

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 14101 E Evans Ave Aurora, CO 80014	
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 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 that residents were free from significant medication errors for one (#2) of three residents reviewed for medication errors out of three sample residents. Specifically, the facility failed to ensure Resident #2 was administered antibiotic medications per physician's orders. Findings include: I. Facility policy and procedure The Medication Administration policy, revised 2/13/23, was provided by the nursing home administrator (NHA) on 7/16/26 at 8:24 a.m. It read in pertinent part, The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. A significant medication error means one which causes the resident discomfort or jeopardizes his or her health and safety. Significance may be subjective or relative depending on the individual situation and duration. II. Resident # 2A. Resident status Resident #2, greater than 65, was admitted on [DATE] and discharged [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included sepsis (an extreme, life threatening response to an infection). The 5/14/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The assessment did not indicate the resident was receiving an antibiotic. B. Record review Review of the May 2026 CPO revealed the following physician's order: Amoxicillin-Pot Clavulanate oral suspension (an antibiotic) reconstituted 400-57 milligram (mg)/5 milliliter (ml). Give 6.3 milliliters by mouth two times a day for UTI (urinary tract infection) for five days, ordered 5/12/26 and discontinued 5/13/26. Amoxicillin-Pot Clavulanate oral tablet 875-125 milligrams (mg), give one tablet by mouth two times a day for UTI for five days, ordered 5/13/26. The 5/12/26 administration note documented the antibiotic was not available in the emergency kit and the on call provider was notified and gave an order to start the medication on 5/13/26. The 5/13/26 nurse practitioner (NP) note documented Resident #2 was currently receiving the antibiotic for the UTI with no adverse reactions. The 5/14/26 nurse note documented Resident #2 continued on monitoring for the use of the antibiotic with no adverse reactions. The 5/14/26 infection preventionist (IP) note documented Resident #2 remained on the antibiotic two times a day for a diagnosis of a UTI. The documentation included the medication was administered without issue. The note revealed the provider wished to continue the full duration of the antibiotic as prescribed. The 5/15/26 nurse note documented Resident #2 continued to be monitored for the antibiotic and had no adverse reaction. -However, Resident #2 was not receiving the antibiotic. The 5/15/26 NP note documented Resident #2 had not received the prescribed antibiotic while residing at the facility due to a pharmacy supply issue. -Review of Resident #2's EMR did not reveal documentation regarding why Resident #2's antibiotic was not administered or why the provider was not notified. According to the May 2026 medication administration record (MAR) Resident #2 missed six out of six doses. III. Staff Interviews Licensed practical nurse (LPN) #1 was (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: 065332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 14101 E Evans Ave Aurora, CO 80014	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed on 7/15/26 at 2:23 p.m. LPN #1 said if a resident was admitted and a medication was not available the nurse should notify the provider to get further guidance to either hold the medication until it arrived, decide on an alternate medication and whether the medication should be continued. LPN #1 said she helped admit the resident to the facility, but did not administer any medications. She said she clarified the medication list with the provider upon Resident #2's admission. The infection preventionist (IP) was interviewed on 7/15/26 at 2:46 p.m. The IP said he was responsible for monitoring the use of antibiotics, the side effects and the effectiveness of the antibiotic. He said if there were any side effects or allergies he would notify the provider. He said he collected information from the 24-hour report and the nurses notes on how the resident was handling the antibiotic. The IP said he was not aware that Resident #2 had not received her antibiotic well she resided at the facility. The IP said he wrote the progress note after reviewing the 24-hour report and the nurse progress notes stating the resident was receiving the antibiotic and that there were no adverse effects. He said if an antibiotic was ordered, the antibiotic should be administered per the physician's order. He said if the medication was not available in the emergency kit, the pharmacy should be notified to deliver it urgently. He said if the medication was not available the provider should be notified in order to make a decision on the continued use of the antibiotic or an alternate antibiotic. Registered nurse (RN) #1 was interviewed On 7/15/26 at 3:25 p.m. RN #1 said she was the first nurse scheduled to administer Resident #2's antibiotic. She said the antibiotic was not available in the emergency kit so she called the on-call provider who gave an order to start the antibiotic the following morning. RN #1 said that was the only time she had worked with Resident #2. The NP was interviewed on 7/15/26 at 3:44 p.m. The NP said the first day she had assessed Resident #2 was on 7/13/26 and was not aware she had not received her antibiotic. She said the antibiotic was changed from liquid form to a tablet, but had never been delivered from the pharmacy. She said she did not become aware of the missed doses of the antibiotic until 7/15/26 when she spoke with the family representative and suggested an alternate antibiotic. At that time the family representative demanded the resident be sent to the emergency department for treatment. The regional director of clinical services was interviewed on 7/15/26 at 4:46 p.m. The regional director of clinical services said the director of nursing (DON), who was unavailable for an interview, was having problems with the pharmacy delivering medications. She said the DON was in constant contact with the pharmacy trying to get the medications delivered. The regional director of clinical services said however, the provider was not contacted after the initial call to the on-call provider to discuss an alternate medication or the continued use of the antibiotic. She said the medication should have been administered per the physician's order and if not administered the provider should have been notified after each missed dose. She said the IP should verify whether a resident was receiving an antibiotic and that the resident was being administered the antibiotic prior to documenting the progress note in the medical record. She said she would immediately provide education to the nurses and the IP regarding medication administration as well as provider notification if medication was not available. IV. Facility follow-up On 7/15/26 at 6:40 p.m. the NHA provided documentation on education to the nurses on the unavailable medication and medication reordering protocol on. The facility also provided education to the IP regarding antibiotic stewardship documentation.		