

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER City Park Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide services in accordance with accepted professional standards for one (#4) of four residents reviewed for ostomy care out of four sample residents. Specifically, the facility failed to ensure Resident #3 was provided appropriate ostomy care per physician's orders. Findings include: I. Resident #4A. Resident status Resident #4, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the October, 2025 computerized physician orders (CPO), diagnoses included morbid obesity, peripheral vascular disease, ileostomy, dementia and cognitive deficit. The 8/13/ 25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for a mental status (BIMS) score of 12 out of 15. She required supervision or touching assistance with toileting hygiene, including managing an ostomy (a surgically created opening (stoma) in the abdomen to allow stool or urine to exit the body, bypassing the normal pathway) and wiping the opening with managing equipment. B. Resident interview Resident #4 was interviewed on 10/21/25 at 10:20 a.m. Resident #4 said she would change her own ostomy appliance if the nurses were too busy to do so. Resident #4 said she learned how to change her own colostomy by watching the nurses. Resident #4 said she did not receive any formal training from the nursing staff regarding how to change her colostomy, but they always let her do it. Resident #4 said on several occasions in August 2025 and September 2025, the facility constantly ran out of her nystatin powder which was supposed to be applied to the reddened areas on her skin around the ostomy appliance. Resident #4 said the nursing staff did not change her colostomy appliance consistently every time. She said each nurse changed her ostomy a different way using different types of appliances because the staff told her they had to use whatever was available for her treatments. C. Observations On 10/21/25 at 10:06 a.m. registered nurse (RN) #1 was observed performing colostomy care for Resident #4. RN #1 said she had worked at the facility for three years. RN #1 did not review Resident #4's treatment orders prior to completing ostomy care for the resident. The colostomy was leaking stool from below the ostomy appliance onto the resident's skin. The skin around and below the ostomy stoma was red, inflamed and according to the resident, was very painful to the touch. RN #1 did not change his gloves between touching the dirty and the clean ostomy appliances. RN #1 did not have dedicated clean ostomy care scissors in his possession. RN #1 used Resident #4's scissors, which were sitting on her bedside table to cut the ostomy supplies. RN #1 proceeded to apply a new ostomy appliance to Resident #4's ostomy site. When he had completed the procedure, RN#1 disposed of the used ostomy bag in the trash and removed it from the room. -RN #1 did not clean the resident's scissors before use. -RN #1 did not follow the physician's treatment orders to apply skin prep to the surrounding ostomy stoma area and use nystatin powder to the area. -RN #1 did not use a wound cleanser to clean the stoma area before applying the new ostomy appliance. -RN #1 did not wash his hands with soap and water after the ostomy treatment was completed. D. Record review Review of Resident #4's ostomy care plan, initiated 2/10/25, revealed the resident had an alteration in gastro-intestinal status related to an ileostomy. Interventions included ileostomy care every shift and as needed, checking the ostomy bag and assisting the resident in emptying if warranted, monitoring the ileostomy site for signs and symptoms of infection and notifying the physician of concerns every shift (initiated 2/10/25), monitoring vital signs as ordered and recording and notifying the physician of significant abnormalities such as rapid pulse, shallow, rapid or labored respirations, low blood pressure (initiated 2/10/25), obtaining and monitoring laboratory or diagnostic work as ordered and reporting results to the doctor and following up as indicated (initiated 2/10/25), ostomy wafer changes were to gently cleanse area around stoma, pat dry, apply skin prep to area, cut hole in wafer to fit the size of stoma, attach drainage bag, wafer/bag size 2 3/4 every day shift on scheduled days (initiated 2/10/25). Review of Resident #4's October 2025 CPO revealed the following physician's orders: Ostomy Care - Cleanse with wound cleanser, pat dry, apply nystatin powder to wound bed, leave open to air, every shift for skin integrity. Monitor for signs and symptoms of infection or worsening, if present notify provider, ordered 10/20/25. Ostomy Wafer Changes: gently cleanse area around stoma, pat dry, apply skin prep to area, cut hole in wafer to fit the size of stoma, attach drainage bag every day shift every Monday, Wednesday and Friday, ordered 10/3/25. II. Staff interviews RN #1 was interviewed on 10/21/25 at 10:35 a.m. RN #1 said the nurses were supposed to assess Resident #4's skin every day the ostomy bag and appliance were changed. He said the ostomy appliance needed to be changed every day. RN #1 said it was the nurse's responsibility to check the treatment order before changing the ostomy bag to</p>		