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	01/15/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide response, action and rational to residents involved in group grievances. Specifically, the facility failed to address and document resolutions to resident concerns brought up in the resident council meetings in a timely manner.Findings include I. Facility policy and procedure The Grievance policy, dated 10/15/25, was provided by the nursing home administrator (NHA) on 1/15/26 at 3:40 p.m. It revealed in pertinent part, It is policy of this facility to establish a grievance process to address resident concerns without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been finished as well as that which has not been furnished, the behavior of staff and of other residents; other concerns regarding their facility stay; and make prompt efforts to resolve grievances the resident may have. General concerns may be voiced at resident and/or family council meetings. II. Group interview A group interview was conducted on 1/14/26 at 2:00 p.m. with six residents (#7, #18, #26, #45, #60 and #68). The residents were interviewable per the facility and assessment. Resident #18, Resident #7 and Resident #60 said they did not feel the facility followed up on their concerns. Resident #18 said she felt like the response time was too long. III. Record review Facility grievances from resident council meetings were provided by the NHA on 1/15/26 at 10:30 a.m. The grievances were reviewed and revealed the following: A 10/25/25 resident council grievance documented a concern that the meat had been hard to cut and requested could the facility work on that. The description of the resolution documented the dietary director would work with the dietary staff to make sure all meats were soft and tender. A 11/19/25 resident council grievance documented a concern the residents voice food had improved but they would like to continue seeing improvements. The resolution documented the dietary manager continued to monitor and improve. A 12/17/25 resident council documented that a resident would like to have the channel TMC on 26 and not ABC, residents would like to have access to [NAME] through Hulu and go to the art museum. The resolution documented maintenance staff changed the channels to TMC and residents had Hulu and [NAME] available now. The aquarium was scheduled on 1/29/26. -However, the 10/25/25, 11/19/25 and 12/17/25 grievances failed to document that the facility followed up with residents regarding the resolutions to the grievances or discussed the resolutions at the next resident council meetings. III. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 1/15/26 at 1:00 p.m. CNA #5 said grievance forms were around the corner from the elevator. CNA #5 said sometimes the residents would tell her they were unhappy with the food. CNA #5 said the kitchen did have alternate items for residents to choose from if they did not like something but she did not typically fill out a grievance for a resident's food complaints. The NHA was interviewed on 1/15/26 at 6:15 p.m. The NHA said grievances were followed up on by department heads. The NHA said the facility did document their resolution and follow up with residents but did not document the resolution for the resident council grievances (see above). The NHA said grievances were reviewed daily at the morning meeting.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of diseases and infection on two of five units. Specifically, the facility failed to;-Ensure housekeeping staff followed proper cleaning procedures for cleaning and disinfecting resident rooms and high-frequency touched areas (door handles, call lights, and bedside tables);-Ensure areas were cleaned from clean to dirty areas;-Ensure surface disinfectant dwell times (the amount of time a disinfectant needs to remain wet on a surface to effectively kill germs) were followed;-Ensure hand hygiene was performed appropriately during the cleaning of residents' rooms; and, -Failure to use appropriate PPE during wound care for enhanced barrier precautions.Findings include: I. Housekeeping failures A. Professional reference According to The Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24), retrieved on 1/20/26 from https://www.cdc.gov.healthcare-associated-infections/hcp/cleaning-global/procedures.html. Wipe surfaces using the general strategies, such as cleaning from dirty areas, high to low, in a systematic manner, making sure to use mechanical action for cleaning steps, and making sure that the surface is thoroughly wetted to allow the required contact time. According to The Centers for Disease Control (CDC) Clinical Safety Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 1/20/26 from https:/www.cdc.gov/clean-hands/hcp/clincial-safety/ Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with soap and water, alcohol-based foam, or alcohol-based hand sanitizer. Cleaning your hands reduces the potential spread of deadly germs to patients, including those resistant to antibiotics. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or patient's surroundings. Always clean your hands after removing gloves. The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward, and facility. Examples of high-touch surfaces include bedrails, intravenous poles, sink handles, bedside edges, privacy edges, call bells, light switches, and doorknobs. B. Manufacturer's recommendations The Sunburst product specification document for Sani-Clean 2 disinfectant was provided by the housekeeping supervisor on 1/15/26 at 3:28 p.m. It read in pertinent part, Wet all surfaces thoroughly with a mop, cloth, or sprayer. Allow surface to remain wet for the required time (1 to 10 minutes). C. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Safe and Homelike Environment policy, dated 10/25/25, was provided by the nursing home administrator (NHA) on 1/15/26 at 4:45 p.m. It read in pertinent part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used to complete activities of daily living. The Daily Room Checklist, not dated, was provided by the housekeeping supervisor on 1/15/26 at 3:28 p.m. It read in pertinent part, Clean and disinfect the bathroom thoroughly, including the toilet, sink, and other fixtures. Follow proper dwell times for each chemical used. Clean and disinfect all reachable flat surfaces, avoiding moving the resident's personal items unless requested. D. Observations On 1/14/26 at 8:45 a.m., housekeeper (HK) #1 was observed cleaning a double occupancy room on the fourth floor. HK #1 donned (put on) gloves without performing hand hygiene and entered the resident's room with two spray bottle containers labeled Sani-Clean 2, and Spray Kleen. She placed the Sani-Clean disinfectant on the sink counter, sprayed the mirror with the Spray Kleen, and immediately wiped it with a small blue towel from her pocket. HK #1 went to her cart, disposed of the blue cleaning rag, took a new cleaning rag, and returned to the residents' room. She sprayed the sink area with the disinfectant labeled Sani Clean 2, and immediately wiped it with a clean blue rag. She went back to her cart and placed the glass cleaner back on the cart. HK #1 removed her gloves and donned a new pair of gloves without performing hand hygiene. She grabbed a container with a cleaning brush labeled Tub and Tile Cleaner and the Sani-Clean spray bottle and went to the residents' bathroom. She placed the container with the brush on the floor and sprayed the surfaces of the toilet with Sani-Clean 2, then immediately used a purple cleaning rag to wipe it down from top to bottom. HK #1 picked up the brush from the container and began cleaning the inside of the toilet bowl. She continued cleaning the inside of the bowl, the top of the seat and the outside around the back of the toilet with the same brush. She sprayed two grab bars in the residents' bathroom. She returned to her cart, placed the tub and tile container, and Sani-Clean 2 sprayer into it. She removed her gloves and donned a new pair. HK #1 retrieved her broom and dustpan from her cart. She swept the floor on side two of the room with the broom. She swept under the bed and around the resident's bedside, then moved the bedside table and swept the corner of the bed between the bed and the bedside dresser. HK #1 then proceeded to side one of the room and swept the floor. -HK #1 did not perform hand hygiene before and after removing gloves. -HK #1 did not allow the disinfectant solution to remain wet on the surfaces for the manufacturer's recommended dwell time (1 to 10 minutes). HK #1 obtained a clean mop rag and mop stick from the cleaning cart and mopped the floor under the bed and towards the second side of the room. She continued to mop the floor towards the first side of the residents' room with the same mop head. HK #1 removed the mop head and stored it in a rag (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plastic bag alongside the mop stick. She removed her gloves and placed a wet floor sign in front of the resident's door. The HK then applied alcohol based hand sanitizer. -HK #1 used the same mop head to mop sides one and two of the residents' room. -HK #1 failed to disinfect and clean high-frequency touched areas, such as call lights, door handles, light switches and headboards of the residents' room. On 1/15/26 at 11:28 a.m. HK #2 was observed cleaning room [ROOM NUMBER], a double occupancy room. HK #2 donned gloves without performing hand hygiene. HK #2 entered room [ROOM NUMBER] and began spraying the entire surface of the toilet with Sani-Clean disinfectant cleaner, then immediately wiped it down with a purple cleaning rag she had in her hand. HK #2 removed a toilet riser from the resident's toilet and placed it in the middle of the resident's room to make room to clean other parts of the resident's toilet. She returned to the cleaning cart and grabbed a container labeled tub and tile all-purpose cleaner and a container with two cleaning brushes. HK #2 held the bathroom door handle to return to the bathroom to finish cleaning it. HK #2 grabbed a long green brush from the container and began cleaning the toilet bowl. She cleaned the inside and used the same brush to clean the outside of the toilet bowl. She placed the brush in the tub and tile container and continued to wipe down with the same cleaning rag. She used the same rag to clean the underside of the toilet seat, the rim of the toilet, then the top of the toilet seat, and the basin. HK #2 placed the toilet brush back in the cleaning cart without disinfecting it. -HK #2 failed to clean from the cleanest area to the dirtiest -HK failed to perform hand hygiene after her hands became contaminated. HK #2 grabbed a mop head and placed it on the floor by the bedside of bed two and began mopping that side. HK #2 used the same mop pad to mop the first side of the room. HK #2 retrieved a new mop head and put it on the bathroom floor, and mopped the bathroom. She returned to her cart, placed the mop head and stick away, removed her gloves and performed hand hygiene. After finishing the room, HK #2 realized the toilet commode was sitting in the middle of the resident's room. HK #2 retrieved the Sani-Clean disinfectant, without wearing gloves she sprayed the commode and immediately wiped it down with a cleaning rag. She placed it back in the bathroom. She returned to her cart and performed hand hygiene with alcohol-based hand sanitizer. -HK #2 failed to clean high-frequency touched areas. -Failed to sweep the resident's room before mopping the bedroom floor. The floor had debris on it. -HK #2 failed to follow the dwell time for the Sani-Clean 2 and the tub and tile disinfectant E. Staff interviews HK #2 was interviewed on 1/15/26 at 12:15 p.m. HK #2 said it was okay to use the same brush to clean the inside of the toilet bowl and the outside to remove hard-tickened substances. HK #2 said (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she should have performed hand hygiene and changed her gloves more often. She said she should perform hand hygiene between tasks, but she forgot. HK #2 said she should have put on gloves to clean the toilet commode. The infection preventionist (IP) was interviewed on 1/15/26 at 12:35 p.m. The IP said HK #1 and HK #2 should have worn gloves at all times while cleaning the residents' rooms. The IP said the housekeepers should have changed gloves frequently and performed hand hygiene between dirty and clean tasks. The IP said HK #2 should have washed her hands with soap and water after cleaning the resident toilet commode without gloves. The IP said HK's should not clean inside the toilet bowl and the outside with the same brush to prevent the spread of harmful germs. The IP said it was important to keep surfaces wet for at least three minutes to allow the chemical to work, according to the manufacturer's recommendation. She said the housekeepers should always clean from the cleanest to the dirtiest. The IP said she would ensure education was provided to the HK's immediately to prevent the spread of harmful germs. The housekeeping supervisor was interviewed on 1/15/26 at 1:20 p.m. The housekeeping supervisor said HK #1 and HK #2 received education and performance evaluation to follow the facility's housekeeping policy and procedures. The housekeeping supervisor said HK #2 should have swept the resident's room before mopping the floor. She said both HK's would immediately receive education to ensure proper hand hygiene and appropriate infection control measures were followed during housekeeping procedures. II. EBP failures A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 1/27/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. A. Resident interview Resident #5 was interviewed on 1/12/26 at 10:05 a.m. Resident#5 said he had an ulcer on the bottom (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of his foot. B. Observation On 1/14/26 at 10:10 a.m. the IP entered Resident #5's room to perform wound care. She put on gloves. She did not put on a gown to perform Resident #5's wound care. , C. Staff interviews The IP was interviewed on 1/14/26 at 10:30 a.m. The IP said she forgot to put her gown on. She said she realized she forgot to put her gown on when she left his room. She said she would gown and glove for any treatments for enhanced barrier precautions. The medical director was interviewed on 1/15/26 at 9:30 a.m. The medical director said Resident #5 had a right heel pressure injury.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#21) of one resident out of 46 sample residents were provided prompt efforts by the facility to resolve a grievance. Specifically, the facility failed to complete and provide prompt resolution to grievances for Resident #21.Findings include: I. Facility policy and procedure The Grievance policy and procedure, revised 10/15/25, was provided by the nursing home administrator (NHA) on 1/15/26 at 3:40 p.m. It read in pertinent part, It is the policy of the facility to establish a grievance process to address residents' concerns without fear of discrimination or reprisal, make prompt efforts to resolve grievances the resident may have. The grievance official completes the Grievance resolution forms and takes appropriate corrective action in accordance with State law if the alleged violation of the resident's rights is confirmed by the facility or an outside entity having jurisdiction. II. Resident #21 A. Resident status Resident #21, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician order (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), fibromyalgia, dependence on supplementary oxygen, depressive disorder, presence of a cardiac pacemaker, and personal history of transient ischemic attack (TIA). The 1/2/26 minimum data set (MDS) assessment revealed the resident was cognitively intact, with a brief interview for mental status score (BIMS) of 14 out of 15. She required partial/moderate assistance with toileting and personal hygiene. B. Resident interview Resident #21 was interviewed on 1/13/26 at 2:46 p.m. Resident #21 said she reported that she was missing her portable oxygen tank to the NHA over three months ago. She said she has not received any resolution to the issue. Resident #21 said the original tank had not been found and she personally informed the NHA. She said the NHA had done nothing about it, so she stopped talking about it. Resident #21 said the NHA did not discuss with her what action they would take to rectify the situation. C. Record Review A review of the facility's grievance forms for Resident #21 over the previous six months revealed no records of any grievances filed by the resident. D. Staff interviews Registered nurse (RN) #2 was interviewed on 1/14/26 at 2:03 p.m. RN #2 said all nursing staff were responsible for reporting grievances to their supervisor. RN #2 said she would assist the resident in resolving any grievance reported to her and, if unable to resolve the issue, would immediately inform her supervisor. RN #2 said she thought the grievance forms were only for reporting abuse incidents.The NHA was interviewed on 1/14/26 at 4:14 p.m. The NHA said that grievance forms were located on each nurse's station by the facility's elevators. He said the facility staff were trained to handle grievances by providing residents with the form and assisting them in completing it and by immediately reporting them to the grievance official. The NHA said Resident #21 had informed him about the missing portable oxygen tank several months ago. The NHA said he was unable to locate the tank since the facility was under new management. He said the resident was currently using a facility-acquired tank when needed. The NHA said he did not file out a grievance form when he became aware of the missing tank. He said he should have filed one out immediately when he became aware.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#23) of three residents reviewed for accidents out of 46 sample residents received adequate supervision to decrease and/or prevent risk for accident hazards. Specifically, the facility failed to reassess Resident #23 for safe smoking practices. Findings include: I. Resident status Resident #23, age less than 65, was admitted on [DATE] and re-admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included chronic respiratory failure with hypoxia (not enough oxygen in the blood), congestive heart failure, anxiety, chronic kidney disease (kidneys did not effectively filter waste), obstructive sleep apnea (sleeping disorder where breathing stops due to an obstructed airway) and the presence of automatic (implantable) cardiac defibrillator (device to monitor heart rhythms). The 11/11/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She needed substantial or moderate assistance with activities of daily living and was independent at meals. II. Observations On 1/14/26 at 10:19 a.m. Resident #23 was in her room seated in her wheelchair. She placed a blanket over her lap and removed her oxygen cannula (flexible tube that delivers oxygen to the nostrils). She exited her room (while in her wheelchair) and took the elevator to the first floor. At 10:25 a.m. Resident #23 was talking to an unidentified staff member inside near the facility exit door that led to the outdoor smoking patio. The staff member asked the resident if she needed her oxygen. Resident #23 responded she did not wear her oxygen outside to smoke. Resident #23 exited the building. At 10:27 a.m. Resident #23 was outside, had a cigarette in her hand and self-propelled her wheelchair toward the sidewalk and away from the facility. III. Record review Resident #23's smoking care plan, initiated 6/7/25 and revised 9/12/25, documented she had the potential for injury related to smoking. Pertinent interventions, initiated 9/12/25, included to complete a smoking assessment as needed; educate the resident on safe smoking practices; education was to be provided to the resident regarding the health complications related to smoking; and explain the smoking policy. -However, Resident #23's smoking assessment was completed 5/10/25 and the facility failed to complete additional smoking assessments until 1/14/26 (during the survey). The 5/10/25 smoking evaluation documented the resident smoked five times a day, utilized oxygen, safely lit smoking materials, held smoking materials safely and disposed of smoking materials appropriately. The evaluation also documented that a plan of care was used to assure the resident was safe while smoking. -However, the care plan's intervention to complete a smoking assessment as needed was not implemented after 5/10/25. A review of Resident #23's electronic medical record (EMR) revealed the following: A 6/5/25 nursing note documented Resident #23 left the facility at 12:00 p.m. to a local hospital for a procedure. A 6/6/25 nursing note documented Resident #23 returned from the hospital. A 7/22/25 physician note documented the resident was counseled that smoking was not advised. An 8/14/25 activities note documented Resident #23 liked to go outside and smoke or just hang out with friends. An 8/21/25 nurse practitioner (NP) note documented the resident was seen at request of nursing for chest pain that was ongoing for four to five days. The resident was sitting in her wheelchair, having just returned from smoking. An 8/29/25 physician note documented the resident was seen later smoking and discussed with her it was a significant risk to her heart and overall health. The resident stated she was cutting back. A 10/24/25 physician note documented the resident continued heavy cigarette smoking and to continue on 4 L (liters) nasal cannula. An 11/10/25 social services note documented the social services director (SSD) met with the resident who wanted more information and resources on quitting smoking. The SSD went over support services with the resident that included options for a nicotine patch which the resident expressed interest in. The SSD reached out to the resident's attending physician as well as the nursing team to inform them of the resident's desire (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to quit smoking and utilize nicotine patches through this process. An 11/11/25 activities note documented the resident liked to go outside and smoke or just hang out with friends. IV. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 1/15/26 at 1:00 p.m. CNA #5 said Resident #23 did smoke. CNA #5 said Resident #5 left her oxygen in her room when she went outside to smoke. CNA #5 said Resident #23 did attempt to stop smoking for about three days but continued to smoke after that. Licensed practical nurse (LPN) #5 said a smoking assessment was done upon admission to the facility and monthly. LPN #5 said if the resident was hospitalized , a smoking assessment would be completed again upon the resident's return to the facility. -However, Resident #23 did not have a smoking evaluation completed after her return from the hospital and re-admission to the facility on 6/6/25 (see EMR review above). Registered nurse (RN) #2 was interviewed on 1/15/26 at 4:30 p.m. RN #2 said they filled out a smoking assessment upon admission and then another one either a week later or three days in a row when they admit. She said she could not remember the exact protocol, but knew they did it multiple times when a resident first admitted because sometimes people change their mind about smoking. RN #2 said the smoking evaluation was triggered to be filled out quarterly and was completed by a nurse. RN #2 said if residents wanted to quit smoking, and used the patch or were still smoking, a smoking evaluation would be completed. The director of nursing (DON) and nursing home administrator (NHA) were interviewed together on 1/15/26 at 5:00 p.m. The DON said a smoking evaluation could be scheduled and assessment could then be triggered to be completed automatically. The DON said Resident #23's smoking evaluation was not triggered and he was unsure why. The NHA said smoking evaluations were completed for residents who expressed a desire to smoke, or could have been observed smoking. The NHA said facility nurses completed the smoking evaluations. The social services director (SSD) was interviewed on 1/15/26 at 5:30 p.m. The SSD said the importance of the smoking evaluation was to determine whether or not the resident needed assistance or supervision.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for two (#2 and #1) of three residents reviewed for dialysis out of 46 sample residents. Specifically, the facility failed to:-Ensure Resident #2's blood pressure was taken post dialysis treatment according to the physician's order and resident's comprehensive care plan; and,-Ensure the facility followed up on Resident #1's dialysis facility's fluid restriction recommendation on the dialysis communication form.Findings include: I. Facility dialysis contract The Outpatient Dialysis Services Care Coordination Agreement, signed on 8/27/24, provided by the nursing home administrator (NHA) on 1/12/26 read in pertinent part, For the purposes of care coordination, in advance of each resident's dialysis treatment, the long term care facility shall furnish all information and documentation necessary for the dialysis facility to provide safe and appropriate care, including any and all information reasonably requested by the dialysis facility. The long term care facility shall ensure that all renal dialysis services to be furnished to residents, including drugs, biologicals and laboratory tests furnished in the long term care facility are furnished by, or in coordination with the dialysis facility. II. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (partial or total paralysis) affecting right dominant side, end stage renal disease (permanent kidney failure), dependence on renal dialysis (process to filter wastes from the body), and hypertension (high blood pressure). The 11/4/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required substantial to maximum assistance for activities of daily living (ADL). The MDS assessment documented the resident received dialysis treatment. B. Record review Resident #2's dialysis care plan, initiated 8/8/24, documented the resident required hemodialysis due to a diagnosis of renal failure. Pertinent interventions included to obtain vital signs and weight and report significant changes in pulse, respirations and blood pressure immediately (initiated 8/8/24) and to obtain blood pressure upon return from dialysis (initiated 10/22/24). A review of Resident #2's CPO revealed the following orders: -Resident attended dialysis; the chair time was at 6:20 a.m. on Monday, Wednesday, and Friday, ordered 8/25/25. (continued on next page)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide adequate outside ventilation by means of windows and/or mechanical ventilation for five of eight resident bathrooms. Specifically, the facility failed to ensure the exhaust fans in five resident bathrooms were functioning.Findings include: I. Facility policy and procedure The Safe and Homelike Environment policy, revised 10/25/25, was provided by the nursing home administrator (NHA) on 1/15/26 at 4:45 p.m. It read in pertinent part, In accordance with the resident's rights, the facility would provide a safe, clean, comfortable, and homelike environment. Environment refers to any environment in the facility that is frequented by residents, including but not limited to the residents, rooms, bathrooms, hallways, dining areas, lobbies, outdoors, patios, therapy areas, and activity areas. II. Observations An observation of the facility was completed with the maintenance director on 1/14/26 at 3:40 p.m. To check the function of each exhaust fan, a small square of single-ply toilet paper was placed against the vent in room [ROOM NUMBER], #318, #416, #510, and #511. The exhaust fans were unable to hold the toilet tissue in place, indicating they were not functioning at that moment. None of the bathrooms had windows and the vents were not functioning.III. Staff interviews The maintenance director was interviewed on 1/14/26 at 4:05 p.m. The maintenance director said he monitored the motor operation of the vents once a month and immediately fixed any concerns that arose from his review. The maintenance director said he was not aware of the broken vents in the resident bathrooms. He said it not only moves air but also removes moisture, odors, and pollutants from the building, allowing residents to breathe fresh air. The maintenance director said it was important to ensure that all vents are functioning properly. The maintenance director was interviewed again on 1/15/26 at 11:20 a.m. He said upon reviewing the facility's ventilation fan, he noticed one of the roof-mounted ventilation motors was broken. He said he had placed an order for the parts and would replace it as soon as they arrived at the facility.