STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Ahc of Lakewood, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11155 W 15th Pl Lakewood, CO 80215	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure one (#8) of five residents received treatment and care in accordance with professional standards of practice out of 35 sample residents.Specifically, the facility failed to:-Ensure Resident #8's blood sugar levels were being monitored consistently per physician's orders; and,-Ensure the physician was notified, per physician's orders, when Resident #8's blood sugar levels were out of range.Findings include:I. Facility policy and procedureThe Blood Glucose Testing policy and procedure, dated 9/11/23, was provided by the nursing home administrator (NHA) on 3/23/26 at 12:53 p.m. The policy read in pertinent part, Blood glucose testing will be performed by a licensed nurse or nursing assistant per physician order. Appropriate infection control practices will be utilized by staff when performing blood glucose. Knock and gain permission before entering the resident's room. Verify the identity of the resident. Identify yourself and ask the resident's permission to perform blood sampling. If the resident refuses the care, explain the risks of not receiving care, the benefits of receiving care and acceptable alternatives to suggested treatment. If permission is obtained from the resident, explain the procedure to the resident, including treatment process and expected sensations. Answer any questions and proceed. If the resident refuses testing, document it in the medical record.II. Resident #8A. Resident statusResident #8, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with ketoacidosis without coma (life-threatening acute metabolic crisis where high blood sugar and elevated ketones cause blood acidity without leading to unconsciousness) and chronic kidney disease. The 2/25/26 minimum data set (MDS) assessment revealed that the resident was cognitively intact and with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent in indoor mobility and required some help with self care.B. Record review Review of the March 2026 CPO revealed the following physician's order:Check blood sugar twice a day. If blood glucose is greater than 250 milligrams/deciliter (mg/dl) and a sliding scale has not been ordered, notify the physician. If blood glucose is less than 60 mg/dl, follow hypoglycemia (low blood sugar level) procedure.Review of Resident #8's February 2026 and March 2026 vital signs report revealed Resident #8's blood sugar was checked on 2/25/26 at 8:45 p.m. Resident #8's blood sugar was 302 mg/dl. -However, there was no documentation in #8's electronic medical record (EMR) to indicate the physician was notified of the high blood glucose level, despite the physician's order to notify if the blood sugar level was greater than 250 mg/dl (see physician's order above).Review of Resident #8's February 2026 and March 2026 medication administration records (MAR), from 2/18/26 to 3/18/26, revealed there was no blood sugar documented on the afternoon of 2/19/26, 2/20/26, 2/24/26 and 3/9/26. The MARs revealed documentation indicating the resident was unavailable (on 2/19/26, 2/24/26 and 3/9/26) and the resident refused (on 2/20/26). The documentation on all four dates was completed by registered nurse (RN) #2.-However, there was no further documentation in the resident's EMR to indicate why the resident was unavailable or why the resident refused the blood sugar or what education was provided to the resident regarding the refusal. Review of Resident #8's February 2026 and March 2026 MARs, from 2/18/26 to 3/18/26, revealed there was no blood sugar documented on (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/22/26. -However, there was no documentation in the resident's EMR to indicate why a blood sugar was not checked.III. Staff interviewsRN #2 was interviewed on 3/19/26 at 3:28 p.m. RN #2 said when documenting that a resident was unavailable, it would mean a resident was out of the building, at an appointment, at the hospital, or at therapy. RN #2 said normally, nurses could go back and complete the assigned task at a later time if the resident was unavailable prior. RN #2 said he was not sure what Resident #8 was doing on the dates it was charted that Resident #8 was unavailable. The director of nursing (DON) was interviewed on 3/19/26 at 6:55 p.m. The DON said diabetic ketoacidosis was a complication of diabetes and was caused by high blood sugar and insufficient insulin. The DON said diabetes management was up to the physician's discretion on how often to check blood sugars, but they were typically checked two to three times a day before meals and there could be a late evening blood sugar check as well. The DON said nurses checked blood sugars on residents with diabetes to make sure their blood sugar level was not too high or too low and to make sure they were giving the correct amount of insulin. The DON said if blood sugars were too high, it could cause increased thirst, frequent urination, fatigue and blurry vision. The DON said staff should notify the physician immediately if a blood sugar was out of range.The DON said it would not be appropriate to chart that a resident was unavailable. The DON said the nurse should have been explaining why the resident was not available because otherwise it did not give a good picture of what was going on. The DON said there was a spot in the MAR where nursing staff could click the option of other and then be able to provide a better description. The DON said if the resident was at an appointment or out of the building, she would still expect the nurse to check the resident's blood sugar level when they returned. The DON said the nurse could have documented a note in Resident #8's MAR that the resident was out of the facility. The DON said she was not sure where Resident #8 was when he was documented as being unavailable for a blood sugar check on 2/19/26, 2/24/26 and 3/9/26 (see record review above).

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent (%).Specifically the facility's medication error rate was 6.5%, or three errors out of 31 opportunities.Findings include:I. Facility policy and procedureThe Administration of Medication policy and procedure, dated 5/5/26, was provided by the nursing home administrator (NHA) on 3/23/26 at 12:53 p.m. The policy read in pertinent part, Licensed personnel, in accordance with professional standards of practice, will appropriately administer prescribed medications. Compare the prescription label to the order on the electronic medication administration record (eMAR). Verify the six medication administration rights: right patient, right drug, right dose, right dosage form, right route, right time.II. ObservationsOn 3/18/26 at approximately 8:20 a.m. licensed practical nurse (LPN) #1 was preparing to administer a lidocaine (topical medication used to treat pain) 4% patch to Resident #19. Review of Resident #19's March 2026 computerized physician orders (CPO) revealed the following physician's order: Lidocaine 4% adhesive patch. Apply to lower back in the morning and remove every night at bedtime, ordered 3/13/26.LPN#1 told Resident #19 that she had a lidocaine pain patch for her lower back. Resident #19 said she had pain in both her lower back and her right shoulder. LPN #1 placed the lidocaine patch on Resident #19's upper right shoulder.-However, the resident did not have an active physician's order to apply the pain patch to her right shoulder (see physician's orders above). LPN #1 went back to the medication cart and retrieved another lidocaine 4% patch. LPN #1 placed the second lidocaine 4% patch on Resident #19's lower back. On 3/18/26 at 8:28 a.m. LPN #1 was preparing to administer medications to Resident #44. Review of Resident #44's March 2026 CPO revealed the following physician's order:Amlodipine (medication to treat high blood pressure) tablet 2.5 milligrams (mg). Amount to administer: 5 mg orally every day. Hold for systolic blood pressure less than 100 millimeters of mercury (mm/Hg). LPN #1 dispensed Resident #44's medications into a medication cup. LPN #1 dispensed one 2.5 mg amlodipine tablet into the medication instead of two tablets (in order to equal the 5 mg dose). LPN #1 administered the medications to Resident #44, including the one tablet of amlodipine. -LPN#1 failed to administer the correct dose of amlodipine to Resident #44 (see physician's orders above).III. Staff interviewsLPN #1 was interviewed on 3/18/26 at 8:28 a.m., after administering the incorrect dose of amlodipine to Resident #44. LPN #1 said she did not realize she needed to give 5 mg of amlodipine to the resident. LPN #1 said she should have administered another 2.5 mg tablet of amlodipine to Resident #44 in order to equal the full dose ordered. LPN #1 retrieved a second 2.5 mg tablet of amlodipine from the medication cart and administered it to the resident.-However, LPN #1 failed to identify her medication error prior to the interview.LPN #1 was interviewed a second time on 3/19/26 at 2:04 p.m. LPN #1 said staff should make sure they had the right medication, the right dose and administered the medication at the right time. LPN #1 said it was important to make sure all information was accurate before going into a resident's room to administer medications. LPN #1 said it was important to have all medication information correct, in order to prevent medication errors.LPN #1 said Resident #19 had a physician's order for a lidocaine patch to her lower back only. LPN #1 said Resident #19 said her shoulder was hurting so she administered the patch on her shoulder and then got the physician's order for the second pain patch to be placed on the shoulder right away. LPN #1 said she should have called the physician to obtain the physician's order for the second lidocaine patch before placing the patch on the resident's shoulder.The director of nursing (DON) was interviewed on 3/19/26 at 7:52 p.m. The DON said the seven rights of medication administration were the right resident, right medication, right dose, right time, right route, right reason and right documentation. The DON said nurses should always have a physician's order in the resident's electronic medical record (EMR) before administering a medication to a resident. The DON said LPN #1 should have told Resident #19 that she needed to talk to the physician to get another physician's order for an additional lidocaine patch for her shoulder. The DON said LPN #1 should have offered the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident a non-pharmacological intervention for her shoulder pain while waiting for the physician's order to be obtained for the lidocaine patch for her shoulder. The DON said amlodipine was given to ensure a resident's blood pressure did not get too high. The DON said if blood pressure got too high it could lead to health issues of heart attacks, strokes, or vision loss. The DON said nurses should be following the seven rights of medication administration. IV. Facility follow-upA second review of Resident #19's March 2026 CPO on 3/19/26 revealed the following physician's order:Lidocaine 4% adhesive patch. Special instructions: apply one patch to the lower back and over the top of the right shoulder in the morning and remove every night at bedtime.-However, the physician's order to place apply the lidocaine patch to the resident's shoulder was not obtained until the medication error made by LPN #1 was brought to the attention of the facility (see observations above).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain accurately documented medical records for one (#45) of two residents reviewed out of 35 sample residents.Specifically, the facility failed to ensure the administration of Resident #45's as needed (PRN) hydromorphone (opioid analgesic used to treat moderate-to-severe pain when other options are inadequate) on 3/12/26 and 3/13/26 was documented in the resident's electronic medication administration record (eMAR).Findings include:I. Facility policy and procedureThe Administration of Medication policy, updated 5/5/25, was provided by the nursing home administrator (NHA) on 3/23/26 at 1:59 p.m. It read in pertinent part, Licensed personnel, in accordance with professional standards of practice, will appropriately administer prescribed medications. Identify each resident before administering any medication. Use picture identification located in the resident's eMAR and/or verify by asking the resident to state his/her full name, checking with a family member or another staff member. Identify the medication on the eMAR. Compare the prescription label to the order on the eMAR. As you pour each pill into the medication cup, prepare the medication on the eMAR. After administering the medication, return to the eMAR and immediately chart the administration. If a resident does not take a medication for any reason, document the refusal on the eMAR identifying the reason the medication was not received. Logout of the eMAR before leaving the medication cart.II. Resident #45A. Resident statusResident #45, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included encounter for surgical aftercare following surgery on the digestive system, esophageal obstruction, gastro-esophageal reflux disease (GERD) with esophagitis (irritation and swelling of the esophagus, the tube that carries food from mouth to stomach) without bleeding and dysphagia (difficulty swallowing).The 3/17/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident was able to walk independently with a walker. She needed some help completing the activities of daily living (ADLs).The MDS assessment indicated the resident complained of difficulty or pain in swallowing.B. Resident interviewResident #45 was interviewed on 3/18/26 at 11:34 a.m. Resident #45 said she did not receive her as needed pain medication timely after requesting it from licensed practical nurse (LPN) #2 on 3/13/26 Resident #45 said her pain worsened on 3/13/26 because she did not receive the as needed pain medication quickly enough.C. Record reviewResident #45's pain care plan, revised 3/16/26, revealed the resident had acute and/or chronic pain related to general aches and pains. Interventions included administering medication per physician's order, encouraging the resident to express concerns or fears regarding pain management, establishing an acceptable level of pain and notifying the physician if the current regimen was ineffective in managing pain.A physician's order, dated 3/12/26, revealed to administer hydromorphone 4 milligrams (mg) tablet orally every four hours as needed (PRN) for pain on a scale of 6 to 10.The controlled drug record sheet for Resident #45's hydromorphone 4 mg, dated 3/11/26, documented LPN #2 administered hydromorphone to Resident #45 as follows:-One 4 mg tablet was administered by LPN #2 on 3/12/26 at 10:30 a.m.;-One 4 mg tablet was administered by LPN #2 on 3/12/26 at 5:30 p.m.;-One 4 mg tablet was administered by LPN #2 on 3/13/26 at 6:30 a.m.;-One 4 mg tablet was administered by LPN #2 on 3/13/26 at 11:30 a.m.; and;-One 4 mg tablet was administered by LPN #2 on 3/13/26 at 5:00 p.m.-However, review of Resident #45's March 2026 eMAR revealed no documentation of the 4 mg hydromorphone administration by LPN #2 to the resident on 3/12/26 and 3/13/26.III. Staff interviewsCertified nurse aide (CNA) #2 was interviewed on 3/19/26 at 4:08 p.m. CNA #2 said if a resident complained of pain, she would notify the nurse and let the resident know the nurse would be with them shortly. CNA #2 said she would not interrupt the nurse during lunch break. CNA #2 said on 3/13/26 at approximately 4:00 p.m. she did not notify LPN #2 when Resident #45 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complained of pain because LPN #2 was on lunch break. CNA #2 said Resident #45 pressed the call light a second time before she told LPN #2 about the resident's pain complaint.LPN #2 was interviewed on 3/19/26 at 12:43 p.m. LPN #2 said she usually let CNAs know when she was going on lunch break. She said CNAs could come get her if something was going on with a resident. LPN #2 said she should document all PRN medication in the eMAR after administration. She said on 3/13/26 she went on lunch break at 4:30 p.m. She said when she came back at approximately 5:00 p.m., she was on the phone with the physician regarding a critical laboratory result for another resident. LPN #2 said she administered the hydromorphone to Resident #45 shortly after 5:00 p.m. She said she documented the pain medication administration in Resident #45's eMAR. -However, review of Resident #45's March 2026 eMAR revealed no documentation of the hydromorphone administration by LPN #2 on 3/13/26 at 5:00 p.m. Additionally, several other administrations of the medication by LPN #2 on 3/12/26 and 3/13/26 were not documented in the eMAR(see record review above).The director of nursing (DON) was interviewed on 3/19/26 at 7:10 p.m. The DON said CNAs should notify her if a resident complained of pain and needed pain medication while the floor nurses were on lunch break. The DON said nurses should document all narcotic medications after administration in the resident's eMAR and on the narcotic sheet. The DON said she was unable to locate documentation of hydromorphone administration by LPN #2 in Resident #45's eMAR on 3/12/26 and 3/13/26.