

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Rowan Community, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 E Asbury Cir Denver, CO 80222	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</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 (#2) of five residents out of 14 sample residents were treated with respect, dignity and care in a manner that promoted quality of life or recognized the residents' individuality. Specifically, the facility failed to: -Knock prior to entering Resident #2's room, introduce themselves and the care they were going to be providing; and, -Respect Resident #2's wish to have staff enter her room wearing a face mask. Findings include: I. Resident #2A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), the diagnoses included bipolar disorder (mental illness), chronic respiratory failure and type 2 diabetes mellitus. The 9/3/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 12 out of 15. She was dependent on staff for activities of daily living (ADL), including eating, oral hygiene, showering, toileting and dressing. B. Observations During a continuous observation on 10/1/25, starting at 1:50 p.m. and ending at 4:28 p.m. the following was observed: At 1:50 p.m. three handwritten signs were attached to Resident #2's door which requested any staff member who entered the resident's room, except to administer medications, wore a face mask over their nose. One of the handwritten signs was written in Spanish. At 3:44 p.m. an unidentified medical supply staff member entered Resident #2's room without knocking or wearing a mask. At 3:53 p.m. certified nursing assistant (CNA) #1 entered Resident #2's room without knocking or wearing a mask. C. Resident interview Resident #2 was interviewed on 10/6/25 at 5:00 p.m. Resident #2 said it made her feel horrible when the staff entered her room without wearing a face mask. She said the facility had face masks available. She said it made her feel bad when staff entered her room without knocking or announcing themselves. D. Record review Review of Resident #2's care plan, initiated on 11/6/21, revealed the resident preferred to wear a mask when outside of her room. The pertinent intervention included keeping a mask on Resident #2 at all times while she was out in the community. -However, Resident #2's care plan failed to include the resident's preference for staff members to wear a mask upon entering her room. E. Staff interviews An unidentified CNA was interviewed on 10/6/25 at 3:15 p.m. The CNA said there was a box of face masks available in Resident #2's room for staff members who did not present to the room wearing a face covering. The nursing home administrator (NHA) was interviewed on 10/7/25 at 11:46 a.m. The NHA said staff should have knocked on the resident's doors to announce themselves and the care they would provide in order to protect the resident's dignity. She said individual resident preferences, such as Resident #2's preference for staff to put on a face mask prior to entering the resident's room, should have been communicated in the care plan in order to provide consistent care. The NHA said in this case, Resident #2's family member placed the signs on the door to communicate the resident's preference to staff. She said face masks should have been donned prior to entering the resident's room, and face masks were accessible and stored at the nursing</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 065206	Facility ID: 065206 If continuation sheet Page 1 of 7

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to facilitate resident self-determination for one (#4) of five residents reviewed for choices and preferences out of 14 sample residents. Specifically, the facility failed to honor Resident #4's choice to return to his room. Findings include: I. Resident #4A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI), post traumatic seizures and chronic respiratory failure. The 8/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on staff for activities of daily living (ADL), including personal hygiene, dressing, eating and mobilizing. B. Observations During a continuous observation in the dining room on 10/1/25, starting at 12:55 p.m. and ending at 2:11 p.m., the following was observed: At 1:06 p.m. Resident #4 asked an unidentified staff member to assist him back to his room. The unidentified staff member told the resident his room was being cleaned and he had to wait 15 minutes. At 1:32 p.m. an unidentified housekeeping staff member asked Resident #4 how he was doing. The resident responded by saying he would like to go to his room. The staff member walked away without responding to the resident. At 2:02 p.m. Resident #4 began shouting get me the (explicit language) out of here. At 2:06 p.m. Resident #4 asked the activities director (AD) to bring him back to his room. The AD did not respond to the resident. Resident #4 then asked an unidentified kitchen staff member to bring him back to his room. The kitchen staff member said he would find a staff member to help him. The AD said she was busy setting up for the Bingo activity. At 2:11 p.m. Resident #4 said he wanted to go home, then repeated himself and said he wanted to go to his room. -The facility failed to assist Resident #4 out of the dining room for over an hour after he requested. C. Resident interview Resident #4 was interviewed on 10/6/25 at 2:00 p.m. Resident #4 said when he wanted to go back to his room he was often required to wait long periods of time it made him feel bad. D. Staff interviews The nursing home administrator (NHA) was interviewed on 10/7/25 at 11:46 a.m. The NHA said the facility should have honored all of the residents' choices. She said Resident #4's experience did not occur as a result of a staffing issue. The NHA said the unidentified staff member who told Resident #4 he would have to wait just 15 minutes to return to his room probably forgot to follow up with him.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure a dependent resident received the necessary services to maintain activities of daily living (ADL) for two (#4 and #5) of five residents out of 14 sample residents. Specifically, the facility failed to:-Ensure timely repositioning and incontinence care for Resident #4; and,-Ensure timely repositioning for Resident #5. Findings include:</p> <p>I. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury (TBI), post traumatic seizures and chronic respiratory failure.</p> <p>The 8/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on staff for ADLs, including personal hygiene, dressing, eating and mobilizing.</p> <p>B. Resident interview and observation</p> <p>During a continuous observation on 10/2/25, starting at 12:37 p.m. and ending at 2:30 p.m., the following was observed:</p> <p>At 12:37 p.m. Resident #4 was sitting in his geri chair (specialty wheelchair) in the dining room staring at the wall. There were no activities or engagement for the residents and only dining room staff members were present.</p> <p>At 12:50 p.m. Resident #4 remained in the same position.</p> <p>At 1:37 p.m. Resident #4 remained in the same position</p> <p>At 1:54 p.m. Resident #4 remained in the same position</p> <p>At 2:00 p.m. Resident #4 said he had been sitting in his chair for a long time and would like to go back to his room. He said it had been a long time since he had been offered incontinence care.</p> <p>At 2:02 p.m. the activities director (AD) entered the dining room and was notified that Resident #4 would like to be assisted back to his room and changed. The AD left the dining room and said she would find a certified nursing assistant (CNA).</p> <p>At 2:04 p.m. the AD returned to the dining room and said she notified CNA staff.</p> <p>At 2:11 p.m. no staff members had come to the dining room to assist Resident #4. The AD was walking in and out of the dining room, but did not provide further assistance to the resident.</p> <p>At 2:14 p.m. CNA #2 arrived on shift and was asked to assist Resident #4 with incontinence care. CNA #2 assisted the resident to his room and said she was going to get the Hoyer lift (mechanical lift</p> <p>(continued on next page)</p>		

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