

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2023
NAME OF PROVIDER OR SUPPLIER Lowry Hills Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 10201 E 3rd Ave Aurora, CO 80010	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135</p> <p>Based on interviews and record review the facility failed to ensure one (#1) of three sample residents were free from sexual abuse.</p> <p>The facility failed to protect Resident #1 who no longer wanted her prior consensual intimate relationship with Resident #2. On 3/22/23 (one day after Resident #1 returned from the hospital) Resident #2 came into Resident #1's room while she was sleeping and without her consent did a sexual act on her. Resident #1 said she was sleeping on 3/22/23 and the sexual act was non-consensual. After the 3/22/23 abuse, Resident #1 was moved to a different hallway in the facility to keep her away from Resident #2. On 4/6/23 Resident #2 came into her new room while she was sleeping and did a sexual act to her which again, which Resident #1 said also was non-consensual. The facility failed on both dates to protect Resident #1 from abuse by Resident #2. Resident #1 expressed she did not feel safe even after changing rooms until Resident #2 discharged from the facility on 4/13/23.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect and Exploitation policy 1/1/22, and revised 6/1/22 was provided by the nursing home administrator (NHA) on 4/18/23 at 3:08 p.m. It revealed in pertinent part,</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.</p> <p>'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>'Sexual Abuse' is non-consensual sexual contact of any type with a resident.</p> <p>(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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Prevention of Abuse, Neglect and Exploitation</p> <p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship;</p> <p>The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;</p> <p>Protection of Resident</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:</p> <p>Responding immediately to protect the alleged victim and integrity of the investigation;</p> <p>Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;</p> <p>Increased supervision of the alleged victim and residents;</p> <p>Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;</p> <p>Protection from retaliation;</p> <p>Providing emotional support and counseling to the resident during and after the investigation, as needed.</p> <p>II. Resident status</p> <p>A. Resident #1 (victim)</p> <p>Resident #1, age 73, was admitted on [DATE] and readmitted on [DATE]. According to the April 2023 computerized physician orders (CPO), the diagnoses included emphysema (damage of lung tissue), chronic obstructive pulmonary disease (COPD), stage three chronic kidney disease, Parkinson's Disease, hypertension (high blood pressure), unspecified dementia, difficulty walking, and dysphagia (difficulty swallowing).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 3/23/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. She required extensive assistance with dressing, toilet use, and personal hygiene. She did not walk in her room or the corridors. She had adequate vision.</p> <p>B. Resident interview</p> <p>Resident #1 was interviewed on 4/18/23 at 4:05 p.m. She said she had been in a consensual romantic relationship with Resident #2. She said after her hospital stay in March 2023 she no longer wanted to be anything but friends with him. She said she certainly would never allow him to come into her room while she was sleeping and have sexual acts with her without her permission. She said she was sleeping on both occasions when Resident #2 came into her room and performed sexual acts on her. She said she had good vision but had a hard time keeping her eyes open. She said after the first time he took advantage of her the facility moved her onto another wing to live to keep her safe from Resident #2. She said she still talked to him in the hallways and dining room because they were once friends. She said in her new room he came in and did the same thing to her again. She said, I heard he doesn't live here anymore and that makes me feel safe. I didn't feel safe from him until he moved.</p> <p>C. Record review</p> <p>The sexual expression care plan was signed by Resident #1 on 2/1/23. Resident #1 signed a consent which read she wanted the facility to honor her wishes to have sexual relations. The target date on the facility form was only documented as ongoing.</p> <p>-This agreement was never re-evaluated or discussed with her again, including after both sexual abuse incidents on 3/22/23 and 4/6/23 (see social service director interview below). The form did not document any other review dates for her sexual expression.</p> <p>The progress note on 3/21/23 revealed, Resident #1 was readmitted to the facility from the hospital.</p> <p>The nursing progress note 3/22/23 at 2:39 p.m. revealed, the resident was unable to consent to sexual interactions. Her roommate went to a nurse to get help for Resident #1. The nurse witnessed Resident #2's pants down and (his) private areas were in Resident #1's mouth. Resident #2 was informed to put his pants up and leave the room. Resident #2 was told no sexual interaction could occur when the other person could not consent. Both residents remained separated.</p> <p>The comprehensive care plan updated 3/23/23 revealed in pertinent part,</p> <p>Focus: Psychosocial well-being: Resident #1 was at risk for emotional distress with a history of a sexual relationship with a resident of the opposite gender. She received unwanted sexual contact from another resident while she was sleeping and (was) unable to give consent. Resident #1 was previously agreeable to this sexual relationship but indicated she does not want it to continue. Resident #1 was able to discuss her feelings and concerns.</p> <p>Goal: Resident #1 will remain free from emotional distress with resident to resident altercation through the review date of 6/14/23.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions: Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears as needed. Anticipate and meet the resident's needs. Ensure (the) resident feels safe in the facility. Frequent checks as needed when incidents occur.</p> <p>The social service progress note 3/24/23 revealed Resident #1 said she wanted to only meet with Resident #2 in the common areas such as the lobby and not in her room. Follow-up visits to be continued to ensure resident's safety.</p> <p>The social service progress note 3/27/23 revealed a BIMS test was conducted on Resident #1 and she scored a 14 out of 15, she was cognitively intact.</p> <p>The nursing progress note 4/6/23 at 2:39 a.m. revealed Resident #1 was unable to consent to sexual interactions. The nurse and a certified nurse aide (CNA) witnessed Resident #2 with his pants down and his private parts were in Resident #1's mouth while the resident was in her bed trying to sleep. Resident #2 was asked to leave the room and told sexual encounters cannot take place without consent.</p> <p>The social service progress note 4/6/23 at 2:09 p.m. revealed Resident #1 said, Resident #2's behavior was not acceptable and she did not want to see Resident #2 in her room again or in the common areas.</p> <p>III. Resident status</p> <p>A. Resident #2 (perpetrator)</p> <p>Resident #2, age under 65, was admitted on [DATE] and was discharged on [DATE]. According to the April 2023 CPO, the diagnoses included cerebral infarction (stroke), hypertension (high blood pressure), altered mental status, alcohol abuse, alcohol hepatitis (inflammation of liver) and homelessness.</p> <p>The 2/25/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required extensive assistance with dressing, and personal hygiene. He required limited assistance with bed mobility. He was independent in his room, and walking in his room and in the corridors.</p> <p>B. Record review</p> <p>The nursing progress note 3/22/23 at 2:30 p.m. revealed Resident #2 was found in the room of Resident #1 with his pants down and his private parts in her mouth. Resident #2 was reminded he was unable to have sexual interactions with an individual without their consent.</p> <p>The comprehensive care plan 3/23/23 revealed,</p> <p>Focus: Resident #2 has a potential behavior problem with sexually inappropriate activity. He has a history of exploring sexually consensual relationships with residents of the opposite gender, but he may attempt to engage in sexual activity when they are not able to give consent (when they are sleeping). He needs to have his care needs met daily without causing harm to himself or others.</p> <p>Goal: Resident #2 will have no evidence of behavior problems by review date.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions: Frequent checks as needed when incidents occur. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Divert attention, remove from(the) situation, and take to (an) alternate location as needed. Document behavior and potential causes.</p> <p>The comprehensive care plan was updated on 4/11/23 and revealed as an intervention, one-to-one as needed when incident(s) arise.</p> <p>The nursing progress note 4/6/23 at 2:21 a.m revealed Resident #2 was found in the room that Resident #1 had recently been moved into (see nursing home administrator below that Resident #1 was moved to another room to keep her safe from Resident #2). A nurse and a CNA witnessed Resident #2 with his pants down, and he extended his penis in Resident #1's mouth while she was sleeping. Resident #2 (was) reminded he was not allowed to have sexual encounters with others without their consent.</p> <p>-Resident #2 was placed on one-to-one care with a CNA until a discharge plan could be achieved.</p> <p>The social service progress note 4/6/23 revealed Resident #2 was told not to come into the resident's room, or near Resident #1 or the police would be called.</p> <p>The nursing progress note 4/10/23 revealed Resident #2 was found sitting in his wheelchair in a female's room. The note did not document who the female resident was. Fifteen minute checks were to go on for both residents.</p> <p>IV. Facility investigation</p> <p>The investigation summary of the 3/22/23 incident was provided by the NHA on 4/18/23 at 1:45 p.m. The summary revealed in pertinent part,</p> <p>On 3/22/23 it was reported to the administration that an alleged sexual abuse occurred where one of the other residents with whom resident has a history of sexual relationship on a consensual basis. On this day the alleged perpetrator was observed attempting to make sexual contact (with Resident #1).</p> <p>Resident #1 said, She was unaware of the alleged sexual abuse. Resident #1 stated she is not okay with that kind of behavior and does not want the alleged perpetrator in her room.</p> <p>Resident #2 said, Whosoever is saying that is lying. When Resident #2 was told that Resident #1 did not want him in her room he responded, Whatever.</p> <p>The investigation summary of the second incident on 4/6/23 was provided by the NHA on 4/18/23 at 3:35 p. m. (After it was revealed in a progress note that a second sexual abuse incident had occurred) It revealed in pertinent part,</p> <p>On this day the alleged perpetrator (Resident #2) was observed penetrating Resident #1's mouth while she was sleeping and hence, it was without her consent.</p> <p>V. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA was interviewed on 4/18/23 at 2:10 p.m. She said the CNAs were to do 15-20 minute checks on Resident #2 after the 3/22/23 incident. She said the facility CNAs did not observe him closely enough. She said Resident #1 was moved to a different hallway to protect her from Resident #2.</p> <p>The assistant director of nursing (ADON) was interviewed on 4/18/23 at 2:47 p.m. She said on 3/22/23 Resident #1's roommate came to alert her that Resident #2 was in the room and something sexual was going on. She said when she entered she could see Resident #2's private parts were on Resident #1's face. She said she told him to remove himself from the room. She said the facility moved Resident #1 to another room on a different hallway to keep her safe from Resident #2. She said Resident #2 was supposed to be watched by the CNAs but apparently he was not watched closely enough and on 4/6/23 he went into Resident #1's new room and did the same non-consensual sex act again.</p> <p>The social service director (SSD) was interviewed on 4/18/23 at 3:10 p.m. She said Resident #1 and Resident #2 had signed a sexual consent document back in February 2023. She said the facility had both Resident #1 and Resident #2 sign the paperwork called a consensual sexual expression care plan. She said as far as she knew Resident #2 was the only person Resident #1 had relations with. She said Resident #1 went to the hospital for pneumonia and respiratory failure in March 2023. She said when Resident #1 returned to the facility she noticed changes in her and did some cognitive tests. She said she never re-evaluated Resident #1 about her sexual consent paperwork. She said after both incidents, 3/22/23 and 4/6/23, she did not re-evaluate the sexual consent assessment with either Resident #1 or Resident #2. She said she interviewed Resident #1 after both incidents. She said Resident #1 told her she did not consent to either sexual incidents. She said Resident #1 was asleep both times Resident #2 was found in her room doing sexual acts.</p> <p>She said after the first incident Resident #2 said he did not care about what had happened. She said after she spoke to him after the second sexual incident he refused to speak or respond to her when she attempted to speak to him. She said he just shrugged his shoulders in front of her.</p> <p>The NHA was interviewed again on 4/18/23 at 3:40 p.m. She said there was no behavioral tracking done for either resident after the 3/22/23 or 4/6/23 incidents. She said after the first incident she put in a request for counseling for Resident #1 but had not heard back from the company yet and she would call the counseling company soon to see what had happened with her request. She said Resident #1 was moved to another hallway to keep her safe from Resident #2. She said after the 4/6/23 incident the CNAs were to do one-to-one observations 24 hours, seven days a week with Resident #2 until he could be discharged from the facility. She said on 4/6/23 he was found in Resident #1's new room and again had non-consensual sexual relations with her. She said apparently the 15-20 minute checks were not enough to stop him from doing this act again. She said the CNA was not watching him on 4/6/23 closely enough. She said Resident #2 was very quick when he walked. She said she did not know how Resident #2 got to Resident #1's room without being noticed on 4/6/23 except that he was not being watched closely enough. She did not know how Resident #2 knew where Resident #1's new room was except maybe Resident #1 talked to him in the halls and dining room area prior to 4/6/23 and told him. She said maybe Resident #2 noticed her coming out of the beauty salon which was close to her room and watched her go to her room.</p> <p>VI. Facility follow-up</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/19/23 at 12:29 p.m. the NHA emailed follow-up staff interviews the facility had done after the 4/18/23 survey. During the recent interviews of the incidents almost a month later, the staff had variances in their story of where exactly Resident #2's private parts were during the incidents. During the follow-up interviews the facility staff verified Resident #2's pants were down and his private parts were exposed.</p> <p>On 4/19/23 at 12:29 p.m. the NHA also provided interdisciplinary care team (IDT) notes after the incidents which revealed in pertinent part,</p> <p>-On 3/23/23 Resident #1 only wanted to see Resident #2 in the hallways. Resident #1 was moved to another room to give her some space from Resident #2. Resident #2 was started on frequent safety checks.</p> <p>-On 4/6/23 after the incident occurred staff were educated on one-to-one supervision for Resident #2. Resident #2 remained with one-to-one care 24 hours, seven days a week until he was discharged to another facility.</p>		