STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Specifically, the facility failed to: -Ensure enhanced barrier precautions (EBP) were followed;-Ensure hand hygiene was performed during medication administration;-Ensure hand hygiene was performed during cleaning of resident rooms; and,-Ensure urine collectors were bagged, dated and labeled when not in use. Findings include: I. Failure to ensure enhanced barrier precautions were followed A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Frequently Asked Questions about EBP in Nursing Homes (6/28/24), retrieved on 8/12/25 from: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally-inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. The presence of an indwelling device is a major risk factor for being colonized with or acquiring a MDRO. Therefore, the safest practice would be to wear a gown and gloves for any care (dressing changes) or use (injecting or infusing medications or tube feeds) of the indwelling medical device. B. Observations and staff interview On 8/5/25 at 9:08 a.m., licensed practical nurse (LPN) #1 was providing tube feeding for Resident #78 through her feeding tube. LPN #1 had a mask on. She gathered supplies and entered Resident #78's room. She washed her hands and donned (put on) clean gloves. She removed the cap to the feeding tube and hooked an empty syringe to Resident #78's feeding tube. She measured out 30 milliliters (ml) of water. She pushed the water into the syringe. She poured 240 ml of tube feeding formula into the syringe and let it drain into the tube by gravity. She pushed 30 ml of water into the syringe. She clamped the feeding tube and removed the syringe. She screwed the cap onto the feeding tube and unclamped the feeding tube. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-LPN #1 did not wear a gown during the tube feeding procedure. LPN #1 said she should have worn a gown during the administration of tube feeding formula. II. Failure to ensure hand hygiene was completed during medication administration A. Professional reference According to CDC's Clinical Safety: Hand Hygiene for Healthcare Workers (February 2024), retrieved on 7/28/25 from: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Recommendations to clean your hands include immediately before touching a patient, before performing an aseptic technique, before moving from work on a soiled body site to a clean body site, after touching a patient or patient's surroundings, after contact with body fluids and immediately after glove removal. B. Observations On 8/5/25 at 8:54 a.m. registered nurse (RN) #2 was administering medications. She was preparing medications for Resident #42. RN #2 gathered supplies and entered Resident #42's room. RN #2 donned clean gloves. RN #2 checked Resident #42's blood glucose level. RN #2 administered an insulin injection to Resident #42's abdomen. RN #2 removed her gloves and left the room. RN #2 donned clean gloves and sanitized the blood glucose machine. RN #2 removed the gloves and walked to locate another staff member to help her translate in Resident #42's native language. RN #2 and the other staff member walked into Resident #42's room together and discussed the medications. RN #2 walked out to the medication cart and gathered the additional medications which consisted of a cup of pills and another insulin injection. RN #2 entered Resident #42's room and donned clean gloves, without performing hand hygiene RN #2 handed Resident #42 the cup of pills and administered the insulin injection into Resident #42's lower abdomen. RN #2 removed the gloves and went back out to the cart to put the insulin pen away and began to prepare another resident's medications. -RN #2 failed to perform hand hygiene between gloves changes. III. Failure to ensure hand hygiene was completed during cleaning of resident rooms A. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy and procedure, revised August 2013, was received from the nursing home administrator (NHA) on 8/4/25 at 10:05 a.m. It documented in pertinent part, Perform hand hygiene after removing gloves. B. Observations During a continuous observation on 8/7/25, beginning at 8:05 a.m. and ending at 8:23 a.m., the following was observed: Housekeeper (HK) #1 was cleaning resident room [ROOM NUMBER]. HK #1 began by donning clean gloves. She removed used trash bags from the bedroom and bathroom. HK #1 sprayed down the sink and toilet. HK #1 wiped down the high touch surfaces on side A of the room with purple top (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	disinfectant wipes. HK #1 wiped down the sink with a rag. HK #1 disposed of rag. HK #1 wiped down the toilet with a new rag. HK #1 disposed of rag. HK #1 removed gloves and donned clean gloves, without performing hand hygiene. HK #1 wiped down door handles with purple top disinfectant wipes. HK #1 swept the floor. HK #1 mopped the bedroom floor. HK #1 changed the mop head and mopped the bathroom. HK #1 said she was finished cleaning the room and pushed the cart down the hallway. -HK #1 failed to perform hand hygiene between glove changes. IV. Staff interviews The infection prevention nurse (IP) and the nurse consultant were interviewed together on 8/7/25 at 11:00 a.m. The IP said hand hygiene should be completed before resident care, during care if there are gloves changes and after resident care. He said residents should be offered hand hygiene before each meal. He said the importance of hand hygiene is to reduce the transmission of disease. The nurse consultant said residents who have chronic wounds, catheters, ostomies, feeding tubes and tracheostomies should be placed on EBP. She said staff should wear a gown and gloves at minimum when providing resident care to these residents on EBP. She said the importance of this is to reduce the risk of spreading MDROs. The director of nursing (DON) was interviewed on 8/7/25 at 2:25 p.m. She said hand hygiene should be performed by staff before resident care, before gloves were donned and after removing gloves. She said the importance of hand hygiene was to decrease the risk of infection. She said there was no process for offering hand hygiene to residents prior to meals. She said residents who had a feeding tube, wounds, catheters and ostomies should be on EBP and the staff should be wearing a gown and gloves during resident care. She said EBP helped reduce the risk of infection. V. Failure to ensure urine collectors were stored appropriately A. Facility policy and procedures The Cleaning and Disinfection of Resident Care Items and Equipment policy, revised September 2022, was provided by the director of clinical risk management on 8/6/25 at 3:48 p.m. The policy revealed that resident-care equipment, including reusable items and durable medical equipment would be cleaned and disinfected according to current centers for disease control (CDC) recommendations for disinfection and the occupational safety and health administration (OSHA) Bloodborne Pathogens Standard. Critical items consisted of items that carried a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (urinary catheters) or the vascular system (intravenous catheters) were considered critical items and must be sterile when used, based on acceptable sterilization procedures. Sterilization destroyed all viable microorganisms to prevent disease transmission associated with the use of that item. Reusable items (such as stethoscopes and durable medical equipment) were cleaned and disinfected and/or sterilized between residents. B. Observations On 8/4/25 at 9:50 a.m. observations of resident room [ROOM NUMBER] (two female residents) revealed two urinal collectors in the bathroom. One sat upright on the toilet tank lid and the second one was on its side on the wood shelf above the toilet. Neither urine collectors were dated, labeled or bagged. The urine collectors contained brown discoloration on the inside plastic. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/4/25 at 11:31 a.m. observations of resident room [ROOM NUMBER] revealed two urine hat collectors (one clear and one white). The urine collectors sat on the wood shelf above the toilet tank lid. Neither urine hat collectors were dated, labeled, or bagged. The white urine hat collector contained brown discoloration on the inside plastic. On 8/6/25 at 9:30 a.m. observations of resident room [ROOM NUMBER] revealed two urinal collectors in the bathroom. One sat upright on the toilet tank lid and the second was on its side on the wood shelf above the toilet. Neither urine collectors were dated, labeled, or bagged. The urine collectors contained brown discoloration on the inside plastic. On 8/6/25 at 11:35 a.m. observations of resident room [ROOM NUMBER] revealed two urinal collectors in the bathroom. One sat upright on the toilet tank lid and the second was on its side on the wood shelf above the toilet. Neither urine collectors were dated, labeled, or bagged. The urine collectors contained brown discoloration on the inside plastic. On 8/6/25 at 11:38 a.m. observations of resident room [ROOM NUMBER] revealed two urine hat collectors (one clear and one white). The urine collectors sat on the wood shelf above the toilet tank lid. Neither urine hat collectors were dated, labeled, or bagged. The white urine hat collector contained brown discoloration on the inside plastic. C. Staff interviews The director of nursing (DON) was interviewed on 8/6/25 at 11:35 a.m. The DON said she observed the urinal collectors in the bathroom. The DON said neither urine collector was dated, labeled or bagged. The DON said they should have been dated, labeled or bagged. The DON said the urinals contained brown discoloration on the inside plastic. The DON said she did not know why urinals were in female rooms. The DON said observed resident room [ROOM NUMBER]. The DON said there were two urine hat collectors. The DON said they should have been dated, labeled, or bagged. The infection preventionist (IP) was interviewed on 8/7/25 at 11:00 a.m. The IP said male urine collectors and urine hat collectors should be labeled with date and room number. The IP said they were starting a new process for disposing of urinals and collector hats. The IP said the facility would replace them weekly. The assistant director of nursing (ADON) was interviewed on 8/7/25 at 12:43 p.m. The ADON said urine collectors should be labeled with the resident's name, date, and room number. The ADON said she was unsure if they should be bagged. The ADON said the urine collectors should be cleaned after each use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure consent was obtained for the use of psychotropic medications for one (#16) out of five residents reviewed for unnecessary medications out of 43 sample residents.Specifically, the facility failed to obtain consent prior to the administration of an antipsychotic antidepressant medication for Resident #16. Findings include:I. Facility policy and proceduresThe Psychopharmacological policy, dated 3/10/23, was provided by the nursing home administrator (NHA) on 8/4/25 at 10:05 a.m. The policy revealed the community supported the appropriate use of psychopharmacological drugs that are therapeutic for residents suffering from mental illness. The interdisciplinary team would proceed to care planning for the use of psychopharmacological drugs, and the care plan for psychopharmacological medications would be implemented. The care plan conference summary (CPCS) would be utilized to document discussions with the resident and/or resident representative about the resident's diagnosis, behaviors, and medications, including the use of psychopharmacological drugs.The Psychpharm Committee members would review residents on psychopharmacological drugs on admission, quarterly, and any change of status. The committee members would ensure the resident was on the most appropriate psychopharmacological drug for specific behavior symptoms and/or diagnosis and at the lowest possible dose to control these symptoms. The committee would ensure dosages were within the guidelines provided by federal regulations or for appropriate treatment of resident's diagnosis, behavioral symptoms and past mental health history. A licensed pharmacist would review residents' psychopharmacological drug regimen on a monthly basis and document his/her findings on the Pharmacy Consultant Report. The pharmacist would report any irregularities to the director of nursing (DON). The policy did not specify that a consent for the use of an antipsychotic medication was necessary/required before the administration of the medication.II. Resident #16A. Resident status Resident #16, greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), the resident's diagnoses included dementia with anxiety, depression and adjustment disorder with mixed disturbance of emotions and conduct.The 6/19/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of ten out of 15 with no behaviors. The assessment indicated the resident was administered an antidepressant antipsychotic medication on a routine basis only.B. Record reviewA care plan for the use of an antidepressant related to depression was revised on 3/31/25. Interventions included monitoring the resident for the use of an antidepressant medication, staff were to educate the resident/family/caregivers about the risks, benefits and the side effects and/or toxic symptoms of anti-depressant medications, staff were to monitor/document/report as needed adverse reactions to the antidepressant therapy such as a change in the resident's behavior/mood/cognition; hallucinations/delusions and social isolation. Staff were also to monitor for suicidal thoughts, withdrawal; decline in activities of daily living, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, dry mouth, dry eyes. The resident's medications would be reviewed by the interdisciplinary team (IDT) quarterly and as needed to attempt a gradual dose reduction when clinically indicated.A care plan for the resident's use of an anti-psychotic medication for the symptoms/behaviors associated with the diagnosis of depression was revised on 6/10/25. The interventions included for staff to administer psychotropic medications as ordered by a physician and for staff to monitor for side effects and effectiveness.A physician order dated 5/9/25 at 8: 37 a.m. revealed to administer two tablets of 50 milligrams of Sertraline (antidepressant) HCl orally once a day for depression.The medication administration record (MAR) for June 2025, July 2025 and August 2025 (8/1/25 to 8/6/25) revealed the resident was administered the two tablets of 50 milligrams of Sertraline HCL daily according to the physician's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. The resident received a total of 57 doses of this medication.Review of Resident #16's electronic medical record (EMR) did not reveal documentation that the resident or their representative provided consent prior to the administration of the Sertraline. IIII. Staff interviewsThe social worker quality mentor was interviewed on 8/7/25 at 11:32 a.m. She said the MDS dated [DATE] revealed the resident was administered an antidepressant antipsychotic medication on a routine basis only. She said a consent for the use of two tablets of 50 milligrams of Sertraline HCL daily for depression was completed on 8/6/25 during the survey. The social worker quality mentor said consent should be obtained prior to the administration of the antidepressant medication. She said according to the MAR for June 2025, July 2025 and August 2025 the resident was administered the medication.The director of nursing (DON) was interviewed on 8/7/25 at 12:28 p.m. She said the MDS dated [DATE] revealed the resident was administered an antidepressant antipsychotic medication on a routine basis only. The DON said the consent for the use of two tablets of 50 milligrams of Sertraline HCL daily for depression was completed on 8/6/25 (during the survey). The DON said the consent for the antidepressant should have been obtained prior to administration. She agreed with the administration documentation on the resident's MARs for June, July and August 2025.The assistant director of administration (ADON) was interviewed on 8/7/25 at 12:43 p.m. The ADON said a consent should be obtained before the administration of a psychoactive medication. The ADON agreed the MDS dated [DATE] revealed the resident was administered an antidepressant antipsychotic medication on a routine basis only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#59 and #63) of three residents reviewed for activities of daily living (ADL) received the necessary care and services to maintain their ADL abilities out of 43 sample residents.Specifically, the facility failed to:-Ensure Resident #59 consistently received assistance with personal hygiene, such as showering, shaving and trimming his nails; and,-Provide language communication tools for Resident #63 in order for her to effectively communicate her needs.Findings include:I. Failed to ensure Resident #59 consistently received assistance with personal hygiene, such as showering, shaving and trimming his nailsA. Facility policy and procedureThe Supporting Activities of Daily Living policy and procedure, revised March 2018, was received from the nursing home administrator (NHA) on 3/10/25 at 10:46 a.m. It read in pertinent part, Appropriate care and services will be provided for residents who are unable to carry out activities of daily living (ADL) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing and grooming) and dining.B. Resident #591. Resident statusResident #59, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), depressive disorder, history of traumatic brain injury, anxiety disorder, dependence on a wheelchair and contracture of the right wrist and hand.The 5/30/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. The resident required moderate assistance with personal hygiene, toileting and maximal assistance with showers. The MDS assessment revealed the resident had no behavior problems and did not refuse care. 2. ObservationsOn 8/4/25 at 2:14 p.m. Resident #59 was in his bed in his room. His hair was unkempt and uncombed. His hair was long and shiny with varying lengths sticking out in different directions. The resident had facial hair that was not shaped. The resident's beard covered a significant portion of the lower face, including his cheeks, chin, and neck. The resident's fingernails were untrimmed and about one and a half inches long. On 8/5/25 at 10:15 a.m., Resident #59 was lying in his bed. His hair and beard were long and uncombed and were scattered in various directions. The resident was wearing black sweatpants with a white long sleeved t-shirt. The white t-shirt had food debris on it.At 3:20 p.m. the resident was in bed wearing the same clothes (black as the day before. His hair was stringy, shiny and greasy in appearance. His fingernails remained black sweatpants with a white long sleeved t-shirt) long and untrimmed.On 8/6/25 at 2:14 p.m. the resident was sitting partially up on his bed, leaning against the wall. His fingernails remained long. The nail on his index finger was missing.3. Resident interviewThe resident was interviewed on 8/6/25 at 3:00 p.m. Resident #59 said he had not had a shower in a long time. He said his fingernails were too long and he preferred them short and trimmed. The resident said a few days ago he was going through his drawer and he bumped his fingernail against an object in his drawer. He said this caused him to loose his nail on his index finger. The resident said that it hurt and he would like his nails cut and trimmed. Resident #59 said he would like to be shaved and also get a haircut. He said he did not get assistance from the staff to shave his facial hair. He said he had not been shaved or received a haircut for a long time. He said he preferred keeping his hair short and with no facial hair. The resident said he needed assistance with personal hygiene. 4. Record reviewThe ADL care plan, revised on 8/1/23, revealed Resident #59 had an ADL self-care performance deficit related to a history of traumatic brain injury and limited physical mobility related to contractures and weakness. The care plan indicated the resident needed limited assistance with showers. Interventions included checking nail length and trimming and cleaning on bath day, and as needed. -The care plan failed to include interventions for refusal of showers and shaving.Review of the resident's progress notes from 1/1/24 through 8/6/25 did not include documentation regarding the resident refusing to shower. The 3/11/24 behavior services note (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the resident was happy to be shaved, he was in a good mood, having adequate sleep and his weight and appetite were stable.Review of Resident #59 electronic medical record (EMR) revealed the resident preferred to shower twice a week on Tuesday and Thursday evenings. Further review of Resident #59's EMR did not include any documentation indicating the resident had received a shower, was shaved or had his fingernails clipped. -A request for Resident #59's shower, fingernail care and shaving records were requested for the previous six months. The documentation was not provided during the survey. C. Staff interviewsCNA #11 was interviewed on 8/7/25 at 2:00 p.m. CNA #11 said Resident #59 required moderate assistance with his ADLs, which included showers, shaving, and fingernail care. She said the CNA's were responsible for providing showers and personal hygiene care for dependent residents. CNA #11 said when a resident refused to shower, she would offer it at a different time, and if still unsuccessful, then she would inform the charge nurse. CNA #11 said charge nurse would attempt to speak to the resident and offer education about the importance of good personal hygiene. She said if all attempts were unsuccessful, they would offer the resident a bed bath and document refusal for showers in the resident's EMRLicensed practical nurse (LPN) #4 was interviewed on 8/7/25 at 2:39 p.m. LPN #4 said Resident #59 had a right hand contracture and required assistance with ADL's. LPN #4 said the resident stayed in his room a lot of the time. She said the CNA's were responsible for showers and personal hygiene care for dependent residents. LPN #4 said completed showers, fingernail care, shaving, including refusals, were documented in the EMR. LPN #4 said she did not know why the records were not showing for Resident #59. LPN #4 said long and jagged fingernails could cause a skin tear. She said poor personal hygiene had several adverse effects, such as illness due to germs.The DON was interviewed on 8/7/25 at 3:03 p.m. The DON said during admission, a new resident was asked how many showers they wanted a week, and it was added to the resident's bathing profile/choices. She said residents' bathing choices were reviewed at the quarterly care conferences. She said if a resident refused a shower, the staff would try to accommodate them. She said shower refusals were documented on the shower sheet, and verbal notification given to the assigned nurse by the CNA. The DON said the nurse was to attempt to offer a shower to the resident. She said if the resident continued to refuse, the nurse was to document the refusal in the progress notes. The DON said the facility was in the process of hiring a beautician to render services such as haircuts, fingernail care and shaving at no cost to the residents. The DON said she did not know why the shower records were not showing on the PCC. She said she would immediately offer education for the facility staff.II. Failed to provide language communication tools for Resident #63 in order for her to effectively communicate her needsA. Facility policy and procedureThe Communication With Persons With English As A Second Language (ESL) policy and procedure, dated 2/29/24, was received from the nursing home administrator (NHA) on 8/7/25 at 3:25 p.m. It revealed in pertinent part, The facility will take reasonable steps to ensure that persons with English as a second language (ESL) have meaningful access and an equal opportunity to participate in our services, activities, programs and and other benefits. The policy of this facility is to ensure meaningful communication with ESL residents and their authorized representatives involving their medical conditions and treatment. Language assistance will be provided through the use of technology and telephonic interpretation services. The facility will conduct a regular review of the language access needs of our resident population, as well as update and monitor the implementation of this policy and this procedure as necessary.B. Resident #631. Resident statusResident #63, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnosis included type 2 diabetes mellitus, major depressive disorder, chronic kidney disease, unsteadiness on feet, reduced mobility and history of falling.The 5/21/25 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 moderate assistance with personal hygiene and supervision or touch assistance with bathing, toileting and lower body dressing.The MDS assessment indicated Resident #63's communication preference was in her native language of Spanish.2. Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewResident #63 was interviewed on 8/4/25 at 3:40 p.m. Resident #63 said she preferred to speak in her native language of Spanish. She said it had been difficult for her to communicate with staff and attend activities because the staff did not understand her when she spoke. Resident #63 said she stopped attending her preferred activities, such as bingo, religious groups and social interactions. She said the staff have never used a communication line or any device to assist her in communicating her needs. Resident #63 said all activities, religious services and social interactions were conducted in English, making it difficult to understand.Cross-reference F679 for failure to provide a personalized activity program.3. Observations On 8/6/25 at 10:46 a.m. Resident #63 was in her bedroom after lunch, sitting in her wheelchair. Licensed practical nurse (LPN) #3 entered the resident's room to administer her medication. Both LPN #3 and Resident #63 could not understand each other, however, the resident took her medication. LPN #3 left the resident's room without attempting to use the translator line to communicate with the resident. On 8/6/25 at 2:15 p.m. Resident #63 was sitting by herself on her side of the shared room while bingo was going on in the main dining room. Certified nurse aide (CNA) #10 entered the resident's room to pick up a food tray. CNA #10 did not say a word to the resident. 4. Record reviewThe activities care plan, initiated 10/7/24, revealed Resident #63 spoke Spanish and would require Spanish-speaking staff, family or an online translator for communication and assistance with activities. The care plan intervention included staff would utilize Spanish-speaking staff, family, translation line or an online translator when communicating with the resident.C. Staff interviewsCertified nurse aide (CNA) #10 was interviewed on 8/6/25 at 1:50 p.m. CNA #10 said Resident #63 only spoke Spanish. She said the resident stayed in her room most of the time, except when her family visited her. CNA #10 said the resident kept to herself a lot of the time and refused activities. CNA #10 said she believed Resident #10 refused activities due to the language barrier. CNA #10 said she did not speak Spanish, but she tried her best to make sense of what Resident #63 said to her in Spanish.LPN #3 was interviewed on 8/6/25 at 2:00 p.m. LPN #3 said Resident #63 only spoke Spanish. LPN #3 said the facility had a translation line to assist with communication with the resident. AA #1 and AA #2 were interviewed together on 8/7/25 at 8:50 a.m. AA #1 said she did not speak Spanish, but AA #2 spoke Spanish. Both activities assistants agreed that all of the facility's activities were conducted in English. AA #2 said she could speak to Resident #63 in Spanish, but she was not aware the resident had a language barrier. The activities director (AD) was interviewed on 8/7/25 at 9:20 a.m. The AD said Resident #63 had a language barrier and preferred speaking Spanish.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, record review and interviews the facility failed to provide the necessary services for one (#14) of four residents reviewed for services to maintain highest practicable quality of life out of 43 sample residents.Specifically, the facility failed to ensure Resident #14 consistently received assistance with dining. Findings include:I. Facility policy and procedureThe Supporting Activities of Daily Living policy and procedure, revised March 2018, was received from the nursing home administrator (NHA) on 3/10/25 at 10:46 a.m. It read in pertinent part, Appropriate care and services will be provided for residents who are unable to carry out activities of daily living (ADL) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing and grooming) and dining. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem.II. Resident #14A. Resident statusResident #14, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included pulmonary embolism (a blood clot in the lungs), malignant neoplasm of the esophagus (cancer in the throat), symptoms and signs involving cognitive functions and awareness, depression, bipolar disorder (mental illness) and adult failure to thrive.The 5/28/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The resident was independent for most activities of daily living (ADL). The assessment documented the resident was occasionally incontinent and had less than seven episodes of incontinence in the assessment lookback period.-However, record review and interviews revealed Resident #14 frequently needed staff assistance for ADLs including toileting hygiene and eating (see record review and interviews below).B. ObservationsDuring a continuous observation on 8/5/25 from 11:08 a.m. to 1:00 p.m., the following was observed:At 11:21 a.m. an unidentified housekeeping staff member delivered laundry to Resident #14's room.At 11:26 a.m. certified nurse aide (CNA) #5 delivered a lunch tray to Resident #14's roommate.At 11:37 a.m. CNA #5 delivered a drink to Resident #14's roommate.At 11:40 a.m. CNA #6 entered Resident #14's room and took out his breakfast tray from that morning, still with the cover on. CNA #6 delivered Resident #14's lunch tray and left the tray covered on Resident #14's bedside table several feet away from the resident's bed. Resident #14 was lying in bed on his side and was awake but still lying down.-CNA #6 failed to set up the lunch tray for Resident #14 and encourage him to eat.At 11:45 a.m. registered nurse (RN) #4 entered Resident #14's room and delivered medications to the resident. RN #4 asked Resident #14 if he needed anything else and left the room. RN #4 did not encourage Resident #14 to eat his lunch or ensure he was able to reach it.At 11:48 a.m. RN #4 entered Resident #14's room to deliver medications to his roommate.At 12:41 p.m. CNA #3 entered Resident #14's room and retrieved his lunch tray from his bedside table. The lunch tray was still covered and untouched.On 8/6/25 at 11:53 a.m. CNA #7 delivered Resident #14's lunch tray to his room, left it covered on his bedside table and left the room.-CNA #7 failed to set up Resident #14's tray for him or encourage him to eat.At 11:57 a.m. Resident #14 was lying in bed asleep on his side. Resident #14's lunch tray was on his tray table several feet away from his bed and still had the cover on.On 8/7/25 at 11:14 a.m. Resident #14 was lying in bed. An unidentified staff member entered Resident #14's room and offered a drink to the resident's roommate but did not speak with Resident #14.C. Record reviewThe ADL care plan, revised 5/30/25, revealed Resident #14 had an ADL self-care performance deficit due to his esophageal cancer. Pertinent interventions included monitoring, documenting and reporting any changes or declines in function.-The ADL care plan did not include any interventions to assist with the resident's eating.The hospice care plan, revised 5/28/25, revealed Resident #14 was receiving additional support through hospice care. Pertinent interventions included adjusting the provision of ADLs to compensate for Resident #14's changing abilities.A progress note, dated 6/20/25 at 11:15 a.m., (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #14 was being followed by the facility's nutrition at risk team. Resident #14 had poor meal intakes and was refusing meals at times. Staff were to encourage intakes as Resident #14 was able and willing to accept. A progress note, dated 6/25/25 at 11:06 a.m., revealed Resident #14 was being followed by the facility's nutrition at risk team. Resident #14 had poor meal intakes and was refusing meals at times. Staff were to encourage intakes as Resident #14 was able and willing to accept. A progress note, dated 7/11/25 at 12:12 p.m., revealed Resident #14 was being followed by the facility's nutrition at risk team. Resident #14 had poor meal intakes for most meals. Staff were to encourage intakes as Resident #14 was able and willing to accept. A progress note, dated 7/18/25 at 12:24 p.m., revealed Resident #14 was being followed by the facility's nutrition at risk team. Resident #14 had poor meal intakes for most meals. Staff were to encourage intakes as Resident #14 was able and willing to accept. A progress note, dated 7/25/25 at 12:09 p.m., revealed Resident #14 was being followed by the facility's nutrition at risk team. Resident #14 had poor meal intakes for most meals. Staff were to encourage food and fluids as Resident #14 was able and willing to accept. -However, observations revealed the staff failed to consistently encourage the resident to eat at meals (see observations above).Review of the eating resident ability task from 7/9/25 through 8/7/25 revealed the following:-Resident not available was marked four times;-Resident refused his meal was marked 11 times;-Not applicable was marked ten times;-Independent with eating was marked 23 times;-Setup/clean-up assistance with eating was marked seven times;-Partial/moderate assistance with eating was marked three times;-Substantial/maximal assistance with eating was marked three times; and,-Dependent on staff for eating was marked 14 times.D. Staff interviewsCNA #5 was interviewed on 8/7/25 at 9:13 a.m. CNA #5 said Resident #14 often refused meals. CNA #5 said the staff brought Resident #14 his tray and let him know it was in his room, but his willingness to eat ebbed and flowed. CNA #5 said Resident #14 sometimes ate cereal but never finished his whole tray.CNA #4 was interviewed on 8/7/25 at 9:44 a.m. CNA #4 said the facility staff made sure Resident #14 was clean and fed him. CNA #4 said Resident #14 needed help with eating. CNA #4 said Resident #14 was getting up when he first got to the facility, but now they had to help him since he was getting weaker. CNA #4 said the facility CNAs set up Resident #14's meal trays for him but the resident could drink and feed himself. CNA #4 said Resident #14 refused his meals most of the time.RN #5 was interviewed on 8/7/25 at 12:33 p.m. RN #5 said the nursing staff usually needed to help Resident #14 with eating. The director of nursing (DON) was interviewed on 8/7/25 at 3:31 p.m. The DON said Resident #14's ADL self-care abilities ranged from needing substantial assistance to being dependent on nursing staff. The DON said Resident #14 needed setup assistance from staff for eating and needed substantial assistance to complete dependence on staff for toileting. The DON said setup assistance for meals involved the staff uncovering the tray, opening any containers the resident needed opening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide two (#63 and #31) of three residents reviewed for activities with an ongoing program of activities designed to meet needs and interests and promote physical, medical and psychosocial well-being out of 43 sample residents.Specifically, the facility failed to ensure Resident #63 and #31 received a personalized activity program.Findings include: I. Facility policy and procedure The Activity policy, revised 3/14/23, was received from the nursing home administrator (NHA) on 8/7/25 at 3:25 p.m. It read in pertinent part, The facility will provide daily activities that not only meet the requirements of state and federal guidelines, but also the interests, preferences, hobbies, and culture of the participants and community. Daily activities include community-sponsored group and individualized activities, in addition to assistance with independent daily activities. Activities will be designed to meet and support the participants physical, mental, intellectual, and psycho-social well-being. Activities will create opportunities for each participant to have a meaningful life by supporting their domains of wellness. Activities will be designed to meet participants' best ability to function, incorporating their strengths and abilities. Participants will have advanced notice of when activities take place, including the location where they are taking place. Activity offerings, in addition to spiritual services/events, shall be provided on the weekends. II. Resident #63 A. Resident status Resident #63, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, major depressive disorder, chronic kidney disease, unsteadiness on feet, reduced mobility and history of falling. The 5/21/25 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 moderate assistance with personal hygiene and supervision or touch assistance with bathing, toileting and lower body dressing. The 9/20/24 MDS assessment documented the resident's activity preferences included listening to preferred music, being around animals, keeping up with the news, doing activities with groups of other people and going outside when the weather was good. B. Resident interview Resident #63 was interviewed via the language line on 8/4/25 at 3:30 p.m. Resident #63 said she liked bingo when it was conducted in her native language. She said she attended bingo a few times, but she stopped attending because the bingo activity was conducted in the English language so she did not understand, and it did not meet her preference. Resident #63 said her previous facility conducted bingo in Spanish and she did enjoy attending. Resident #63 said if the facility had bingo in Spanish, she would be interested in attending. Resident #63 said all activities were conducted in English, so it was not beneficial to her. Resident #63 said she spent more time with her family when they visited, but they were unable to visit every day, so she spent more time in her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross-reference F676 for failure to provide effective communication tools to ensure residents who spoke a language other than English were able to effectively communicate their needs to staff. During the interview, an activity calendar printed in Spanish, in normal size print, was observed approximately six feet high up on the west wall of Resident #63's room. The resident used a wheelchair and needed assistance to stand. Resident #63 said she was unable to read the activities calendar C. Observations On 8/5/25 at 1:46 p.m. Resident #63 was sitting on her bed in her room. She was not involved in any meaningful activities while there was a bingo activity going on in the main dining room. During a continuous observation on 8/5/25, beginning at 3:00 p.m. and ending at 4:01 p.m., Resident #63 was lying in her bed with her television turned off. She was not participating in any meaningful activities. During a continuous observation on 8/6/25, beginning at 10:05 a.m. and ending at 11:30 a.m., Resident #63 was sitting in her wheelchair by her bed. Several staff members walked by but did not offer to assist the resident to the activities in the dining room or offer to provide the resident with the facility's language line for translation of the activities being offered in the dining room. On 8/6/25 at 2:15 p.m. Resident #63 was sitting by herself on her side of the shared room while bingo was going on in the main dining room. Certified nurse aide (CNA) #10 entered the resident's room to pick up a food tray. -CNA #10 did not speak to the resident and did not invite Resident #63 to go to the bingo activity. D. Record review The 9/13/25 activity assessment documented that Resident #63 enjoyed listening to music of her preference, being around animals/pets, keeping up with the news, going out for fresh air when the weather permitted, religious activities and group activities. -The activities assessment did not indicate that independent activities were Resident #63's preference. The activities care plan, initiated 10/7/24, documented that Resident #63 enjoyed activities like games such as cards, arts and crafts, exercise, Spanish Mexican music, going outdoors when the weather was nice, cooking, keeping up with current events, getting her nails done, watching television, Spanish western movies and religious activities. The activity care plan revealed Resident #63 spoke Spanish and needed Spanish-speaking staff, family, or a google translator for communication and assistance with activities. The care plan intervention included reminding and inviting Resident #63 to activities of interest, such as games, social outings and religious activities. -However, per the resident's interview, staff did not provide activities in Spanish and observations revealed staff did not offer to provide a translator for the resident to attend activities (see resident interview and observations above). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The activities care plan, initiated on 10/7/24, identified Resident #59 had vision difficulties and would need large print during activities. -However, the activities calendar was posted six feet high on the resident's wall and printed in normal size print (see observations above). E. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 8/6/25 at 1:50 p.m. CNA #10 said Resident #63 only spoke Spanish. She said the resident stayed in her room most of the time, except when her family visited her. CNA #10 said the resident kept to herself a lot of the time and refused activities. CNA #10 said she believed Resident #10 refused activities due to the language barrier. Licensed practical nurse (LPN) #3 was interviewed on 8/6/25 at 2:00 p.m. LPN #3 said Resident #63 only spoke Spanish and refused activities most of the time. LPN #3 said the facility had a translation line to assist with communication with the resident. LPN #3 said all activities were held in English and she believed that was the reason Resident #63 refused to participate. Activities assistant (AA) #1 and AA #2) were interviewed together on 8/7/25 at 8:50 a.m. AA#1 said Resident #63 had never expressed concerns about not understanding English. She said the resident refused several activities and preferred to remain in her room and go out with her family. AA#1 said all activities were conducted in English, though a member of the activities team, AA#2, spoke fluent Spanish and could interpret activities in Spanish. AA #1 said she often used other staff members and an online translator tool to interpret when she could not understand Resident #63. AA#2 said when a resident refused activities frequently, she usually would ask again, and if the resident continued to refuse, she would honor the refusal and document it in the resident's chart. The activities director (AD) was interviewed on 8/7/25 at 9:25 a.m. The AD said she reviewed the activities chart every quarter, but was not aware of Resident #63 refusing group activities and other activities. She said Resident #63's activities calendar was posted too high on the wall in the resident's room. She said she expected the activities assistants to inform her when they noticed a pattern of refusal by any resident. The AD said there was an initial activities assessment done upon admission and annually for all residents. She said she expected the activities staff to follow the resident's care plan. She said she did not know why the activities staff was not reporting Resident #63'd refusals of her preferred activities. The social worker quality mentor was interviewed on 8/7/25 at 10:00 a.m. The social worker quality mentor said Resident #63's care plan should be followed by the activities staff. She said if the resident's preferred language was Spanish, she expected the staff to offer interpretations of activities and also report patterns of refusals to the AD. The social worker quality mentor said the facility staff should be utilizing the translator line. She said she would immediately offer education to the activities staff and ensure the AD reviewed the residents' activities logs for patterns of refusals and developed interventions to assist the residents. III. Resident #31 A. Resident Status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included schizoaffective disorder, bipolar type (combination of schizophrenia and bipolar disorder symptoms), retention of urine and atrial fibrillation (abnormal heart rhythm). The 5/21/25 MDS assessment documented the resident was cognitively intact with a BIMS score of 12 out of 15. The MDS assessment documented Resident #31's preferred language was Spanish. He was independent with all ADLs other than toileting. He required partial assistance with toileting. The 2/20/25 annual MDS assessment revealed it was very important for Resident #31 to listen to music he liked, be around animals, do things with groups of people, do his favorite activities, go outside for fresh air when the weather was good and participate in religious services. B. Resident interview Resident #31 was interviewed via the language line on 8/4/25 at 12:41 p.m. Resident #31 said he primarily spoke Spanish. He said there were no activities offered in Spanish. He said he would like to go to more activities if they were offered in Spanish. He said he enjoyed bingo, going outside, religious services, listening to music, watching television and talking with others. He said there was an activity calendar in his room but it was printed in English. He said it would be nice to have one in Spanish so he could read it. During the interview, an activities calendar printed in English was observed in the resident's room. Resident #31 was interviewed again on 8/6/25 at 10:08 a.m. Resident #31 said he knew about the coffee social and the church service going on, but he said he did not want to go participate because they were in English. C. Observations On 8/5/25 during a continuous observation, beginning at 2:55 p.m. and ending at 4:13 p.m., the following was observed: At 2:55 p.m. Resident #31 was lying on his bed in his room. At 3:11 p.m. Resident #31 got up to go shut off the wander guard alarm by the smoker's patio. He sat down in the living room and watched the television that was turned on with no sound or subtitles on. At 3:15 p.m. the activity assistants were walking around inviting residents to pray the rosary activity. -No staff members invited Resident #31 to the rosary activity. At 3:37 p.m. the rosary activity was going on in English in the chapel. At 3:50 p.m. Resident #31 walked back into his room from the living room to use the bathroom and lie down in his bed. On 8/6/25 during a continuous observation, beginning at 8:50 a.m. and ending at 10:08 a.m., the following was observed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:50 a.m. Resident #31 was walking around in his room. He then went to lie down on his bed. At 9:00 a.m. the activity assistants were walking around inviting residents to a coffee social in the dining room. -No staff members went into Resident #31's room to invite him to the coffee social. At 9:15 a.m. the coffee social was going on in the dining room. At 10:00 a.m. a church service was going on in the chapel. -No staff members went into Resident #31's room to invite him to the church service. D. Record review The 2/20/25 activity assessment revealed that Resident #31 preferred to participate in indoor, outdoor, group, independent and one-on-one activities. It documented that Resident #31 preferred action television and movies, listening to Mexican music, being around pets, doing things with groups of people, participating in his favorite activities, going outside when the weather was good and participating in religious activities. The activities care plan, revised 9/13/24, revealed that Resident #31 enjoyed both group and independent activities such as exercises for his abdominal muscles and walking, sports such as soccer, music such as Norteña (type of Mexican music), spiritual services for Catholics, movies such as action movies, being outdoors for fresh air, table games such as cards, blackjack poker and bingo, some arts and crafts on occasion, pets such as dogs, surfing the internet online, parties and social events and spending time with his family. Interventions included inviting Resident #31 to outings, reminding and escorting him to and from groups of interest, inviting and reminding him to go to spiritual services for Catholics and offering him independent material of interest. -The care plan failed to reveal documentation that the resident spoke primarily Spanish and preferred activities in Spanish. E. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 8/7/25 at 12:30 p.m. CNA #4 said Resident #31 was independent with most things. She said he mostly watched television in his room or in the living room by himself. She said the only group activity she saw him participate in consistently was bingo. She said he primarily spoke Spanish. She said he knew a little English. She said to communicate, he understood most things she would say in English or she could get a staff member who spoke Spanish. She said there was always a staff member working who spoke Spanish. The AD was interviewed on 8/7/25 at 12:40 p.m. The AD said the facility was trialing passing out a daily list of activities each morning to residents in their preferred language (starting the week of the survey). She said they were getting good feedback from the residents they tried it with, so they were going to continue it. She said residents got monthly activity calendars with each activity listed in their preferred language. -However, observations and resident interview revealed Resident #31's calendar was printed in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	English (see resident interview and observations above). The AD said Resident #31 was friends with other Spanish speaking residents and they sat by each other at group activities. She said they did not currently offer activities in languages other than English. The director of nursing (DON) was interviewed on 8/7/25 at 2:26 p.m. The DON said every resident should have an activity calendar printed in their preferred language and get personal invitations to activities they preferred. She said each resident should get a daily chronicle in the language of their preference and they should be offered books/magazines in their language of preference. She said the facility currently did not offer activities in languages other than English. She said if a resident spoke a language other than the language staff spoke, the expectation would be to utilize a translator service or another staff member who spoke that language.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries from occurring or worsening for one (#38) of three residents reviewed for pressure injuries out of 43 sample residents.Specifically, the facility failed to ensure staff consistently provided care planned interventions to Resident #38, who was admitted to the facility with a stage 4 pressure injury to his sacrum (a triangular bone at the base of the spine that is formed by the fusing of the sacral vertebrae).Findings include:I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved on 8/11/25 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk).Category/Stage 2: Partial Thickness Skin LossPartial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.Category/Stage 3: Full Thickness Skin LossFull thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.Category/Stage 4: Full Thickness Tissue LossFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpableUnstageable: Depth UnknownFull thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover' and should not be removed.Suspected Deep Tissue Injury: Depth UnknownPurple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.II. Facility policy and procedureThe Pressure Injury policy and procedure, revised 2/29/24, was received from the nursing home administrator (NHA) on 8/4/25 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:05 a.m. It read in pertinent part, Protect skin against the effects of pressure, friction, and shear by reducing pressure over bony prominences by offloading and positioning, and develop turning and repositioning plans for residents in bed or in their chair. Provide dressings and treatments as ordered by the physician and per the plan of care.III. Resident #38A. Resident statusResident #38, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (chronic autoimmune disease that affects the central nervous system), stage 4 pressure ulcer to the sacral region, paraplegia (paralysis of the legs and lower body) and muscle weakness.The 7/15/25 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. The resident was dependent on staff for most activities of daily living (ADL). The assessment documented the resident was dependent on staff for rolling left and right in bed.The assessment indicated the resident was at risk of developing pressure ulcers. The assessment indicated the resident had a stage 4 pressure ulcer present on admission. The assessment indicated the resident was not on a turning or repositioning program. The assessment documented the resident had a pressure-reducing device for his bed.B. Resident interview and observationsResident #38 was interviewed on 8/4/25 at 10:55 a.m. Resident #38 said he had a wound on his bottom. Resident #38 said the facility staff cleaned his wound and changed the dressing every day. Resident #38 said the wound was a little bit painful. Resident #38 said he always laid on his back and the staff did not try to help him roll over.During the interview, Resident #38 was lying on his back on an air mattress. The air mattress was set to the 600 pound (lb)to 1000 lb weight setting on a 30-minute alternating pressure cycle.During a continuous observation on 8/5/25, beginning at 11:08 a.m. and ending at 3:58 p.m., the following was observed:At 11:08 a.m. Resident #38 was lying on his back in bed. Resident #38's mattress was set to the 600 lb to 1000 lb weight setting.At 11:29 a.m. certified nurse aide (CNA) #4 knocked on Resident #38's door and entered his room. CNA #4 asked Resident #38 what he wanted to drink with his lunch and prepared a glass of juice for the resident. CNA #4 set the juice glass on Resident #38's tray table and gave him his bed remote before leaving to continue passing out drinks.At 11:31 a.m. CNA #5 delivered Resident #38's lunch tray and set it up for the resident on his tray table. Resident #38 adjusted his bed so he was sitting at a higher angle, and CNA #5 left the room to continue passing lunch trays.At 11:56 a.m. Resident #38 activated his call light. CNA #5 answered the call light, asked what Resident #38 needed and began cutting the entree on the resident's plate into smaller pieces. CNA #5 left the room promptly after he finished cutting the food.At 12:00 p.m. registered nurse (RN) #4 entered Resident #38's room with a nutritional supplement bottle, opened the bottle and left the bottle on Resident #38's tray table. RN #4 left the room shortly thereafter.At 12:10 p.m. CNA #3 asked Resident #38 if he was finished with his lunch tray. CNA #3 collected Resident #38's lunch tray and left the room.-CNA #3 did not offer to reposition the resident.At 12:15 p.m. Resident #38 activated his call light. CNA #3 and RN #4 entered the room together. Resident #38 requested he be shifted over in his bed and RN #4 left the room. CNA #3 donned a pair of gloves and pulled Resident #38's sheets to the left to pull his body over to the left side of the bed.-However, Resident #38 continued to lie flat on his back and CNA #3 did not encourage the resident to reposition off of his back.At 12:31 p.m. Resident #38 activated his call light. CNA #3 entered the room and asked Resident #38 what he needed. Resident #38 requested for his tablet to be plugged in. CNA #3 plugged the tablet in and asked Resident #38 if he needed anything else before leaving the room. At 12:41 p.m. Resident #38 activated his call light. CNA #5 entered Resident #38's room and the resident told him his wound vacuum was beeping. CNA #3, who was in the hallway outside the resident's room, told CNA #5 the nurse on shift was going to turn off the wound vacuum because it kept malfunctioning.At 12:47 p.m. RN #4 performed hand hygiene, donned a pair of gloves and entered Resident #38's room. RN #4 turned off Resident #38's wound vacuum and left the room. At 12:57 p.m. RN #4 entered Resident #38's room with wound dressing supplies and said she was going to remove the resident's negative pressure dressing. RN #4 left the room to don a gown and gloves and then re-entered the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. RN #4 removed Resident #38's negative pressure dressing and placed a wet-to-dry dressing on an abdominal (wound dressing) pad. RN #4 helped Resident #38 turn back over in bed and laid him flat on his back before leaving the room.-RN #4 did not adjust Resident #38's air mattress settings to the physician ordered and care planned setting of less than 250 pounds (see record review below) before or after providing wound care to the resident. Resident #38's air mattress remained set to the 600 lb to 1000 lb weight setting.At 1:29 p.m. Resident #38 activated his call light and CNA #3 entered the room. Resident #38 requested he be pulled toward the head of his bed. CNA #3 donned gloves and pulled Resident #38 up closer to the head of his bed by pulling his sheets. -However, Resident #38 remained lying flat on his back and CNA #3 did not encourage the resident to reposition off of his back At 1:33 p.m. Resident #38 activated his call light. An unidentified staff member entered Resident #38's room and placed a pillow under his head before promptly leaving.At 1:55 p.m. RN #1 entered Resident #38's room, and the resident requested she help him shift in bed. RN #1 pulled Resident #38 over slightly in bed. -However, Resident #38 was still lying flat on his back and RN #1 did not encourage the resident to reposition off of his back At 2:01 p.m. Resident #38 activated his call light and RN #4 entered the room. RN #4 donned a gown and gloves and briefly entered Resident #38's room to adjust the resident's colostomy bag. RN #4 left the room shortly thereafter and Resident #38 continued lying flat on his back in bed.At 2:24 p.m. the director of rehabilitation (DOR) entered Resident #38's room and began working on breathing exercises with the resident. At 2:40 p.m. the DOR left Resident #38's room. Resident #38 was still lying flat on his back.At 3:58 p.m. Resident #38 was lying flat on his back in bed asleep. Resident #38's air mattress was still set to the 600 lb to 1000 lb weight setting.-Resident #38 was not repositioned, or encouraged to reposition, off of his back and the setting for his air mattress was on the 600 lb to 1000 lb setting for the entirety of the four hour and 50 minute continuous observation.On 8/6/25 at 8:10 a.m. Resident #38 was lying on his back in his bed. Resident #38's air mattress was set to the 600 lb to 1000 lb weight setting.At 10:38 a.m. CNA #7 entered Resident #38's room to clean his wound vacuum and left shortly afterward. Resident #38 continued to lie on his back in bed.At 10:51 a.m. RN #1 entered Resident #38's room and asked him what he needed. RN #1 spoke with Resident #38 briefly before exiting his room. At 11:05 a.m. an unidentified wound care physician was in the hallway speaking with one of the facility's staff members. The unidentified wound care physician asked the staff member if Resident #38 was still refusing to be repositioned. The staff member's answer was not audible.At 11:12 a.m. the unidentified wound care physician exited Resident #38's room. The unidentified wound care physician said Resident #38's wound looked a little bit better.At 11:42 a.m. an unidentified staff member donned a gown and gloves and entered Resident #38's room to ask the resident what he wanted to drink for lunch. The staff member asked Resident #38 if he was comfortable, and the resident said he was. Resident #38 was lying flat on his back.On 8/7/25 at 8:54 a.m. Resident #38 was lying on his back in bed. Resident #38's air mattress was set to the 600 lb to 1000 lb weight setting.At 9:56 a.m. the assistant director of nursing (ADON) entered Resident #38's room. The ADON asked Resident #38 if he was in any pain and the resident said he was. The ADON asked Resident #38 if he wanted any pain medications before she looked at his wound but the resident declined to take anythingResident #38 was turned to his side by an unidentified nursing staff member. The ADON said there was a wound vacuum to Resident #38's coccyx and black foam covered Resident #38 from his coccyx to his hip. The wound vacuum was set to 125 millimeters of mercury (mmHg).-However, Resident #38's air mattress was set to the 600 lb to 1000 lb weight setting, which was not the physician ordered and care planned setting for the mattress (see record review below).C. Record reviewThe skin integrity care plan, revised 7/24/25, revealed Resident #38 admitted to the facility with a stage 4 sacral pressure injury and was at increased risk for alteration in skin integrity due to decreased mobility. Pertinent interventions included using an air mattress set to 250 pounds (lbs) firmness, following facility protocols for the treatment of Resident #38's pressure injury and using caution during transfers and bed mobility.Review of Resident #38's August 2025 CPO revealed the following (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's orders:Alternating pressure mattress to bed, set at less than 250 lbs firmness. Check the mattress each shift for proper setting and function. May adjust for resident comfort, ordered 7/11/25.Encourage resident to turn and reposition as tolerated every shift for wound care, ordered 7/17/25.Review of the July 2025 treatment administration record (TAR), from 7/9/25 through 7/30/25, revealed the physician's orders to encourage Resident #38 to turn and reposition and to monitor the resident's air mattress for setting and function were documented as completed each day, as ordered. There were no documented refusals from Resident #38 for repositioning or turning.Review of Resident #38's August 2025 TAR, from 8/1/25 through 8/7/25, revealed the physician's orders to encourage Resident #38 to turn and reposition and to monitor the resident's air mattress for setting and function were documented as completed each day, as ordered. There were no documented refusals from Resident #38 for repositioning or turning.A wound progress note, dated 7/17/25 at 12:41 p.m., revealed Resident #38's sacral wound had been evaluated by the wound care physician (WCP). Interventions in place included an air mattress which was functioning properly, a side bar to the right side for independent mobility in bed, nutritional supplements and wound debridement. Updates included following up with a plastic surgeon for a procedure to close the wound. A wound progress note, dated 7/23/25 at 7:21 p.m., revealed Resident #38's sacral wound had been evaluated by the WCP and had improved. Interventions in place included an air mattress which was functioning properly, a side bar to the right side for independent mobility in bed, nutritional supplements and wound debridement. Updates included following up with a plastic surgeon for a procedure to close the wound and discontinuing the negative pressure dressing (wound vac) due to the wound size getting too small.A wound progress note, dated 7/30/25 at 6:55 p.m., revealed Resident #38's sacral wound had been evaluated by the WCP and had worsened. Interventions in place included an air mattress which was functioning properly, a side bar to the right side for independent mobility in bed, nutritional supplements and wound debridement. The note documented Resident #38 did not like to turn and reposition.A wound progress note, dated 8/7/25 at 11:57 a.m., revealed Resident #38's sacral wound had been evaluated by the WCP and had improved. Interventions in place included an air mattress which was functioning properly, a side bar to the right side for independent mobility in bed, nutritional supplements and wound debridement. Updates included following up with a plastic surgeon for a procedure to close the wound. The WCP visit note, dated 7/16/25, revealed Resident #38's sacral wound was a stage 4 pressure ulcer. The wound measured 4.6 centimeters (cm) in length, 3.4 cm in width and 0.3 cm in depth. Tunneling of the wound (a wound that extends into the surrounding tissue, forming a channel or tract beneath the skin's surface) was noted at the 12:00 position with a maximum distance of 0.5 cm. The wound bed was 90% granulation (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) and 10% slough (a type of tissue that is not actively healing and can delay the wound healing process and typically appears as yellow or white, soft, and moist material in the wound bed). The periwound skin (the area of skin immediately surrounding a wound, typically extending about 1.5 inches from the wound's edge) exhibited maceration (refers to the softening and breakdown of skin due to prolonged exposure to moisture). Orders included cleansing the wound with wound cleanser and applying a negative pressure dressing (wound vacuum). Additional orders included turning and repositioning Resident #38 frequently while he was in bed or in his chair and shifting his weight frequently, placing the resident on an air mattress and checking for mattress function each shift.-However, observations revealed staff did not reposition, or encourage Resident #38 to reposition off of his back, for nearly five hours on 8/5/25 (see observations above).The WCP visit note, dated 7/23/25, revealed Resident #38's sacral wound was a stage 4 pressure ulcer. The wound measured 3.5 cm in length, 2.4 cm in width and 0.3 cm in depth and had improved. The wound bed was 90% granulation and 10% slough. The periwound skin was normal. Orders included cleansing the wound with wound cleanser, applying a periwound skin protectant, applying a silver alginate dressing with barrier cream followed by bordered foam every day. Additional orders included turning and repositioning Resident #38 frequently while he (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in bed or in his chair and shifting his weight frequently, placing the resident on an air mattress and checking for mattress function each shift.-However, observations revealed staff did not reposition, or encourage Resident #38 to reposition off of his back, for nearly five hours on 8/5/25 (see observations above).The WCP visit note, dated 7/30/25, revealed Resident #38's sacral wound was a stage 4 pressure ulcer. Nursing staff reported to the WCP that Resident #38 had refused to turn and reposition in bed despite encouragement from the wound care team and staff. The wound measured 4.4 cm in length, 2.5 cm in width and 0.4 cm in depth and had deteriorated. There was tunneling at the 7:00 position with a maximum distance of 1 cm. Bone was exposed. The wound bed was 80% granulation and 20% slough. The periwound skin exhibited maceration and erythema. Orders included cleansing the wound with wound cleanser and applying a negative pressure dressing. Additional orders included turning and repositioning Resident #38 frequently while he was in bed or in his chair and shifting his weight frequently, placing the resident on an air mattress and checking for mattress function each shift.-However, observations revealed staff did not reposition, or encourage Resident #38 to reposition off of his back, for nearly five hours on 8/5/25 (see observations above).The WCP visit note, dated 8/6/25, revealed Resident #38's sacral wound was a stage 4pressure ulcer. The wound measured 4.4 cm in length, 2.5 cm in width and 0.4 cm in depth and had improved. There was tunneling at the 12:00 position with a maximum distance of 0.5 cm. The wound bed was 70% granulation 20% slough and 10% epithelialization. The periwound skin exhibited erythema. Orders included cleansing the wound with wound cleanser and applying a negative pressure dressing. Additional orders included turning and repositioning Resident #38 frequently while he was in bed or in his chair and shifting his weight frequently, placing the resident on an air mattress and checking for mattress function each shift.-However, observations revealed staff did not reposition, or encourage Resident #38 to reposition off of his back, for nearly five hours on 8/5/25 (see observations above).Review of Resident #38's CNA bed mobility task records, from 7/9/25 through 8/7/25, revealed there were no refusals of bed mobility documented for Resident #38 during the time period. The records revealed Resident #38 was dependent on staff or required partial to substantial assistance with bed mobility almost every day during the time period.IV. Staff interviewsCNA #5 was interviewed on 8/7/25 at 9:13 a.m. CNA #5 said Resident #38 had a lot of needs he needed assistance with. CNA #5 said Resident #38 used his call light whenever he wanted his meal trays removed, his colostomy bag checked or his legs moved over in bed. CNA #5 said Resident #38 mostly listened to his music and kept to himself. CNA #5 said Resident #38's legs turned to the left, so the staff had to help him adjust his legs and put a pillow under his neck. CNA #5 said Resident #38 was not able to roll to the left or right by himself. CNA #5 said once the staff put Resident #38 into a certain position, he stayed that way. CNA #5 said Resident #38 was not on any repositioning or turning programs.The ADON was interviewed on 8/7/25 at 9:56 a.m. The ADON said Resident #38's air mattress was set to the 600 lb to 1000 lb weight setting because the mattress was changed to auto-firm when they were about to perform wound care. The ADON said the auto-firm setting on the air mattress automatically adjusted the weight setting to the 600 lb to 1000 lb, and the nursing staff had to manually change it back to the correct less than 250 lb setting when they were done.-However, observations revealed the mattress was left on the 600 lb to 1000 lb weight setting on multiple occasions when wound care was not being provided (see observations above).The ADON was interviewed a second time on 8/7/25 at 3:01 p.m. The ADON said Resident #38 had admitted to the facility with a stage 4 pressure ulcer to his coccyx. The ADON said Resident #38 did not have a wound vacuum when he first admitted to the facility, but the WCP ordered a wound vacuum after his first assessment of the wound. The ADON said the WCP had discontinued Resident #38's wound vacuum a few weeks prior because the resident's wound had gotten smaller. The ADON said the week prior (week of 7/27/25) Resident #38's wound had gotten a bit bigger so the wound vac was replaced. The ADON said Resident #38's wound looked a bit better the week of the survey (8/7/25). The ADON said the interventions in place for Resident #38 included having an air mattress and turning and repositioning the resident as tolerated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON said Resident #38 was noncompliant with repositioning and turning. The ADON said the facility staff had talked to Resident #38 about repositioning and told him if he wanted his wound to heal he needed to turn on his side.-However, record review did not reveal documentation that the resident refused to reposition (see record review above). The ADON said Resident #38 needed assistance from the staff to turn on his side, as he could not turn on his own but could shift his weight independently. The ADON said the nursing staff were expected to go into Resident #38's room and encourage him to reposition or turn. The ADON said the nursing staff offered repositioning/turning every time they went into his room.-However, repositioning was not offered, nor did staff encourage Resident #38 to reposition off of his back, during observations throughout the survey process (see observations above). The ADON said Resident #38's air mattress was supposed to be set to less than 250 lbs. The ADON said the air mattress was set to the 600 lb to 1000 lb weight setting whenever the nursing staff were doing wound care, but it required unlocking the mattress, setting it to that weight and then relocking the mattress. The ADON said it did not make sense that Resident #38's mattress would stay set at the 600 lb to 1000 lb weight setting.-However, during multiple observations on several occasions, Resident #38's mattress was set to the 600 lb to 1000 lb setting (see observations above).The DOR was interviewed on 8/7/25 at 10:54 a.m. The DOR said he had worked with Resident #38 for physical therapy. The DOR said Resident #38 was assessed by the therapy team on 7/17/25. The DOR said Resident #38 required minimal staff assistance for bed mobility during his assessment and was able to turn left and right in bed with minimal staff assistance. The DOR said Resident #38 had a grab bar in place in his room to help him roll over. The DOR said Resident #38 did about 75% of the work in rolling over and needed an additional 25% of work from the staff in order to roll over.RN #5 was interviewed on 8/7/25 at 12:33 p.m. RN #5 said Resident #38 had a wound on his sacrum and she had changed out his wound vac the day prior. RN #5 said Resident #38 sometimes used his call light to ask for help with repositioning. RN #5 said Resident #38 needed help from the staff to turn over. RN #5 said Resident #38 was repositioned whenever he used his call light and told the nursing staff how he wanted to be repositioned.-However, Resident #38 was supposed to be offered repositioning and turning throughout the day (see interviews below and record review above).The WCP was interviewed on 8/7/25 at 2:48 p.m. The WCP said Resident #38 initially had a wound vacuum, but his wound was too small for the wound vacuum so it was removed. The WCP said the following week Resident #38's wound had deteriorated, so the wound vacuum was put back in place. The WCP said Resident #38's wound had improved during the week of the survey process (8/7/25). The WCP said he had discussed offloading weight and nutrition for Resident #38, and he was in contact with a surgeon at a hospital regarding surgically closing the resident's wound. The WCP said he documented any resident care refusals in his notes. The WCP said Resident #38 had an air mattress in place. The WCP said the air mattress redistributed pressure over the body's pressure points, as hard pressure points pinched bony prominences. The WCP said the air mattress settings were based on weight and physician's orders for the weight settings were done by the facility.The nurse consultant was interviewed on 8/7/25 at 2:55 p.m. The nurse consultant said the WCP had the facility staff raise the pressure of the air mattress high before wound rounds so the resident did not sink into the mattress during his exam and so he could see the full extent of the wound. The nurse consultant said the nursing staff were supposed to decrease the air mattress settings back to what they were normally after completing their care.The director of nursing (DON) was interviewed on 8/7/25 at 3:31 p.m. The DON said Resident #38 had physician's orders in place for a wound vacuum for his sacral wound. The DON said Resident #38 had interventions including an air mattress, wound rounds with the WCP once per week, a grab bar on the wall to help with repositioning and nutritional supplements. The DON said Resident #38 was partially to substantially dependent on help from staff for bed mobility. The DON said Resident #38's air mattress was supposed to be set to less than 250 lbs normally, but the air mattress was set to auto firm or 600 lb to 1000 lbs for wound care. The DON said Resident #38's physician's orders and the care plan both specified his air mattress should be set to less than 250 lbs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	firmness. The DON said the nursing staff should offer Resident #38 repositioning and turning whenever they were in his room and talking with him. The DON said the nursing staff would ideally offer repositioning for Resident #38 every two hours, or at least between mealtimes and when providing other cares. The DON said the staff could document Resident #38's refusals to reposition in the TAR under the physician's order to offer and encourage repositioning.-However, review of Resident #38's TARs did not reveal any documented refusals for repositioning (see record review above).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents with indwelling catheters received the appropriate care and services according to professional standards for one (#12) of two residents reviewed for catheter care out of 43 sample residents.Specifically, the facility failed to ensure Resident #12's catheter tubing and catheter bag were positioned below the resident's bladder. Findings include:I. Facility policy and procedureThe Urinary Catheter Care policy, revised August 2022, was provided by the director of clinical risk management on 8/6/25 at 3:48 p.m. The policy revealed the purpose of this policy was to prevent urinary catheter-associated complications, including urinary tract infections. The staff were to check the resident frequently to be sure he or she was not lying on the catheter and to keep the catheter and tubing free of kinks. Staff were to position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. Staff were to notify the supervisor if the resident refused the procedure.II. Resident #2A. Resident statusResident #2, age less than 65, admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), the diagnoses included multiple sclerosis, anxiety, weakness, need for assistance with personal care and neuromuscular dysfunction of the bladder.The 5/29/25 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) of 13 out of 15. The resident required staff setup or clean up assistance for toileting. The assessment indicated the resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube) related to a neurogenic bladder. The resident had a urinary tract infection within the last 30-days.B. ObservationsOn 8/4/25 at 9:50 a.m. the resident was sitting in her wheelchair in her room. The resident had a catheter bag attached to the back part of her wheelchair. The catheter bag hung approximately at the location of the resident's mid back. The resident's catheter tubing was positioned on the resident's left thigh and was coiled in two loops. The tubing contained clear fluid with a yellow sediment.On 8/6/25 at 9:30 a.m. the resident was sitting in her wheelchair in her room. The resident had a catheter bag attached to the back part of her wheelchair. The catheter bag hung approximately at the location of the resident's mid back. The resident's catheter tubing was positioned on the resident's left thigh and was coiled in two loops. The tubing contained clear fluid.On 8/6/25 at 11:35 a.m. the resident was sitting in her wheelchair in her room. The resident had a catheter bag attached to the back part of her wheelchair. The catheter bag hung approximately at the location of the resident's mid back. The resident's catheter tubing was positioned on the resident's left thigh and was coiled in two loops. The tubing contained clear fluid.C. Record reviewReview of the August 2025 CPO revealed the following physician's orders:Suprapubic catheter: 16 French (is completely inert for less tissue irritation and encrustation during extended periods of indwelling use) 30 cubic-centimeters balloon for a neurogenic bladder, ordered 5/29/25. Staff were to monitor for placement and function every 24-hours as needed, ordered 5/29/25. Staff were to change the catheter for complication and prior to obtaining a urine sample, ordered 5/29/25. Each shift the staff were to provide catheter care. The staff could apply a drain sponge as needed and ensure the privacy bag was in place. Staff were to ensure the catheter was unobstructed, secured and draining appropriately, ordered 5/25/25. Every Sunday night shift the staff were to replace the graduated cylinder or urinal used for draining the catheter bag. Staff were to as needed change catheter tubing and bag prior to obtaining urine sample, ordered 5/25/25.The suprapubic catheter care plan, revised 12/20/24, revealed due to the resident's neurogenic bladder related to multiple sclerosis the resident required a catheter. The interventions included positioning the catheter bag and tubing below the level of the bladder, providing catheter care every shift to ensure the catheter was unobstructed, secured, and draining appropriately and checking the catheter tubing for kinks with cares and on each shift.III. Staff interviewsThe director of nursing (DON) was interviewed on 8/6/25 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 11:35 a.m. The DON observed Resident #2 sitting in her wheelchair in her room [ROOM NUMBER]. The DON said the resident's catheter bag was attached to the back of the resident's wheelchair at approximately mid back level of the resident. The DONsaid the resident's catheter tubing was coiled, rested on the resident's left leg lap area and contained clean fluid. The DON said the catheter bag and the catheter tubing should not be positioned above the resident's bladder.The infection preventionist (IP) was interviewed on 8/7/25 at 11:00 a.m. T The IP said Foley and suprapubic catheters should be positioned free of coils and kinks so the urine can flow into the drainage bag. The IP said catheter bags should be positioned below the bladder so the urine could flow and the catheter was not obstructed.The assistant director of nursing (ADON) was interviewed on 8/7/25 at 12:43 p.m. The ADON said the catheter bag and tubing should be positioned below the resident's bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one (#82) of three residents out of 43 sample residents.Specifically, the facility failed to:-Ensure an assessment was completed to identify potential trauma behaviors for Resident #82, who had a diagnosis of post-traumatic stress disorder (PTSD); and,-Develop a care plan for Resident #82's PTSD that included possible escalating triggers (stimuli that cause a person to experience intense emotional distress or for the person to react in ways that were reminiscent of past traumatic experiences) and appropriate interventions.Findings include:I. Facility policy and procedureThe Trauma-Informed and Culturally Competent Care policy, revised August 2022, was provided by the nursing home administrator (NHA) on 8/7/25 at 11:55 a.m. The policy revealed that it guided staff in providing care that was culturally competent and trauma-informed in accordance with professional standards of practice. The policy was to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trauma resulted from an event, series of events, or set of circumstances that was experienced by an individual as physically or emotionally harmful or life threatening and that had lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma-informed care was an approach to delivering care that involved understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognized the widespread impact, signs and symptoms of trauma in residents, and incorporated knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.Triggers were highly individualized. Some common triggers might include experiencing a lack of privacy or confinement in a crowded or small space; exposure to loud noises, or bright/flashing lights; certain sights, such as objects; and/or sounds, smells, and physical touch.The staff would perform universal screening of residents, which included a brief, non-specialized identification of possible exposure to traumatic events. Staff would utilize screening tools and methods that were facility-approved, competently delivered, culturally relevant and sensitive. Screening might include information such as a trauma history, including type, severity and duration; depression, trauma-related or dissociative symptoms; risk for safety (self or others); concerns with sleep or intrusive experiences; behavioral, interpersonal or developmental concerns; historical mental health diagnosis; substance use; protective factors and resources available; and physical health concerns.The assessment involved an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. The assessment utilized licensed and trained clinicians who had been designated by the facility to conduct trauma assessments. The staff would use assessment tools that were facility-approved and specific to the resident population.The staff would develop individualized care plans that addressed past trauma in collaboration with the resident and family, as appropriate. The staff would identify and decrease exposure to triggers that might re-traumatize the resident and recognize the relationship between past trauma and current health concerns (substance abuse, eating disorders, anxiety and depression). The staff would develop individualized care plans that incorporated language needs, culture, cultural preferences, norms and values. These values might include food preparation and choices; clothing preferences such as covering hair or exposed skin; physical contact or provision of care by a person of the opposite sex; and/or cultural etiquette, such as avoiding eye contact or not raising the voice.II. Resident #82A. Resident statusResident #82, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Parkinsonism, schizoaffective disorder bipolar type, depression, moderate intellectual disability and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PTSD.The 6/24/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. The assessment indicated the resident had no behaviors. The assessment indicated the resident had a diagnosis of PTSD.B. Record reviewA psychological follow up note, dated 7/2/25 at 8:15 a.m. and written by a nurse practitioner (NP), revealed Resident #82 continued to have severe cognitive deficits with behavioral disturbances secondary to dementia. The resident had diagnoses of dementia with behavioral disturbances, schizoaffective disorder and PTSD.-Review of Resident #82's electronic medical record (EMR) failed to reveal an assessment for trauma behaviors. -Review of Resident #82's EMR failed to reveal a care plan for the resident's diagnosis of PTSD which included identified triggers and appropriate interventions.III. Staff interviewsThe social worker quality mentor was interviewed on 8/7/25 at 11:31 a.m. The social worker quality mentor agreed Resident #82's 6/24/25 MDS assessment revealed the resident had a diagnosis of PTSD. The social worker quality mentor said she was unable to find the original trauma behavior assessment in the resident's EMR. She agreed the Resident Trauma Behavior assessment was completed on 8/6/25 at 9:10 a.m., during the survey. She said this assessment should have been completed in 2022 when the regulation for trauma informed care was initiated. The social worker quality mentor said the facility completed a care plan for Resident #82's PTSD on 8/6/25, during the survey. She said since the resident's MDS assessment had a diagnosis of PTSD, a care plan with triggers and interventions should have been developed prior to 8/6/25. The director of nursing (DON) was interviewed on 8/7/25 at 12:13 p.m. The DON agreed Resident #82's 6/24/25 MDS assessment revealed the resident had a diagnosis of PTSD. The DON said the PTSD diagnosis should have generated a care plan for PTSD. The DON said a care plan for PTSD was developed on 8/6/25, during the survey. She said trauma informed assessments should be completed within the first seven days after a resident was admitted to the facility.The assistant director of nursing (ADON) was interviewed on 8/7/25 at 12:43 p.m. The ADON said for a resident with a diagnosis of PTSD, such as Resident #82,, a trauma assessment should have been completed and a care plan developed. The ADON said the PTSD assessment and care plan should be developed within the first seven days after admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 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 observations, record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#42) of two residents reviewed for medications errors out of 42 sample residents.Specifically, the facility failed to ensure that Resident #42 was administered the correct dose of insulin by properly priming the insulin pen before insulin administration.Findings include: I. Facility policy and procedureThe Medication Administration policy and procedure, revised 8/4/25, was received from the nursing home administrator (NHA) on 8/7/25 at 3:25 p.m. It documented in pertinent part, Medication is to be given in compliance with the physician orders and/or the manufacturer's recommendations.II. Manufacturer's recommendationsThe Lantus Solostar (prefilled insulin pen) medication package insert (2022) was retrieved on 8/11/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sanofi.com/assets/countries/canada/docs/p It revealed in pertinent part, Solostar is a prefilled pen for the injection of insulin. Always use a new sterile needle for each injection. Wipe the rubber seal with alcohol. Remove the protective seal from a new needle. Line up the needle with the pen and keep it straight as you attach it (screw or push on, depending on the needle type). Always perform a safety test before each injection. This ensures that you get an accurate dose by ensuring the pen and needle work properly and removing air bubbles. You must always perform safety tests before you use the pen until you see insulin coming out of the needle tip. If you see insulin coming out of the needle tip, the pen is ready to use. If you do not see insulin coming out before taking your dose, you could get an underdose or no insulin at all. This could cause high blood sugar.III. Resident #42A. Resident status Resident #42, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (high blood sugar levels) with neuropathy (nerve damage).The 4/3/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status score (BIMS) score of 12 out of 15. The MDS assessment indicated the resident was on daily injection medication for diabetes. B. ObservationsOn 8/9/25 at 8:54 a.m. registered nurse (RN) #2 was preparing Resident #42's medications for administration. RN #2 prepared the medications and went to the refrigerator for a new Lantus insulin pen. She said she was going to administer the other medications to the resident and let the pen warm up to room temperature. She checked Resident 42's blood glucose level which was 155 milligrams (mg)/deciliter (dl). She administered Resident #42's Humalog insulin. Resident #42 was eating breakfast and started to speak in Spanish. RN #2 said she did not speak that language and went to find another staff member who could translate for her. While RN #2 was waiting for the other staff member to come translate, she prepared the Resident #42's Lantus insulin pen. She sanitized the rubber stopper, applied the needle and turned the dose meter dial to 24 units of insulin. She went back into Resident #42's room with another staff member who assisted with translation. RN #2 explained to Resident #42 that she was giving her the morning medications and insulin. RN #2 administered the resident's pills and then injected the Lantus insulin into Resident #42's lower abdomen. -RN #2 failed to prime the Lantus insulin pen prior to drawing up the 24 units of insulin. C. Record review A review of Resident #42's August 2025 CPO revealed the following physician's order: Insulin glargine solution 100 units/milliliter (ml), inject 24 units subcutaneously one time a day for diabetes with breakfast and inject 20 units subcutaneously at bedtime for non-insulin dependent diabetes mellitus (NIDDM), ordered 7/14/25.IV. Staff interviewsRN #2 was interviewed on 8/5/25 at 9:15 a.m. RN #2 said she primed Resident #42's Lantus insulin pen with two units of insulin before she put the needle on. The director of nursing (DON) was interviewed on 8/6/25 at 10:46 a.m. The DON said all insulin pens should be primed with two units of insulin, with the needle in place, prior to drawing up the insulin dose to administer to the resident. She said this was important to do so the resident got the full correct dose of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper storage of medications in two of four medication storage carts and one of two medication storage rooms. Specifically, the facility failed to: -Ensure medications were labeled with the date they were opened; and,-Ensure expired medications were removed and discarded from medication carts. Findings include: I. Professional ReferencePharMerica (1/12/25) Abridged List of Medications with Shortened Expirations Dates, was retrieved on 8/12/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://pharmerica.com/wp-content/uploads/2025/01/PI it revealed in pertinent part, Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's Package Insert (PI) under the ?How Supplied/Storage & Handling' section. A drug product's Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening (see BUD Notes below), whichever comes first. These In-Use medications should be labeled such that the ?date opened' is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration.Pharmcare USA (4/9/23) Medication Disposal Practices in Assisted Living and Long Term Care, was retrieved on 8/12/25 from https://pharmcareusa.com/education/medication-disposal-practices-in-assisted-living-ltc/#:~:text=As%20an%2 It revealed in pertinent part, When medications are not disposed of correctly, they can pose serious threats to bother human health and the environment. Improper disposal can lead to accidental ingestions, overdose and even death.II. Failure to ensure medications were labeled with the date they were openedA. Observations and staff interviews On 8/6/25 at 1:59 p.m., the South back medication cart was observed with licensed practical nurse (LPN) #1. The following items were found: -An open inhaler of Trelegy 200 micrograms (mcg)/62.5 mcg/25 mcg (long term maintenance inhaler for asthma and chronic obstructive pulmonary disease) was labeled with a resident's name and dosage information, but no open date. -An open inhaler of Trelegy 100 mcg/62.5 mcg/25 mcg was labeled with a resident's name, but no open date. -An open inhaler of Spiriva (medication to relax the muscles in the airway) 2.5 mcg was labeled with a resident's name, but no open date. -An open inhaler of Airsupra (medication for asthma) 90 mcg/90 mcg was labeled with a resident's name, but no open date.-An open inhaler of Albuterol (medication to relax the muscles in the airway) 90 mcg was labeled with a resident's name, but no open date.LPN #1 said she was not aware that the inhaler medications should have been labeled with an open date. On 8/6/25 at 3:15 p.m., the North front medication cart was observed with LPN #2. The following items were found:-An open inhaler of Albuterol 90 mcg was labeled with a resident's name, but no open date.-An open bottle of Dorzolamide-timolol 2%/0.5% (eye drop) was labeled with a resident's name, but no open date.-An open bottle of Polymyxin B sulfate and trimethoprim (eye drop) was labeled with a resident's name, but no open date.-An open bottle of Timolol malate 0.25% (eye drop) was labeled with a resident's name, but no open date.-An open bottle of Simbrinza 1%-0.2% (eye drop) was labeled with a resident's name, but no open date.LPN #2 said he did not know the inhalers or the prescription eye drops should have been labeled with an open date.IV. Failure to ensure expired medications were removed and discarded from medication cartsA. Observations and staff interviews On 8/6/25 at 1:59 p.m., the South back medication cart was observed with LPN #1. The following items were found: -An open bottle Biofreeze (pain relief) gel 4% was labeled with a resident's name and had an expiration date verified with LPN #1 of 7/20/25. -A partially used medication card containing duloxetine (antidepressant) was labeled with a resident's name and had an expiration date verified with LPN #1 of 3/29/25. LPN #1 said they no longer used (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that medication for that resident. She said expired medication should be discarded. On 8/6/25 at 3:15 p.m., the North front medication cart was observed with LPN #2. The following was observed: -An open bottle of Biofreeze gel 4% was labeled with a resident name and had an expiration date verified with LPN #2 of July 2025. -An open bottle of ferrous sulfate (iron pills) 325 milligrams (mg) had no expiration date verified with LPN #2 on the bottle. -A partially used medication card containing hydralazine (blood pressure medication) 25mg was labeled with a resident's name and had an expiration date verified with LPN #2 of 6/29/25. -An open bottle of guaifenesin (mucous relief medication) 600 mg had an expiration date verified with LPN #2 of April 2025. -An open bottle of calcium 600 mg had an expiration date verified with LPN #2 of March 2025. -A partially used medication card containing furosemide 40 mg labeled with a resident name had an expiration date verified with LPN #2 of 8/2/25. LPN #2 said it was not best practice to keep expired medications in the medication carts. He said night shift nurses audit the medication carts and storage rooms. III. Additional staff interviews The director of nursing (DON) was interviewed on 8/7/25 at 2:26 p.m. She said she was not sure of the previous DON's process for auditing medication carts and storage rooms. She said the new process going forward would be for the nurse managers to audit the carts and rooms on a weekly basis and for the DON to audit them on a monthly basis. She said it was important to dispose of expired medications to decrease the possibility of medication errors and for the availability of space in the medication cart and storage rooms. She said eye drops should be labeled with an open date because they were generally good for 30 days. She said inhalers should be labeled with an open date. She said she was not aware about the specific time frames each inhaler was good for after the open date (see professional references above).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for one (#14) of two residents reviewed for hospice services out of 43 sample residents.Specifically, the facility failed to ensure the hospice agency notes regarding Resident #14's care were easily accessible to the facility staff in an attempt to effectively coordinate care with the hospice agency.Findings include:I. Facility policy and procedureThe Hospice Care policy and procedure, revised 2/29/24, was received from the nursing home administrator (NHA) on 8/7/25 at 3:25 p.m. It read in pertinent part, When a facility resident elects to have hospice care, the facility staff communicates with the hospice agency to establish and agree upon a coordinated plan of care that is based upon an assessment of the resident's needs and living situation in the facility. Hospice communication will be reviewed and added to the medical record.II. Facility-Hospice contractThe contract between the facility and the hospice services company, dated 5/27/25, was found in Resident #14's electronic medical record (EMR). It read in pertinent part, The hospice and nursing facility shall each prepare and maintain complete and detailed clinical records concerning each residential hospice patient receiving services. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each hospice patient. The nursing facility and the hospice shall promptly document in the resident's records the services rendered.III. Resident #14A. Resident statusResident #14, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included pulmonary embolism (a blood clot in the lungs), malignant neoplasm of the esophagus (cancer in the throat), symptoms and signs involving cognitive functions and awareness, depression, bipolar disorder and adult failure to thrive.The 5/28/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The resident was independent for most activities of daily living (ADL). The assessment documented the resident was receiving hospice care. B. ObservationsDuring a continuous observation on 8/5/25 from 1:19 p.m. to 3:58 p.m., the following was observed:At 2:50 p.m. an unidentified member of the therapy team entered Resident #14's room to see if his roommate was there before promptly leaving the room.At 2:58 p.m. RN #4 briefly entered Resident #14's room, checked in with him, and left the room.At 2:59 p.m. an unidentified member of the therapy team entered Resident #14's room with his roommate.At 3:03 p.m. unidentified member of the therapy team left Resident #14's room and continued working on therapy skills with his roommate in the hallway.At 3:48 p.m. Resident #14 was lying on his side and wearing an incontinence brief. At 3:55 p.m. an unidentified hospice staff member entered Resident #14's room, closed the door, then left the room one minute later.C. Record reviewThe August 2025 CPO revealed a physician's order for Resident #14 indicating he was receiving hospice care, ordered 5/23/25.The hospice care plan, revised 5/28/25, revealed Resident #14 was receiving additional support through hospice care. Pertinent interventions included the hospice nurse visiting one to two times per week, the hospice CNA visiting twice weekly to assist with showers, grooming and hygiene, the hospice chaplain and social worker to visit monthly and as needed, and adjusting the provision of ADLs to compensate for Resident #14's changing abilities.Resident #14's hospice binder was provided by an unidentified nursing staff member on 8/6/25 at 10:25 a.m. The hospice binder revealed two hospice nurse visits, dated 5/23/25 and 5/24/25. Review of the hospice CNA documents in the binder revealed the hospice CNAs were scheduled to visit twice a week on Tuesday and Thursday afternoons. There were documented CNA visits on 6/17/25, 6/19/25, 7/10/25, 7/15/25, 7/17/25, 7/24/25, 7/29/25, 7/31/25 and 8/5/25. -The 8/5/25 CNA visit documented the hospice CNA visited Resident #14 from 1:55 p.m. to 2:15 p.m. -However no staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members were observed entering Resident #14's room during that time (see observations above).A progress note, dated 5/23/25 at 5:43 p.m., revealed hospice staff were at the facility to evaluate Resident #14.A progress note, dated 6/10/25 at 1:06 p.m., revealed Resident #14 refused all of his medications. The hospice provider was notified.A progress note, dated 6/16/25 at 1:35 p.m., revealed Resident #14 refused all of his medications. The hospice provider was notified.A progress note, dated 6/19/25 at 9:05 a.m., revealed Resident #14 refused all of his medications. The hospice provider was notified.A progress note, dated 6/24/25 at 8:47 p.m., revealed Resident #14 refused all of his medications. The hospice provider was notified.A progress note, dated 6/27/25 at 9:47 a.m., revealed Resident #14 was receiving hospice care and refused to work with staff at times.A progress note, dated 7/7/25 at 10:54 p.m., revealed Resident #14 refused all of his medications. The hospice provider was notified.A progress note, dated 7/14/25 at 4:12 p.m., revealed a CNA called the nurse to evaluate Resident #14's bottom. The nurse noted Resident #14 had hemorrhoids. The hospice nurse was notified when she was in the building that day and said she would fax over a new order to the facility.A progress note, dated 7/18/25 at 10:03 p.m., revealed Resident #14 refused all of his meals and fluids. The hospice nurse was notified.A progress note, dated 7/18/25 at 10:14 p.m., revealed Resident #14 refused all of his meals and fluids. The hospice nurse was notified.A progress note, dated 7/25/25 at 4:58 p.m., revealed Resident #14 had bruised areas on his bilateral forearms. Resident #14 said they were caused by him sleeping with his arm under his bed. Resident #14 was offered another pillow and declined it. The hospice nurse was notified.A progress note, dated 7/28/25 at 1:49 p.m., revealed Resident #14 refused all of his medications. The hospice nurse was notified.-Review of Resident #14's EMR failed to reveal any documentation from the hospice provider regarding hospice services and/or hospice visits provided to the resident IV. Staff interviewsCNA #5 was interviewed on 8/7/25 at 9:13 a.m. CNA #5 said a staff member from the hospice services team came to check in on Resident #14 sometimes. CNA #5 said the facility staff let the hospice staff member know how Resident #14 had been.CNA #4 was interviewed on 8/7/25 at 9:44 a.m. CNA #4 said Resident #14 was on hospice, so the facility CNAs were there just to make sure the resident was clean and fed. CNA #4 said the hospice staff came in to talk with him and sometimes offered him a shower. CNA #4 said the hospice staff members came in every day. CNA #4 said the hospice staff checked in with the nurse to tell them what they did for Resident #14 and what he still needed, and the nurse then told the facility CNAs what they still needed to do for him.-However, there were only documented hospice CNA visits for Resident #14 on 6/17/25, 6/19/25, 7/10/25, 7/15/25, 7/17/25, 7/24/25, 7/29/25, 7/31/25 and 8/5/25 (see record review above). Registered nurse (RN) #5 was interviewed on 8/7/25 at 12:33 p.m. RN #5 said Resident #14 was receiving hospice care. RN #5 said hospice visits were usually documented in a hospice binder.The director of nursing (DON) was interviewed on 8/7/25 at 3:31 p.m. The DON said Resident #14 was receiving hospice services. The DON said the hospice CNAs visited the facility multiple times per week and the hospice nurses visited one to two times per week. The DON said Resident #14's care plan specified the hospice CNAs would visit twice per week. The DON said the hospice nurses checked in with her or the assistant director of nursing (ADON) before they left the facility. The DON said she did not know if there was anyone at the facility that monitored and saw how often the hospice staff members visited the facility. The DON reviewed Resident #14's hospice binder and said there were missing hospice visits for the resident. The DON said she would call the hospice provider and get Resident #14's records.The NHA was interviewed on 8/7/25 at 4:15 p.m. The NHA said he or the DON oversaw the hospice visits for the residents. The NHA said a hospice caseworker had recently checked in with the facility staff. The NHA said he was not aware of any missing hospice CNA or nurse documentation for Resident #14.V. Facility follow-upAdditional hospice documents were provided by the NHA via email on 8/10/25 at 11:47 a.m. The documents revealed Resident #14 had been visited by a hospice nurse at least twice per week from 5/23/25 through 8/7/25. The hospice documents additionally documented that a CNA had visited Resident #14 on 6/17/25, 6/19/25, 6/24/25, 7/10/25, 7/15/25, 7/17/25, 7/22/25, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/24/25, 7/29/25, 7/31/25 and 8/5/25.-However, the hospice documents were obtained from the hospice provider during the survey process and were not readily available to nursing staff during the survey. -Additionally, there were no documented hospice CNA visits on 6/26/25, 7/1/25, 7/3/25, 7/8/25 and 7/10/25 provided in the additional information sent by the NHA.