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	12/10/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for 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 notify the resident's physician when there was a significant change in the resident's condition for one (#1) of two residents out of 12 sample residents. Specifically, the facility failed to notify the physician for Resident #1 when she had slurred speech.Findings include: I. Professional referenceAccording to Nursing Skills (2023), retrieved on 11/17/25 from https://www.ncbi.nlm.nih.gov/books/NBK596735/, Document and notify physician if new unexpected findings including slurred words or inability to speak. Critical findings to report immediately and or obtain emergency assistance include slurred speech or inability to speak.II. Facility policy and procedureThe Change in Condition policy, revised 4/2/24, was provided by the director of operations on 11/5/25 at 1:55 p.m. It read in pertinent part, As part of the evaluation, the nurse will help identify individuals for having any changes of condition during their stay. In addition, the nurse shall evaluate and document/report difficulty speaking. The nursing staff will notify the physician if any of the above signs and symptoms are identified. The physician will indicate if the patient requires additional evaluation/ treatment at the facility or if the resident needs to be sent out to the hospital. III. Resident #1A. Resident status Resident #1, age [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (an artery is blocked by a clot leading to brain tissue death from a lack of oxygen) due to unspecified occlusion or stenosis of right carotid arteries, type 2 diabetes mellitus and essential hypertension (high blood pressure). According to the 10/18/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She used a walker and a wheelchair. She required set up assistance with eating and supervision with oral and personal hygiene. She required moderate assistance with toileting. B. Record reviewThe 10/18/25 nurse progress note revealed the resident experienced a brief episode of slurred speech during assessment in the morning. The slurred speech resolved and the resident appeared back to baseline. Her vital signs were within normal limits. There was no facial droop observed. Her extremities were equal and strong. The resident was alert and responsive. The facility would continue to monitor for any recurrence. -However, there was no documentation to indicate the resident's physician was notified of the resident's episode of slurred speech. The 10/22/25 nurse progress note revealed Resident #1 was again found in her room with slurred speech. At the initial assessment, the resident was alert and at baseline with bilateral upper and lower extremity strength equal. Her vital signs were within normal limits. The physician was notified and assessed the resident at the bedside. The physician ordered a transfer of the resident to the hospital. 911 was called and emergency medical services (EMS) arrived fifteen minutes later. Upon EMS arrival, the resident was noted with mild confusion and generalized weakness. The resident was transferred to the hospital. Resident #1 has a history of a recent stroke and had a remote cardiac monitor attached to her upper chest during the event. The resident's family was updated. The 10/22/25 hospital history and physical physician note revealed Resident #1 had nonsensical speech upon exam. The nursing facility was called by the hospital and the facility reported the resident was normally sociable with intermittent slurred speech. When the facility noted the resident's speech was slurred again, a neurological exam was completed that was okay. The nursing facility's physician was notified and recommended calling 911. The facility reported this happened last Saturday (10/18/25) but was worse today (10/22/25) with weakness and confusion. The episode on 10/18/25 was brief.-However, the facility's physician was not notified that the resident was exhibiting slurred speech until the resident's second episode of slurred speech on 10/22/25, despite the fact that she had initially demonstrated slurred speech on 10/18/25, four days prior to being transferred to the hospital (see progress notes above).IV. Staff interviews Registered nurse (RN) #1 was interviewed on 11/5/25 at 12:07 p.m. RN #1 said he was the nurse who assessed Resident #1 on 10/18/25. RN #1 said Resident #1 had slurred speech so he completed an assessment and notified his assistant director of nursing (ADON) because it was a change in condition for the resident. RN #1 said the ADON completed an assessment. RN #1 was interviewed a second time on 11/5/25 at 12:30 p.m. RN #1 said the ADON did not tell him to notify the physician about Resident #1's slurred speech on 10/18/25. RN#1 said he notified the ADON because he did not know the resident's baseline due to the fact that 10/18/25 was the first full shift he had cared for the resident. The ADON was interviewed on 11/5/25 at 12:15 p.m. The ADON said she worked on 10/18/25 and was notified by RN #1 about Resident #1's slurred speech. The ADON said she completed vital signs and an

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure four (#1, #3, #2 and #4) of five residents out of 12 sample residents were provided services that met professional standards of quality. Specifically, the facility failed to: -Ensure staff followed the physician's orders for Resident #1's anti-fungal medication;-Ensure staff followed the physician's orders for Resident #3's skin treatment; and, -Ensure staff obtained a physician's order before providing skin treatment for Resident #2 and Resident #4.Findings include: I. Professional reference According to the National Institutes of Health (NIH), National Library of Medicine, Nursing Rights of Medication Administration (September 2023), retrieved on 11/17/25 from https://www.ncbi.nlm.nih.gov/books/NBK560654/, It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. Incorrect dosage is a prevalent modality of medication administration error. This error type stems from nurses giving a patient an incorrect dose of medications, even if it is the correct medication and the patient's identity is verified, without first checking to ensure it is the correct strength for the patient. According to the Institute of Medicine (IOM) Committee on Quality of Healthcare in the United States (January 2025), retrieved on 11/17/25 from https://pubmed.ncbi.nlm.nih.gov/30085607/, An error is the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. The IOM identifies medical errors as a leading cause of death and injury. II. Facility policy and procedure The Medication Administration policy and procedure, revised 4/2/24, was provided by the director of operations on 11/5/25 at 1:55 p.m. It read in pertinent part, It is the policy of this facility that medications are to be administered as prescribed by the attending physician. Medications must be administered in accordance with the written orders of the attending physician. III. Resident #1 A. Resident status Resident #1, age [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (an artery is blocked by a clot leading to brain tissue death from a lack of oxygen) due to unspecified occlusion or stenosis of right carotid arteries, type 2 diabetes mellitus and essential hypertension (high blood pressure). According to the 10/18/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She used a walker and a wheelchair. She required set up assistance with eating and supervision with oral and personal hygiene. She required moderate assistance with toileting. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review Review of the October 2025 CPO revealed Resident #1 had the following physician's order: Miconazole external powder 2%. Apply to the groin topically every day shift related to weakness until 10/30/25, ordered 10/16/25. -Review of Resident #1's October 2025 treatment administration record (TAR) revealed the miconazole was not documented as administered from 10/16/25 to 10/21/25. -Review of Resident #1's electronic medical record (EMR) revealed there was no documentation as to why the miconazole medication was not administered. IV. Resident #3 A. Resident status Resident #3, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included cellulitis of the left lower limb, open wound of the right hand, osteoarthritis, osteoporosis, hypertension and altered mental status. According to the 10/23/25 MDS assessment, the resident was cognitively intact with a BIMS score of 14 out of 15. She used a walker and wheelchair. She required moderate assistance with eating and was dependent with toileting. She required substantial assistance with oral hygiene and lower body dressing. The assessment revealed applications of non-surgical dressings, ointments and medications were used for skin treatments. B. Resident interview Resident #3 was interviewed on 11/4/25 at 10:31 a.m. in her room. Resident #3 was sitting in her wheelchair on the left side of her bed. She said she did not have any skin conditions. However, two small abrasions were observed on her right hand that appeared to be healing. Resident #3 said she did not know what the abrasions were from. C. Resident observation On 11/4/25 at 12:14 p.m. Resident #3 was observed in her room with registered nurse (RN) #2. On the outer aspect of the resident's right hand there were two abrasions/scabs that appeared to be healing. There was no drainage and no dressing on the abrasions. RN #2 said Resident #3 did not need wound care for the two abrasions on her right hand. -However, the resident had an active physician's order for a daily treatment and dressing to the abrasions on her right hand (see physician's orders below). D. Record review (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3's skin breakdown care plan, initiated 10/18/25 and revised 11/4/25, revealed the resident had potential for skin breakdown related to impaired mobility secondary to weakness and debility. Resident #3 was admitted with a wound to her right hand. Interventions included dressing changes per physician's orders and skin treatment per physician's orders. Review of Resident #3's November 2025 CPO revealed the following physician's orders: Cleanse the right hand with wound cleanser or normal saline, pat dry, apply hydrogel (a type of wound treatment) and cover with bordered foam. Monitor and change daily every day shift, ordered 10/18/25. Monitor the small open area to right lateral hand every shift. Assess for any signs and symptoms, complications and or signs of infection. Report to the physician as noted. Leave the site open to air and discontinue the every shift monitoring once the open area has fully resolved, ordered 11/4/25. -The above physician's order was obtained during the survey, after the issue was brought to the facility's attention. -Review of Resident #3's October 2025 TAR revealed the treatment to the resident's right hand was not documented as being provided on 10/20/25 and 10/30/25. The 11/4/25 nurse note revealed, per hospital documentation, Resident #3 sustained a fairly large wound to the lateral portion of her right hand as the result of a mechanical fall. The resident was admitted with corresponding treatment orders. Upon assessing the site on 11/4/25 the area had almost entirely resolved. There was a very small and superficial opening currently measuring approximately 0.2 centimeters (cm) in width by 0.2 cm in length and less than 0.1 cm deep still being appreciated. The nurse was informed the resident had a scab covering the area earlier today and thought the resident scratched the scab off as faint scratch marks were noted to the surrounding tissue. There was no drainage or active bleeding and no signs or symptoms of infection present. The condition of the hand was discussed with the physician and an order to discontinue the hydrogel treatment was received. The physician believed the best thing to do was to just keep it open to air and let it heal up. The hydrogel order was discontinued and a new order was entered to keep the area open to air, asking the nurses to monitor the site every shift, looking for any signs and symptoms of complication and signs of infection and reporting any concerns to the physician if noted. The order was to be discontinued once the open area resolved. Resident #3 was updated to the plan and voiced no related questions or concerns during the conversation. -The progress note was documented during the survey. V. Resident #2 A. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included atherosclerosis, heart disease of native coronary artery, type 2 diabetes mellitus, pneumonia and sepsis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 10/24/25 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. He required set up assistance with eating and personal hygiene. He required substantial assistance with oral hygiene and upper body dressing. The assessment revealed he had a pressure ulcer, a formal assessment tool was used and a clinical assessment was used. He had a stage 2 pressure ulcer and a diabetic foot ulcer. Treatments included applications of ointments and medications. B. Observation On 11/4/25 at 11:42 a.m., Resident #2 was observed in his room with RN #1. There were dressings present on both of the resident's right and left great toes, dated 11/3/25. The dressings were dry and intact. RN #1 said he could not find the wound care orders in the resident's electronic medical record (EMR) for dressings to the right and left great toes. C. Record review The 10/21/25 admission skin evaluation revealed Resident #2 had a wound to the right great toe with a dressing in place. The 10/22/25 wound skin evaluation revealed there was a diabetic ulcer on the resident's right greater toe measuring 0.5 cm in length by 0.5 cm in width and 0.1 cm deep. The note revealed the area presented with 80% granulated tissue (red, bumpy tissue in a wound bed) and 20% epithelial tissue (tissue in a wound that appears pink or white and wrinkles when touched) and scant serous drainage (thin, watery, clear to pale yellow fluid that leaks from wounds). The area would continue to be treated with medihoney (wound treatment) and hydrocolloid (wound dressing) every other day and as needed and left open to air. The 10/29/25 wound skin evaluation revealed there was a diabetic ulcer on Resident #2's right greater toe measuring 0.5 cm in length by 0.5 cm in width and 0.1 cm deep. The note revealed the area was improving and presented with 80% granulation tissue and 20% epithelial tissue with scant serous drainage. The area would continue to be treated with medihoney and hydrocolloid every other day and as needed and left open to air. The 11/3/25 skin evaluation revealed the wound to the resident's right great toe. The wound had a scabbed area. The wound was to be patted dry and medihoney applied then covered with a dry dressing. There was a wound to the resident's left toe. The left toe wound was to be cleaned with normal saline, patted dry and medihoney applied and covered with a dry dressing. The 11/4/25 skin evaluation revealed Resident #2's right great toe ulcer was relatively smaller in size, 0.4 cm in length by 0.3 cm in width and 0.1 cm in depth. The resident's left great toe ulcer had 100% epithelial tissue. Review of Resident #2's October 2025 CPO revealed no physician's orders for the resident's right great toe diabetic wound. Review of Resident #2's November 2025 CPO revealed the following physician's orders: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound care, right foot great toe. Cleanse with normal saline, pat dry, apply medihoney to wound bed, cover with border dressing every other day and as needed related to difficulty in walking, ordered 11/4/25 (added during the survey). Wound care, left foot great toe. Cleanse with normal saline, pat dry, apply povidone iodine, cover with border gauze daily, ordered 11/4/25 (added during the survey). -However, wound treatment was provided to Resident #2's right great toe from 10/22/25 to 11/4/25 without a physician's order and wound treatment was provided to the resident's left right great toe on 11/3/25 without a physician's order (see staff interviews below). VI. Resident #4 A. Resident status Resident #4, age [AGE], was admitted to the facility on [DATE]. According to the November 2025 CPO, diagnoses included cellulitis (skin infection caused when germs enter through a crack in the skin) of left lower limb, edema and difficulty in walking. The 11/4/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The functional and mobility assessment had not been completed at the time of the survey. B. Resident interview Resident #4 was interviewed on 11/4/25 at 9:40 a.m. Resident #4 said he was not aware of his wound care treatment schedule. He said WCN #1 provided wound care treatment to both legs on 10/31/25. Resident #4 said licensed practical nurse (LPN) #1 provided wound care to his left leg on 11/3/25 but did not complete the treatment for his right leg. He said he asked LPN #1 about the treatment for the right leg, and LPN #1 told him she could not complete it at that time. Resident #4 said LPN #1 left the room and did not come back. C. Record review The skin care plan, initiated 10/30/25 and revised 11/4/25, documented Resident #4 had a potential for skin breakdown related to impaired mobility secondary to weakness and debility. Interventions included completing dressing changes per physician's order, notifying the physician of any signs and symptoms of infections and completing skin evaluations as ordered and as needed. The wound care evaluation, dated 10/31/25, documented a vascular wound on the front of Resident #4's left lower leg. The wound measured 19 cm in length by 15 cm in width with 0.1 cm in depth. The evaluation documented another vascular wound on the rear of Resident #4's right lower leg. The wound measured 15 cm in length by 15 cm in width with 0.1 cm in depth. The 10/31/25 progress note revealed WCN #1 cleansed, dried, and placed silver antimicrobial gel (wound care treatment) on the wounds. WCN #1 overlaid the wounds with an adaptec dressing, covered with an abdominal (ABD) pad, wrapped with kerlix, and secured with an ace wrap. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, there was no documentation in the resident's October 2025 CPO indicating an active physician's order for the wound treatment provided on 10/31/25. Review of Resident #4's November 2025 CPO revealed the following physician's orders: Normal saline with instructions to cleanse and pat dry every other day for the left lower extremity wound, ordered 11/2/25. Silver antimicrobial gel with instructions to apply to open areas every other day for the left lower extremity wound, ordered 11/2/25. Adaptec dressing and abdominal pad with instructions to cover the left lower extremity wound, ordered 11/2/25. Kerlix and Ace wrap with instructions to wrap the lower left lower extremity wound, ordered 11/2/25. -Review of the November 2025 CPO revealed the resident did not have physician's orders for the right lower extremity wound until 11/4/25, during the survey (see physician's orders below). The November 2025 CPO revealed the following physician's orders: Normal saline with instructions to cleanse and pat dry every other day for the right lower extremity wound, ordered 11/4/25. Silver antimicrobial gel with instructions to apply to open areas every other day for the right lower extremity wound, ordered 11/4/25. Adaptec dressing and abdominal pad with instructions to cover the right lower extremity wound, ordered 11/4/25. Kerlix and Ace wrap with instructions to wrap the lower right lower extremity wound, ordered 11/4/25. VII. Staff interviews The director of nursing (DON) was interviewed on 11/4/25 at 12:20 p.m. The DON said residents' skin was assessed at admission by the floor nurse, by the WCN within 24 hours, weekly and as needed. The DON said if a resident came with discharge orders for wound treatment, the floor nurse who admitted the resident did not obtain wound treatment orders, the ADON or another nurse entered the wound treatment orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound care nurse (WCN) #1 was interviewed on 11/4/25 at 2:53 p.m. WCN #1 said she had worked at the facility for one month and was the wound care nurse for all residents. WCN #1 said residents' skin was assessed at admission by the floor nurse, by the wound care nurse within 24 hours, weekly and as needed. WCN #1 said she documented her skin assessments on a paper log and then transcribed the paper log notes into the residents' EMRs, either as a skin assessment or a wound assessment, depending on what she saw during her skin assessment. WCN #1 said she documented the wound treatment orders on the wound assessment. WCN #1 said she was familiar with Resident #1. WCN #1 said when she saw Resident #1, she documented her findings on the paper log. WCN #1 said she updated Resident #1's EMR on 10/23/25. WCN #1 said she obtained physician's orders for miconazole on 10/16/25 and she did not enter the orders into Resident #1's EMR until 10/23/25. WCN #1 said since she did not enter the physician's orders into the EMR timely, the floor nurses were unable to administer the medication to Resident #1 as ordered. WCN #1 said she completed wound care to Resident #4's both legs on 10/31/25 even though there were no active physician's orders at that time. She said wound care physician's orders for Resident #4 were entered on 11/2/25 for the resident's left leg only. LPN #1 was interviewed on 11/5/25 at 12:26 p.m. LPN #1 said she completed wound care on 11/3/25 for Resident #4's left leg only as it was the only treatment order listed on the resident's TAR at that time. LPN #1 said she did not know who completed the wound care for the right leg, noting the bandage was clean, without drainage, and not soiled. LPN #1 said she thought there might have been a physician's order for the right leg wound scheduled for a different day but she could not find any documentation. LPN #1 said she did not ask WCN #1 about the resident's right leg wound treatment nor document it. The DON was interviewed a second time on 11/5/25 at 1:10 p.m. The DON said all physician's orders should be entered into the residents' EMRs as a physician's order, not in a skin evaluation assessment or wound evaluation assessment. The DON was familiar with Resident #1. The DON said she talked to WCN #1 after Resident #1 was discharged to the hospital and that was when the DON found out WCN #1 did not enter the skin assessment and the physician's order for miconazole in Resident #1's EMR until 10/23/25. The DON said WCN #1 should have entered the physician's order for the miconazole as soon as it was obtained so the floor nurses could administer the medication timely. The DON was familiar with Resident #2. The DON said the resident's toe wound treatment orders should have been in Resident #2's EMR as a physician's order so the floor nurses were aware of the treatment orders and when to provide care. The DON was familiar with Resident #3. The DON said the nursing staff needed to notify the physician when the physician's order was not followed so the physician could provide further orders if needed. The DON said there were no physician's orders in place for Resident #4's wounds when WCN #1 provided treatment on 10/31/25. However, she said WCN #1 documented the treatment in the resident's progress notes. The DON said as of 11/4/25 (during the survey), the facility had entered physician's orders into Resident #4's November 2025 CPO for wound treatment of both legs.