

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Uptown Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 745 E 18th Ave Denver, CO 80203	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide resident care in a dignified and respectful manner for one (#1) of four residents reviewed for dignity out of 10 sample residents. Specifically, the facility failed to ensure that Resident #1 was allowed to sit on the floor per his request. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/27/26, 4/28/26, and 4/29/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/13/26. I. Situation of lack of dignity On 3/12/26 at approximately 11:40 p.m. Resident #1, who lived on the second floor of the facility, was in his wheelchair on the first floor of the building. Staff observed Resident #1 slide out of his wheelchair to sit on the ground, according to his own wishes. When staff asked to assist Resident #1 to get back into his wheelchair, Resident #1 refused. At 11:45 p.m. licensed practical nurse (LPN) #1 told certified nurse aide (CNA) #3 to contact CNA #2 to come help put Resident #1 back into his wheelchair. LPN #1 told CNA #2 and CNA #3 to place a blanket underneath Resident #1 so that he could be dragged while he laid on the blanket because he would not get in his wheelchair. Resident #1 said I tried to fight them like crazy. CNA #3 approached the resident's back and put their arms under his armpits. CNA #2 held the resident's pants at his ankles, while LPN #1 pulled on the blanket with Resident #1 on it. The three staff members then dragged the blanket onto the elevator with the resident on the blanket. When the elevator reached the second floor, the staff members pulled Resident #1 off the elevator and onto the second floor, where he lived. When Resident #1 was on the blanket on the second floor, he agreed to have two staff members help him sit in his wheelchair. -LPN #1, CNA #2 and CNA #3 failed to treat Resident #1 with dignity and respect by not allowing to remain seated on the floor, per his resident right, and dragging him across the floor on a blanket to the second floor. On 3/13/26 Resident #1 told the nursing home administrator (NHA) about the incident that occurred on 3/12/26. Resident #1 told the NHA that he had wanted to sit on the floor. The NHA reviewed the facility's video surveillance footage, which revealed Resident #1 had been dragged across the floor to the elevator and onto the second floor by LPN #1, CNA #2 and CNA #3. II. Facility plan of correction On 3/13/26 the NHA and the facility's management team met to develop a plan of action in response to Resident #1's lack of dignity situation, in order to ensure safety and dignity for all of the residents in the facility. A. Immediate action On 3/13/26 all three staff members (LPN #1, CNA #2 and CNA #3) were suspended immediately pending an investigation. Resident #1 had a fall protocol initiated, a skin assessment was given and a trauma interview was provided. B. Identification of other residents On 3/13/26 all residents in the facility were interviewed to assess any concerns related to resident rights, safety, dignity and safe practices. All staff members who worked the night of 3/12/26 (staff not involved in the incident) were interviewed as part of the investigation. C. Systemic change On 3/13/26 all staff were educated on the following, with all staff notified that education must be completed before working in the facility: -Fall policy/management training; -Competency of using lifts and the sit to standing position lifts; -Abuse and Mandatory reporting in the facility training; -Resident Rights training; -CNA - Safely Moving Residents - lifting and (continued on next page)</p>

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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