hygiene. She was dependent on toileting, dressing and transfers. She refused bathing. The resident did not demonstrate delusions or hallucinations. The assessment indicated the resident reported acute left shoulder pain and chronic generalized pain which limited her activities. She received scheduled medication for the pain, and had also received non-pharmacological interventions.B. Resident interviewResident #1 was interviewed on 12/16/25 at 2:25 p.m. Resident #1 said she was in pain all the time. She said her legs, ankles, wrists and hands hurt the most. She said the pain was usually as intense as a 8, 9 or 10 on a scale of zero to 10. She said the pain was due to neuropathy and fibromyalgia. She said she was taking Oxycontin for pain and it did help to decrease her pain. She said she received Oxycontin around 9:00 a.m and 9:00 p.m. She said she had received her pain medications later than the medications were scheduled several times in the last 30 days but she did not remember the dates. C. Record reviewResident #1`s pain care plan, initiated 6/7/25 and revised 6/10/25 revealed that interventions included non-pharmaceutical pain management, administering opioids as prescribed and the expected benefit of opioid use was to reduce acute/chronic pain conditions.Review of Resident #1's December 2025 CPO revealed the following physician's orders: Lyrica Oral Capsule 25 milligrams (mg) three times a day, ordered 12/3/25Oxycontin 10 mg every twelve hours, ordered 10/9/25. Acetaminophen oral tablet 325 mg, two tablets four times a day for chronic pain, ordered 7/11/25. The progress note, dated 12/18/25, revealed that Resident #1 had multiple comorbidities requiring medication management that necessitated frequent clinical evaluations. Without regular monitoring and management, the patient was at moderate to high risk of symptom exacerbation and complications resulting in hospitalization or death. Resident #1 required multiple medications which required close monitoring to avoid any drug related adverse events. She had significant pain. Review of Resident #1`s December 2025 medication administration records (MAR), from 12/1/25 to 12/18/25, revealed that Oxycontin 10 mg was scheduled at 9:00 a.m. and 9:00 p.m. daily. The December 2025 MAR revealed the following:Resident #1's Oxycontin 10 mg 9:00 a.m. dose was not administered timely on the following days:-12/10/25, the medication was administered at 10:52 a.m., which was 52 minutes after the allowed administration time; and,-12/14/25, the medication was administered at 10:02 a.m., which was two minutes after the allowed administration time. Resident #1's Oxycontin 10 mg 9:00 p.m. dose was not administered timely on the following days:-12/6/25, the medication was administered at 10:44 p.m., which was 44 minutes after the allowed administration time;-12/7/25, the medication was administered at 11:27 p.m., which was one hour and 27 minutes after the allowed administration time;-12/8/25, the medication was administered at 10:01 p.m., which was one minute after the allowed administration time; and,-12/10/25, the medication was administered at 10:52 a.m., which was 52 minutes after the allowed administration time-12/10/25, the medication was administered at 10:09 p. m., which was nine minutes after the allowed administration time.-12/14/25, the medication was administered at 10:02 a.m., which was two minutes after the allowed administration time. III. Resident #8A. Resident