

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Aviva at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE 13525 E 23rd Ave Aurora, CO 80045	
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 Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident's provider when there was a significant change in the resident's condition for one (#4) of four residents out of 12 sample residents. Specifically, the facility failed to notify the resident's provider for Resident #4 when he had a change in blood pressure from his baseline. Findings include: I. Facility policy and procedure The Change in Resident Condition policy, revised 2/29/24, was received from the nursing home administrator (NHA) on 7/8/26 at 12:48 p.m. It documented in pertinent part, A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (a deterioration in health, mental, or psychosocial status in either life - threatening conditions or clinical), a need to alter treatment significantly (a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) or a decision to transfer or discharge the resident from the facility. II. Resident #4A. Resident status Resident #4, age [AGE], was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), the diagnoses included metabolic encephalopathy (brain dysfunction caused by chemical imbalances or system illness), tracheostomy, quadriplegia (paralysis causing loss of function to parts of the body) and cognitive communication deficit. The 6/8/26 minimum data set (MDS) assessment revealed the resident had cognitive impairment with a short term and long term memory problem. He was dependent on staff with all activities of daily living. B. Observations Resident #4 was observed on 7/6/26 at 1:10 p.m. laying in bed with his feet elevated and head of bed up. He had tube feeding running through his gastrostomy tube. C. Record review A review of nursing progress notes from 5/19/26 included the following: A nursing progress note on 5/19/26 at 3:00 p.m. documented a series of events that occurred on 5/19/26. At 6:30 a.m. Resident #4's blood pressure was 69/40 millimeters of mercury (mmHg) . The on-call provider was called and there was a new order to give 150 milliliters (ml) of free water, give scheduled Midodrine (medication to raise blood pressure) and recheck the blood pressure in one hour. The note documented the resident was not at baseline with regards to eye movement. The resident was usually able to track staff with his eyes and also blink yes and no. The note documented the resident was not currently normally responding. At 7:45 a.m. Resident #4's blood pressure was 69/42 mmHg. At 9:00 a.m. the pulmonologist, physician assistant and the director of nursing (DON) made rounds and assessed the resident. -However, the pulmonologist and physician assistant reviewed the residents respiratory status and was not aware of the change in blood pressure (see interviews below). At 10:30 a.m. Resident #4's blood pressure was 75/42 mmHg with no change in mentation. At 10:40 a.m. there was a new order to place a peripheral intravenous (IV) line and start normal saline at 100 ml/hour for a total of one liter. An IV (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: The nursing home is disputing this citation.	was attempted to the right hand without success. At 10:55 a.m. an outside company to place IV lines was notified to place IV. At 11:15 a.m. scheduled Midodrine 20 milligrams (mg) was given. At 11:30 a.m. the assistant director of nursing (ADON) was notified of the regimen that was ordered. At 12:00 p.m. the IV nurse was present and placed a 22 gauge IV in the right forearm with ultrasound guidance. At 12:15 p.m. the IV fluids were started. At 12:30 p.m. Resident #4's blood pressure was 81/42 mmHg. At 1:30 p.m. Resident #4's blood pressure was 72/38 mmHg and the nurse notified Resident #4's wife of the new orders. At 2:30 p.m., Resident #4's blood pressure was 75/72 mmHg. At 2:40 p.m. Resident #4's wife was present and spoke with the physician assistant. At 2:45 p.m. there was a new order to send the patient out to the emergency room for evaluation. -The facility staff failed to notify Resident #4's provider of the change in blood pressure at 7:45 a.m., which was two hours after the resident's blood pressure continued to be below his baseline. A progress note by physician assistant on 5/19/26 at 1:00 p.m. documented a follow up for hypotension, anisocoria (unequal pupil sizes) and a concern for a stroke. The resident was seen and assessed laying in bed. Resident #4 was seen by the pulmonologist that morning who did not note any pulmonary concerns. The nurse reported hypotension, administered Midodrine 20 mg, but the resident was persistently hypotensive at 80/48 mmHg. The patient was maxed out on Midodrine and remained severely hypotensive at 76/48 mmHg. On exam, the resident did not have reactive pupils, anisocoria, the left pupil was contracted and the right pupil was dilated. The resident did not track and was not responsive. He was a full code. The note documented they would push IV fluids and discuss the resident's status with the wife who wanted the resident to remain a full code. The resident was sent to the emergency room for evaluation and treatment. D. Staff interviews Certified nursing aide (CNA) #1 was interviewed on 7/7/26 at 2:35 p.m. She said she was responsible for getting vital signs in the evening. She said she has a reference range for normal vital signs and if they are outside of the range, she reported the vital signs to the nurse right away. Registered nurse (RN) #1 was interviewed on 7/7/26 at 2:40 p.m. She said when a resident had a change in condition, she completed vital signs and completed an assessment. She said she would get in touch with a provider to communicate the abnormal findings, notify the resident's representative and follow any new orders from the provider. She said a low blood pressure could lead to fainting, poor perfusion and unresponsiveness. She said a low blood pressure would be considered and change in condition and she would follow the facility's procedure. Licensed practical nurse (LPN) #1 was interviewed on 7/7/26 at 2:45 p.m. She said if a resident has a systolic blood pressure in the 60 to 70's, it meant the heart was not pumping adequately and the cells and organs in the body were not getting adequate oxygenation. She said she would immediately reach out to the provider for orders to address the low blood pressure. The physician assistant and the regional nurse consultant #1 were interviewed together on 7/6/26 at 5:24 p.m. The physician assistant said the morning of 5/19/26, she rounded with the pulmonology doctor starting at 9:00 a.m. She said the pulmonologist assessed Resident #4 and had no concerns regarding his pulmonary status. The physician assistant said nobody had mentioned any episode of hypotension to her. The physician assistant said she had access to the on call triage notes and she did not look at Resident #4's notes from 5/18/26 or 5/19/26 before she got to the facility. She said she usually looked through these notes before rounding and she dropped the ball on this one. The physician assistant said she was notified of the hypotensive episodes shortly after 10:00 a.m. (two hours after the resident had a change in baseline blood pressure) and ordered IV fluids. The physician assistant said she assessed Resident #4 and was worried about a stroke so they decided to send him out to the emergency room for further evaluation.		