

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Center at Lowry, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and interviews the facility failed to distribute food in a sanitary manner in the main kitchen. Specifically, the facility failed to ensure employees performed hand hygiene appropriately during meal service. Findings include: I. Professional reference The Colorado Retail Food Regulations, (3/16/24), retrieved on 4/6/26, read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15) II. Observations During a continuous observation on 3/31/26, beginning at 5:08 p.m. and ending at 5:30 p.m., the following was observed during meal service in the main kitchen: At 5:10 p.m. cook (CK) #1 had gloves on and was touching several high traffic surface areas (counter tops, the refrigerator handle and using utensils to plate the meal). Without changing gloves, CK #1 used the same gloved hands to retrieve clean plates and clean bowls for service. He placed gloved hands on the eating surfaces of the clean dishware. Without performing hand hygiene, CK #1 used the same gloved hands to place bread on the plates. At 5:20 p.m. CK #1 had not changed his gloves and touched the counter top of the serving table, wiped the sneeze guard top with his gloved hand and used utensils for plating food. CK #1 took carrots to a cutting station with the same gloved hands. He used a knife and scooped up carrots to plate the carrots with the same gloved hands. CK #1 continued to plate bread without utensils wearing the same gloves. -During the observation time, CK #1 had not changed his gloves during service, although he had left the service area, touched the refrigerator handle, picked up utensils and touched counter tops prior to handling plates and food. During a continuous observation on 4/1/26, beginning at 11:27 a.m. and ending at 12:17 p.m. the following was observed during meal service in the main kitchen: At 11:31 a.m. the dietary manager (DM) put on gloves and took plates from the clean dish rack for service. With the same gloved hands, he scooped up lettuce and plated the lettuce for a salad. He then used utensils to put the toppings on the salad. He continued to use the same gloved hands for scooping the lettuce. Without changing gloves, the DM placed rolls on the plates with his gloved hands. He left the service area to retrieve more plates, touching the eating surface of the plates, and scooped the lettuce without changing his gloves. At 11:36 a.m. CK #2 washed his hands and put on gloves. He then left the service area to retrieve wrapped sandwiches from the reach-in refrigerator with the same gloves. With the same gloved hands, he unwrapped the sandwiches and used his gloved hands to steady the sandwiches while he cut them in half. He then plated the sandwiches with the same gloved hands. At 11:41 a.m., with the same gloved hands, CK #2 went to the grill and removed cooked chicken with a utensil, cut the chicken on the cutting board and then scooped up the chicken with his gloved hands and plated the (continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>chicken for a resident. At 11:45 CK #2 removed his gloves, washed his hands and donned (put on) another pair of gloves. He then returned to the refrigerator with the gloves on, removed more sandwiches, unwrapped the sandwiches, placed them on the cutting board and placed his hands on the sandwiches to stabilize them while he cut them in half, then plated each sandwich. -During the continuous observation, CK #2 had not removed his gloves after touching high surface areas, such as the refrigerator handle, counter tops, the top of the sneeze guard and leaving the service area before handling food. With gloved hands he touched his personal clothing and went back to touching food without changing gloves. At 11:50 a.m. the DM put on gloves, touched several surfaces and scooped the lettuce with his gloved hands. He used utensils for salad toppings and without changing gloves placed bread on each plate. -During this time, without changing gloves, the DM retrieved a bag of sliced bread, removed the bread from the bag and made sandwiches after touching several surfaces.</p> <p>III. Staff interviews CK #2 was interviewed on 4/1/26 at 12:18 a.m. CK #2 said hands should be washed before handling food. He said gloves should be changed when they were dirty or greasy. CK #2 said hands should be washed in between changing gloves. He said he changed gloves often, especially when moving to spots such as the serving line to the grill. The DM was interviewed on 4/2/26 at approximately 10:00 a.m. The DM said gloves should be changed when surfaces were touched and before handling food. He said if a staff member stepped away from the service area, they should remove gloves, wash hands and put on new gloves before starting food service. The DM said the staff should use utensils when plating food and not their hands. The DM said he was in the process of starting to have his staff go through an online food safety course.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure one (#8) of nine residents out of 30 sample residents was provided services that met professional standards of quality. Specifically, the facility failed to ensure Resident #8's medications were administered in a timely manner and not left at the resident's bedside. 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 4/6/26 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 time is a prevalent modality of medication administration error. This error type stems from nurses giving a patient medication at an incorrect time, even if it is the correct medication and the patient's identity is verified, without first checking to ensure it is the correct time for the medication to be administered to the patient. II. Facility policy and procedure The Medication Administration policy and procedure, revised 4/2/24, was provided by the director of nursing (DON) on 4/2/26 at 3:15 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 attending physician's written orders. Medications may not be set up in advance and must be administered one hour before or one hour after their prescribed time. III. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included surgical after care following surgery to the nervous system (lumbar surgery), radiculopathy to the lumbar region (pinched nerve resulting in sciatica), multiple sclerosis, difficulty walking, pulmonary embolism (sudden blockage in a lung artery), hypertension, long-term use of anticoagulant medications and major depressive disorder. The 3/30/26 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. He required partial assistance with activities of daily living (ADL) and moderate assistance for ambulation. He used a walker and a wheelchair. B. Observations On 3/30/26 at 2:15 p.m. a medication cup with two tablets in it was sitting on the cover of Resident #8's lunch tray. On 3/30/26 at 2:43 p.m. the same medication cup with two tablets in it was still sitting on Resident #8's lunch tray. On 3/30/26 at 2:45 p.m., upon prompting, LPN #3 entered Resident #8's room and administered the two tablets in the medication cup on the resident's lunch tray cover to Resident #8. -However, the medications were administered over an hour after the allowed medication administration time (see record review below). C. Resident interview Resident #8 was interviewed on 4/1/26 at 11:12 a.m. Resident #8 said that he did not know if the medication cup with the two tablets in it that was left on his bedside table the day prior (3/31/26) was his medication. D. Record review Review of Resident #8's March 2026 medication administration records (MAR) revealed the following medications were to be administered to Resident #8 at 12:00 p.m.: Gabapentin (anticonvulsant medication primarily used to treat neuropathic pain and partial seizures). Give one 600 milligram (mg) tablet by mouth three times a day, ordered 3/30/26. Cyclobenzaprine HCl (muscle relaxant used for muscle spasms). Give one 10 mg tablet by mouth three times a day, ordered 3/24/26. -However, the medications were observed sitting in a medication cup over one hour after the allowed medication administration time (see observations above). IV. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 3/30/26 at 2:45 p.m. LPN #3 entered Resident #8's room and said the resident had been in the bathroom when he (LPN #3) came to administer the resident's medications. LPN #3 said he left the resident's medications on the bedside table and exited the room. LPN #3 said it was inappropriate to leave medication on the resident's bedside table and not observe the resident taking the medication. LPN #3 said one tablet in the medication cup was Neurontin (gabapentin) and the other was cyclobenzaprine. The director of (continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>nursing (DON) was interviewed on 4/1/26 at 10:50 a.m. The DON said that LPN #3 had told her that Resident #8 was on the phone when he went to administer the medications to the resident. The DON said LPN #3 said he left the resident's medication on the bedside table and exited the resident's room. The DON said it was not appropriate to leave medications with a resident and not observe the resident taking the medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations and interviews, the facility failed to ensure that all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards for two of five medication carts. Specifically, the facility failed to:-Ensure medications, such as inhalers, eye drops and tuberculin purified protein derivative (PPD - a skin test antigen used to detect infection with tuberculosis) were dated when opened;-Ensure medications were not stored in a medication cup instead of a labeled medication bottle in the medication cart; and,-Ensure loose pills were not in the bottom of the medication cart drawers.Findings include:I. Professional referenceAccording to Drugs.com (1/23/25) Can You Use An Expired Albuterol Inhaler?, retrieved on 4/6/26 from https://www.drugs.com/medical-answers/you-expired-albuterol-inhaler-3556003/, An albuterol inhaler should be discarded after it passes its expiration date. It should be thrown out even sooner if it has been 13 months since it was removed from its foil packaging.According to the Spiriva Respimat (tiotropium bromide) inhaler package insert, retrieved on 4/6/26 from https://pro.boehringer-ingenelheim.com/us/products/spiriva/copd/, After assembly, the Spiriva Respimat inhaler should be discarded, at the latest, three months after first use or when the locking mechanism is engaged, whichever comes first.According to Drugs.com (10/27/25), Arnuity Ellipta: Package Insert/Prescribing Info, retrieved on 4/9/26 from https://www.drugs.com/pro/arnuity-ellipta.html. Discard Arnuity Ellipta six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first.According to Drugs.com (12/29/25) Xalatan Package Insert/Prescribing Information, retrieved on 4/9/26 from https://www.drugs.com/pro/xalatan.html Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees celsius (C) (77 degrees Fahrenheit (F) for six weeks.According to Drugs.com (10/10/24), Tuberculin Purified Protein Derivative (Interdermal) (monograph), retrieved on 4/8/26https://www.drugs.com/monograph/tuberculin-purified-protein-derivative-interdermal.html#:~:text=for%2Tuberculin%20PPD%2C%20diluted%20(Aplisol),is%20supplied%20as%20multi-dose%20vials%20containing%205%20Tuberculin%20Units%20(TU)%20per%200.1%20milliliters%20(ml)%20for%20intradermal%20injection.%20Store%20vials%20at%202%20to%208%20degrees%20C%20(36-46%20degrees%20F);%20do%20not%20freeze;%20protect%20from%20light.%20Vials%20in%20use%20for%20more%20than%2030%20days%20should%20be%20discarded%20due%20to%20possible%20oxidation%20and%20degradation,%20which%20may%20affect%20potency.II.%20Facility%20policy%20and%20procedureThe%20Storage%20of%20Medications%20policy,%20revised%202/9/26,%20was%20provided%20by%20the%20director%20of%20nursing%20(DON)%20on%204/1/26%20at%203:34%20p.m.%20It%20read%20in%20pertinent%20part,%20Medications%20are%20stored%20properly,%20following%20pharmacy%20or%20provider%20instructions%20to%20maintain%20their%20integrity%20and%20support%20safe,%20effective%20medication%20administration.%20The%20pharmacy%20dispenses%20the%20medication%20in%20containers%20with%20labels.%20Medications%20are%20to%20remain%20in%20the%20containers%20until%20dispensing.%20Medications%20requiring%20refrigeration%20are%20kept%20refrigerated.%20Outdated,%20discontinued,%20and%20expired%20medications%20should%20be%20removed%20from%20stock.%20Medication%20storage%20should%20be%20kept%20clean,%20organized,%20and%20free%20of%20clutter.%20Medication%20storage%20conditions%20are%20monitored%20randomly%20as%20a%20quality%20assurance%20program.III.%20ObservationsOn%203/30/26%20at%208:20%20a.m.%20the%20second%20floor%20medication%20cart%20A%20was%20observed%20with%20registered%20nurse%20(RN)%20#3.%20The%20following%20items%20were%20found:%20One%20bottle%20of%20Xalatan%20(latanaprost%200.005%)%20eye%20drops%20(used%20to%20reduce%20high%20eye%20pressure)%20was%20not%20dated%20when%20opened.%20One%20vial%20of%20tuberculin%20(PPD)%20was%20not%20dated%20when%20opened%20and%20was%20being%20stored%20in%20the%20medication%20cart%20and%20not%20the%20refrigerator.%20One%20Spiriva%20inhaler%20(medication%20used%20to%20help%20open%20airways%20to%20improve%20breathing)%20was%20not%20dated%20when%20opened.%20One%20loose%20pill%20was%20in%20the%20bottom%20of%20the%20second%20drawer%20of%20the%20medication%20cart.%20There%20was%20a%20medication%20cup%20sitting%20in%20the%20top%20drawer%20of%20the%20medication%20cart.%20The%20medication%20cup%20contained%20seven%20burgundy%20colored%20softgel%20tablets.%20The%20medication%20cup%20was%20not%20labeled%20with%20a%20resident's%20name%20or%20the%20medication%20name%20of%20the%20softgel%20tablets.On%203/30/26%20at%208:40%20a.m.%20the%20third%20floor%20medication%20cart%20C%20was%20observed%20with%20RN%20#4.%20The%20following%20items%20were%20found:Two%20Albuterol%20inhalers (continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>were not dated when opened. One Spiriva inhaler was not dated when opened. One Arnuity Ellipta inhaler (inhaled medication used to treat asthma) was not dated when opened. Seven loose pills were in the bottom of the second drawer of the medication cart. IV. Staff interviews RN #3 was interviewed on 3/30/26 at 8:20 a.m. RN #3 said the nurses cleaned the medication carts on each shift. RN #3 said the one loose medication at the bottom of the second drawer of the second floor medication cart A was a Senna Plus (medication used to treat constipation). RN #3 said the risk of not putting an open date on the medication was giving an expired medication. RN #3 said expired medications may not be effective. She said the burgundy colored softgel tablets sitting in the medication cup in the top drawer of the medication cart were Preservision Eye Supplement tablets. She said she ran out of the medication in her cart and went to another medication cart to get some. She said she poured seven softgel tablets from the over the counter medication bottle in the other cart into a medication cup and brought them back to her medication cart. RN #4 was interviewed on 3/30/26 at 8:40 a.m. RN #4 said every nurse was responsible for cleaning the medication carts on each shift that they worked. RN #4 said she knew that two of the loose medications in the bottom of the second drawer of the third floor medication cart C were acetaminophen (medication used to treat pain and fever) and one loose medication was omeprazole (medication that reduces stomach acid). She said she was not sure what the other four loose medications were. RN #4 said the risk of loose medications was that a medication could drop to the floor and be taken by a resident. RN #4 said nurses should always put an open date label on medications so they knew when the medication expired. She said expired medications might no longer be potent. The DON was interviewed on 4/1/26 at 10:50 a.m. The DON said it was the nurses' responsibility to clean the medication carts on their shifts. The DON said there should not be any medications in a medicine cup without a label in the medication cart. The DON said it was important for the nurses to mark medications with an open date to prevent giving an expired medication because the medication might then be ineffective.</p>		