

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 S Potomac St Aurora, CO 80012	
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 and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases on two out of three units. Specifically, the facility failed to: -Ensure resident rooms were cleaned in a sanitary manner; -Implement a water management plan; and, -Ensure vital sign machines were disinfected between residents. Findings include: I. The facility failed to ensure proper disinfectant practices were followed during housekeeping. A. Professional reference The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, revised 3/19/24w, as retrieved on 6/29/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html . It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. B. Facility policy and procedure The Housekeeping Services policy, undated, was received from the nursing home administrator (NHA) on 6/25/26 at 5:29 p.m. It read in pertinent part, To effectively monitor infections within the facility by gathering data and assessing possible trends; to assist in minimizing the spread of infection within the facility. Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior environment are provided. Sufficient housekeeping personnel and equipment is provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. C. Observations On 6/24/26 at 9:57 a.m. housekeeper (HK) #1 was cleaning room [ROOM NUMBER], a single occupancy room. At 10:05 a.m. HK #1 wiped the inside of the sink that was in the bedroom, then wiped the faucet and handles, and then the counter top. At 10:10 a.m. HK #1 wiped the inside of the bathroom sink bowl, then wiped the faucet and handles and then the counter top. -HK #1 failed to clean from the cleanest to dirtiest areas of the sink. On 6/24/26 at 11:09 a.m. HK #2 was cleaning an unidentified single occupancy room. At 11:13 a.m. HK #2 wiped the inside of the bathroom sink with a rag, then wiped the counter top and the bathroom railing/grab bar with the same rag. -HK #2 failed to clean from the cleanest to dirtiest areas of the sink. D. Staff interviews HK #1 was interviewed on 6/24/25 at 10:21 a.m. H K#1 said the inside of the sink may be dirty because residents brushed their teeth in the sink bowl or residents may wash their hands in there, which could contain stool or urine. HK #1 said once she wiped the inside of the sink bowl she should use a different rag. HK #2 was interviewed on 6/24/26 at 2:00 p.m. HK #2 said the inside of the sink had more bacteria than the outside of the sink. HK #2 said she may have cleaned the sink in the incorrect manner. HK #2 said she was supposed to change her rag after cleaning the inside of the sink so that she did not contaminate the outside of the sink with her dirty rag. The housekeeping director was interviewed on 6/25/26 at 11:36 a.m. The housekeeping director said when cleaning a sink, housekeepers should clean from clean to dirty. The housekeeping director said it would not be appropriate for housekeepers to wipe the inside of the sink and then use the same rag (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to wipe the sink handles, counter top, or bars after already wiping the inside of the sink. The housekeeping director said the facility would provide education to the housekeepers to ensure they were cleaning properly, as he wanted to ensure germs were not getting spread around.II. The facility failed to implement a water management [NAME]. Professional referenceThe Centers for Disease Control and Prevention (CDC) Overview of Water Management Programs, revised 3/15/24, was retrieved on 6/29/26 from https://www.cdc.gov/control-legionella/php/wmp/index.html. It read in pertinent part, Developing and maintaining a water management program is a multi-step process that requires continuous review. The seven steps of a Legionella water management program are to:-Establish a water management program team;-Describe the building water systems;-Identify areas where Legionella could grow and spread;-Decide where to apply and how to monitor control measures;-Establish interventions when control limits are not met;-Ensure the program runs as designed and is effective; and,-Document and communicate all the activitiesThe Centers for Disease Control and Prevention (CDC) Monitoring Building Water, revised 3/15/24, was retrieved on 6/29/26 from https://www.cdc.gov/control-legionella/php/guidance/monitor-water-guidance.html. It read in pertinent part, It's important to monitor the temperature, disinfectant residuals, and pH of building water, and identify areas where water moves slowly. Promptly addressing any identified issues can help reduce the risk of Legionella growth and spread within a building's water system. Legionella grows best between 77 degrees Fahrenheit (F) to 113 degrees F (25 degrees Celsius to 45 degrees Celsius). There's potential for Legionella growth in the absence of other Legionella controls under either of the following conditions: Cold water temperatures rise above 77 degrees F (25 degrees Celsius). Warm water temperatures fall below 120 degrees F (49 degrees Celsius). Measure disinfectant residual. Maintaining a disinfectant residual throughout a system can help prevent Legionella growth. Action: Measure the disinfectant residual to confirm its presence. Measure pH. Certain disinfectants work best within an optimal pH range. Identify areas where water moves slowly. Slowly moving or stagnant water increases water age, which provides opportunities for Legionella growth. Increased water age also contributes to disinfectant residual loss and water temperatures favorable for Legionella. Action: Look for faucets or fixtures that aren't used regularly and flush them to maintain water flow.B. Facility policy and procedureThe Legionnaire's Disease Legionella policy and procedure, undated, was received from the NHA on 6/25/26 at 5:29 p.m. It read in pertinent part, Legionnaires' disease is not transmitted person to person; therefore, residents with Legionnaires' disease can be cared for using standard precautions.-However, the Legionnaire's Disease / Legionella policy and procedure did not provide guidance on Legionnaire's preventative measures specifically related to a water management program.C. Record review The facility's water management plan was requested on 6/24/26 at 2:00 p.m. The maintenance director said the facility did not have a current water management plan (see interviews below).D. Staff interviewsThe maintenance director was interviewed on 6/24/26 at 2:00 p.m. The maintenance director said the facility had undergone a change in maintenance directors. The maintenance director said the previous maintenance director had a binder which contained a water management plan and supplies/ordering information. The maintenance director said the information was not passed on before the previous manager left the facility. The maintenance director said the facility did not currently have a physical log or binder which contained legionella tracking and testing information. The maintenance director said the facility was currently out of legionella testing supplies. The maintenance director said the facility had not tested the building's water for legionella for a couple of months because the facility needed supplies. The maintenance director said the facility planned to order additional supplies immediately.III. The facility failed to ensure vital sign machines were disinfected between residentsA. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Professional referenceThe Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised 4/12/24 was retrieved on 6/29/26 from https://www.cdc.gov/infection-control/hcp/core-practices/index.html. It read in pertinent part, Clean and reprocess (disinfect or sterilize) reusable medical equipment (blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes, surgical instruments, endoscopes) prior to use on another patient or when soiled.B. Facility policy and procedureThe Infection Control Surveillance and Reporting policy and procedure, undated, was received from the nursing home administrator (NHA) on 6/25/26 at 5:29 p.m. It read in pertinent part, Routine Surveillance will be conducted via walking rounds, observation and evaluation of patient care techniques, and review of patient records. Routine Surveillance will be conducted via walking rounds, observation and evaluation of patient care techniques, and review of patient records. The IP will evaluate all Healthcare Associated and Community Acquired infections for appropriate interventions such as isolation precautions and other patient care practices to reduce the spread of infectious organisms and maintain a safe and healthy environment for patients, employees and visitors.C. ObservationsOn 6/22/26 at 2:06 p.m. an unidentified certified nursing aide (CNA) left a resident's room with a vitals machine and entered room [ROOM NUMBER]. At 2:06 p.m. the same CNA left room [ROOM NUMBER] with the vitals machine, left to retrieve a pulse oximeter from the nurses station, and entered room [ROOM NUMBER]. The CNA did not have wipes or spray present on the vitals cart. No hand hygiene was performed between rooms. On 6/23/26 at 3:18 p.m. in hallway number three, an unidentified CNA went from one resident's room to another resident's room with the vital signs cart machine. The unidentified CNA did not clean the vital signs machine between taking the resident's vital signs. On 6/24/26 at 2:36 p.m. an unidentified CNA was taking resident's vital signs. The unidentified CNA used the blood pressure cuff on a resident in room [ROOM NUMBER] and then took the vitals cart into room [ROOM NUMBER] and took the resident's vital signs. The unidentified CNA did not clean the blood pressure cuff or vital signs machine in between resident uses.D. Staff interviewsThe infection preventionist was interviewed on 6/25/26 at 12:43 p.m. The infection preventionist said the CNAs should be cleaning vital sign equipment between residents for sanitary purposes.The director of nursing (DON) was interviewed on 6/25/26 at 12:43 p.m. The DON said CNAs should be cleaning vital signs equipment when using after each resident as a best practice.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure residents were provided services that meet professional standards for three (#42, #63 and #50) of six residents out of 39 sample residents. Specifically, the facility failed to: -Hold Resident #42's antihypertensive medication per physician's order; -Hold laxative medications for Resident #50 and Resident #63 per physician's orders; and, -Administer Resident #50's Eliquis (an anticoagulant medication) and duloxetine (an antidepressant medication) per physician's order. Findings include: I. Facility policy and procedure The Administration of Medications policy and procedure, undated, was received from the nursing home administrator (NHA) on 6/25/26 at 5:29 p.m. It read in pertinent part, Verify the six medication administration rights: 1. Right patient 2. Right drug 3. Right dose 4. Right dosage form 5. Right route 6. Right time Ensure ancillary tasks such as blood pressure or apical pulse are performed with appropriate medications. If a medication is unavailable, contact the pharmacy and request the medication stat (immediately). If unable to obtain the medication during the administration time, contact the provider for further orders. II. Resident #42 A. Resident status Resident #42, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure, acute kidney failure, chronic obstructive pulmonary disease, congestive heart failure and atrial fibrillation. According to the 5/18/26 minimum data (MDS) assessment, the resident was cognitively intact with (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a brief interview for mental status (BIMS) score of 15 out of 15. B. Record review The cardiac care plan, revised 4/28/26, revealed Resident #42 had a diagnosis of hypertension. Pertinent interventions included administering medications per Resident #42's physician's orders and notifying the physician as needed. Review of Resident #42's May 2026 and June 2026 CPO, from 5/1/26 through 6/25/26, revealed the following physician's orders: -Hold hypertension medications for systolic blood pressure (SBP) less than 100 milligrams of mercury (mmHg) or diastolic blood pressure (DBP) less than 50 mmHg, ordered 5/5/26; -Nebivolol 5 milligram (mg) tablets, give 5 mg by mouth once a day for hypertension, ordered 5/5/26 and discontinued 5/28/26; -Nebivolol 5 mg tablets, give 2.5 mg by mouth once a day for hypertension, ordered 5/28/26 and discontinued 6/8/26; and, -Nebivolol 5 mg tablets, give 2.5 mg by mouth once a day for hypertension and atrial fibrillation, ordered 6/8/26. Review of Resident #42's May 2026 medication administration record (MAR), from 5/5/26 through 5/31/26, revealed the following: -Resident #42's SBP was measured and documented to be less than 100 mmHg on 5/24/26 and 5/31/26, and her nebivolol was documented as administered. Review of Resident #42's June 2026 MAR, from 6/1/26 through 6/23/26, revealed the following: -Resident #42's SBP was measured and documented to be less than 100 mmHg on 6/7/26, 6/13/26 and 6/14/26, and her nebivolol was documented as administered. -Review of Resident #42's electronic medical record (EMR) did not reveal any documentation indicating the resident's physician was notified regarding the resident's blood pressure being low during any of the above administrations. C. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 6/24/26 at 3:48 p.m. LPN #2 said before administering an antihypertensive medication, she checked the resident's vital signs and assessed their condition to ensure they were feeling stable and not dizzy. LPN #2 said she would check the CPO to see what parameters the physician had ordered to see if she needed to hold the medication. LPN #2 said there were usually orders to hold antihypertensive medications if the resident's SBP was (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	below 100 mmHg or if their DBP was below 40 mmHg. LPN #2 said she would alert the resident's physician if their blood pressure was low to see if she could administer the medication later if the resident's blood pressure returned to a normal threshold. LPN #2 said if a resident's blood pressure was low and there was no hold order she would still hold the medication and alert the resident's physician. LPN #2 said she would need to hold the antihypertensive medication if a resident's blood pressure was low because the medication would make the resident's blood pressure even lower. Registered nurse (RN) #2 was interviewed on 6/25/26 at 2:27 p.m. RN #2 said for residents on antihypertensive medications, the certified nurse aides (CNA) checked their vital sign measurements, including blood pressure, prior to administration. RN #2 said if a resident's blood pressure was low they would encourage fluids and monitor the resident. RN #2 said Resident #42 was on nebivolol, a medication used to treat high blood pressure. RN #2 said she held Resident #42's nebivolol that morning (6/25/26) because her blood pressure was too low. RN #2 said she had to contact the resident's physician if she withheld a medication, and said there were orders to hold the nebivolol if Resident #42's blood pressure dropped below a certain threshold. RN #2 said she would hold the nebivolol if Resident #42's blood pressure was low because the medication would drop her blood pressure even lower. The director of nursing (DON) and the nurse manager were interviewed together on 6/25/26 at 3:25 p.m. The DON said nursing staff should follow the physician's orders for antihypertensive medications when administering them. The nurse manager said the facility used standing hold orders for most residents in which the medication would be held if their SBP was lower than 100 mmHg or their DBP was lower than 50 mmHg. The nurse manager reviewed Resident #42's June 2026 CPO and said there were no specific hold orders for her nebivolol order. The DON said the nursing staff would then defer to the standing hold parameters of 100/50 mmHg. The nurse manager and DON said the nursing staff should have consulted with Resident #42's physician if they were unsure if they should hold the nebivolol. The DON said the nursing staff may have verbally consulted with Resident #42's physician or medical providers but said the nursing staff should have documented that discussion in Resident #42's EMR. The DON said antihypertensives should be held when a resident's blood pressure was low to prevent their blood pressure from dropping lower. The nurse practitioner (NP) was interviewed on 6/25/26 at 4:27 p.m. The NP said antihypertensive medications should be administered per physician's orders, and said the facility used standing orders for the nursing staff to know when to hold the medications. The NP said if a resident's blood pressure was low, the nursing staff should communicate with one of the resident's medical providers, as sometimes if a medication was also being used to treat arrhythmias the provider may approve administering the medication despite a low blood pressure. The NP said he did not think the nursing staff would need to document that communication. The NP said nursing staff should reach out to the resident's physician if they were unclear with any of the resident's medication orders. III. Resident #63 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #63, age [AGE], was admitted on [DATE] and discharged to another facility on 6/25/26. According to the June 2026 CPO, diagnoses included displaced fracture of left femur, hypertensive chronic kidney disease, type 2 diabetes and vascular dementia with anxiety. According to the 6/22/26 BIMS assessment, the resident had severe cognitive impairments with a BIMS score of six out of 15. B. Resident representative interview Resident #63's representative was interviewed on 6/25/26 at 10:11 a.m. The resident's representative said Resident #63 had been having diarrhea since Saturday (6/20/26) and had been receiving a laxative medication since then as well. The resident's representative said she entered the facility on Monday (6/22/26) and found Resident #63 sitting in bed in an incontinence brief which was soiled with diarrhea, and said the resident appeared dehydrated at the time. The resident's representative said she brought this issue to the attention of the NHA and said the nursing staff had increased her hydration over the last few days, but said she was concerned about the resident receiving a laxative while having diarrhea. C. Record review The incontinence care plan, initiated during a prior stay on 11/17/25, revealed Resident #50 had episodes of urinary and bowel incontinence. Pertinent interventions included notifying the physician if signs or symptoms occurred and providing peri-care after each incontinence episode. Review of Resident #63's June 2026 CPO revealed the following order: -Senna laxative 8.6 mg tablets, give two tablets by mouth once a day for constipation prevention, hold for loose stools, ordered 6/18/26. Review of Resident #63's bowel movement records from 6/18/26 through 6/25/26 revealed the following: -Resident #63 was documented to have had a loose or liquid bowel movement on 6/20/26, 6/21/26, 6/22/26 and 6/23/26. -Resident #63 additionally had bowel movements documented on 6/21/26 and 6/23/26 with no description of their consistency noted. Review of Resident #63's June 2026 MAR, from 6/18/26 through 6/25/26, revealed the Senna laxative order was marked as administered each day from 6/19/26 through 6/25/26. -Resident #63 received Senna from 6/20/26 through 6/23/26 despite having noted loose or liquid stools during that time. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 6/23/26 at 9:11 a.m., revealed Resident #63 was seen by her physician's assistant (PA). The progress note documented the PA discussed Resident #63's plan and progress with the nursing staff and therapy team. Resident #63 endorsed some mild constipation and did not have any complaints of diarrhea. The PA documented Resident #63's constipation was discussed with the internal medicine team and Senna was continued. -However, Resident #63 was experiencing loose and liquid bowel movements at the time. -Review of Resident #63's EMR did not reveal any documentation indicating the resident's physician was contacted regarding or informed of her loose stools. IV. Resident #50 A. Resident status Resident #50, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included chronic pancreatitis, generalized muscle weakness, polyneuropathy and anemia. According to the 6/11/26 BIMS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. B. Resident interview Resident #50 was interviewed on 6/22/26 at 10:39 a.m. Resident #50 said she had been having terrible diarrhea for the last four days. Resident #50 said she had not been given anything by the nursing staff that seemed to improve her diarrhea. Resident #50 was interviewed a second time on 6/24/26 at 1:37 p.m. Resident #50 said the facility had started working to address her diarrhea. Resident #50 said her stools had otherwise been normal in color, just loose. C. Record review A bowel care plan, revised 6/16/26, revealed Resident #50 had episodes of bowel incontinence. Pertinent interventions included notifying the physician if signs or symptoms occurred and providing peri-care after each incontinence episode. Review of Resident #50's June 2026 CPO revealed the following orders: -Senna laxative 8.6 mg tablets, give two tablets by mouth once a day for constipation prevention, hold for loose stools, ordered 6/8/26; -Lactobacillus acidophilus oral capsule, give one capsule once a day for gastrointestinal support, ordered 6/8/26; (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #2 was interviewed on 6/25/26 at 2:52 p.m. CNA #2 said if a resident had two or three loose bowel movements she would report it to the nurse. CNA #2 said her nurse told her Resident #50 had loose stools earlier that morning, and said she had not heard any report of Resident #63 having loose stools. CNA #3 was interviewed on 6/25/26 at 2:56 p.m. CNA #3 said Resident #50 told her she was having loose stools the day prior (6/24/26), but said she was not working with her that day so she was not sure if her stools were actually loose or not. CNA #3 said if a resident was having multiple bouts of diarrhea, maybe four to five bouts, she would tell the nurse about it. CNA #3 said she would otherwise just check on the resident more frequently. The DON and the nurse manager were interviewed together on 6/25/26 at 3:25 p.m. The DON said CNAs would report loose stools to the nurse, and the nurse would follow up to see if the resident had chronic loose stools. The DON said laxative medications would need to be held for any loose stools, and said this was usually noted in the physician's order. The DON said Resident #50 had chronic pancreatitis and constipation. The nurse manager reviewed Resident #50's record and said she had not received Senna on 6/17/26 through 6/19/26 and 6/23/26 through 6/24/26 due to the resident refusing the medication. The DON said Resident #50's Senna order read to hold the order for loose stools and said the nursing staff should not have offered it to Resident #50 while she was having loose stools. The DON said Resident #63's representative complained she was having diarrhea and said Resident #63 was getting Senna at night. The nurse manager said Resident #63 had documented loose bowel movements on 6/20/26, 6/21/26 and 6/23/26. The nurse manager said Resident #63's Senna order said to hold the medication for loose stools. The DON said Resident #63 would have needed her Senna held due to her loose stools. The DON said laxative medications needed to be held when residents were having diarrhea due to the risk of dehydration. The DON said she saw a note from Resident #63's physician from 6/22/26 in which the resident endorsed constipation and noted per the hospital to continue administering Senna. The DON said the note documented the physician discussed Resident #63's case and progress with the nursing staff. The NP was interviewed on 6/25/26 at 4:27 p.m. The NP said he was aware of Resident #63 having loose stools. The NP said the facility had been monitoring the resident for dehydration to ensure she was not getting dehydrated. The NP said Resident #63 was receiving Senna and said the laxative should have been held if she was having loose stools. The NP said if a resident experiencing loose stools received a laxative medication the nursing staff would need to monitor them for any dehydration or medication side effects. -However, review of Resident #63's EMR did not reveal any documentation indicating the NP had been (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 S Potomac St Aurora, CO 80012	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified of the resident's loose stools or any monitoring for signs or symptoms of dehydration. V. Resident #50 A. Resident status Resident #50, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included atrial fibrillation, generalized muscle weakness, polyneuropathy, chronic pancreatitis and anemia. According to the 6/11/26 BIMS assessment, the resident was cognitively intact with a score of 15 out of 15. B. Record review Review of Resident #50's June 2026 CPO revealed the following physician orders: On 6/25/26 at 9:15 a.m. RN #2 was preparing and administering medications for Resident #50. Resident #50 had the following medications ordered: -Eliquis (apixaban) 2.5 mg tablet, give 2.5 mg twice a day for clot prophylaxis, ordered on 6/8/26. -Duloxetine 30 mg capsule, give 30 mg once a day for neuropathy, ordered 6/8/26. C. Observations and staff interview On 6/25/25 at 9:15 a.m. RN #2 was preparing medications for Resident #50. RN #2 was unable to find the duloxetine or Eliquis for Resident #50. -Resident #50 did not receive these medications during the medication pass. D. Additional staff interviews RN #2 was interviewed on 6/25/26 at 9:20 a.m. RN #2 said she would let the physician assistant (PA) know that the medications were not available during rounds which occurred around 9:00 a.m. to 10:00 a.m. RN #2 said she would request the medications from the pharmacy. RN #2 was interviewed on 6/25/26 at 3:34 p.m. RN #2 said the pharmacy had not delivered the medications yet. RN #2 said the last refill was on 6/8/26. RN #2 said the nurses requested medication refills electronically and also faxed the pharmacy to get medications refilled. The pharmacist was interviewed on 6/25/26 at 4:08 p.m. The pharmacist said Eliquis was an anticoagulant that prevented blood clots from forming. The pharmacist said Eliquis was often used for people who had atrial fibrillation. The pharmacist said that taking all doses was important. The pharmacist said there was a small risk of forming a clot if the dose was missed by a few hours. The (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacist said duloxetine had a long half life so the drug stays in the system for a long time. The pharmacist said if duloxetine was late for a few hours, it should not affect the resident a lot. The pharmacist said the facility had to request new or additional medications from the pharmacy. The pharmacist said the facility normally requested a refill request via fax, phone call, or electronically. The pharmacist said once the pharmacy received the request, they delivered the medication within one business day, The pharmacist said they provided three deliveries per day to the facility. The pharmacist said the last time the medications were requested and delivered was on 6/8/26. The pharmacist said the medications were also requested that morning on 6/25/26 and the medications were in route to be delivered to the facility. The DON was interviewed on 6/25/26 at 5:09 p.m. The DON said that the three medications were not delivered by pharmacy yet. The DON said that eliquis was a blood thinner and it helped prevent blood clots from forming. The DON said duloxetine was used for pain or depression. The DON said that Resident #50's duloxetine was ordered for peripheral neuropathy. The DON said that nurses should reorder medications. The DON said the nurses should have requested the medications 72 hours prior to running out of supply, so that the facility did not run out of medication and so the resident did not go without medications. The DON said that Eliquis and duloxetine were not present in the emergency medication supply kit, but that the facility was working to increase the medications available in the kit. The DON said if nurses did not have medications present in the medication cart, they should check their resources and emergency supplies. The DON said that nurses should notify the provider that they did not have the medication available and also let the family know. The DON said nurses should let her know if they did not have medications available to give residents so she could reach out to the pharmacy.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, the facility failed to prevent medication administration errors. Specifically, the facility had a medication error rate of 8.1%, which was three errors out of 37 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2021), E. [NAME], St. Louis Missouri, pp. 605-606. A medication error is any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/or failing to administer a medication. II. Facility policy and procedure The Medication Error policy, revised May 2026, was received from the nursing home administrator (NHA) on 6/25/26 at 5:29 p.m. It read in pertinent part, Medication errors are to be minimized by following the six rights of medication administration. The director of nursing will track and report the facility's medication error rate to the Quality Assurance Committee at least quarterly. B. Record review Review of Resident #50's June 2026 CPO revealed the following physician orders: On 6/25/26 at 9:15 a.m. registered nurse (RN) #2 was preparing and administering medications for Resident #50. Resident #50 had the following medications ordered: -Eliquis (Apixaban) (blood thinner) 2.5 milligram (mg) tablet, give 2.5 mg twice a day for clot prophylaxis, ordered on 6/8/26. -Duloxetine (antidepressant medication) 30 mg capsule, give 30 mg once a day for neuropathy, ordered 6/8/26. -Aspirin (an antiplatelet medication that works to inhibit platelet aggregation) 81 mg tablet, give 81 mg once a day for clot prophylaxis, ordered on 6/8/26. C. Observations / interview On 6/25/25 at 9:15 a.m. RN #2 was preparing medications for Resident #50. RN #2 was unable to find the duloxetine, eliquis, and aspirin for Resident #50. -Resident #50 did not receive these medications during the medication pass. Cross reference F760: failure to prevent a significant medication error. D. Staff interviews RN #2 was interviewed on 6/25/26 at 9:20 a.m. RN #2 said she would let the physician assistant (PA) know that all three drugs were not available during rounds which occurred around 9:00 a.m to 10:00 a.m. RN #2 said she requested the medications from the pharmacy. RN #2 was interviewed on 6/25/26 at 3:34 p.m. RN #2 said the pharmacy had not delivered the medications yet. RN #2 said the last refill was on 6/8/26. RN #2 said nurses requested medication refills electronically and also faxed the pharmacy to get medications refilled. The pharmacist was interviewed on 6/25/26 at 4:08 p.m. The pharmacist said eliquis was an anticoagulant that prevented blood clots. The pharmacist said that taking all doses was important. The pharmacist said that duloxetine was a SNRI (serotonin and norepinephrine reuptake inhibitor, a medication used to treat major depressive disorder, anxiety, and chronic nerve pain) and was used for depression or nerve pain. The pharmacist said duloxetine had a long half life so the drug stays in the system for a long time and that being late for a few hours should not affect the resident a lot. The pharmacist said aspirin was an antiplatelet that helped people prevent a clot from being formed. The pharmacist said the pharmacy was alerted about new medication requests or refills through the facility. The pharmacist said the facility normally requested a refill request via fax, phone call, or electronically. The pharmacist said once the pharmacy received the medication request they delivered the medication within one business day. The pharmacist said they provided three deliveries per day to the facility. The pharmacist said the last time the medications were requested and delivered was on 6/8/26. The pharmacist said the medications were also requested that morning on 6/25/26 and the medications were in route to be delivered to the facility. The director of nursing (DON) was interviewed on 6/25/26 at 5:09 p.m. The DON said that the three medications were not delivered by (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy yet. The DON said that eliquis was a blood thinner and it helped prevent blood clots from forming. The DON said that aspirin was used as a prophylactic medication that could have helped prevent strokes and pain. The DON said duloxetine was used for pain or depression. The DON said that Resident #50's duloxetine was ordered for neuropathy. The DON said that nurses should reorder medications. The DON said the nurses should have requested the medications 72 hours prior to running out of supply so that the facility did not run out of medication and so the resident did not go without medications. The DON said that eliquis and duloxetine were not present in the pyxis but that the facility was working to increase the medications available in the pyxis. The DON said if nurses did not have medications present in the medication cart, they should check their resources and emergency supplies. The DON said that nurses should notify the provider that they did not have the medication available and also let the family know. The DON said nurses should let her know if they did not have medications available to give residents so she could reach out to the pharmacy.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#58 and #70) of four residents reviewed received food and fluids prepared in a form designed to meet his or her needs out of 39 sample residents. Specifically, the facility failed to:-Ensure Resident #58 was served a mechanically altered diet per physician's orders; and,-Ensure Resident #70 received nothing by mouth (NPO) per physician's orders. Findings include:I. Professional referenceThe International Dysphagia (difficulty swallowing) Diet Standardization Initiative (IDDSI) (atool to standardize mechanically altered diets and liquids) (January 2019), retrieved on 6/29/26from https://iddsi.org/Resources/Patient-Handouts read in pertinent part, Soft and bite sized foods: soft, tender and moist, but with no thin liquid leaking/dripping from the food. Ability to bite off a piece of food is not required. Ability to chew bite-sized pieces so that they are safe to swallow is required. Bite sized pieces are no bigger than 1.5 centimeters (cm) by 1.5 cm in size. Food can be mashed/broken down with pressure from a fork. A knife is not required to cut this food. Level 6 - Soft and bite-sized food may be used if you are not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow. Soft & bite-sized foods need a moderate amount of chewing, for the tongue to 'collect' the food into a ball and bring it to the back of the mouth for swallowing. The pieces are 'bite-sized' to reduce choking risk. If you notice the food pieces are not being chewed well though, please contact your clinician to make sure you are on the correct food texture to reduce choking risk. Soft & Bite-Sized foods are eaten using a fork, spoon or chopsticks. Avoid foods with skins or an outer shell, including peas. No regular dry bread due to high choking risk.II. Facility policy and procedureThe Texture and Consistency - Modified Diets policy and procedure, undated, was received from the nursing home administrator (NHA) on 6/25/26 at 5:29 p.m. It read in pertinent part, Texture and consistency-modified diets will be individualized with modifications made by the speech language pathologist (SLP) and physician in conjunction with the registered dietitian (RD) or designee and nutrition services director. The food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency as ordered.III. Resident #58A. Resident statusResident #58, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included metabolic encephalopathy (brain dysfunction), Parkinson's disease and convulsions.The 6/2/26 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 required supervision or touching assistance with eating.The assessment indicated the resident did not have signs and symptoms of a swallowing disorder and required a mechanically altered diet.B. Resident representative interviewResident #58's representative was interviewed on 6/24/26 at 9:07 a.m. The resident's representative said Resident #58 had been getting speech therapy as he had problems with chewing and swallowing. The resident's representative said the facility had to cut up Resident #58's food for him, but said they had not done that for a while. The resident's representative said Resident #58 had difficulty eating peas and rice due to his dexterity. The resident's representative said she had not heard from anyone at the facility about liberalizing Resident #58's diet, but said he usually got a regular plate which looked like everyone else's in the dining room.C. ObservationsOn 6/23/26 at 11:59 a.m., during the lunch meal service, Resident #58 was served a regular texture meal including a roll, a slice of cake, whole fettucini noodles with strips of chicken approximately two inches long and peas. Resident #58's meal (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 S Potomac St Aurora, CO 80012	
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ticket was observed and revealed the resident had a regular diet, regular texture. Resident #58 ate alone at his table without consistent, meaningful supervision from staff. On 6/23/26 at 5:32 p.m., during the dinner meal service, Resident #58 was served a regular diet meal including a key lime bar, roasted vegetables cut into one-inch pieces, breaded fried fish cut into one inch pieces, and potato wedges cut into 3/4 inch-sized pieces. Resident #58's meal ticket was observed and revealed the resident had a regular diet, regular texture. Resident #58 ate alone at his table without consistent, meaningful supervision from staff. However, Resident #58's diet order was Level 6, soft and bite sized on 6/23/26 (see physician's order below). D. Record review The nutrition care plan, initiated 6/22/26, revealed Resident #58 was at risk for alteration in nutritional status due to recovering from an acute illness, poor endurance and fatigue. Pertinent interventions included assessing oral and feeding status and arranging therapy as needed, and providing diet as ordered. Review of Resident #58's June 2026 CPO revealed the following orders: Fortified regular diet, soft and bite sized texture (Level 6), thin liquids. Cut up all meats due to bilateral upper extremity weakness; deli/breakfast meat, fish, breads, hamburger patties okay whole per SLP, ordered 6/4/26; May have regular texture diet per patient request, ordered 6/23/26 at 5:52 p.m. (during the survey); and, Fortified regular diet, regular texture, thin liquids. Cut up chicken breast, pork chops, ham and steak per SLP, ordered 6/24/26 (during the survey). The speech therapy note, dated 5/26/26, revealed Resident #58 was assessed by the facility SLP. Resident #58's diagnoses included dysarthria (a motor-speech disorder) and oropharyngeal phase dysphagia. Resident #58 admitted to the hospital on [DATE] following an episode of reduced responsiveness at home. Resident #58 was seen by the SLP in the hospital and was referred for speech therapy in the facility for speech and dysphagia management. Clinical impressions on assessment revealed Resident #58 had moderate oropharyngeal dysphagia characterized by difficulty with solids in oral phase and liquids in the pharyngeal phase. The SLP recommended mechanical soft diet textures with close supervision while eating. However, observations revealed the resident did not receive a mechanical soft diet texture or meaningful supervision while eating (see observations above). A nutritional assessment, dated 5/26/26, revealed Resident #58 was assessed by the dietary manager (DM). The assessment indicated Resident #58 knew what diet the physician had ordered and did not want his diet liberalized or changed. The assessment indicated Resident #58 was ordered to have a fortified regular diet, regular texture. However, the facility SLP had recommended a mechanically altered diet texture per her evaluation notes on 5/26/26. A progress note, dated 6/17/26 at 1:49 p.m., revealed Resident #58 was reviewed for a nutritional follow-up by the dietitian. Resident #58 was receiving a fortified regular diet with a soft and bite-sized texture. A progress note, dated 6/23/26 at 9:25 a.m. (during the survey), revealed Resident #58 was assessed by his physician's assistant (PA). The PA's assessment notes revealed Resident #58 was reviewed and found to have concerns for dysphagia or slow swallow transit and was referred to the SLP. A written statement from the SLP, dated 6/24/26 (during the survey), revealed Resident #58 was admitted on [DATE] when his diet textures were modified by the SLP as appropriate for the resident in agreement with the resident himself. Resident #58 was compliant with his diet textures as ordered. There was no need, thus, for a refusal of treatment form to be signed. However, Resident #58's modified texture diet order was changed to a regular texture per his or his representative's request (see interviews below). E. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 6/23/26 at approximately 11:59 a.m. CNA #4 said Resident #58 was on a regular diet texture with cut up meats. CNA #1 was interviewed on 6/23/26 at 1:28 p.m. CNA #1 said CNAs were responsible for passing out meal trays. CNA #1 said she did not look at the diet texture information on the meal ticket because she trusted the dietary staff to do that, and said she set up (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's meal for them. CNA #1 said if she noticed a resident was served the wrong diet texture she would bring the meal ticket with her and talk to the kitchen about it. CNA #1 said if she saw a meal with the wrong diet texture she would leave the meal tray in the room with the resident while she spoke with the kitchen. CNA #5 was interviewed on 6/23/26 at 1:35 p.m. CNA #5 said whenever a new resident entered with an altered diet texture she received training on what to look for with their diet texture. CNA #5 said CNAs were responsible for passing out meal trays, and said she checked the resident's food texture to ensure it matched their diet order before serving it. CNA #5 said if she saw a resident was served the wrong diet texture she would take it back to the kitchen and take the tray with her while doing so. Cook #1 was interviewed on 6/23/26 at 1:55 p.m. [NAME] #1 said he had received training on the different diet textures on hire and annually. [NAME] #1 said food items for a soft and bite-sized diet needed to be smaller than the end of a fork and easy to mash. [NAME] #1 said the meal service process involved the cook serving the meal and the dietary aide at the kitchen window checked the meal to ensure what was served matched the resident's diet texture. Registered nurse (RN) #2 was interviewed on 6/23/26 at 2:27 p.m. RN #2 said Resident #58 was on a soft and bite-sized diet texture. RN #2 said Resident #58 had Parkinson's disease and dysphagia, and had been working with speech therapy. RN #2 said a resident on a soft and bite-sized diet could not have whole length pasta noodles. The dietary manager (DM) was interviewed on 6/23/26 at 2:53 p.m. The DM said meal ticket information was entered into their system and meal tickets were printed for the next day at the end of the night prior. The DM said he updated residents' diet textures as needed. The DM said he provided monthly trainings for the dietary staff members which covered different subjects, and said he had covered the different diet textures recently. The DM said whole spaghetti, linguini or fettuccini noodles would not be appropriate for a soft and bite-sized diet and would need to be chopped up. The DM said Resident #58 was on a soft and bite-sized diet with cut up meats, and could not have whole pasta noodles. The DM said their process for meal service was having the cook plate the meal, the dietary aide plate the dessert and check the diet texture, and the CNAs in the kitchen window and delivering the room trays were their final check. The director of nursing (DON) was interviewed on 6/23/26 at 5:39 p.m. The DON said Resident #58's diet may have been liberalized by the SLP or RD and the order was not put into his electronic medical record (EMR). The DON said the most updated diet order she saw in Resident #58's EMR was for a soft and bite-sized diet texture with whole breakfast patties and fish. The DON entered the dining room where Resident #58 was eating dinner (see observations above) and said the key lime bar and vegetables were definitely for a regular textured diet. The DON was interviewed a second time on 6/23/26 at 6:16 p.m. The DON said the SLP and Resident #58's physician had been in communication with Resident #58's representative regarding his diet texture and she or Resident #58 had requested a regular diet. The DON said she did not know if any diet waivers had been signed. -However, Resident #58's representative said no one from the facility had reached out to her regarding Resident #58's diet texture (see interview above). The SLP was interviewed on 6/24/26 at 8:40 a.m. The SLP said a soft and bite-sized diet texture was characterized by being a cut up diet which was not dry or crumbly. The SLP said Resident #58's representative said he had a lot of swallowing problems and had choked at home. The SLP said Resident #58 was on a soft and bite-sized diet at the time with a lot of exceptions, including whole fish and hamburger patties. The SLP said Resident #58 still had a soft and bite-sized diet as of the last time she worked with him in speech therapy four days prior. The SLP said the residents' medical providers could make changes to residents' diet orders without consulting her but it was almost unheard of. The SLP said she had not been working with Resident #58 to advance his diet texture to regular. The SLP said Resident #58 did have a diagnosis of dysphagia and said that (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis should be listed in his EMR. The RD was interviewed on 6/24/26 at 10:16 a.m. The RD said when a new resident was admitted, the admission nurse had a diet communication sheet with diet orders at the top, which was then given to the DM or the kitchen staff. The RD said the DM would enter the resident's diet information into their meal ticket software and update it as needed. The RD said she told the kitchen staff to refer to the IDDSI extension sheets to see what was and what was not allowed for each diet texture. The RD said soft and bite-sized diets should be soft foods cut to the size of the end of a fork. The RD said long pasta noodles would not be acceptable for a soft and bite-sized diet. The RD said Resident #58 had orders for a soft and bite-sized diet but had been working with the SLP so there were more items allowed back into his diet. The RD said if Resident #58 refused a soft and bite-sized diet and it was unsafe for him to have a regular diet he would need a diet texture waiver, but said she would want the SLP to evaluate him again before doing so. The RD said she usually provided education to the resident and their representative prior to doing a diet texture waiver as well. The DON and the nurse manager were interviewed together on 6/24/26 at 2:00 p.m. The DON said Resident #58 would say he did not have any chewing or swallowing problems. The DON said she was not sure if he was just eating too fast and the SLP was concerned he was going to choke so she downgraded his diet texture. The DON said she thought Resident #58's diet never should have been downgraded from regular texture. The DON said she did not think Resident #58 had any diagnoses or issues with dysphagia, and said the SLP said he may have had some issues with aspiration in the past. The DON and the nurse manager said they had spoken with the SLP about making her diet orders more clear, which was why Resident #58's diet order had been changed the day prior (6/23/26). The nurse manager said she had provided the SLP with education, since her diet order recommendations needed to be all or nothing. The nurse manager said the SLP recommended a regular diet for Resident #58 if he was sitting with his friends, and said he was otherwise cleared to have some breads and uncut meats. -However, Resident #58's physician ordered diet was a Level 6 soft and bite sized diet and specified the resident could have certain meats or bread whole. The order did not specify any modifications that could be made depending on the level of supervision Resident #58 had any company with him at the dining table (see record review above). The DON and the nurse manager said the CNAs in the kitchen window and the CNAs passing out room trays were the third and fourth checkers to ensure residents received the correct texture diet, and said the CNAs should check the meals prior to serving to ensure they were correct. The DON and the nurse manager said the nursing staff should not leave a meal tray in the room with the resident if they needed to clarify which diet texture the resident should have received. IV. Resident #70A. Resident status Resident #70, age [AGE], was admitted on [DATE] and discharged to the hospital on 6/21/26. According to the June 2026 computerized physician orders (CPO), diagnoses included encephalopathy, intracerebral hemorrhage (a type of stroke caused by a ruptured blood vessel within the brain), pneumonitis due to inhalation of food or vomit and dysphagia. An admission assessment, dated 6/19/26, revealed the resident was disoriented and usually able to make himself understood and understand others. The assessment documented the resident had a percutaneous endoscopic gastrostomy (PEG) tube (feeding tube) in place. B. Record review Hospital discharge notes, dated 6/19/26, revealed Resident #70 had a PEG tube placed on 6/16/26 for enteral feeding given persistent oropharyngeal dysphagia. Resident #70 was NPO per the hospital SLP but was okay to have limited ice chips with supervision and oral care provided afterwards. Resident #70's bed was to be kept elevated at a 45 degree angle or higher given his high risk of aspiration. Resident #70 would likely depend on tube feedings for the foreseeable future. Review of the July 2026 CPO revealed a diet order for NPO and tube feedings, ordered 6/20/26. An admission note, dated 6/19/26 at 6:18 p.m., revealed Resident #70 admitted to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 S Potomac St Aurora, CO 80012	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility from an acute care hospital that day (6/19/26) at 4:30 p.m Resident #70 was not verbally responsive toward staff but did speak and answer to his wife, who was present at bedside during admission. Resident #70 would need frequent checks as he had mild confusion and attempted to ambulate when he needed to use the restroom.A progress note, dated 6/19/26 at 6:50 p.m., revealed registered nurse (RN) #1 entered Resident #70's room to see if his enteral feeding was set up. Resident #70 was supposed to be NPO according to the ticket on his room tray but Resident #70 had in front of him an intact plate of food and a glass that contained juice was empty. RN #1 asked Resident #70 if he drank the juice, but the resident did not respond. RN #1 removed the meal tray and noted the resident did not appear to be in distress at the time. Resident #70's physician was notified.A progress note, dated 6/19/26 at 8:15 p.m., revealed licensed practical nurse (LPN) #1 entered Resident #70's room to assist RN #1 with setting up the resident's enteral feed. LPN #1 saw Resident #70 had an empty glass and plate of food in front of him. LPN #1 said Resident #70 was NPO, and RN #1 looked at the meal ticket in front of Resident #70 which said NPO. The tray was removed from Resident #70's room and LPN #1 instructed RN #1 to contact Resident #70's physician. LPN #1 set up Resident #70's enteral feed and alerted the administration.A progress note, dated 6/20/26 at 9:41 a.m., revealed LPN #1 notified Resident #70's physician about the resident receiving fluids. Resident #70's vital sign measurements were elevated that morning, with his pulse at 106 beats per minute, oxygen saturation of 89% and a fever of 101.2 degrees Fahrenheit (F).A progress note, dated 6/20/26 at 11:07 a.m., revealed Resident #70 was sent to the hospital per his physician. Resident #70 was given liquids during the night shift on 6/19/26. Resident #70 was running a fever of 102.9 degrees F and had an elevated pulse. Resident #70 was transferred via ambulance to the emergency room.A new admission nutrition services review form, dated 6/20/26, revealed Resident #70 had orders to have tube feedings. The form indicated the RD did not need to immediately assess Resident #70, and was completed on 6/20/26.-However, the form did not document Resident #70 was NPO.C. Staff interviewsCNA #1 was interviewed on 6/23/26 at 1:28 p.m. CNA #1 said if a resident had an order to be NPO, that meant they could not eat or drink anything by mouth.The DM was interviewed on 6/23/26 at 2:53 p.m. The DM said residents who were NPO would not get a meal tray. The DM said depending on the physician's orders the resident may be okay to have ice chips, but that would be resident-dependent. The DM said the night Resident #70 had admitted the admission nurse had written a diet slip and was working to determine if the resident was NPO. The DM said he believed Resident #70 had a diet slip that said he was NPO and had a diet texture, which was why he received a room tray that evening. The DM said he and the nursing staff clarified with the dietitian afterward to determine he was NPO. The DM said he had not done any reeducation on NPO status for residents.The SLP was interviewed on 6/24/26 at 8:40 a.m. The SLP said she worked collaboratively with the RD and the resident's physician whenever a resident admitted NPO. The SLP said when Resident #70 entered she had checked with the admitting nurse to see if he needed to be evaluated that day or if her evaluation could wait until the following week, and the nurse responded by saying it was okay for the evaluation to wait until the following week. The SLP said a meal tray would not have been appropriate for Resident #70 since he was NPO. The SLP said the process for reintroducing an oral diet required physician's orders and SLP evaluations. The SLP said she thought Resident #70 getting a room tray while being NPO was a mistake from the floor nursing staff or the CNAs who thought they just had a newly admitted resident who needed a tray.The RD was interviewed on 6/24/26 at 10:16 a.m. The RD said if a resident had orders for enteral nutrition she was usually notified fairly quickly by the nursing staff, and their diet order should be marked NPO so the kitchen did not prepare a meal tray for the resident. The RD said Resident #70's diet communication sheet had been handed to the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 S Potomac St Aurora, CO 80012	
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kitchen staff when it should have been handed to the DM since a meal tray did not need to be made. The RD said she did not know why or how Resident #70 was served a meal tray. The RD said serving a meal tray to a resident with dysphagia who had orders to be NPO could put the resident at risk of choking or potentially death. The DON and the nurse manager were interviewed together on 6/24/26 at 2:00 p.m. The DON said she was not at the facility when Resident #70 arrived. The DON said with newly admitted residents, the nursing staff reviewed the hospital discharge orders and filled out a diet communication form which was then given to the DM or the kitchen staff. The DON said Resident #70 was NPO and received enteral nutrition. The DON said the admission nurse filled out the diet communication form and gave it to the kitchen staff. The DON said she was informed Resident #70 had received a room tray and there was an empty cup on the tray, but no one witnessed Resident #70 have any intake by mouth. The DON said all of the nursing staff present at the time had been informed Resident #70 was NPO, and said she was not sure why he got a meal tray. The DON said the facility staff's assumption was that Resident #70 did drink from the glass on the tray, but said the physician reviewed his most recent hospital notes and did not see any significant changes in their diagnostics from his last hospitalization. The DON said Resident #70 was going to return to the facility after his hospitalization. The DON said when Resident #70 returned she would put signs up indicating he was NPO, and said the RD had provided education to all nursing and dietary staff on what NPO meant. VI. Staff education Education regarding diet textures was provided by the NHA on 6/24/26 at 4:06 p.m. (during the survey process) and revealed the following: LPN #1 received education on 6/24/26 which identified she did not follow the admission process as required, and specifically failed to clarify an NPO diet order for the dietary staff. The failure to complete the process may have resulted in inaccurate dietary orders and possible harm to the resident. LPN #1 was expected to physically write down NPO on a diet order sheet and obtain signs which indicated the resident was NPO to hang in their room. Education was provided to ten members of the nursing staff on 6/24/26 related to the different IDDSI diet texture levels, including what they were supposed to look like and what each diet level could not have. Education was provided to CNA #1 on 6/24/26 on the importance of verifying resident diet orders and meal tickets before delivering meal trays, and incorrect meal trays being removed from residents' rooms immediately and not left at their bedside. The education noted when residents received food not consistent with their prescribed diet order, there was an increased risk of choking, aspiration, aspiration pneumonia, blood sugar fluctuations, allergic reactions, or even death. Education was provided to four of 14 members of the dietary staff on 6/24/26 about the minced and moist and the soft and bite-sized IDDSI diet textures. However, this education was provided on 6/24/26, five days after Resident #70 was served a meal despite a physician's order to be NPO. Additionally, the facility did not provide record of any training materials for the dietary staff on NPO resident orders.		