STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065419	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Lowry, LLC	8550 E Lowry Blvd Denver, CO 80230

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#1) of three residents reviewed for accidents out of three sample residents.Resident #1 was admitted on [DATE] with diagnoses of metabolic encephalopathy (a change in how the brain works), weakness, difficulty in walking, heart failure and unspecified dementia.On 6/18/25 a nursing staff member documented Resident #1 was wandering, angry and saying he wanted to leave. The facility initiated a care plan for wandering on 6/19/25, however, the care plan did not identify the resident was at risk for elopement, despite the resident indicating he wanted to leave. The facility did not implement any interventions to prevent a potential elopement from the facility for Resident #1. On 6/22/25 Resident #1 was on the phone with a family member and said he was going home. When the family member called the facility to check on the resident, the facility was unable to locate the resident. Resident #1 was found by the police in a soccer field an hour and a half later and transported to the hospital. Resident #1 suffered a laceration (a deep cut) to his head, extensive bruising to his upper extremities, left temple and face, and abrasions (scrapes) to both knees. The resident was transported to the hospital for treatment prior to returning to the facility.Specifically, the facility failed to:- Identify Resident #1 was at risk for elopement; and,-Ensure Resident #1 was provided with the supervision necessary to prevent an elopement. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 7/15/25, resulting in the deficiency being cited as past noncompliance with a correction date of 6/26/25. I. Elopement incident on 6/22/25On 6/22/25 the facility staff received a phone call from Resident#1's family member who said she was on the phone with the resident and he said he was going home. The facility was unaware the resident had exited the facility. The police found the resident an hour and a half after he was noted as missing. He was found in a soccer field and had extensive bruising and a laceration to his head. Police transported the resident to the hospital. II. Facility plan of correctionThe corrective action plan the facility implemented in response to Resident #1's elopement incident on 6/22/25 was provided by the nursing home administrator (NHA) on 7/15/25 at 2:05 p.m. The plan documented the following:A. Immediate action On 6/22/25 all staff was educated on the facility's policy and procedure for elopement. The NHA and the regional director of operations completed a facility audit on 6/24/25 and reviewed the wander risk assessment to determine which residents were high risk for elopement. Once identified, residents' care plans were updated to prevent residents from eloping. The binder at the front desk was updated to include pictures and information of residents who were high risk for elopement.Signs were placed at the front exit, on visitor elevators and displayed at the reception desk to alert visitors not to assist residents outside, unless approved by a staff member.B. Identification of other residentsCurrent residents in the facility were reviewed and residents who were high risk for elopement were identified. Effective immediately, new admissions to the facility would be assessed for elopement risk and interventions would be initiated to prevent elopement.C. Systemic changesOn 6/22/25 to 6/26/25 the NHA completed in-services to all staff on the facility's elopement policy to include an elopement assessment, updating the care plan and the basics on conducting a search. All new admissions were assessed and care planned for elopement risk if the assessment indicated moderate to high risk elopement. An elopement drill would be conducted once a month to ensure all staff members were aware of what to do when there was an elopement, per the facility policy.D. MonitoringThe NHA or designee would review random residents' elopement risk assessments to ensure they were completed and that residents who identified as high risk had interventions in place. Monitoring would continue for two weeks and then one time a month for three months. The NHA or designee would monitor that elopement drills were completed monthly for the following three months. III. Facility policy and procedureThe Elopement policy and procedure, revised 3/28/24, was provided by the NHA on 7/14/25 at 1:30 p.m. It read in pertinent part, It is the policy of the facility that staff shall investigate and report all cases of missing residents.If an employee discovers that a resident is missing from the facility, he/she should determine if the resident was out on an authorized leave or pass. If the resident was not authorized to leave, initiate a search of the facility and premises. If the resident was not located, notify the NHA and the director of nursing (DON), the resident's legal representative, the attending physician and law enforcement officials.IV. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE], readmitted on [DATE] and discharged to the hospital on 7/12/25. According to the July 2025 computerized physician orders (CPO), diagnosis included