STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065321	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arvada Care and Rehabilitation Center	6121 W 60th Ave Arvada, CO 80003

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 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 had the right to refuse to participate in occupational therapy activities for one (#2) resident reviewed for resident rights out of 12 sample residents. Specifically, the facility failed to ensure Resident #2 was allowed to refuse occupational therapy services. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation from 8/19/25 to 8/20/25, resulting in the deficiency being cited as past noncompliance with a correction date of 6/12/25.I. Facility policy and procedureThe Resident Rights policy and procedure, undated, was provided by the corporate consultant (CC) on 8/26/25 at 10:26 a.m. It read in pertinent part, As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility. Planning and Implementing Care. You have the right to be informed of, and participate in, your treatment, including the right to request, refuse, and/ or discontinue treatment.II. Resident #2A. Resident statusResident #2, age [AGE], was admitted to the facility on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (weakness or paralysis on one side of the body), following cerebral infarction (blood flow to the brain is interrupted, leading to brain tissue damage) affecting the right dominant side, aphasia (impairment in ability to communicate) and hypertension (high blood pressure).The 8/7/25 minimum data set (MDS) assessment documented the resident was unable to answer questions to complete the brief interview for mental status (BIMS) assessment. Staff assessment of the resident revealed the resident had severely impaired cognition and no behavioral issues. The resident had functional limitations in range of motion (ROM) due to impairment on both sides of his upper extremity and was dependent for all activities of daily living (ADL).B. Record review1. Care plan and assessmentsThe resident's comprehensive care plan, revised 2/16/25, included a care focus for communication deficits related to expressive aphasia and dependence on staff and family for cognitive stimulation. Pertinent interventions included anticipating and meeting the resident's needs, using gestures and providing extra wait time for the resident's response when asking questions, monitoring the resident for nonverbal indicators of discomfort and distress, giving the resident time after refusing participation and re-approach later, conversing with the resident while providing care and watching for hand gestures and shaking of the head, yes or no, to understand what he wants.The 7/2/25 activity quarterly evaluation documented Resident #2 was non-verbal and used non-verbal communication such as shaking his head (yes and no), smiling, laughing when happy and fully understanding conversations going around him.2. Facility investigationThe facility investigation, dated 5/26/25, documented Resident #2 was in the dining room when occupational therapist (OT) #2 started the occupational therapy group session. OT #2 attempted to engage Resident #2 in the therapy session, but Resident #2 was not interested. OT #2 did not acknowledge or honor Resident #2's right to refuse treatment. As a result of witness statement OT #2 was suspended and later separated from employment with the facility (see interviews below). The investigation documented soon after the therapy session started, Resident #2's representative removed him from the dining room and reported concerns that OT #2 was very aggressive in his approach to try to convince Resident #2 to participate in therapy when the resident was saying no. The representative said OT #2's behavior was inappropriate and upsetting to Resident #2.The investigation documented based on witness interviews the facility investigation found that OT #2 was inappropriate in his approach and failed to honor Resident #2's right to decline to participate in the group therapy session. Witness statements revealed that OT #2 failed to listen to the resident saying no to the therapy session. Despite Resident #2 saying no to therapy, OT #2 proceed to set the resident up for the session. OT #2 failed to take care while removing the resident's wheelchair lap tray. The OT's action caused the resident's paralyzed arm, which rested on the lap tray to drop unsupported. In that action, the resident's arm dropped and hit the wheelchair's armrest. A small bruise developed later in the day, on the resident's right arm where it hit the armrest. The resident, however, did not complain of any lasting pain and no first-aid treatment was required After removing the lap tray OT #2 began tossing a bean bag to the resident to his unaffected arm. The resident shook his head no and pushed the bean bag away. When that was unsuccessful OT #2 got a hand weight and tried to strap it to the resident's hand so the resident would lift the weight. The resident pushed the hand weight away and shook his hand no. Witnesses said the resident was getting mad because