

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/16/2025
NAME OF PROVIDER OR SUPPLIER  University Heights Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  656 Dillon Way Aurora, CO 80011	

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.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure one (#6) of three residents reviewed were free from abuse out of 18 sample residents. Specifically, the facility failed to protect Resident #6 from physical abuse by certified nurse aide (CNA) #7. Findings include: I. Facility policy and procedure The Abuse policy, revised September 2025, was provided by the nursing home administrator (NHA) on 12/16/25 at 3:42 p.m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's medical symptoms. The Resident Rights policy, revised February 2021, was provided by the NHA on 12/16/25 at 3:42 p.m. The policy read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; e. self-determination; f. communication with and access to people and services, both inside and outside the facility; g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; h. be supported by the facility in exercising his or her rights; and, i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. II. Resident #6A. Resident status Resident #6, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included multiple contractures and reduced mobility. The 9/9/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident was dependent on staff for activities of daily living (ADL). B. Facility investigation The 10/22/25 facility investigation revealed the following: The social services director (SSD) was notified that CNA #7 refused to stop care when Resident #6 had asked the CNA to. The resident yelled out for the CNA to stop. Resident #6 reported pain at the time of this incident but the facility found no lingering physical or mental injury. CNA #7 was suspended following the incident. The SSD interviewed Resident #6 on 10/22/25. The resident told the SSD that CNA #7 entered his room and asked if he was ready to be changed. The resident said CNA #7 pushed him really hard against the wall. The resident said he told CNA #7 that he was hurting him and that he tried to lay back. The resident said CNA #7 then pushed him harder into the wall and his knees were pushed into the window. The resident said he asked CNA #7 to stop and he did not. The resident said he was yelling out and CNA #7 still did not stop. Resident #6 told the SSD that nobody should be treated like that and said he was afraid of CNA #7. The resident said he no longer wanted to be in the facility if CNA #7 was around. The SSD asked the resident if he would feel alright if CNA #7 cared for other residents at the facility and not him. Resident #6 said he would be okay if he never saw CNA #7 again. The investigation documented Resident #15 was interviewed on 10/22/25 by the SSD. Resident #15 was Resident #6's roommate at the time of the incident and was present at the time of incident. Resident #15 said he was behind a curtain during the incident, but heard his roommate yell and ask CNA #7 to stop. Resident #15 said CNA #7 continued despite Resident #6's requests. Resident #15 said he did not believe CNA #7 had any business caring for people. The investigation documented CNA #7 provided a written statement, dated 10/28/25, describing the details of the incident and Resident #6's allegation. The statement documented CNA #7 asked Resident #6 if she could change him and the resident responded that he did not need to be changed. CNA #7 then asked Resident #6 if it was okay if she checked the resident for incontinence. CNA #7 said the resident responded that he did not need to be changed. CNA #7 documented the resident was wet and smelled of feces. CNA #7 wrote that she educated the resident about the importance of being changed to protect the skin. CNA #7 said Resident #6 responded that he did not need to be changed. CNA #7 documented that the resident made a personal attack against her, identified her as a man and then asked for a female CNA. CNA #7 wrote that she then changed the resident. CNA #7 said the resident said stop and that she responded that she was almost done and would not bother him again. C. Resident #15 interview Resident #15 (roommate of Resident #6) was interviewed on 12/16/25 at 12.10 p.m. Resident #15 said he had overheard the incident (on 10/22/25) from behind a curtain. Resident #15 said CNA #7 had continued to change Resident #6's briefs, despite Resident #6 refusing help from CNA #7. Resident #15 said CNA #7 then pushed Resident #6 into a wall following his</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure a thorough investigation of alleged misappropriation of funds for two (#1 and #4) of two residents out of 18 sample residents. Specifically, the facility failed to maintain thorough documentation that an alleged violation was thoroughly investigated for the misappropriation of Resident #1 and Resident #4's funds/property. Findings include: I. Facility policy and procedure The Community Standard Operating policy and procedure, dated 9/4/25, was provided by the nursing home administrator (NHA) on 12/16/25. It read in pertinent part, This policy outlines the community's zero-tolerance stance against resident abuse, neglect, misappropriation of resident property, and exploitation by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Resident and family training and education is offered at least annually. A Concern/Complaint Report form is completed, in writing, when missing items (clothing, personal care items, jewelry,) are reported. Staff and families are encouraged to complete the reports as necessary. Management staff completes a thorough investigation. The social services director/designee maintains a file of concern/complaint reports and the community action taken. In addition to an investigation by the police department, the community conducts an internal investigation. While the investigation is ongoing, the alleged assailant has interventions implemented to help ensure the safety of the alleged victim as well as other residents. The investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident. II. Occurrence of misappropriation of funds for Resident #1 on 8/1/25A. Facility investigation The facility's investigation, dated 8/2/25, was provided by the NHA on 12/16/25. The investigation revealed the following: On 8/2/25 Resident #1 reported to the NHA that two unidentified individuals entered her room and asked Resident #1 for her debit card to purchase snacks. Resident #1 gave the two individuals her debit card and they never returned with Resident #1's debit card or snacks. Resident #1 described the two assailants as one individual wearing business attire and the other person in nursing clothes. Camera footage reviewed by the NHA revealed no pertinent information matching the description of the two individuals entering Resident #1's room at the time of the alleged incident. The investigation documented the business office manager wrote a letter that documented the resident did not have a debit card while at the facility. -However, the resident had a bank account prior to admission and the details of which bank and what type of account the resident held was unknown to the facility. The facility failed to document if they took any action to obtain the resident's banking information to investigate whether or not the resident had a debit card for her account and to determine if there were any unauthorized charges on her account (see record review and interviews below). The facility investigation documented six other residents who were interviewed regarding the incident. -However, the facility failed to interview facility staff or family. The incident was reported to the police; however the facility did not follow up with the police to see if the case was still active or closed. The facility investigation was closed because the resident was discharged to the hospital before the investigation was completed and did not return to the facility. For this reason, the facility concluded the investigation was unsubstantiated. -However the facility did not continue the investigation to determine if there were any other residents at risk of being victimized by financial exploitation. B. Resident #1 (victim) 1. Resident status Resident #1, age less than 65, was admitted on [DATE] and discharged to the hospital on 8/11/25. According to the December 2025 computerized physician orders (CPO), diagnoses included drug induced polyneuropathy, unspecified asthma, depression and hypothyroidism. The 7/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required substantial assistance with all of her activities of daily living (ADL). 2. Record review Review of progress notes dated 8/1/25 to 8/4/25 failed to document: -When Resident #1 alerted facility staff of the missing debit card; and, -Attempts to contact Resident #1's family to obtain the resident's banking documentation for the investigation. 3. Staff interviews The business office manager was interviewed on 12/16/25 at 3:52 p.m. The business office manager said she had no involvement in the facility's investigation into Resident #1's allegation of misappropriation of funds but was working with the resident to complete a health insurance application. The business office manager said, during the time Resident #1 was in the facility, the resident did not have a debit card in her possession. The business office manager said Resident #1 moved from another state and the facility was trying to get a hold</p>		

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F 0925  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.  (continued on next page)

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations, record review and interviews, the facility failed to maintain an effective pest control program so the environment was free of pests. Specifically, the facility failed to prevent and take adequate measures to eliminate cockroaches within the facility kitchen, the resident dining room, resident rooms, resident shower rooms and in the facility hallways. Findings include:</p> <p>I. Professional reference According to the Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by:</p> <p>-Routinely inspecting incoming shipments of food and supplies</p> <p>-Routinely inspecting the premises for evidence of pests</p> <p>-Using methods, if pests are found, such as trapping devices or other means of pest control as specified under; and,</p> <p>-Eliminating harborage conditions. (Chapter 6)</p> <p>II. Facility policy and procedure The Pest Control policy, undated, was provided by the nursing home administrator (NHA) on 12/16/25 at 3:42 p.m. The policy read in pertinent part, The facility shall maintain an effective pest control program.</p> <p>III. Observations On 12/15/25 at 6:54 a.m. there was a large spill of a red syrup liquid on a tray. The tray was on a shelf underneath the counter. The floor in the main kitchen and the shelves were soiled with crumbs and food debris. On 12/15/25 at 7:50 a.m. multiple cockroaches were seen crawling on the wall near the baseboard in shower room two. There were also dead cockroaches near the baseboard in shower room two On 12/15/25 at 8:02 a.m. a cockroach was crawling on the floor in the resident common area. On 12/16/25 at 9:05 a.m. a dead cockroach was in the middle of the hallway near the resident common area On 12/16/25 at 9:24 a.m. a glue based cockroach trap was observed in shower room two. The trap was about three by six inches and was covered in cockroaches. Most of the cockroaches appeared to be dead, however one was seen wriggling on the trap.</p> <p>IV. Resident interviews and observations Resident #5 was interviewed on 12/15/25 at 7:32 a.m. Resident #5 said there were a lot of cockroaches in her room and she would watch them crawl on her wall all night. Resident #5 said the last few days have been slightly better and there have been less cockroaches. She said she still saw several in her room every night. Resident #5 said she did not feel enough was being done to combat the cockroaches. Resident #7 was interviewed on 12/15/25 at 8:02 a.m. Resident #7 said cockroaches were a problem throughout the facility. He pointed to the wall in the hallway lounge bringing attention to a live cockroach crawling around where he was sitting. Resident #7 said he also saw a lot of them in the shower room and his room. Resident #18 was interviewed on 12/16/25 at 1:02 p.m. Resident #18 said there were cockroaches everywhere in the facility. Resident #18 said he had lived in the facility for multiple years and said the cockroach infestation began about a year ago. He said the roaches had never been eliminated. Resident #18 said he has found cockroaches in his bed, saw them on the dining room tables during meal time and crawling all over the floor. The resident said a friend in the facility had found a cockroach in her food. Resident #18 said the facility had closed some rooms down for cockroach treatment, but had told him they did not have enough money to close and treat the entire facility aggressively.</p> <p>V. Record review Pest control records were provided by the NHA on 12/18/25. Records for the last four visits revealed cockroach activity throughout the facility. The records documented the following treatments:</p> <p>-Pest control service on 10/24/25 revealed multiple areas had cockroach activity including the kitchen, bathroom, breakroom and basement.</p> <p>-Pest control service on 11/7/25 revealed both rodent and cockroach activity was found in the kitchen interior areas. The area was treated with boractin powder and a full flush was recommended.</p> <p>-Pest control service on 11/19/25 revealed cockroach and mice activity had been found and the kitchen was specifically treated.</p> <p>-Pest control service on 12/1/25 revealed cockroach activity in the kitchen. The kitchen area was closed and treated. One resident room was also treated. Resident council minutes from 10/8/25 documented the about concerns about cockroaches in the facility. The facility responded they were seeking a different pest control provider. The November 2025 and December 2025 resident council meetings revealed the residents continued to complain about the cockroach problem despite some minor improvement.</p> <p>VI. Staff interviews The dietary manager (DM) was interviewed on 12/15/25 at 7:02 a.m. The DM said the facility had problems with cockroaches. The DM said the cockroaches were mainly in the residents' rooms, but sometimes they came into the kitchen area. The DM said the facility was serviced by a pest control provider She said the cockroach problem in the kitchen during service hours was slowly improving. The DM said they had a cleaning schedule for the kitchen which targeted different areas each day for a deeper cleaning. The DM said she would have staff clean up the juice machine counter area and would consider increasing the</p>		