STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of four residents were free from abuse out of 18 sample residents.Specifically, the facility failed to ensure Resident #1 was free from abuse from Resident #2.Resident #1 was admitted on [DATE] with diagnoses of dementia and right-sided hemiplegia and hemiparesis following cerebral infarction. Resident #2 was admitted on [DATE] with diagnoses of diabetes mellitus type 2, dementia with behavioral disturbance, schizoaffective disorder, heart disease and chronic kidney disease. On 9/7/25 Resident #1 told Resident #2 to shut up. Resident #2 responded by pushing Resident #1. Resident #1 fell to the ground and sustained a left wrist fracture. Findings include: I. Physical abuse by Resident #2 towards Resident #1 on 9/7/25. A. Facility investigation The 9/7/25 facility investigation was provided by the nursing home administrator (NHA) on 10/29/25 at 9:30 a.m. The investigation documented that on 9/7/25 at approximately 1:40 p.m. Resident #2 was seated in the common area watching the television. Resident #1 was ambulating through the same area making noises and then told Resident #2 to shut up. Resident #2 stood up and pushed Resident #1, which caused her to fall. The investigation documented that staff interviews confirmed Resident #1 spoke first, followed by Resident #2's response and physical action. The facility also interviewed and documented the responses of all residents who resided on the floor of the facility where the incident occurred. The investigation revealed that on 9/7/25, the social services director (SSD) documented the following staff statements regarding the altercation: Registered nurse (RN) #1 said she saw Resident #1 walking around and talking aloud to herself. She said Resident #2 was sitting on the couch talking to himself. RN #1 said she saw Resident #1 walked over to Resident #2 and told him to shut up. RN #1 said Resident #2 then stood up and she saw Resident #1 fall. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	Cook (CK) #1 said he was bringing snacks upstairs and when he got off the elevator he witnessed Resident #1 tell Resident #2 to shut up. CK #1 said Resident #2 responded by pushing Resident #1, and she fell. Certified nurse aide (CNA) #1 said she saw Resident #1 walking around and talking out loud and Resident #2 was sitting on the couch, watching television and talking to himself as he normally did. CNA #1 said she saw Resident #1 walk over to Resident #2 and say shut up. CNA #1 said Resident #2 then stood up and pushed Resident #1. The investigation revealed that documentation review showed a history of behavioral expressions for Resident #2, while Resident #1 had no prior involvement in altercations. The investigation documented Resident #1 sustained a left wrist fracture. The investigation documented that the SSD spoke with adult protective services (APS), who said they would be substantiating the event and closing the case due to no evidence of abuse. -However, abuse occurred due to Resident #2 pushing Resident #1, which resulted in a wrist fracture. B. Resident #1 (victim) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included dementia and right-sided hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke). The 10/9/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted as the resident was rarely understood. The 10/9/25 MDS assessment revealed the resident was independent with activities of daily living (ADL), including eating and oral hygiene. She required set-up or clean-up assistance with toileting, mobility and upper body dressing, and supervision assistance with showering, lower body dressing and putting on/removing footwear. 2. Record review Resident #1's dementia care plan, initiated 11/20/24, documented she had impaired cognitive function and dementia or impaired thought processes. Pertinent interventions, initiated 5/27/25, included to report to the nurse any changes in cognitive function, specifically awareness of surroundings and others and difficulty expressing self or understanding others. Resident #1's psychosocial care plan, initiated 11/20/24, documented she was at risk for a psychosocial well-being problem related to her dementia. Pertinent interventions, revised 9/8/25, included to provide support to identify potential solutions to present problems and to provide support to identify problems that could not be controlled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	A late entry social services progress note, documented on 9/7/25 at 11:29 a.m., but back dated to 1:40 p.m. (prior to the incident) revealed the SSD was informed by facility staff that Resident #1 was involved in a resident-to-resident incident that resulted in Resident #1 falling. According to the nurse on the floor, the resident had no visible injuries and the nurse's assessment was that Resident #1 presented at baseline, however, the resident reported pain to her left side. The SSD spoke to the staff on the floor who reported that Resident #1 told another resident (Resident #2) who was sitting across from her in the common area to shut up and the resident who was talking to himself got up and pushed Resident #1, resulting in her falling. Resident #1 was immediately assessed by nursing staff and taken to the emergency room (ER) by emergency medical services (EMS). Review of Resident #1's hospital Discharge summary, dated [DATE], revealed the resident sustained a closed left distal radius fracture. The discharge summary documented the following physician's order: Maintain splint for closed left distal radius fracture. Nonoperatively managed. Follow up with the doctor in the clinic in one to two weeks. No weightbearing to the left upper extremity (LUE). C. Resident #2 (assailant) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included diabetes mellitus type 2, dementia with behavioral disturbance (agitation including verbal and physical aggression, wandering) schizoaffective disorder (bipolar type), heart disease, and chronic kidney disease. The 9/3/25 MDS assessment revealed the resident was rarely understood and had a memory problem impairment. He was independent with ADLs. The assessment documented the resident did not have physical or verbal behaviors toward others. 2. Record review Resident #2's psychotropic medication care plan, initiated and revised 1/16/25, documented the resident used psychotropic medication for a diagnosis of schizoaffective disorder. Pertinent interventions, initiated 1/16/25, included to monitor episodes of delusions, hallucinations, and paranoia; monitor side effects such drowsiness, dry mouth, blurred vision, constipation and less common side effects including edema, extra pyramidal symptoms, urinary retention, stiff or tight muscles, and restlessness. Non-pharmacological interventions included: back rubs, redirection, speak to and approach the resident in a calm manner, reposition, offer snacks, fluids, milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities and provide reassurance. Resident #2's antipsychotic medication care plan, initiated 1/3/25 and revised 9/8/25, documented the resident used an antipsychotic medication for a diagnosis of schizoaffective disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	Pertinent interventions, revised 9/25/25, included to document episodes of behavior; monitor episodes of delusions/hallucinations, talking to the television, and paranoia (non-stop screaming). Non-pharmacological interventions included redirection, speak to and approach the resident in a calm manner, offer television and quiet shows, offer snacks and/or fluids, assess for pain, provide a quiet environment or music in the resident's room. Resident #2's psychosocial care plan, initiated 1/21/25, documented he had potential for well-being problems from a diagnosis of schizoaffective disorder and the resident had limited cognitive function. Pertinent interventions, initiated 1/21/25, included the resident needed assistance, encouragement, and support to identify problems that cannot be controlled; encouraging participation from the resident who depended on others to make decisions, the resident needed assistance/supervision/support to identify causative and contributing factors; the resident needed assistance, supervision, and support to identify precipitating factors and/or stressors, and the resident needed assistance, supervision and support with the identification of potential solutions to problems. Resident #2's mood care plan, initiated and revised 3/28/25, documented he had potential for a mood problem due to his disease process. The resident could get very angry and frustrated at times. Pertinent interventions, initiated 3/28/25, included administering medications as ordered, encouraging the resident to express his feelings and assist the resident to identify strengths, positive coping skills and reinforce these. Resident #2's behavior care plan, initiated 3/28/25 documented he had the potential for a behavior problem of touching himself in public places due to his disease process. Pertinent interventions, initiated 3/28/25, included to anticipate and meet needs, approaching the resident in a calm manner, documenting behaviors, and resident response to interventions, if reasonable, discuss the behavior and explain or reinforce why the behavior was inappropriate and or unacceptable. Resident #2's physical behaviors care plan, initiated 9/8/25, documented he had the potential to demonstrate physical behaviors and may resort to physical behaviors against others due to a dementia diagnosis and poor impulse control. Triggers included being told to shut up or approached in a confrontational manner. Pertinent interventions, initiated 9/8/25, included analyzing the key times, places, circumstances, triggers, and what de-escalated the resident's behavior and document the findings; documenting the resident's observed behavior and attempted interventions; ff the resident began talking out loud to himself in an argumentative manner, please redirect him to an activity of his choice such as listening to music in his room or watching television; when the resident became agitated, guiding the resident away from the source of distress, engaging calmly in conversation and if his response was aggressive, staff were to walk away and approach the resident later. -The care plan did not included in the interventions to guide other residents away from Resident #2 if he demonstrated physical behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #2's progress notes revealed a history of documented behaviors: A 5/29/25 behavior note, documented by licensed practical nurse (LPN) #1, revealed Resident #2 was very agitated off and on all throughout the shift. He was yelling at the television and at the ceiling at times. A 6/5/25 behavior note, documented by LPN #1, revealed Resident #2 was becoming more and more vocal, yelling at the television and other residents; he would walk around and stare at the ceiling frequently. A 6/6/25 nursing note, documented by LPN #1, revealed Resident #2 continued to yell at other residents and the television and continued to walk around the unit staring at the ceiling. A 6/12/25 behavior note documented Resident #2 continued to yell at other residents, the television and the ceiling. A 6/12/25 physician's progress note documented a report of an acute episode. Nursing requested that Resident #2 be seen. The chief complaint was that the resident's behavior continued to escalate and the resident also was very threatening during his interview. A 6/17/25 physician's note documented Resident #2's assessment and plan included a diagnosis of unspecified dementia, unspecified severity with psychotic disturbance and to restart risperidone (antipsychotic medication used to treat schizophrenia) 1 milligram (mg) every evening. A 9/7/25 progress note documented Resident #2, who had a diagnosis of dementia with severe cognitive impairment, was seated in the common area watching television. Resident #1, who also had a diagnosis of dementia with a BIMS score of five indicating severe cognitive impairment, was ambulating through the same area making noises. Both residents were known to ambulate independently without the use of assistive devices. There was no indication of prior interaction or any identifiable trigger between the two residents before the incident occurred. Resident Resident #2 stood up, verbally stated shut up and pushed Resident #1, causing Resident #1 to fall. Resident #2 was unable to articulate what happened due to cognitive deficit but he said, It is her, it is her. Staff responded immediately and separated both residents. Resident #2 was placed on 15-minute checks. Resident #2 had no skin issues except a mark from the police handcuffs. The physician, medical director and the resident's representative were notified. -However staff interviews (see interviews below) and the facility investigation (see investigation above) revealed Resident #1 told Resident #2 to shut up, and Resident #2 pushed Resident #1 causing her to fall. A 9/7/25 social services note documented the social services director (SSD) came in to speak to Resident #2 regarding the resident-to-resident incident that occurred earlier in the day (see above note). The resident did not display any outward signs of distress or discomfort. The resident stated he was okay and did not seem to be able to recall the incident and the resident had severe cognitive impairments. III. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	CNA #2 was interviewed on 10/30/25 at 11:45 a.m. CNA #2 said she was not present for the resident altercation between Resident #1 and Resident #2. She said Resident #2 talked to himself and frequently refused care including oral care and dressing. RN #1 was interviewed on 10/30/25 at 2:59 p.m. RN #1 said she could not see the altercation between Resident #1 and Resident #2 because a pillar blocked her view. She said she could hear Resident #2 talking out loud and increasing his volume. RN #1 said Resident #2 frequently talked out loud, and talked louder and louder but she had never seen him hit or strike out. RN #1 said the day of the altercation, Resident #2 was particularly loud and she said she heard Resident #1 yell at Resident #2 to stop or shut up. She said she and CNA #1 went over to assess both residents immediately after Resident #1 fell. She said the NHA and the director of nursing (DON) and EMS were notified. IV. Additional staff interviews CNA #4 was interviewed on 10/30/25 at 11:40 a.m. CNA #4 said Resident #1 lived on the current unit for approximately a month. CNA #4 said Resident #1 kept to herself, and came out for coffee social, breakfast and lunch. CNA #4 said Resident #1 did not have many interactions with other residents and was the quiet type. CNA #4 said she received abuse training during her facility orientation and had received abuse training in person in which different types of abuse were reviewed. CNA #4 said she would report abuse immediately. CNA #4 said if a resident told another resident sitting at the same table to shut up she would intervene and ask the resident if they needed help. CK #1 was interviewed on 10/30/25 at 1:07 p.m. CK #1 said he was taking some snacks to the unit on 9/7/25. CK #1 said he was trying to check the status of a game on the television and was facing the television while standing at the nurses' station. CK #1 said Resident #2 was yelling while sitting down on the couch. CK #1 said Resident #1 stood up and she yelled shut up. CK #1 said Resident #1 was not standing over Resident #2 and Resident #2 walked over to her. CK #1 said he had no idea Resident #2 would push Resident #1. CK #1 said Resident #2 went right up to Resident #1 and faced her and he saw Resident #2 make contact with Resident #1. CK #1 said Resident #1 fell on the floor and she was moaning in pain. CK #1 said Resident #2 was yelling (on 9/7/25) like he always did. CK #1 said Resident #2 frequently yelled as his baseline. CK #1 said Resident #2 sat in a chair by himself and would yell and talk in his native language and not to anyone in particular. CNA #1 was interviewed on 10/30/25 at 1:28 p.m. CNA #1 said Resident #1 walked independently prior to the incident (on 9/7/25). CNA #1 said on 9/7/25 Resident #2 was talking a lot and it was getting on Resident #1's nerves, so Resident #1 told Resident #2 to shut up. CNA #1 said Resident #2 stood up and walked over and pushed Resident #1 down, and it happened so quickly. CNA #1 said Resident #2 did not like being told to shut up. CNA #1 said Resident #1 fell on the floor and hit the floor hard. CNA #1 said she ran to the Resident #1 and she and a nurse separated Resident #2 from Resident #1. CNA #1 said Resident #1's behaviors were primarily yelling and making a lot of noise but he had not physically harmed anyone. CNA #1 said when the resident would get louder, the staff would redirect him. CNA #1 said when other residents told Resident #2 to shut up the staff told the residents to not tell Resident #2 to shut up. CNA #1 said Resident #2 spoke a foreign language but he understood shut up and it triggered him, and he did not like it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0600 Level of Harm - Actual harm Residents Affected - Few	The SSD was interviewed on 10/30/25 at 1:40 p.m. The SSD said she came to the building on 9/7/25 after the incident between Resident #1 and Resident #2 was reported. The SSD said she and the social services assistant (SSA) interviewed all residents on the unit to ensure the residents felt safe. The SSD said if the staff heard something out of the norm prior to the incident between Resident #1 and Resident #2, they would have turned and given the residents their attention. V. Facility follow up The in-service education record for interventions for Resident #2, dated 9/8/25, was provided as part of the facility investigation on 10/29/25 at 9:30 a.m. The education included the following: Resident #2 may exhibit behaviors such as talking to or yelling at the television. If he was becoming agitated at the television it may increase the chances of him becoming agitated with other residents and could place them at risk of an altercation. Please encourage other residents to avoid him if he appears to be agitated. Interventions that may reduce his agitation include: redirection, speak to/approach in a calm manner, offer tv-change to quiet shows, offer snacks and fluids, assess for pain and provide a quiet environment and music in his room These interventions may be found in the Kardex (staff directive tool) and in the monitoring order. The resident spoke English as a second language but may need a translation service at times (information is available at the nurses' station). The in-service education record for Abuse/Neglect Allegations, dated 9/8/25, was provided as part of the facility interventions on 10/29/25 at 9:30 a.m. The education included the following: The resident had the right to be free from abuse, neglect, misappropriation of resident property and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Physical abuse included hitting, slapping, throwing objects, pushing, spitting, grabbing and restraints. Verbal abuse included threats, yelling, profanity, and mocking. Sexual abuse included any non-consensual sexual contact. Neglect included failure to provide necessary care or supplies. If a resident exhibited increased signs of agitation/frustration, please attempt to intervene and calm the resident down. Early interventions may reduce the risk of any altercation.