Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51710 Based on record review and interviews, the facility failed to notify the physician timely for one (#15) of three residents reviewed out of 18 sample residents. Specifically, the facility failed to ensure Resident #15's physician was notified when the resident consistently refused her anticoagulant medication (medication used to decrease the risk of stroke and blood clots). Findings include: I. Resident #15 A. Resident status Resident #15, age 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included infection and inflammatory reaction due to internal right knee prosthesis, end-stage renal disease, atrial fibrillation (irregular heart rhythm) and peripheral vascular disease. The 10/10/24 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 maximum assistance with toileting, showering and transfers. No documentation in MDS assessment, dated 10/10/24, was found stating the resident was receiving anticoagulant medication. B. Record review The 11/4/24 nurse practitioner (NP) follow-up note documented Resident #15 was on Eliquis as a treatment for her atrial fibrillation. Review of Resident #15's November 2024 CPO revealed the resident had a physician's order for Eliquis 2.5 milligrams (mg) by mouth two times a day for atrial fibrillation, ordered 4/16/24. Resident #15's October 2024 medication administration record (MAR) revealed the resident refused her Eliquis medication on 40 out of 62 opportunities for administration. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's November 2024 MAR revealedResident #15 refused her Eliquis medication on six out of 11 opportunities for administration. The nursing note dated 9/3/24 at 9:36 p.m. documented Resident #15 refused her Eliquis due to a concern that her dialysis fistula would bleed the following day once her bandage was removed. The registered nurse (RN) documented the resident was educated on the use of Eliquis and her need to take it, yet the resident still refused. -The note did not reveal that the resident's physician was notified regarding the resident's refusal of the medication. -Review of Resident #15's electronic medical record (EMR) revealed there were no progress notes documented in October 2024 to indicate the resident's physician had been notified of the resident's frequent refusals of the Eliquis medication (see MAR above). The nursing note dated 11/7/24 at 12:04 p.m. documented Resident #15 refused her Eliquis that morning. The RN documented that she explained the consequences of refusing the medication and the resident stated I don't care. The RN documented the provider was notified and that she was advised to continue offering the medication to the resident. -However, there were no further progress notes documented to indicate the resident's physician had been notified the other five times she had refused the medication in November 2024 (see MAR above). C. Staff interviews RN #1 was interviewed on 11/7/24 at 11:10 a.m. RN #1 said Resident #15 frequently refused to take her Eliquis on days she received dialysis treatment due to long bleeding times. RN #1 said she often educated the resident on the benefits versus the risks of taking/not taking her medication. RN #1 said she was supposed to offer the resident her medication two to three times, and if the medication was continually refused, refusals were to be documented in the MAR and the progress notes and the provider should be notified. The assistant director of nursing (ADON) was interviewed on 11/7/24 at 12:40 p.m. The ADON said the staff were supposed to offer medications to residents three times. She said if the resident continued to refuse, then staff were supposed to document the refusal in the MAR and progress notes and notify the provider. The facility's NP was interviewed on 11/7/24 at 2:42 p.m. The NP said that nurses would occasionally tell her Resident #15 was refusing her Eliquis. However, she said the nurses mentioned it in passing and she did not know the resident was refusing the medication so frequently. She said she would discuss discontinuing the medication with the resident and the resident's representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on observations, record review and interviews, the facility failed to take steps to protect one (#1) of five residents reviewed for abuse out of 18 sample residents. Specifically, the facility failed to ensure Resident #1 was kept free from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy and procedure, revised September 2022, was provided by the nursing home administrator (NHA) on 11/6/24 at 1:49 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and resident to resident altercations. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to, responding immediately to protect the alleged victim and integrity of the investigation, examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed, increased supervision of the alleged victim and residents, room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator, protection from retaliation, providing emotional support and counseling to the resident during and after the investigation, as needed and revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. II. Incident of physical abuse between Resident #1 and Resident #2 on 8/9/24 The 8/9/24 facility abuse investigation documented the allegation occurred on 8/9/24 at 7:30 p.m. The investigation documented Resident #2 saw Resident #1 touching the videocassette recorder (VCR) and told him to stop. Resident #2 was observed hitting Resident #1 in the mouth/nose. The residents were immediately separated. Certified nurse aide (CNA) #4 notified the nurse of the events. Resident #1's lower lip was red, swollen and slightly bleeding. The investigation documented CNA #4 witnessed the resident-to-resident altercation and Resident #2 was placed on monitoring. It documented Resident #1 was an at-risk adult. The police, residents' families, the ombudsman and the physician were notified of the resident-to resident-altercation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 Home St, Castle Rock, CO 80108	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was assessed by the assistant director of nursing (ADON) on 8/9/24 at 7:30 p.m. Resident #1 sustained two small cuts to his lower lip with some swelling. The ADON cleaned Resident #1's lip and applied ice. Resident #1 was at his baseline. The investigation documented the ADON interviewed Resident #1 following the incident. Resident #1 was unable to verbalize what occurred, showed no signs of fear of agitation, was smiling and was eating a peanut butter sandwich. There were no non-verbal responses or behavioral changes observed. The investigation documented Resident #1 had been involved in three previous resident-to-resident altercations, allegations or events. The investigation documented Resident #2 was interviewed by the ADON on 8/9/24 at 7:40 p.m. Resident #2 said Resident #1 was playing with the VCR and had his fingers in it. Resident #2 said he told Resident #1 to stop but he did not listen. Resident #2 said he grabbed Resident #1's arm to stop him. Resident #2 said Resident #1 swung at him but did not hit him. Resident #2 said he hit Resident #1. There were changes in the resident's behavior. The investigation documented Resident #2 had not been involved in any previous allegations, altercations or events. The investigation included a statement, dated 8/12/24, from CNA #4 who witnessed the altercation. She said she heard a verbal argument in the television room. She said when she entered the area, Resident #2 and Resident #1 were sitting next to one another near the television in their wheelchairs. She said she saw Resident #2 hit Resident #1 with a closed fist in the nose and mouth. She said Resident #2 also had ahold of Resident #1's left forearm with a tight grip. She said the nurse removed Resident #1 and assessed Resident #1 because his lower lip was swollen and bleeding a little bit. The investigation included a statement, dated 8/9/24, from the ADON. The ADON said at approximately 7:50 p.m., she was notified that Resident #2 punched Resident #1 in the mouth. The ADON said when she approached Resident #1, he was eating a sandwich and looked up at her and smiled. The ADON said Resident #1's lower lip was swollen on the right side and there were two small, fresh appearing cuts on his lip. She said the areas surrounding the cuts were mildly pink but not actively bleeding. Resident #1 said his mouth did not hurt. Resident #1 was not able to report what happened or if he was afraid of anything or anyone. The ADON said she also interviewed Resident #2 (see Resident #2 interview above). The investigation documented the plan of action included separating the residents immediately. Resident #1 was placed on frequent checks. The residents resided on opposite ends of the hall and the incident happened in the television common room. Resident #2, who was alert and oriented, was educated not to put himself in that situation and to let staff handle situations with other residents. Resident #2 agreed. The investigation concluded the abuse was substantiated. III. Resident #1 - victim A. Resident status Resident #1, age 83, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbances, major depressive disorder, cognitive communication deficit, need for assistance with personal care and muscle weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 Home St, Castle Rock, CO 80108	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/12/24 minimum data set (MDS) assessment revealed the resident had short term and long term memory problems and was severely impaired with daily decisions per staff assessment. He required set-up assistance for eating. He required substantial assistance with eating and was dependent on staff for toileting, showering and personal hygiene. The MDS assessment revealed the resident displayed physical behaviors directed towards others one to three days in the review period. B. Record review The care plan, revised on 4/19/24, documented Resident #1 had impaired cognitive function and or impaired thought processes related to dementia. The care plan indicated the resident had displayed verbal or physical aggression towards staff and was an elopement risk. Pertinent interventions included keeping the resident's routine consistent, providing consistent caregivers in order to decrease confusion, cueing, reorienting and supervising the resident as needed, monitoring for target behavior symptoms (pacing, wandering, disrobing, inappropriate responses, violence/aggression towards staff and other residents) and monitoring for effectiveness of medication administration. The 8/10/24 nursing progress note documented by registered nurse (RN) #2 revealed that Resident #1 was in an altercation with Resident #2 because he was doing something that Resident #2 did not like it. Resident #1 was swinging his fists but did not make contact with Resident #2. Resident #2 then struck Resident #1 on the mouth. Upon assessment, Resident #1 had a bloody, swollen lip with a small scab forming. The altercation was unwitnessed by RN #2. The ADON was notified for further instructions. -Review of Resident #1's electronic medical record (EMR) did not reveal further documentation, monitoring or assessments, besides the 8/10/24 nursing progress note, following the resident-to resident-altercation on 8/9/24. IV. Resident #2 - assailant A. Resident status Resident #2, age 73, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included post traumatic stress disorder (PTSD), depressive disorder, morbid obesity and diabetes. The 8/29/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He required setup assistance with eating and oral hygiene. He required substantial assistance with toileting and showering. He required moderate assistance with personal hygiene. The MDS assessment indicated the resident did not have any behaviors in the review period. B. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan, revised on 7/8/24, documented Resident #2 had displayed behaviors that included verbal outbursts, throwing items at staff, urinating on the floor and refusing care and showers. He described himself as stubborn and required time alone to calm down when agitated, as he did not respond well to redirection when he was upset. Resident #2 responded well to direction from his sons when he was at his baseline mood state. Pertinent interventions included respecting the resident's preferences for privacy, specifically avoiding others, allowing the resident to remain as independent as possible as related to self care, providing the resident the right to choose mental health services, providing the resident with positive interaction, discussing the resident's behavior when he was de-escalated and explaining why it was inappropriate, intervening to protect the rights and safety of others, approaching the resident in a calm manner, monitoring behavior patterns (location, time of day, persons involved and situations) and monitoring effectiveness of medications. A review of Resident #2's EMR revealed the resident was on safety checks every 30 minutes for 72 hours following the resident-to-resident altercation on 8/9/24. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 11/7/24 at 10:23 a.m. LPN #1 said she had not witnessed any resident-to-resident altercations. LPN #1 said Resident #2 usually spent the day alone in his room and only came to the common area to watch television on occasion or if his spouse visited. LPN #1 said Resident #2 had behaviors, she had not been provided specific training to meet the needs of Resident #2's behavior. CNA #5 was interviewed on 11/7/24 at 10:44 a.m. CNA #5 said he had not received training regarding resident specific behaviors. The ADON was interviewed on 11/7/24 at 12:16 p.m. The ADON said the staff received verbal updates at shift change regarding residents' behaviors and the staff had access to the Kardex (a staff directive tool) which was updated with resident specific information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 Note: The nursing home is disputing this citation.	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** 20287 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for three (#10 and #16) of four residents reviewed out of 18 sample residents. Specifically, the facility failed to: -Provide Resident #10 and Resident #16 with timely incontinence care; and, -Provide the necessary assistance for Resident #10, who required physical assistance and encouragement with meals. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADLs), Supporting policy, undated, was provided by the director of nursing (DON) on 11/7/24 at 10:41 a.m. It revealed in pertinent part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Residents will be provided with care, treatment and services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLS are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLSs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, groom and oral care); mobility (transfer and ambulation, including walking); elimination (toileting); dining (meals and snacks); and, communication (speech, language, and any functional communication systems). II. Resident #10 A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO) diagnoses included anxiety, bipolar disorder (mental illness that causes unusual shifts in a person's mood and behavior) and dysphagia (difficulty swallowing). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

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 Note: The nursing home is disputing this citation.	The 10/11/24 minimum data set (MDS) assessment revealed the resident had short term memory deficits, was cognitively impaired and her daily decisions skills were moderately impaired based on the staff assessment for mental status. She required supervision and touching assistance with meals. The resident was dependent on staff for personal hygiene. The resident was incontinent of bowel and bladder. She was not on a toileting program. B. Observations 1. Meal assistance During a continuous observation of the lunch meal on 11/5/24, beginning at 12:25 p.m. and ending at 1:15 p.m., the following was observed: At 12:25 p.m. an unidentified certified nurse aide (CNA) served the resident her meal in her room .The resident was served a whole baked potato with her meal and the unidentified CNA did not slice it open for her. The resident was not eating her meal. At 12:30 p.m. the resident was not eating and had not received any encouragement or cuing from staff. At 1:03 p.m. the resident self propelled herself and left her room. She had not eaten any of her meal. At 1:15 p.m. the resident remained in the hallway and was not encouraged to return to her meal. -Resident #10 was not provided encouragement or cueing from 12:25 p.m. to 1:15 p.m. During a continuous observation of the dinner meal on 11/5/24, beginning at 4:55 p.m. and ending at 5:21 p.m. the following was observed: At 4:55 p.m. the resident was lying in bed. At 5:04 p.m. the resident was served her meal which consisted of a grilled cheese sandwich with no sides. At 5:07 p.m. Resident #10 was eating half of the grilled cheese sandwich. At 5:21 p.m. the resident was no longer eating the grilled cheese. She stopped eating and did not receive any encouragement. She had fallen asleep. -Resident #10 was not provided encouragement or cueing from 4:55 p.m. until 5:21 p.m. when she fell asleep. 2. Toileting assistance During a continuous observation on 11/6/24, beginning at 9:15 a.m. and ending at 1:15 p.m. the following was observed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 Note: The nursing home is disputing this citation.	At 9:15 a.m. the resident was in the common area self propelling herself in the wheelchair. At 10:00 a.m. the resident was self propelling with the occupational therapist. At 10:30 a.m. the resident continued to sit in her wheelchair and was talking with the occupational therapist. At 11:00 a.m. the resident continued to propel herself throughout the hallway. At 11:30 a.m. Resident #10 continued to propel herself though the hallway. She had not been offered to be checked and changed for urine incontinence or assisted to the bathroom. At 11:54 a.m. Resident#10 was asked if she wanted to go to the dining room. CNA #3 assisted her to the dining room to await her meal. She was not offered any toileting assistance. At 12:15 a.m. the resident received her meal. At 1:15 p.m. Resident #10 was changed. There was redness noted on the resident's bottom and her brief was soiled with urine. -Resident #10 was not offered or provided incontinence care for four hours from 9:15 a.m. until 1:15 p.m. C. Record review The care plan last updated on 6/20/24, identified the resident at nutritional risk related to dementia. She had a history of variable intakes related to dementia. Pertinent interventions included encouraging Resident #10 to eat her meals and if she refused, offer sandwiches or chips.The care plan indicated the resident required cueing at meals. The care plan last updated on 7/30/24 identified the resident required assistance with ADL care in toileting. Pertinent interventions included the resident required assistance for incontinence care. -Review of the care plan did not include how often to offer the resident assistance with incontinence care. D. Staff interviews CNA #1 was interviewed on 11/7/24 at 9:25 a.m. CNA #1 said Resident #10 was able to feed herself, however she did require encouragement and cueing to eat. CNA #1 said the resident would wander off from her meal and become distracted. He said she needed to be assisted back to the dining room or to where she was eating so she could eat. Licensed practical nurse (LPN) #1 was interviewed on 11/7/24 at 10:00 a.m. LPN #1 said Resident #10 was able to feed herself, but she needed and encouragement to eat. She said the resident ate best when she was provided food that the resident could move with, such as a sandwich. She said Resident #10 would leave her plate and it was difficult to get her to come back to the table or her meal tray. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

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 Note: The nursing home is disputing this citation.	Registered nurse (RN) #1 was interviewed on 11/6/24 at 12:29 p.m. RN #1 said he was an agency employee and it was his first day working at this facility. He said he was not aware Resident #10 had not been offered to be toileted or checked and changed recently. He said he reviewed the resident's electronic medical record (EMR) and said the resident's skin was clear, however she was at risk for pressure injuries due to the incontinence. He said the resident should be changed and offered toileting assistance every two hours and prior to meals. III. Resident #16 A. Resident status Resident #16, age 83, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included muscular dystrophy (genetic disease that causes decrease in muscle function), difficulty in walking, weakness and adult failure to thrive. The 9/17/24 MDS assessment revealed Resident #16 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was dependent on staff for toileting hygiene. The assessment indicated the resident was not on a toileting program and was frequently incontinent of bowel and bladder. B. Resident interview Resident #16 was interviewed on 11/5/24 at 5:41 p.m. Resident #16 said he was often not provided assistance with changing after an incontinence episode. He said on the night shift on 11/2/24 he was not changed for over three hours he said he slept in pee. He said it was terrible. He said he had complained to the staff prior, however he had not seen any improvement. C. Record review The care plan last updated on 10/7/24 identified the resident had self care deficit related to muscular dystrophy. -Review of the resident's comprehensive care plan did not reveal any approaches related to the resident's incontinence. The 11/2/24 call light audit revealed Resident #16's call light was activated at 3:45 a.m., and it was not answered for 37 minutes. D. Staff interview The director of nursing (DON) was interviewed on 11/7/24 at 12:03 p.m. The DON said Resident #16 used his call light frequently. She said the resident refused to use the urinal. The DON said call lights should be answered within 15 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interview, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of one (#18) of three residents out of 18 sample residents. Specifically, the facility failed to follow procedures to prevent the drug diversion of Resident #18's Ativan (a Schedule IV controlled substance medication for treatment of anxiety). Findings include: I. Professional reference According to [NAME] S Treas, [NAME] L [NAME], [NAME] H [NAME] (2022). Basic Nursing third addition, Controlled substances are drugs considered to have either limited medical use or high potential for abuse or addiction. Under the Controlled Substances Act (CSA) of the comprehensive drug abuse prevention and control act of 1970, it is illegal to possess a controlled substance without a valid prescription. Controlled substances are classified by Schedules. Schedule II controlled substances are drugs that have an acceptable medical use but a high potential for abuse (opium, morphine, oxycodone). Controlled substances must be stored in locked drawers within a second locked area. The facility must keep a record of every dose administered. A count of all controlled substances is performed at specified times, usually at change of shift. To facilitate counting and tracking inventory, drug manufacturers package many narcotics in sectioned containers, with each labeled separately and consequently numbered. II. Facility policy and procedure The Controlled Substance policy, revised November 2023, was provided by the nursing home administrator (NHA) on 11/6/24 at 2:30 p.m. The policy read in pertinent part, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Drug Abuse Prevention and Control Act of 1976). Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises. The director of nursing (DON) services identifies staff members who are authorized to handle controlled substances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

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 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Nursing staff count on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

III. Record review

Review of the facility's investigation revealed that on 11/1/24, during the 6:00 a.m. shift change, it was discovered that the narcotic count for Resident #18's Ativan was significantly off and a total of 44 Ativan 0.5 milligram (mg) tablets were missing. According to the investigation, the Ativan tablets had been present at the 6:00 p.m change of shift on 10/31/24.

The investigation report documented the narcotic count on the [NAME] unit cart was not conducted between the two offgoing and oncoming licensed nurses at 2:00 a.m. on 11/1/24. When the offgoing nurse counted Resident #18's Ativan with the oncoming nurse at 6:00 a.m. on 11/1/24, all four bottles of the resident's Ativan were empty.

The investigation report documented the nursing management team was investigating. The three licensed nurses who had the keys to the [NAME] medication cart during the time frame of 6:00 p.m. on 10/31/24 until 6:00 a.m. on 11/1/24 were sent for drug testing. The facility notified the local police department and reported the missing narcotics to the State Agency portal.

IV. Staff interviews

The NHA and the director of nursing (DON) were interviewed together on 11/6/24 at 12:30 p.m. The NHA said an investigation in regards to the diverted drugs was initiated on 11/1/24. She said the three nurses were all sent for drug testing. The NHA said the nurses' drug test results were all negative.

The DON said the nurse did not complete a narcotics count during the change of shift at 2:00 a.m. She said when the 6:00 a.m. nurse came in on 11/1/24, she and the offgoing nurse conducted a narcotics count and that was when Resident #18'sAtivan bottles were discovered to be empty. The DON said the facility notified the police department and the police would be following up with an investigation of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 Home St Castle Rock, CO 80108	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51710 Based on record review and interviews, the facility failed to maintain accurately documented medical records for two (#4 and #12) of four residents reviewed out of 18 sample residents. Specifically, the facility failed to ensure nursing staff documented skin assessments accurately for Resident #4 and Resident #12. Findings include: I. Facility policy and procedure The Charting and Documentation policy and procedure, undated, was provided by the director of nursing (DON) on 11/7/24 at 11:22 a.m. It read in pertinent part, All services provided to the resident, progress toward the care plan goals and any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. II. Resident #4 A. Resident status Resident #4, age 75, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), adult failure to thrive and generalized muscle weakness. The 10/11/24 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 minimal assistance with activities of daily living (ADL). B. Resident observation On 11/5/24 at approximately 10:45 a.m. Resident #4 was lying on her bed in her room with her left foot elevated. The resident had an open-to-air wound on the top of her left foot. The wound was approximately three to five inches long and the skin appeared discolored and abnormally dark. C. Record Review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/28/24 nurse progress note documented Resident #4 was complaining of swelling and a rash on her right foot and the resident was examined by the nurse practitioner (NP) who gave new orders for treatment. -The progress note documented Resident #4 had a rash on her right foot, however, observation of the resident revealed the resident had a skin condition on her left foot (see observation above). The 10/28/24 provider note written by the NP documented the resident had swelling in her left ankle. -The note failed to document the rash on the resident's foot or the treatment interventions the NP had prescribed. The Head to Toe Skin Assessment flowsheet, dated 10/29/24, documented new swelling and a rash on Resident #4's left foot. A review of Resident #4's November 2024 CPO revealed a physician's order, dated 10/31/24, to monitor Resident #4's ankle swelling daily. -There were no ordered interventions addressing the resident's swelling or rash/wound. 20287 III. Resident #12 A. Resident status Resident #12, age 79, was admitted on [DATE]. According to the November 2024 CPO diagnoses included personal history of transient ischemic attack, hypertension and type II diabetes. The 11/1/24 MDS assessment revealed the resident was cognitively impaired based on the staff assessment for mental status. The resident was unable to recall the current season, the location of his room or staff faces. The MDS assessment indicated the resident had one unstageable pressure injury. B. Record review The admission skin nursing assessment, dated 10/7/24, documented the resident's skin was intact. -However, the skin assessment directed staff to use the diagram on the assessment and document a description of skin concerns The diagram on Resident #12's admission skin assessment indicated there was an open area on the resident's coccyx but there was no description of the wound. -The skin assessment was documented inaccurately as it indicated the resident's skin was intact, however, it also indicated there was an open wound on the resident's coccyx. The 10/7/24 progress notes showed nothing documented about pressure injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Heights Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Home St Castle Rock, CO 80108	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound physician progress note dated 10/9/24 documented Resident #12 had a sacral unstageable pressure injury. The measurements were 6 centimeters (cm) in length by 3.5 cm in width by 0.2 cm in depth. IV. Staff interviews The NHA, the DON and the assistant director of nursing (ADON) were interviewed together on 11/7/24 at 12:40 p.m. The NHA, the DON and the ADON all agreed the facility's leadership team were responsible for ensuring staff were documenting correctly and that education had been provided to nursing staff regarding accurate documentation. The NHA said staff required additional training regarding accurate documentation. The ADON said Resident #12 was admitted to the facility with an unstageable pressure injury. The ADON reviewed Resident #12's electronic medical record (EMR) and said the resident's admission skin assessment was inaccurate. The ADON said she would provide education to the nurses about how to assess and accurately document pressure injuries.